

YOUTH MENTAL HEALTH FIRST AID

A manual for adults assisting young people

Fourth Edition

Claire Kelly, Betty Kitchener and Anthony Jorm

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The Mental Health First Aid Program

About the Program

In 2000, the Mental Health First Aid Program was created in Canberra, Australia, by Betty Kitchener, an educator and mental health consumer, in partnership with Professor Tony Jorm, a mental health researcher. The aim in creating the program was to extend the concept of first aid training to include mental health problems so that community members were empowered to provide better initial support to someone who is developing a mental health problem, has a worsening of an existing mental health problem or is in a mental health crisis.

The Mental Health First Aid Program is run by Mental Health First Aid International, trading as Mental Health First Aid Australia, which is a not-for-profit company. A distinctive feature of the Mental Health First Aid Program has been the way it has been disseminated. It trains instructors for a fee, who then deliver courses either for their employing organisation (such as an area health service or non-government organisation) or as part of their own business. Mental Health First Aid Australia does not employ the instructors, but continues to provide them with ongoing support. This approach has led to stronger local support than would have been possible if all Mental Health First Aid courses were run by a single national organisation. By 2016, there were over 1300 instructors across Australia and over 400,000 people had received Mental Health First Aid training.

The Mental Health First Aid Program first went outside Australia in 2003 when it was adopted by the Scottish government. Since then, it has gradually spread to many other countries, with 1.7 million people trained by the end of 2016. The countries where Mental Health First Aid training is operating include Bermuda, Canada, Denmark, England, Finland, Hong Kong, Ireland, Japan, Malta, Nepal, Netherlands, New Zealand, Northern Ireland, Pakistan, Portugal, Saudi Arabia, Scotland, Singapore, Sweden, USA and Wales. When the Mental Health First Aid Program was adopted in these countries, either a mental health government agency or a non-government mental health organisation tailored the Mental Health First Aid Australia course materials to their own culture and health system, and worked out the method of dissemination best suited to local conditions. Further details of the international spread of the Mental Health First Aid Program, including licensing arrangements, can be found at: www.mhfa.com.au.

An important factor in the Mental Health First Aid Program's international spread has been the continuing attention to research and evaluation. All course content is as evidence-based as possible and many evaluation studies have been conducted. A range of studies, including randomised controlled trials, have shown that Mental Health First Aid training improves knowledge, reduces stigmatising attitudes, and increases first aid actions towards people with mental health problems.[1] Summaries of these evaluation studies can be found at the Mental Health First Aid Australia website: www.mhfa.com.au.

Youth Mental Health First Aid Course and Manual

The manual has been written to accompany the 14-hour Youth Mental Health First Aid course. The course is designed for adults assisting adolescents. Although there are a number of definitions of adolescence, we generally define this group as those aged between 12 and 18. However, adolescence can start earlier than 12 years and can continue through to the early 20s, so this course could be relevant when helping people who are a little younger or older. The age of 18 also has particular social meanings. Most people complete secondary education at this age, and in Australia, the purchase and consumption of alcohol become legal. When using this manual, first aiders need to use good judgment about whether the information is going to be appropriate for helping a person outside of the age range specified.

The course is designed for members of the public who have frequent contact with young people, for example, parents and guardians, school staff, sports coaches and youth workers. It is most relevant in situations when it is first becoming apparent to an adult that a young person in their family, classroom or other network is developing a mental health problem. However, the course may also provide some useful information on how to assist a young person who has a history of a mental illness or longer-term mental health problems.

Youth Mental Health First Aid also runs in Canada, China, England, Hong Kong, Scotland, Singapore, Sweden and the USA.

The Youth Mental Health First Aid course has been evaluated in a number of studies and found to increase knowledge about adolescent mental health, increase confidence in offering help, decrease stigmatising attitudes and improve application of the Mental Aid First Aid Action Plan.[2, 3]

The mental health first aid actions recommended in this manual are in accordance with international Mental Health First Aid Guidelines that have been developed and updated by researchers in Australia since 2005. These guidelines were developed using the consensus of expert panels of mental health consumers, carers and professionals from developed English-speaking countries. Further details of the guidelines and their development can be found under the 'Resources' and 'Research' menus of the MHFA Australia website: www.mhfa.com.au.

The 4th edition manual contains updated statistical information on mental health problems in young people and incorporates the latest evidence on treatments and services available for them. It also includes newly developed guidelines for communicating with Aboriginal and Torres Strait Islander and LGBTIQ young people with mental health problems, and updated guidelines on how to assist a young person who is suicidal or engaging in non-suicidal self-injury.

Important Note:

The Youth Mental Health First Aid Course and Manual were not developed for use by adolescents themselves. The role of a first aider can be a demanding one, and an adolescent may not have the cognitive and emotional maturity to carry out first aid actions safely. They may try to take on too much, offering counselling to a friend, or may feel trapped and overwhelmed when asked to keep a secret. The *teen Mental Health First Aid* program (see below) fills the need for adolescents themselves to learn the skills to assist each other to seek appropriate help.

Other Mental Health First Aid Courses

A number of other courses and manuals have been developed to suit specific groups within the Australian population.

The *Standard Mental Health First Aid* course looks at developing mental health problems and mental health crises in adults and how someone can provide assistance.

The *teen Mental Health First Aid* course is a program teaching adolescents how to support a friend who is experiencing mental health problems. This course runs over three classroom sessions and emphasises the importance of getting an adult involved as quickly as possible. There are two versions of the course; one for students in Years 7-9 and the other for students in Years 10-12.

The *Mental Health First Aid for the Older Person* course is designed for members of the public to learn how to assist an older person, including a person experiencing confusion or dementia.

The *Aboriginal and Torres Strait Islander Mental Health First Aid* course is suitable for anyone who lives or works in the community with Aboriginal and Torres Strait Islander people, regardless of their own background.

There are also manuals for Vietnamese and Chinese Australians: the *Vietnamese Mental Health First Aid Manual* and the *Mental Health First Aid Manual for Chinese People Living in Australia.*

eLearning and blended versions of some Mental Health First Aid courses are available, primarily tailored to specific professional groups.

Disclaimer

The information provided in this course is for mental health first aid use only and is not intended to be and should not be relied upon as a substitute for professional mental health advice.

MENTAL HEALTH FIRST AID AUSTRALIA

Mental Health First Aid Website

Up-to-date information about the program can be found on the website:

www.mhfa.com.au

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We wish to also thank Kathy Bond and Fiona Blee for additional support in finalising this manual.

The artwork in this manual has been contributed by young people with mental health problems, who have given permission for the images to be reproduced.

The Mental Health First Aid logo combines the international symbol for first aid with the flannel flower. The flannel flower is an Australian native flower chosen by Mental Health Australia as a symbol of mental health.

TABLE OF CONTENTS

The Mental Health First Aid Program iii
Acknowledgements vi
Section 1: Introduction to Mental Health Problems and Mental Health First Aid 1
1.1 Mental Health Problems in Australian Youth 1
What is mental health? 2
What are mental health problems? 2
How common are mental illnesses in young people? 3
Impact of mental illnesses 4
Professionals who can help 7
Self-help strategies and young people 11
1.2 Adolescent Development 12
Definition of adolescence 13
Changes during adolescent development 13
The relationship between mental health problems and adolescent development 15
1.3 Mental Health First Aid and Young People 18
Why mental health first aid for young people? 19
The Mental Health First Aid Action Plan 20
Things that a first aider needs to know to help a young person 23
How to communicate effectively with young people 26
Helpful resources for young people with mental illness and the adults who care for them 31

Section 2: First Aid for Developing Mental Health Problems in Young People 33
2.1 Depression in Young People 34
What is depression? 35
Bipolar disorder 36
Risk factors for depression 37
Interventions for depressive disorders 38
Importance of early intervention for depression 41
The Mental Health First Aid Action Plan for Depression 43
Helpful resources for depression and suicidal thoughts in young people 50
2.2 Anxiety Problems in Young People 52
What are anxiety problems? 53
What are anxiety disorders? 54
Risk factors for anxiety disorders 58
Interventions for anxiety disorders 59
Importance of early intervention for anxiety disorders 60
The Mental Health First Aid Action Plan for Anxiety Problems 62
Helpful resources for anxiety problems in young people 65

2.3 Eating Disorders in Young People 68
What are eating disorders? 69
Types of eating disorders 70
Risk factors for eating disorders 73
Interventions for eating disorders 74
Importance of early intervention for eating disorders 75
The Mental Health First Aid Action Plan for Eating Disorders 77
Helpful resources for eating disorders in young people 81
2.4 Psychosis in Young People 82
What is psychosis? 83
Mental illnesses where psychosis can occur 84
Risk factors for psychotic disorders 87
Interventions for psychotic disorders 88
Importance of early intervention for psychosis 90
The Mental Health First Aid Action Plan for Psychosis 92
Helpful resources for Psychosis in young people 97
2.5 Substance Use Problems in Young People 100
What are substance use problems? 101
What are substance use disorders? 102
Alcohol use problems 102
Drug use problems 104
Risk factors for adolescent substance use problems 107
Interventions for substance use problems 108
The importance of early intervention for substance use problems 109
The Mental Health First Aid Action Plan for Substance Use Problems 111
Helpful resources for substance use problems in young people 116

Section 3: First Aid for Mental Health Crises **119**

3.1 First Aid for Suicidal Thoughts and Behaviours 121
3.2 First Aid for Non-suicidal Self-injury 129
3.3 First Aid for Panic Attacks 135
3.4 First Aid for Adults Affected by a Traumatic Event 137
3.5 First Aid for Children Affected by a Traumatic Event 142
3.6 First Aid for Severe Psychotic States 147
3.7 First Aid for Severe Effects from Alcohol Use 149
3.8 First Aid for Severe Effects from Drug Use 153
3.9 First Aid for Aggressive Behaviours 157

APPENDIX 1 159
Cultural Considerations and Communication Techniques in Providing a Mental Health First Aid to a Young Aboriginal or Torres Strait Islander Person

APPENDIX 2 170
Considerations When Providing Mental Health First Aid to a Young LGBTIQ Person

APPENDIX 3 179
Mandatory Reporting of Abuse

References 180

Introduction to Mental Health Problems and Mental Health First Aid

1



Macabre Madonna
"An image conveying my state of being, emotionless – almost as if I was half machine. Delving into humanity, and finding no connection between the way I am and the way I'm supposed to be." **Kamila K**

1.1 Mental Health Problems in Australian Youth

What is mental health?

There are different ways of defining the term 'mental health'. Some definitions emphasise positive psychological well-being, whereas others see it as the absence of mental health problems.

For example, the World Health Organization has defined mental health as:

"… a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."[4]

In this manual, **mental health** is seen as a continuum, ranging from having good mental health to having mental illness. A person will vary in their position along this continuum at different points in their life. A young person with good mental health will feel in control of their emotions, have good cognitive functioning and positive interactions with people around them. This state allows a person to perform well in their studies and in family and other social relationships.

What are mental health problems?

A variety of terms are used to describe mental health problems: mental illness, mental ill-health, mental health condition, psychiatric illness, nervous exhaustion, mental breakdown, nervous breakdown, and burnout. Slang terms such as crazy, psycho, mad, loony, nuts, cracked up and wacko promote stigmatising attitudes and should not be used.

These terms do not give much information about what the person is really experiencing. A **mental disorder** or **mental illness** is an illness that affects a person's thinking, emotional state and behaviour, and disrupts the person's ability to work or carry out other daily activities and engage in satisfying personal relationships.[5] Some people have only one episode of mental illness in their lifetime, while others have multiple episodes and periods of wellness in between. Only a small minority have ongoing mental health problems.

There are different types of mental illnesses, some of which are common, such as depression and anxiety disorders, and some which are not common, such as schizophrenia and anorexia nervosa. However, mental illnesses, as with any health problem, cause disability, which is sometimes severe. This is not always well understood by people who have never experienced a mental illness.

A **mental health problem** is a broader term including both mental illnesses and symptoms of mental illnesses that may not be severe enough to warrant the diagnosis of a mental illness, as well as mental health-related crises such as having thoughts of suicide.

This manual provides information on how to assist people with mental health problems and not only those with diagnosable mental illnesses. There are so many different types of mental health problems that it is not possible to cover them all in this manual. The most common problems, as well as the most severe problems, are covered. However, it is important to note that the mental health first aid principles in this manual can be usefully applied to other mental health problems.

How common are mental illnesses in young people?

Mental illnesses are common in the Australian community, and young people are at highest risk.

The most recent National Survey of Mental Health and Wellbeing, a community survey of 8,841 people aged 16-85 years of age, living in private dwellings across Australia, found that one in five (20%) had a common mental illness (depressive, anxiety and/or substance use disorder) at some time during the previous 12 months (see table below).[6] This means that one in five Australians aged 16-85 suffer from some form of common mental illness in any year. This is equal to 3.2 million people.

Unfortunately, the National Survey did not report national figures on the rates of mental illnesses specifically in adolescents aged 12-17. However, the survey did include 1471 young people aged 16-24, which straddles both older adolescents and young adults. This group was found to be at the highest risk. More than one in four people in this age group were found to have one or more of the common mental illnesses. Shown below are the rates of common mental illnesses in this age group:

Percentage of Australians aged 16-24 with common mental illnesses in any one year [26]

Type of mental illness	Males	Females	All
Anxiety disorders	9.3%	21.7%	15.4%
Substance use disorders	15.5%	9.8%	12.7%
Depressive disorders	4.3%	8.4%	6.3%
Any common mental illness	**22.8%**	**30.1%**	**26.4%**

These results reflect the overall rates of mental illnesses in Australians aged 16-24 years. Research on specific sub-groups within the population may show higher or lower rates of common mental illnesses. For example, young people in foster care and young Aboriginal people are known to be at higher risk of anxiety and depression.[7-9]

Mental illnesses often occur in combination. For example, it is not unusual for a person with an anxiety disorder to also develop depression, or for a person who is depressed to misuse alcohol or other drugs, perhaps in an effort to self-medicate. Terms used to describe having more than one mental illness are *dual diagnosis, comorbidity* and *co-occurrence*.

The National Survey of Mental Health and Wellbeing did not cover every mental illness. Other research has found that 0.45% of Australian adults aged 18-64 have a psychotic disorder, such as schizophrenia, in any one year.[10] In a study of Australians aged 15 and over, the eating disorders anorexia nervosa and bulimia nervosa both affected less than 1% of people over the last three months, while binge eating disorder affected around 7%.[11]

Many young people with common mental illnesses do not seek any professional help. The National Survey found that professional help is received by only 23% of young people who have a common mental illness in the past year (49% of people with depressive disorders, 32% with anxiety disorders and 11% with substance use disorders).[12] Young people with more severe mental illnesses will generally get some sort of professional help, although there may be delays.

More recently, the Australian Child and Adolescent Survey of Mental Health and Wellbeing was carried out with children aged 4-11 years and adolescents aged 12-17 years.[13] The survey interviewed parents about mental

health problems in their children and covered some anxiety and depressive disorders. This survey provides an underestimate of how common these mental illnesses are, because the diagnosis was based on reports from parents, who may not have always been fully aware of their children's mental health problems, and it did not cover the full range of disorders. The survey found that, over the previous 12 months, 7% of 12-17 year olds had one of the anxiety disorders covered and 5% had a major depressive disorder.

Impact of mental illnesses

Mental illnesses often start in adolescence or early adulthood. In Australia, half of all people who experience a mental illness have their first episode by age 18 and three quarters by age 25.[12] When mental illnesses start at this stage in life, they can affect the young person's education, movement into adult occupational roles, forming of key social relationships including marriage, and the formation of health habits such as the use of alcohol and other drugs. Consequently, mental illnesses can cause disability across a person's lifespan. This is why it is so important to detect problems early and ensure the person is properly treated and supported.

Some illnesses have a major impact by causing premature death, while others are major causes of disability. Mental illnesses have their major impact on disability and medical experts rate them amongst the most disabling illnesses.[14] Disability refers to the amount of disruption a health problem causes to a person's ability to study or work, look after themselves, and carry on relationships with family and friends. However, because the disability caused by mental illnesses may not be readily visible to others, people with mental illnesses can be judged negatively. They may be incorrectly perceived as weak, lazy, selfish, uncooperative, attention-seeking or not really ill. This lack of understanding contributes to the stigma that people with mental illnesses can experience.

In recent years it has been recognised that mental illnesses are a major issue for Australia. The Australian Institute of Health and Welfare has concluded that in 2011 mental illnesses ranked as the third biggest source of disease burden in Australia after cancers and cardiovascular

Disease Burden in Australians aged 15-24, 2011[15]

Rank	Males	Females
1	Suicide and self-inflicted injuries	Anxiety disorders
2	Alcohol use disorders	Depressive disorders
3	Road traffic injuries	Asthma
4	Depressive disorders	Suicide and self-inflicted injuries
5	Asthma	Bipolar disorder
6	Anxiety disorders	Back pain and problems
7	Upper respiratory conditions	Upper respiratory conditions
8	Other musculoskeletal	Polycystic ovarian syndrome
9	Acne	Road traffic injuries
10	Back pain and problems	Alcohol use disorders

(heart) disease.[15] For young people aged 15-19 years, mental illnesses ranked as number one. *Disease burden* is the combined effect across the whole community of premature death and years lived with disability caused by an illness.

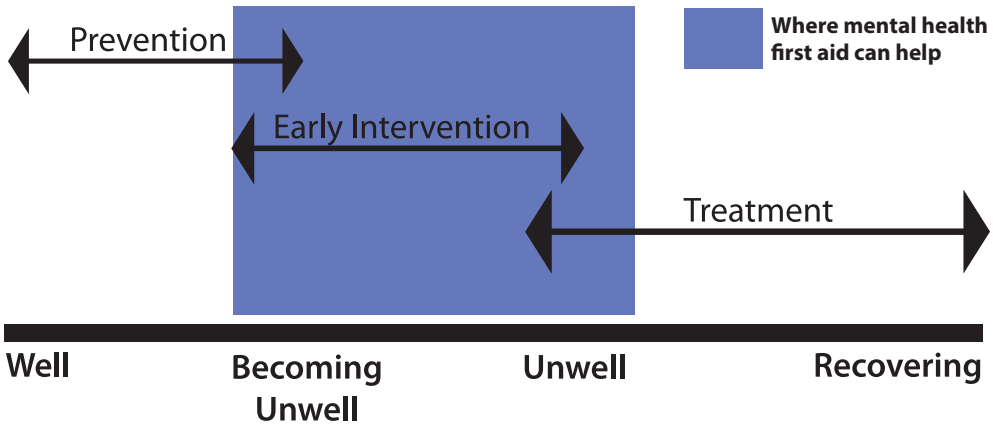
The table on previous page shows the ten leading specific illnesses causing disease burden in Australians aged 15-24. For males in this age group, four of the ten are mental illnesses and for females, five of the ten are mental illnesses.

There is all too often additional suffering caused by stigma and discrimination towards people with a mental illness. Because the disability caused by mental illnesses may not be readily visible to others, people with mental illnesses can be judged negatively. They may incorrectly perceived as weak, lazy, selfish, uncooperative, attention-seeking or not really ill. This lack of understanding contributes to the stigma that people with mental illness can experience. The community's attitudes toward mental illness should be fundamentally the same as approaches to physical illness.[16] People suffering from mental health problems need the respect and assistance of friends, family members and the broader community.

Spectrum of interventions for mental health problems

Society has a wide range of interventions for preventing mental health problems and helping people with mental illnesses. Mental health first aid is just one part of the spectrum of intervention. The diagram below illustrates different states of mental health, ranging from being well to developing mental health problems, to having a mental illness and to recovery. There are different types of interventions appropriate at these states of mental health. For the person who is well or with some mild symptoms, prevention programs are appropriate. For the person who is moving from mild mental health problems to a mental illness, early intervention programs such as Mental Health First Aid can be used. For a person who is very unwell with a mental illness, a range of treatment and support approaches are available, which will assist the person in their recovery process.

Where Mental Health First Aid fits in the spectrum of intervention



Prevention

Prevention programs are available to help everyone in the community, as well as targeted programs for people who are particularly at risk. Examples include parenting skills training, drug education and resilience training programs in schools, promotion of physical exercise to improve mood, stress management courses and policies to reduce stress in the workplace.

Early intervention

Early intervention programs target people with mental health problems and those who are just developing mental illnesses. They aim to prevent problems from becoming more serious and reduce the likelihood of secondary effects such as loss of employment, school dropout, relationship break-up and drug and alcohol problems. Many people have a long delay between developing a mental illness and receiving appropriate treatment and support. The longer people delay getting help and support, the more difficult their recovery can be.[17, 18] It is important that young people are supported by their family, friends, and teachers and other staff at school during this time. People are more likely to seek help if someone close to them suggests it.[19, 20] **It is during this early intervention phase that giving mental health first aid can play an important role.**

Treatment and supports

There are many different types of treatment and supports that can help people with mental illnesses function better and aid their recovery. Once the person has made the decision to seek help, they may choose from a number of helping sources, treatment approaches, and service settings. There is no 'one size fits all' approach for mental illnesses.

Medical treatments include various types of prescribed medications and other treatments given by a doctor.

Psychological therapies involve providing a supportive relationship and changing the way the person thinks or behaves. Usually it is talking face-to-face with a mental health professional, or sometimes in a group to address issues and to promote personal growth and coping skills. Self-help books and computerised psychological treatments are also available.

Complementary therapies and lifestyle changes involve using natural or alternative therapies and changing the way one lives. These can be used under the guidance of a health professional or as self-help. Care should be taken to ensure that the self-help strategies employed are evidence-based or have been recommended by an appropriate professional.

Support groups bring people with common problems together who share experiences and help each other. Participation in mutual aid self-help groups can help reduce feelings of isolation, increase knowledge, enhance coping skills, and bolster self-esteem.

Rehabilitation programs help people regain skills and confidence to live and work in their community.

Family and friends are a very important source of support for a person with a mental illness. Family and friends can help by having an understanding of the illness and providing the same support as they would if the person has a physical illness.

Mental Health First Aid can continue to play an important role in this period if relapses or crises occur. At such times, people need to be supported by those around them, in particular when no expert help is immediately available.

Professionals who can help

Young people often won't seek professional help on their own, because of embarrassment, a fear that the professional will think negatively about them, or negative attitudes of their own. Instead, adolescents will turn to their parents or friends for help.[21] Their parents will often arrange for them to see a professional. A variety of health professionals can provide help to a young person with a mental illness:

General practitioners (GPs)

For many young people developing a mental illness, their GP will be the first professional they speak to about getting help. A GP can recognise symptoms of a mental illness developing and provide the following types of help:

- Look for a possible physical cause
- Explain the illness and how the person can best be helped
- Prescribe medication if needed
- Refer the young person to a psychologist or allied health professional who can help the person learn ways of coping with and overcoming the illness
- Refer the person to a psychiatrist, particularly if the symptoms are severe or long lasting
- Link the person to community supports.

The Better Access Scheme

The purpose of Better Access is to improve treatment and management of mental illness within the community. Better Access provides a Medicare rebate for people with mental health problems to receive treatment from mental health professionals and access team-based mental health care, including general practitioners, psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists.

In order to take advantage of the initiative, the person seeking treatment needs to develop, with their GP, a Mental Health Treatment Plan. The Mental Health Treatment Plan is a document the GP and patient work on together. It includes an assessment of mood, specific life difficulties and goals that may be achievable within a set period of time. Usually 6 sessions of treatment with a mental health professional can be subsidised, but depending on the severity of the problems, this can be increased to 10 individual sessions and 10 group sessions per calendar year.

A Mental Health Treatment Plan can take time to create, so when making an appointment with a GP to do so, it is a good idea to specify that this is what the appointment is for, and to book a long appointment.

The following types of treatment are covered by Medicare under the Better Access Scheme:

- Psychoeducation (providing information about a mental health problem and how to manage it)
- Cognitive behaviour therapy
- Relaxation strategies
- Skills training (including problem solving skills, anger management, social skills, communication training, stress management, and parent management training)
- Interpersonal therapy
- Narrative therapy for Aboriginal and Torres Strait Islander people.

Psychologists

A psychologist is someone who has studied human behaviour at university and has had supervised professional experience in the area. Psychologists are registered with a national registration board. Some psychologists provide treatment to people with mental illnesses. Psychologists do not have a medical degree, so they do not prescribe medication. Some psychologists work for health services, while others are private practitioners.

A **clinical psychologist** is a psychologist who has undergone additional specialist training in how to treat people with mental health problems. They are particularly skilled at providing cognitive behaviour therapy and other psychological treatments.

Psychiatrists

Psychiatrists are medical doctors who specialise in the treatment of mental illnesses. Psychiatrists mostly focus on treating people with severe or long-lasting mental illnesses. They are experts in medication and can help people who are having side effects from their medication or interactions with other medications. It is possible to see a psychiatrist by getting a referral from a GP. A GP might refer a young person to a psychiatrist if they are very ill or are not getting better quickly. Most psychiatrists work in private practice, but some work in clinics or hospitals.

Mental health nurses

Mental health nurses are registered nurses who have specialised in caring for people with mental illnesses. They generally care for people with more severe illnesses who are treated in hospitals or in the community. They can provide assistance with medication, practical support and counselling.

Occupational therapists and social workers

Most occupational therapists and social workers work in health or welfare services. However, some have additional training in mental health and are registered by Medicare. They can provide similar treatments to psychologists.

Counsellors and school counsellors

Counsellors can provide psychological support. However, counsellors are not a profession registered by the government, so anyone can call themselves a 'counsellor' without any qualifications. A well-qualified counsellor may also be a psychologist or other registered professional. Some counsellors may have specific training and skills in an area such as drug and alcohol counselling. Unless a counsellor is registered by Medicare, the client cannot claim a rebate and will have to pay the full fee.

The requirements for school counsellors vary between states. In some states school counsellors must be mental health professionals such as psychologists, while in others they have less specialised qualifications. In some states teaching experience is required as well.

Youth workers

Like counsellors, youth workers are not regulated by the government and have a range of qualifications. Some are psychologists or allied health professionals, some have qualifications in youth work and some have no formal training at all. Youth workers play different roles within different organisations. Some provide therapy, some assist young people to reengage with school or access work or training opportunities, and some are just a friendly face to talk to. Youth workers may be found in youth centres run by the government, local police or community organisations,

accommodation services for young people (for example, homeless shelters), and some schools and health centres.

Case managers

Case managers work mainly with people with severe or complex mental illness and are often attached to mental health services. A case manager may be one of any number of mental health professionals and have a variety of roles. Types of help that case managers can provide include monitoring the mental health of their clients, make suggestions about different sorts of ongoing therapy and recommending a medications review from time to time. A case manager will liaise with other members of the treatment team as described above. They may also liaise with social services, schools and families.

Specialist mental health services for young people

There are a number of specialist health services available for young people in different parts of Australia. They often house professionals from different specialities under one roof. There may be GPs, psychologists, counsellors, social workers and youth workers. Because the illnesses that place the greatest burden on young people are mental illnesses, the workers in these services frequently have specialist training in mental health. These services may be run by local or state government health services. An example of this type of specialty service is headspace centres, located around Australia.

In cities and larger towns, government mental health services usually have specialised services for young people. These are often called *child and adolescent mental health services* (CAMHS) or *child and youth mental health services* (CYMHS), and all will provide services for young people up to the age of 18. Many provide services to young adults as well. Some require referral from another health professional and some will allow family or school referrals, or even self-referrals. Some mental health services only provide ongoing management, and some have crisis services as well.

Accessing mental health services in rural areas

Living in a rural or remote area presents unique challenges and opportunities. Services may be scarce, difficult to access or a long way away. Other services that may be available include telephone counselling, outreach services, online therapy and community services. However, people living in rural and remote areas often develop strong social networks of informal helpers and can be very creative in using other local resources such as libraries, local service organisations and schools.

Shared decision making

Some young people are reluctant to seek or accept help, and having a greater degree of autonomy over their treatment may help. Some mental health professionals are using an approach called shared decision making to enhance young people's involvement in therapy.

Shared decision making is a process by which a young person and their mental health professional (and sometimes, a parent or other carer) reach an agreement about treatment.[22] This is different to the traditional style of doctor-patient relations, where the doctor tells the patient what to do, and the patient just chooses to go along with it – or doesn't. Shared decision making may increase the rate of treatment adherence and therefore improve outcomes.

Steps in shared decision making could involve the mental health professional:[22]

1. Discussing the young person's diagnosis with them.
2. Stating that there is more than one suitable treatment option (i.e. psychotherapy, prescription of different types of medication).
3. Asking the young person about their preferred level of involvement and desire for carer involvement.
4. Discussing the young person's preferred information format (i.e. whether they would like fact sheets, or to discuss the problem orally, or seek information from websites etc.).
5. Discussing the potential risks and benefits of each treatment option (including other available resources and treatment options from other professionals, e.g. psychological therapies).
6. Exploring ideas, fears and expectations of the problem and possible treatments.
7. Checking with the young person about their understanding of the information and reactions to this.
8. Making, discussing or deferring decisions about treatment.
9. Arranging follow up.

Self-help strategies and young people

There is evidence that a lot of self-help strategies, complementary treatments and lifestyle changes can help adults with some mental illnesses, but in general, there hasn't been a lot of research on what can help adolescents and young people. Hopefully, over time, more research will be done. However, young people may wish to try self-help strategies of different kinds.

If a young person wants to try something and there isn't any evidence yet, this doesn't mean they shouldn't do it. Even if it doesn't 'treat' the mental illness it may help them to feel better and boost self-esteem. Self-help strategies that young people should be encouraged to try are those that:

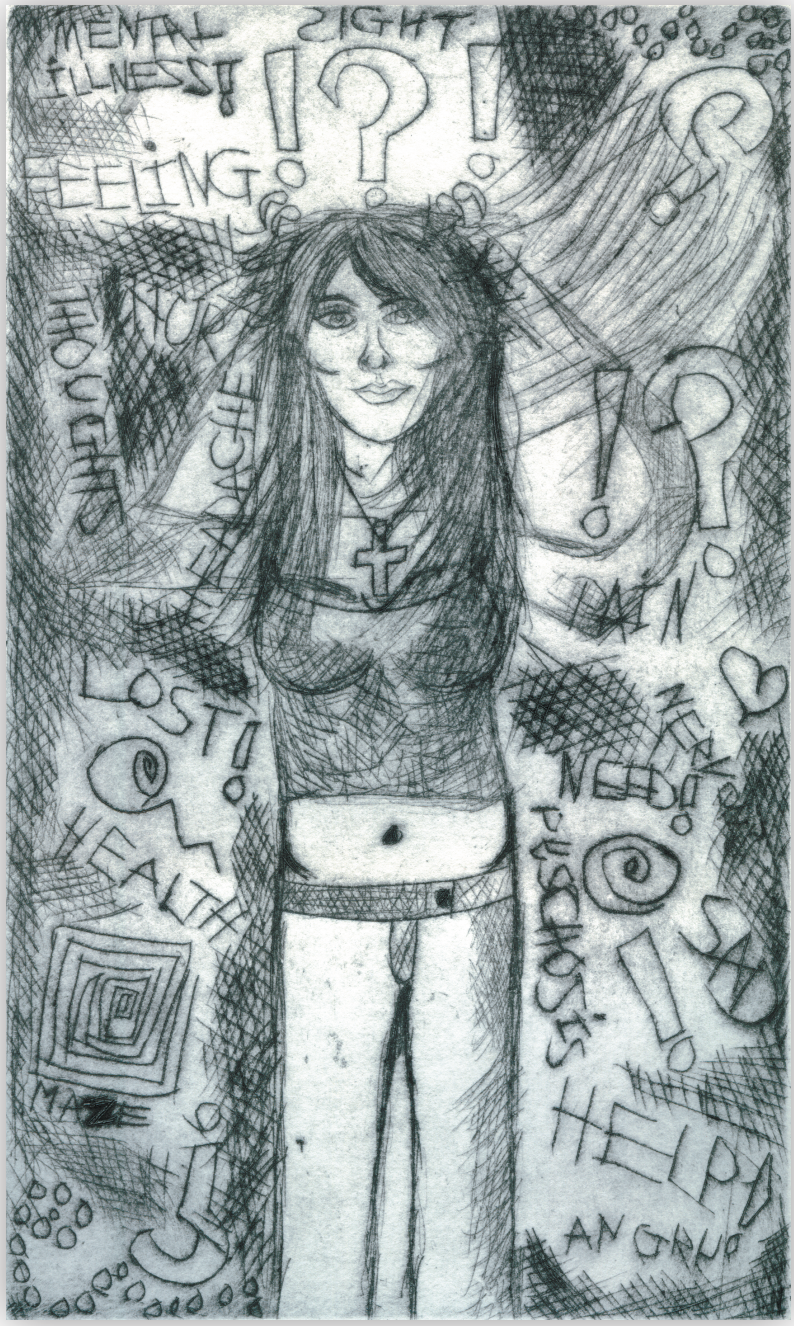
- ***Interest them***
  For example, a young person who enjoys being creative may wish to try expressing their feelings through art or writing and may feel that this has some benefits for them.
- ***Encourage a sense of achievement or satisfaction***
  For example, learning a new piece of music or completing a challenging task
- ***Are social***
  For example, joining a club or making sure to see friends regularly
- ***Are likely to be safe***
  For example, exercise has positive effects on physical and mental health, and few risks. However, young people with eating disorders, physical illnesses (including obesity), or who have not exercised for a long time should get the advice of a doctor before starting an exercise program.

Natural therapies that have been shown to be safe and effective for adults may not be suitable for young people because of ongoing physical and brain development.

Recovery

Mental illness affects people differently and the recovery journey is different for each person. Recovery can progress slowly. Many different factors contribute to recovery. These may include having good support from family and friends, having a meaningful role in society through employment or education opportunities, getting professional help early, getting the best possible treatments and the person's willingness and ability to take up the opportunities available.

Mental health is everyone's business. The attitudes and beliefs that society has about mental illness have a powerful impact on someone's illness and their recovery.



Speak Out

"The way you feel inside makes it hard to speak out." **Vanessa R., aged 18**

1.2 Adolescent Development

Adolescence is a time of massive change and while it is different for every individual, there are some things that are common to all adolescents – the physical, cognitive, social and emotional changes that take a young person from childhood to adulthood. Some of the behaviours and changes that occur in adolescence may look like symptoms of mental illnesses. Alternatively, the symptoms of mental illnesses may be masked by the big changes that occur during this time. Mental health problems can have a serious impact on adolescent development. As well as this, the changes experienced during adolescence, and the stress of being an adolescent, can contribute to the development of mental health problems.

Having an understanding of the changes that occur during adolescence can help adults to tell whether the young person they are trying to help has a mental health problem or is simply experiencing normal changes.

The definition of adolescence

There are many ways to define adolescence. The main definitions rely on markers from physical development or age.

Traditionally it has referred to the years when physical development (puberty) occurs, ending with socially recognised adulthood when sexual maturity has been reached. At this point, a young person was traditionally expected to be independent and start their own family. However, adolescence is often described as lasting longer in modern times, with young people continuing to live with their parents for longer, delaying starting families and sometimes remaining financially dependent on their families for longer, sometimes because of difficulties gaining employment, or continuing with tertiary education.

If age is used as a marker, adolescence may be defined as 12-18 years, or the years when young people attend high school.

These definitions can be useful in some ways and misleading in others. Brain development, for example, continues at least into the early twenties, meaning that some young people think and behave more like adolescents than adults until then.

In Youth Mental Health First Aid, our definition of adolescence is from the age of 12 until a young person's 18th birthday. This is because the age of 18 has some particular social meanings as well. It is the age at which a person is seen by society as an adult; they can buy alcohol, vote, and make decisions without needing the approval of a parent or guardian. However, most of the information in this manual may be useful in assisting young adults as well.

Changes during adolescent development

Adolescent development involves the following broad areas: physical, cognitive, social and emotional changes.

Physical changes

Puberty is a time when a young person's body changes from the body of a child to that of an adult. Typically, in Australia, puberty begins sometime between the ages of 11 and 15, but can begin earlier or later. It is frequently accompanied by an increase in concern about personal appearance.

Some changes are similar for males and females, including an increase in muscle mass and rapid gains in both height and weight. The voice deepens, although this is more pronounced for males. Pubic hair, facial hair and body hair begin to grow. Many adolescents will have difficulties with pimples or acne.

However, the most pronounced changes are in secondary sex characteristics. These are

triggered by an increase in male and female sex hormones, mainly oestrogen in females and testosterone in males. In females, the main changes are the growth of breasts and the start of menstrual periods. In males, there is a lengthening and thickening of the penis.

For both male and female adolescents, these changes mean that the body is preparing to produce children, even though in general adolescents are not psychologically or socially ready for parenthood. These changes frequently trigger an increase in sexual thoughts and feelings and may lead to sexual experimentation and sexual behaviour, whether or not the young person is ready for it in other ways.

Cognitive changes

Adolescent development also involves changes in the way a person thinks about themselves, others, and the world around them. Children think in very concrete ways, and tend to accept what they are told. Adults are able to reason, think about abstract concepts, analyse and critique their own thoughts and what others say and do. Adolescence bridges these two ways of thinking. These changes are a product of a developing brain, an accumulation of life experiences and education.

Adolescents also begin to use more reasoning and logic to solve problems and make decisions, both at school and in their own lives. This includes analysing and critiquing things they see and hear, their behaviour in relationships with others, formulating beliefs, and thinking about consequences and long-term plans.

Developing beliefs about the world means thinking about abstract concepts such as right and wrong, the 'meaning of life' or spiritual or religious convictions. This includes thinking about ethics and justice both in relation to the adolescent's own life and the wider world. This can be accompanied by questioning adults in authority, rules, and social norms; becoming passionate about causes such as animal rights or poverty; and debating topics that are important to them, sometimes becoming intolerant of the beliefs of others.

Adolescents frequently take risks and make poor decisions, even if they are usually sensible and show good judgement, which can be difficult for parents and other significant adults in their lives to understand. This is partly because the brain is undergoing dramatic changes. The part of the brain that is responsible for decision making develops over the course of adolescence. In the meantime, other parts of the brain are doing the job – and not always doing it very well.

Social changes

One of the most important changes during adolescence is the shift from an orientation toward family and parents to an orientation toward friends, in preparation for adulthood and independence. Learning to resolve conflict and cope with peer pressure are important.

Adolescents will begin to ask themselves who they are and who they wish to be. This will include thinking about their future adult roles, desired career and lifestyle. In developing their identity, many adolescents will experiment with different looks and styles; changing hair colour, clothing styles, and other aspects of appearance. This is quite normal, even when it is frustrating to the adults in their lives. It is useful to remember that adolescents are trying out identities to see which one fits best.

Adolescents also need to learn to manage relationships with others, including those with a different gender to their own, and many will experiment with romantic relationships. Adolescents also begin to understand themselves as sexual beings, without necessarily engaging in sexual relationships.

For some additional considerations for assisting young people who may be gay, lesbian, bisexual, transgender, intersex, queer or questioning, turn to Appendix 2.

Emotional changes

There are a number of emotional changes that occur. There is a greater intensity of emotional states and stronger, faster emotional reactions. For example, an argument with a friend may quickly result in a screaming match, and a vow never to speak again, and a romantic attraction may quickly become infatuation. The emotional functions of the brain develop more quickly than many of its other functions, contributing to poor decision making at times. For this reason, adolescents are more likely to take additional risks, be impulsive and look for new ways to have fun without considering consequences.

The relationship between mental health problems and adolescent development

Adolescence is the peak age of onset for mental illness. Half of all people who ever develop a mental illness will have had their first episode prior to the age of 18.[12] This means that as well as being a time of developing psychological maturity, adolescence is also a time of psychological vulnerability.

Mental health problems and adolescent development are interrelated, influencing each other in a number of ways:

- It can be difficult to distinguish the symptoms of mental health problems from normal adolescent behaviours and moods.
- The changes that occur during adolescence can create additional risk factors for developing mental health problems.
- Mental health problems can interfere with adolescent development.

Distinguishing normal adolescence from mental health problems

It is sometimes difficult to tell whether a young person is developing a mental health problem or simply going through normal changes. This is because young people are changing rapidly already, so some of the changes seen in mental health problems may go unnoticed. Adults, on the other hand, are relatively stable, so changes in behaviour or emotional states are easier to recognise.

Many symptoms of mental illness are similar to aspects of normal development. For example, many young people become more secretive during adolescence and while this is a normal and essential part of developing independence, in some cases it may be that the young person is concealing the use of alcohol or drugs, or it

may actually indicate paranoia, sometimes a symptom of psychosis.

It is not always easy to tell whether the behaviour is related to normal adolescence or mental illness, but it can be useful to reflect on the changes that occur during adolescence when trying to decide what is going on. For example, withdrawal is a symptom of many mental illnesses. If the adolescent is withdrawing from family, but spending more time with friends, this is a normal part of growing up. If, however, they are withdrawing from everyone, there may be cause for concern.

Focussing on functioning is a good way to distinguish between symptoms of mental health problems and normal changes. If the young person is beginning to struggle at school, avoiding spending time with friends, or is no longer enjoying the things they used to enjoy, they may have a mental health problem.

Additional risk factors during adolescence

Many things occur during adolescence that increase a young person's risk of developing mental health problems.

Some examples are:

- ***Hormonal changes*** may make adolescents more prone to extremes of emotion. For example young people, particularly girls, become more prone to depression and anxiety.
- ***Orientation toward peers*** can lead young people to do things they would not otherwise do, such as experiment with alcohol and other drugs, and can also lead to distress about not 'fitting in' with a desired peer group.
- ***Additional concerns about appearance*** may lead to increased depression and anxiety, and increased dieting, which may result in the development of an eating disorder.
- ***Experimenting with alcohol and other drugs*** can lead to a substance use disorder or other mental illness.
- ***Increased risk-taking behaviour*** may result in major adverse life events that may in turn lead to the development of a mental illness. For example, driving intoxicated may result in trouble with the law, and sexual risk taking may result in pregnancy or sexually transmitted infections.
- ***Increased autonomy and independence*** can provoke anxiety in some young people, as can the pressure to achieve at school and elsewhere.

Impact of mental health problems on adolescent development

Mental health problems can have an adverse impact on adolescent development. For example:

- ***Lack of concentration and motivation*** can lead to difficulties in cognitive development and educational achievement. Delays in completing education can have long-term ramifications. It can be difficult to return to education later in life, and the self-esteem that might be lost because of a failure to complete education on time can be hard to recover.
- ***Withdrawal*** from family, friends and school creates the risk of delays in psychological and social development.
- ***Use of alcohol and other drugs*** can interfere with normal brain development and cognitive impairments.[23]
- ***Dramatic weight loss*** can lead to problems with fertility in the long term, as it can interrupt normal menstruation, and can also interfere with normal brain development.

Despite all of these challenges and difficulties, it is important to remember than most adolescents do pass through adolescence with relatively little difficulty. First aiders have the opportunity to facilitate early intervention for any developing mental health problems and help to ensure that the young people have the chance to enjoy a happy and productive adolescence.



Pain, Agony and Illness
At the time of doing this piece Cassie reported she was having trouble expressing how she was feeling in words, but through her artwork she was able to express how she was feeling… pain, agony and illness. **Cassie J., aged 17**

1.3 Mental Health First Aid and Young People

Mental health first aid is the help offered to a person developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or until the crisis resolves.

Mental health first aid will typically be offered by someone who is not a mental health professional, but rather by someone in the young person's social network (e.g. family, friend or sports coach) or someone working in a human service occupation, e.g. teacher, police officer, youth worker.

The Mental Health First Aid course teaches how to recognise the cluster of symptoms of different illnesses and mental health crises, how to offer and provide initial help, and how to guide a person towards appropriate treatments and other supportive help. **The Mental Health First Aid course does not teach people to provide a diagnosis or therapy.**

Why mental health first aid for young people?

There are many reasons why people who live or work with young people need training in Mental Health First Aid:

- ***Mental health problems often first develop during adolescence or early adulthood***. These include depressive, anxiety, eating, psychotic and substance use disorders[6] Half of all people who will ever experience a mental illness will have had their first episode prior to the age of 18.[12] Anyone who has frequent contact with young people will inevitably interact with some who are developing these illnesses.
- ***Young people may not be well informed*** about how to recognise mental health problems and what effective treatments are available.[24] They will not have the degree of experience that adults have in how to seek help and knowledge of what sort of help is best. Adults can play an important role in guiding the young person to help. Adults need to improve their own knowledge and attitudes in order to be able to do this. Lack of knowledge may result in an adult avoiding or not responding to a mental health problem.
- ***There is stigma and discrimination associated with mental health problems.*** Stigma involves negative attitudes (prejudice) and discrimination refers to negative behaviour, e.g. exclusion from social activities. This may hinder young people with such problems from seeking help.[21] They may be ashamed to discuss mental health problems with family, friends or school staff. They may also be reluctant to seek professional help for mental health problems because of their concerns about what others will think of them. People with mental health problems can internalise the stigma so that they begin to believe the negative things that others say about them. Better understanding of the experiences of young people with mental health problems can reduce prejudice and discrimination.
- ***Young people with mental health problems may at times not have insight that they need help.*** Some mental illnesses can cloud a person's thinking and rational decision making. Also, the young person can be in such a severe state of distress that they cannot take effective action to help themselves. In this situation, parents or other adults close to them can facilitate appropriate help.
- ***Professional help is not always available when a mental health problem first arises.*** There are professionals that can help young people with mental health problems.

When these sources of help are not available, parents and other adults can offer immediate first aid and assist the young person to get appropriate professional help and supports.

- ***Mental health first aid has been found to be effective.*** A number of research studies have shown that training in Mental Health First Aid results in better knowledge, attitudes and help-giving.[1]

The Mental Health First Aid Action Plan

Before being able to give mental health first aid to a young person, first aiders need some basic knowledge about mental health problems so that they are able to recognise that an illness may be developing. It is important that the first aider does not ignore the symptoms they have noticed or dismiss them as a part of adolescence. If the first aider believes a young person they care about is experiencing symptoms of mental illness, they should approach the young person to talk about how they can assist. Having an action plan can help to do this more effectively.

In any first aid course, participants learn an action plan for the best way to help someone who is injured or ill. The most common mnemonic used to remember the procedure for this is DRSABCD, which stands for Danger, Response, Send for help, Airway, Breathing and Compressions and Defibrillator. The first aider will not always need to apply all actions, as it will depend on the condition of the injured person. For example, once the first aider determines that the person is fully conscious, the subsequent actions of ABCD are not needed.

Similarly, the Mental Health First Aid Program provides an action plan on how to help a person in a mental health crisis or developing mental health problems. Its mnemonic is ALGEE (see box). Although the action of assisting with a crisis is the highest priority, the other actions in the Mental Health First Aid Action Plan may need to occur first. Therefore, these actions are not necessarily steps to be followed in a fixed order. They are numbered purely to help remember them. The first aider has to use good judgment about the order and the relevance of these actions and needs to be flexible and responsive to the person they are helping. Listening and communicating non-judgmentally is an action that occurs throughout the giving of first aid.



Mental Health First Aid Action Plan

Approach the person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give support and information

Encourage the person to get appropriate professional help

Encourage other supports

Action 1: Approach the young person, assess and assist with any crisis

The first task is to approach the young person, look out for any crises and assist the young person in dealing with them. The key points for the first aider are to:

- Approach the young person about their concerns
- Find a suitable time and space where both people feel comfortable
- If the young person does not initiate a conversation with the first aider about how they are feeling, the first aider should say something to them
- Respect the young person's privacy and confidentiality.

In a situation involving a young person with a mental health problem, the possible crises are that:

- The young person may harm themselves, e.g. by attempting suicide, by using substances to become intoxicated, by engaging in non-suicidal self-injury, or as a result of extreme weight loss
- The young person experiences extreme distress, e.g. a panic attack, a traumatic event or a severe psychotic state
- The young person's behaviour is very disturbing to others, e.g. they become aggressive or lose touch with reality.

If the first aider has no concerns that the young person is in crisis, they can ask the young person about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen and communicate non-judgmentally

Listening to the young person is a very important action. When listening and communicating, it is important for the first aider to set aside any judgments made about the young person or their situation, and avoid expressing those judgments. Most young people who are experiencing distressing emotions and thoughts want to be listened to empathetically before being offered options and resources that may help them. When listening non-judgmentally, the first aider needs to adopt certain attitudes and to use verbal and non-verbal listening skills that:

- Allow them to really hear and understand what the young person is saying, and

- Make it easier for the young person to feel they can talk freely about their problems without being judged.

It is important to listen and communicate non-judgmentally at all times when providing mental health first aid.

Action 3: Give support and information

Once a young person with a mental health problem has felt listened to, it can be easier for the first aider to offer support and information. The support to offer at the time includes emotional support, such as empathising with how they feel and giving them hope of recovery, and practical help with tasks that may seem overwhelming at the moment. The first aider can also ask the young person whether they would like some information about mental health problems.

Action 4: Encourage the young person to get appropriate professional help

The first aider can also tell a young person about the options available to them for help and support. A young person with mental health problems will generally have a better recovery with appropriate professional help. However, they may not know about the various options that are available to them, such as medication, counselling or psychological therapy, support for family members, assistance with vocational and educational goals, and assistance with income and accommodation. The first aider might also need to help the young person to make and keep appointments.

Action 5: Encourage other supports

The first aider can encourage the young person to use self-help strategies and to seek the support of family, friends and others. They may also encourage other significant adults in the young person's life to be supportive of them.

Things that a first aider needs to know to help a young person

Providing mental health first aid to a young person can be complicated by a number of different things. If you are a parent assisting your own child, your **parental role** will still be your primary one, as you will be caring for the young person on an ongoing basis. Your actions will be different if you are not the parent. You may have specific **professional responsibilities** and will need to consider how to involve their parents.

Some adolescents are **reluctant to talk with adults about sensitive issues** such as mental illness and others find it difficult to talk about or describe their emotions. In addition, some adults are very skilled at talking with adolescents and find it comes quite naturally. Others **struggle to engage young people** in conversations of any kind, and will find it even more difficult to talk to adolescents about sensitive issues.

If you are helping a young person from a **different background to your own**, communication may be even more difficult. Young Aboriginal and Torres Strait Islander people and young people from culturally and linguistically diverse backgrounds may have different needs, and may have difficulty talking to an adult from a culture or community different to their own.

Young people who have had **negative experiences with adults** may be particularly difficult to communicate with and help. This can include having a history of abuse and neglect, where an important adult in their life has proven not to be trustworthy.

Roles and responsibilities of adults when helping an adolescent

In this section, by 'parent' we also mean any other legal guardian.

Very frequently, the first aider will be a parent, because they are usually the adults who know the young person best. However, anyone can be a first aider – a teacher, a youth worker, a sports coach, or anyone else who knows the adolescent well enough to notice that their behaviour has changed.

There are a number of questions regarding decision making and autonomy for a adolescent that a first aider may have. Some of these are:

- If I'm helping an adolescent, and I am not their parent, should I contact their parents?
- Does the adolescent have the right to make decisions about their health care?
- Does the adolescent have the right to privacy and confidentiality?
- If I am helping my own adolescent child, is there anything else I need to know?

If I'm helping an adolescent, and I am not their parent, should I contact their parents?

If you are not the parent of the adolescent you are helping, you will need to consider whether the parent should be involved and, if yes, how best to involve them.

Especially for younger adolescents, parents will often play a pivotal role in obtaining any necessary professional help. Older adolescents who are sufficiently motivated may decide to seek it for themselves. If the problem is more severe, for example if the young person is at risk of suicide or harm (perhaps from alcohol or other drug use), you may need to involve a parent or guardian urgently. In case

of a medical emergency, you need to call for emergency assistance first. Indications of medical emergencies can be found in Section 3 of this manual.

Even if the problem isn't urgent, it is still best to involve parents when possible. Start by discussing with the adolescent whether they would like to speak directly to their parents by themselves, or they would like you to help, either by talking to their parents along with them or by talking to their parents yourself.

If the adolescent asks you not to involve their parents, you need to find out why. In most cases, they will say they don't think their parents will understand, they will be angry, they don't want to burden their parents, their parents can't afford professional help or something similar. The majority of parents, however, will do everything they can to help their children. Helping the adolescent to tell their parents what is happening will be enough to start them on the road to appropriate help. Explaining this can help the young person to overcome their concerns about speaking to their parents.

The parent or guardian may not have a great deal of knowledge about mental illness themselves, and you may be in a position to give them the information they need to get help for their adolescent child. This may be information about mental illness or information about appropriate professional help and how to access it.

However, there are situations in which it is not appropriate to contact parents. If you are assisting an adolescent and they reveal that they are experiencing abuse, neglect or exploitation at home, contacting the parents may further endanger them. If this happens, you may need to contact appropriate authorities. There are different laws in different states of Australia regarding the reporting of abuse and suspected abuse, including neglect and exposure to violence (see Appendix 3: *Mandatory reporting in Australia*).

If you are unsure whether it is safe or appropriate to approach the young person's parents about a possible mental health problem, seek advice from a mental health professional or welfare agency.

Overcoming barriers to parent involvement

If you are helping a young person who insists that you must not talk to their parents about their mental health problem, try to find out why. Often this will be because the adolescent is fearful of criticism by the parent or mental health professional, and this can be hard to work though. Sometimes, finding more neutral language to talk about the problem can help to make them more acceptable, for example, discussing that fact that mental illnesses are real medical conditions.

However, sometimes, mistaken beliefs create barriers to seeking or accepting help. The adolescent may believe that they will be given treatment they will dislike (e.g. medications they perceive as being harmful), or that there will be other negative consequences. They may be worried that their parents cannot afford treatment. Discussing barriers can help the young person to accept the help they need.

Does the adolescent have the right to privacy and confidentiality?

Young people do have the right to privacy when talking with professionals who are bound to codes of ethical conduct. While other adults may not be constrained by such codes, the principles that professionals follow are a good guide to ethical behaviour.

There are limits to this confidentiality. If an adolescent has shared information with you and has asked that you keep it confidential, you should do so unless:

- You have concerns that they are at risk of harming themselves or others
- The adolescent has disclosed that they are being abused
- You believe that the adolescent does not have sufficient maturity to make decisions about privacy
- As part of your professional role, you have guidelines about reporting that override this.

If the adolescent is in a potentially harmful situation (e.g. experiencing abuse, having suicidal thoughts or engaging in suicidal behaviour), let them know that you want to keep them safe and that in order to do so, you need to break confidentiality. For example, anything that affects the safety of the adolescent or others may need to be discussed with someone in authority such as the police or child services who can act to keep the adolescent (or others) safe. If you are not sure whether you should break confidentiality, call your local mental health service or speak to a colleague.

Even if confidentiality has to be broken, the adolescent does have the right to privacy. This means that information about their mental health should not be shared with people who do not need to know about it. In a school, for example, their teachers may need to know, as well as a school counsellor or nurse, but it does not need to be shared with the whole staff.

Does the adolescent have the right to make decisions about their health care?

Adolescents do have the right to make or be involved in making decisions about their care. Young people under the age of 18 have the right to:

- ***Seek their own health care and make decisions about treatments.*** However, if the health professional they speak to does not believe they have sufficient maturity to understand their condition and treatment options, they have to contact the young person's parent.
- ***Consent to treatment, even if their parent does not consent.*** If the health professional believes that treatment is in the adolescent's best interests, and that they have sufficient maturity to understand the treatment and the risks associated, the health professional can act against the parent's wishes. This may have to be argued in court, and the court will rule in the best interests of the adolescent.
- ***Refuse treatment or intervention, even if a parent has consented to the treatment.*** However, if a health professional or parent can prove that the adolescent does not understand the potential consequences of refusing treatment, they can treat the adolescent against their wishes.

In an emergency, medical professionals can provide treatment without the consent of the adolescent or a parent.

After the age of 18, a young person has the right to refuse health care. However, a health professional can seek the support of the courts to treat a person against their will if they believe that there is a risk to others if the treatment is not given, or the person can't make their own choices.

If I am helping my own adolescent child, is there anything else I need to know?

If your child's teacher, or another adult in their life, has approached you with concerns about your child, it is important that you take this seriously. Sometimes a young person seems relaxed and happy at home, and this may lead you to think that the concerns the person is expressing are exaggerated or untrue.

However, it may be that at school your child is very anxious or fearful, socially isolated, or show other symptoms that are not apparent in the home. It is important that you discuss the concerns with your child and find out whether they feel different when they are outside of the home.

You might be fearful of discussing symptoms you have noticed with your child because you are worried it will alienate them. Remember that for most people, the opportunity to discuss unpleasant feelings can be a huge relief. Let your child know that you will support them to get the help that they need. However, don't let the problem become the main focus of your relationship – spend time enjoying each other's company and talking about other things.

It can be emotionally difficult to accept that your child needs mental health care. Some parents feel that they are to blame for their child's mental illness, either because they feel they should have been able to prevent it, or perhaps because there is a history of mental illness in their own family. The reality is that many things contribute to the development of a mental illness. Focus instead on the opportunity to help your child, and if you need it, seek additional support for yourself. The main thing to remember is that you can only do your best.

How to communicate effectively with young people

Many adults find it easy to communicate effectively with young people. Others struggle to make themselves heard and understood. For those who find communicating with young people difficult, there are a number of strategies that may help.

- ***Be genuine.*** Young people are very adept at recognising when an adult is 'faking it'. If you are uncomfortable in your discussion with a young person, admit it. For example, you might say "This is hard for me to talk about, and perhaps it's difficult for you too."
- ***Be careful about the use of slang.*** Use language you are comfortable with. If you try to use slang you are unfamiliar with or unused to, a young person will be able to tell immediately.
- ***Allow for silence.*** Young people may struggle at times to formulate what they wish to say. Interrupting a silent moment may prevent the adolescent from having adequate time to complete thought processes that enable effective communication.
- ***Try different settings for communication to see what works best.*** Some adults find it easier to talk to a young person while engaged in another activity. Parents may find that taking their children out individually for a meal or snack offers an opportunity in a different setting to talk about anything that they need to. Others may find that that talking to their adolescent children while driving in the car, washing and drying dishes or taking a dog for a walk is easier. Similarly, for a youth worker, teacher or sports coach talking while playing sport (kicking a football

around or playing friendly basketball), may be more appropriate. Activities that don't require a lot of eye contact can make it easier for the young person to talk, and time-limited activities have a definite end point, which can be less overwhelming for them as well. There is no 'right' setting for tricky conversations. Talk to the young person you are helping and find out what would make them most comfortable.

- ***Don't compare the young person's life to your own experiences from that age***. Adults often fall into the trap of thinking that young people today have a much easier life. Remember that your parents' generation thought the same thing about you! Saying "If I had the opportunities at your age that you have today, I would…" is not helpful. The world changes constantly, and new opportunities mean new challenges.
- ***Don't trivialise the young person's feelings.*** Mental illness can occur at any age. Wondering what a young person has to be depressed or anxious about implies that their life experiences are less valid just because of their age.
- ***Don't ask the young person to justify or explain their behaviour.*** Young people often act without thinking through the consequences and later do realise that they made mistakes. Asking a young person why they rode down a hill in a shopping trolley or threw a party without permission, knowing that they would get caught, is not as useful as talking about how such behaviour could be avoided next time. Asking 'why' can put young people on the defensive.
- ***Watch your body language.*** This is always important, no matter who you are talking to. However, with a young person, body language needs extra attention because you may be silently communicating that you, as an adult, are the expert. Arms crossed in front of you, hands on hips, standing over the young person and other defensive or authoritarian body language will make it very hard to conduct a useful conversation. If the young person seems relaxed and open, try to match their body language. If they appear defensive, make your body language as open as possible by appearing relaxed, keeping your palms out, sitting alongside them but angled towards them and keeping your voice calm and low.
- ***Provide positive feedback.*** Young people are told constantly – by their parents, their teachers, and the media – what they are doing wrong. Any positive feedback you provide can help to make them more willing to communicate with you. Even something as simple as "I think it's great that you are willing to talk to me about this. It shows a great deal of maturity" can help.
- ***Help them to find the language they are looking for.*** Many young people find it difficult to express their emotions. This can result in them complaining of physical symptoms, when the emotional symptoms are what is really bothering them. They may simply shrug their shoulders or say they 'don't know' when asked how they are feeling. You can help them to find the emotional language they need. Offering a few terms to pick from could help can help; for example, "To me, you don't look very happy. Are you feeling sad, or angry, or frustrated?"

Communicating with young people from different cultural backgrounds

If you are assisting a young person with a different cultural background to your own, there can be additional difficulties in communication. You may need to make some adjustments to your usual communication. The young person may be used to a different level of eye contact or personal space. There may be issues of age and gender that get in the way of effective communication, for example, it may not be appropriate in the young person's culture to speak alone with an adult of a different gender. In some cultures it is common to talk about mental illness using physical terms instead of emotional ones, e.g. describing stomach aches and headaches rather than anxiety.

It is important, however, not to make assumptions about the needs of a young person based solely on their cultural background. Ask questions about what the young person needs rather than acting on the basis of what you think they need.

Young people from diverse backgrounds may be more comfortable talking to an adult from their own culture. If you are providing mental health first aid to a young person who is not from your own cultural background, you should always be culturally competent, and always practice cultural safety. Having some awareness of culturally appropriate services locally may help.

Being **culturally competent** when providing mental health first aid includes:

- Being aware that a person's culture will shape how they understand health and ill-health
- Learning about specific cultural beliefs that surround mental illness in the person's community
- Learning how mental illness is described in the person's community (knowing what words and ideas are used to talk about the symptoms or behaviours)
- Being aware of what concepts, behaviours or language are taboo (knowing what might cause shame).

Practicing **cultural safety** means:

- Respecting the culture of the community by using the appropriate language and behaviour
- Never doing anything that causes the person to feel shame
- Supporting the person's right to make decisions about seeking culturally-based care.

In Australia, significant groups to consider are young Aboriginal and Torres Strait Islanders and young people who are migrants or refugees.

Young Australian Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people have some unique health issues. Suicide rates are higher in this group, and while fewer Aboriginal and Torres Strait Islander people use alcohol in comparison to the general population, among those who do, rates of problem use are higher.[7]

Inter-generational trauma from colonisation, forced removal of children from their families of origin and social inequality have contributed to poor mental health for many Aboriginal and Torres Strait Islander people. For those who live in rural and remote areas, a lack of health services also contributes to health inequalities. Despite these difficulties, young Aboriginal and Torres Strait Islander people have a vibrant and strong culture to turn to and draw upon.

More detailed information about cultural considerations and communication techniques when giving help to an Aboriginal or Torres Strait Islander young person is given in Appendix 1.

Young people who are migrants and refugees

A young person who has come to Australia as a migrant or refugee may have experienced trauma in their country of origin. This could be because of war, poverty, oppressive government or a family member leaving the family of origin to move to Australia and prepare for the arrival of the rest of the family. In addition, some will find the move to Australia difficult because of attachment to their country of origin, the loss of family and friends, or difficulties in adjustment. Others will adjust relatively quickly and easily.

There may be additional barriers to help seeking in this group as well.

- Experiences of racism and discrimination (these may inhibit the young person from interacting with people from outside their cultural group)
- Language difficulties
- Lack of awareness of the Australian health system
- High degree of stigma about mental illness in the country of origin
- Lack of knowledge about mental illness.

If you live or work in a community with a large migrant or refugee population, it is useful to know about any culturally appropriate services available, particularly those that are tailored for the needs of young people.

Young people with a history of abuse or neglect

Abuse, whether sexual, physical, verbal or emotional, as well as all types of neglect, are a significant risk factor for developing mental illnesses. A history of abuse or neglect may also create additional difficulties with trust and communication.

When a young person has been betrayed by an adult in this way, it creates a number of problems. On top of the original betrayal, they may have tried to talk to other adults and been disbelieved, dismissed or been promised help that they never received. Some might be entirely disengaged from and distrustful of adults, and refuse to talk to a first aider. Others will seek attachments and affection from every adult they meet, resulting in inappropriate physical intimacy, which can be difficult for a first aider to cope with.

A young person with a history of abuse or neglect may be living with one of several different household arrangements. Some will be with their family of origin (usually the abusive adult will have moved out, but some may be continuing to live with them, in which case the abuse may have stopped, changed, or continued). They may be in out-of-home care (e.g. foster care, group housing or living with a member of the extended family) or be living independently (see box on next page).

Facts on out-of-home care[25]

Over 50,000 children and young people under 18 years are living in out-of-home care, which means they have experienced abuse or neglect at the hands of caregivers. Family violence and substance abuse are two key contributors to young people being removed from their homes. Most lived in some sort of home-based care, around half with a member of their extended family and half with a foster carer. Only 5.5% were in staffed residential care. Many experience multiple placement changes. Some remain in foster care until they turn 18 and others return to their families of origin.

If you are assisting a young person with this kind of history, there are a few key things to keep in mind. These are important for all young people, but for those who have experienced betrayal by a significant adult in their lives, they are even more important.

- Be predictable and consistent in your interactions
- Show the young person that:
  - you believe what they have told you about the way they are feeling and what they have experienced
  - what they are sharing is important to you and you want to help
  - there are ways to keep them safe and adults who can be trusted
- Unless you are the long-term guardian, you need to be firm about what your role is as a first aider.
- If you are going to need to refer them to other services, be honest and upfront about this.

If you are helping a young person and they disclose that they are currently being abused, and this is not known to any child protection agency, there are steps you need to take to report it. You may have mandatory reporting responsibilities, depending on where you live and what your professional role is. If you do not have a professional role or other duty of care to the young person you need to know who to tell. It may be a government agency or the police. For information on mandatory reporting, see Appendix 3.

Young people with intellectual disability

Intellectual disability (also referred to as developmental disability) is a condition that shows itself as limitations in the person's ability to learn about and solve the problems of day-to-day life and to be independent in the activities required for daily living. Intellectual disability occurs along a spectrum and is present in some form in about 3% of the population. It is often present from a person's early years of life and generally speaking is permanent. It can also occur as a result of an acquired brain injury.

Mental health problems are more common for people with intellectual disability than for the general population. Those with milder disability or good verbal communication will have a similar presentation of symptoms to the general population. Those with a more significant degree of intellectual disability and inadequate verbal communication are more likely to display their mental health problems through changes in behaviour and behaviour problems.

When interacting with a young person who has intellectual disability, you may need to adjust the way you communicate:

Use appropriate language. Speak clearly and slowly, with short, simple sentences and avoid jargon. Don't shout or raise your voice; ensure your spoken language and body language are non-threatening. Be specific and ask only one question at a time.

Avoid using leading questions, as a young person with intellectual disability may try to give the answer they think you want to hear. Open questions are best. Only use closed questions when you want to clarify something with a 'yes' or 'no' answer.

Check the young person's understanding, and your own, as often as needed. Don't pretend you understand what they have said if you don't.

The young person may also need extra help to access professional help and other supports. If you want additional advice, get in touch with a disability support service.

Providing mental health first aid to a young LGBTIQ person

Guidelines for communicating appropriately when providing mental health first aid to a young LGBTIQ (lesbian, gay, bisexual, transgender, intersex, queer or questioning) person are provided in Appendix 2.

It is important to care for yourself

After providing mental health first aid to a young person who is in distress, you may feel worn out, frustrated or even angry. You may also need to deal with the feelings and reactions you set aside during the encounter. It can be helpful to find someone to talk to about what has happened. If you do this, though, you need to remember to respect the young person's right to privacy; if you talk to someone, don't share the name of the young person you helped, or any personal details might make them identifiable to the young person you choose to share with.

It can also be good to do things that improve your own mood or mental health after helping someone who is distressed, and when caring for a young person with mental health problems. Activities which are known to be helpful for improving mood and reducing anxiety include eating well, keeping regular sleep habits, practicing relaxation techniques such as progressive muscle relaxation, being physically active, talking to supportive people, letting other people know how you are feeling, scheduling enjoyable activities (particularly those that give a sense of achievement), and doing other things you know have been helpful in the past.[26]

Helpful resources for young people with mental illness and the adults who care for them

Websites

Headspace

www.headspace.org.au

In addition to a number of youth-friendly mental health services spread across Australia, the National Youth Mental Health Foundation has a website which includes information suitable for a range of audiences.

eHeadspace is their e-counselling service which is run for young people 12-25.

YouthInMind Australia

www.youthinmind.info

Visitors to this website can fill in the Strengths and Difficulties questionnaire. This questionnaire can give feedback on the presence of emotional, conduct, hyperactivity and peer problems. It can be completed by a young person aged 11-17 or their parents and when completed, gives a readable report about the results and a technical result that can be shown to a health professional. It also directs the user to books and websites that are useful for the problems identified by the questionnaire.

For parents and other adults

National Institute of Mental Health (NIMH)

www.nimh.nih.gov

This US government site gives a wealth of excellent, up-to-date information on mental health problems.

For adolescents and young people

ReachOut

www.reachout.com.au

ReachOut is a website with information about mental health problems, physical and mental wellbeing, young people and the law, relationships, alcohol and other drugs and other issues which concern adolescents and young people. ReachOut has fact sheets, interactive games, training programs and activities and forums where young people can ask for help and offer each other advice.

Online and telephone services

Kids Help Line

1800 55 1800

This is a telephone, web-based and email counselling service that is available 24 hours a day, 7 days a week, for young people aged up to 25 years.

www.kidshelp.com.au

what works 4 U

www.whatworks4u.org

This website allows young people to rate how well treatments have worked for them and share this with others who have similar problems. The website covers a wide range of mental health problems and treatments, including medical, psychological and complementary treatments. This website was developed under the leadership of Professor Tony Jorm, one of the authors of this manual.

Books

For parents

Carr-Gregg M. *When to Really Worry: Mental Health Problems in Teenagers and What to Do About Them.* Camberwell, VIC, Australia: Penguin Books; 2010.

This book is written primarily for parents, but will also be useful for other adults who work with adolescents. It discusses normal adolescent development, signs that a problem is serious, the range of mental illnesses that can affect adolescents, and how to get help.

Carr-Gregg M. *Surviving Adolescents.* Camberwell, VIC, Australia: Penguin Books; 2005.

This book is a manual for parents of teenagers. The focus is on what to expect from normal adolescent development and how to overcome the more common challenges.

First Aid for Developing Mental Health Problems in Young People

2



Halloween Behind the Mind

The picture is a mysterious girl stuck in her thoughts. You can see her thoughts all around her. It is like a painting of thinking. The girl does not necessarily represent Nicole. **Nicole Salter**



Blue

"This work shows how I have spent many days, particularly in my middle to late teens - curled up and crying. The colours represent my emotion during these times." **Kiri Smith**

2.1 Depression in Young People

What is depression?

The word 'depression' is used in many different ways. People feel sad or blue when bad things happen. However, everyday 'blues' or sadness is not a depressive disorder. People with the 'blues' may have a short-term depressed mood, but they can manage to cope and soon recover without treatment. The depression we are talking about in this chapter is major depressive disorder. **Major depressive disorder** lasts for at least two weeks and affects a person's ability to carry out their work and usual daily activities, and to have satisfying personal relationships. This chapter also covers bipolar disorder, another illness in which depression can be a feature.

According to the National Survey of Mental Health and Wellbeing, depressive disorders affect 6.3% of Australians aged 16-24 years in a given year: 8.4% of females and 4.3% of males.[6] The median age of onset is 25 years[12], which means that half the people who will ever have an episode of mood disorder will have had their first episode by this age. Depression often co-occurs with anxiety disorders and substance use disorders.[27] It is often recurrent (that is, people recover but develop another episode later on). If a young person has an episode of depression, they are more likely to have another episode during their life.[28]

Other data come from the Australian Child and Adolescent Survey of Mental Health and Wellbeing, which asked both adolescents and parents about symptoms of major depression.[13] According to adolescents reporting on their own symptoms, 7.7% of 11-17 year olds had a major depressive disorder in the previous 12 months, whereas according to parents reporting on their own adolescent children, only 4.7% were affected. Parents were not always attuned to depressive symptoms in their adolescent children, with two-thirds of adolescents who had major depression by self-report saying that their parents only knew 'a little' or 'not at all' about their feelings.

Signs and symptoms of major depressive disorder [5]

If a person has a depressive disorder, they would have five or more of these symptoms (including at least one of the first two) nearly every day for at least two weeks:

- **A depressed or irritable mood**
- **Loss of enjoyment and interest in activities that used to be enjoyable**
- Lack of energy and tiredness
- Feeling worthless or feeling guilty when they are not really at fault
- Thinking about death a lot or of suicide
- Difficulty concentrating or making decisions
- Moving more slowly or sometimes becoming agitated and unable to settle
- Having sleeping difficulties or sometimes sleeping too much
- Loss of interest in food or sometimes eating too much. Changes in eating habits may lead to either loss of weight or putting on weight.

These symptoms will cause distress to the person and will interfere with their studies or work and their relationships with family and friends.



What might a first aider notice if a young person is depressed?

When we think of depression, we typically imagine someone who appears sad and withdrawn. This is certainly an accurate description of some people with depression. However, there are other presentations, particularly amongst young people, that may make it difficult to identify depression as the underlying problem. This can lead to delayed recognition, unnecessary disciplinary responses, and difficulties in adolescent development, particularly social and educational development.

A first aider cannot diagnose depression. However, a first aider may be able to recognise the cluster of symptoms that indicate that depression may be the problem. Below are some descriptions of a young person's appearance and behaviour that might indicate that depression is a problem.

At home, a depressed young person may:

- Complain of tiredness, even if they are sleeping more than usual
- Have difficulty doing household chores, either forgetting to do them or not doing them thoroughly
- Withdraw from family, spending a lot of time in their bedroom
- Snap at family members, behave irritably, or pick fights with parents or siblings
- Avoid discussing important future events, such as decisions about further education.

In a school environment, a depressed young person may:

- Show a decline in school grades due to not completing work, not doing as good a job as they used to, or missing school
- Fail to engage in classroom discussions or struggle to understand and communicate
- Snap at or start fights with other students, or engage in vandalism
- Struggle to work effectively in the morning, but do better in late afternoon classes.

These presentations can all have an impact on school achievement. Some of these behaviours may result in disciplinary responses.

Teachers may also notice that a student chooses topics such as depression, suicide or self-injury to write about in health or social science classes, or uses these topics as the subject for creative work, e.g. writing or art.

The friends of a depressed young person may notice that they:

- Avoid spending time with their friends altogether
- Spend more time with friends who appear to be depressed as well
- Become excluded from their usual social group over time, either because they continually refuse invitations out or because their friends find them difficult to spend time with
- Use alcohol or other drugs to deal with emotional symptoms.

Bipolar disorder

A young person who is depressed may actually have a mood disorder called **bipolar disorder** (previously called **manic depressive disorder**). People with bipolar disorder have episodes of depression, episodes of mania and long periods of normal mood in between. The time between these different episodes can vary greatly from person to person. Approximately 1.8% of Australians aged 16-85 years experience bipolar disorder.[6] Bipolar disorder affects equal numbers of males and females.[29]

The depression experienced by a young person with bipolar disorder includes some or all of the symptoms of depression listed previously. **Mania** appears to be the opposite of depression. A person experiencing mania will have an elevated mood, be over-confident and full of energy. The person might be very talkative, full of ideas, have less need for sleep, and take risks they normally would not. Although some of these symptoms may sound beneficial (e.g. increased energy and full of ideas), mania often gets people into difficult situations (e.g. they could spend too much money and get into debt, they can become angry and aggressive, get into legal trouble or engage in sexual activity they otherwise would not). These consequences may play havoc with study, work and personal relationships. The person can have grandiose ideas and may lose touch with reality (that is, become psychotic). In fact, it is not unusual for people with this disorder to become psychotic during depressive or manic episodes.[30] Additional information on bipolar disorder can be found in Section 2.4 *Psychosis in Young People.*

Bipolar disorder may have its onset in adolescence or young adulthood. However, a person is not diagnosed with bipolar disorder until they have experienced an episode of mania. It may, therefore, take many years before they are diagnosed correctly and get the most appropriate treatment.

Risk factors for depression

Depression has no single cause and often involves the interaction of many diverse biological, psychological and social factors.[31, 32] The following factors increase a person's risk of developing depression:

- A history of depression in close family members
- Being female (see box on 'Gender differences in adolescent depression')
- Being a more sensitive, emotional and anxious person
- Adverse experiences in childhood, such as lack of care or abuse
- Family poverty and social disadvantage
- Learning and other school difficulties
- Adverse events in the person's life recently, such as being a victim of crime, death or serious illness in the family, having an accident, bullying or victimisation
- Parental separation or divorce
- Lack of a close confiding relationship with someone
- Long-term or serious physical illness
- Having another mental illness such as anxiety disorder, psychotic disorder or substance use disorder
- Premenstrual changes in hormone levels
- Caring full-time for a person with a long-term disability.[33]

Depression can also result from:

- The direct effects of some medical conditions; for example, Vitamin B12 deficiency, hypothyroidism, hepatitis, glandular fever, HIV, some cancers[5]
- The side effects of certain medications or drugs (including some used to control acne)
- Intoxication from alcohol or other drugs
- Lack of exposure to bright light in the winter months.

These risk factors are thought to produce changes in the brain that lead to the symptoms of depression. People who are depressed have a loss of connections between nerve cells in some areas of the brain (the hippocampus and prefrontal cortex) that are important in mood



and memory. Antidepressants are thought to work by helping the production of new nerve cells and the formation of connections between nerve cells in these brain areas. Other types of treatment, such as psychological therapy and exercise, possibly affect the brains of depressed people in a similar way.[34]

Gender differences in adolescent depression[35]

While depression is more common in women than men, this pattern is not seen across the whole lifespan. In childhood, depression is not common and boys tend to have slightly higher rates than girls. In adolescence, depression increases dramatically and girls begin to have 2-3 times the rate seen in boys. There are several reasons why the gender difference in depression emerges in adolescence. One of these is hormonal. The rise in depression in adolescent girls is associated with the onset of puberty, with girls who reach puberty earlier having more depressive symptoms. However, there are other factors involved as well. For example, adolescent girls invest more in relationships with friends than boys do and are more likely to become depressed when there are problems in relationships. Girls are also more likely to take on caring roles (e.g. with parents or siblings), which can increase their risk for depression.

Risk factors for bipolar disorder[36]

The causes of this disorder are not fully understood. However, the following factors are known to be involved:

Having a close relative with bipolar disorder. This is the most important risk factor known. Someone with a parent or sibling affected has around 9% risk.[37] While this is an increased risk, it means that over 90% of people with an affected relative will not develop the disorder.

No other risk factors are firmly established. However, there is some research supporting pregnancy and obstetric complications (which may affect the developing brain), birth in winter or spring (which may reflect the influence of maternal infections that vary by season), brain injury before the age of 10 years, and multiple sclerosis.

Factors that increase the risk of an episode of bipolar disorder include recent stressful life events and substance use.

The various risk factors for bipolar disorder are believed to lead to disruption to the development of the brain early in life, specifically to brain networks that control emotions. This disruption leads to instability of moods, including mania and depression.[38]

Treatments for depressive disorders

Professionals who can help

A variety of health professionals can provide help to a person with depression. They are:

- GPs
- Psychologists
- Counsellors
- Psychiatrists
- Mental health nurses

- Allied health professionals such as occupational therapists, youth workers and social workers.

More information about these professionals can be found in Section 1.1 *Mental Health Problems in Australian Youth.*

Only in the most severe cases of depression, or where there is a danger a person might harm themselves, is a depressed person admitted to a hospital. Most people with depression can be effectively treated in the community.

Treatments available for depressive disorders

Most people recover from depression and lead satisfying and productive lives. There are a range of treatments available for both depression and bipolar disorder. The following treatments have good evidence that they are effective for depression in young people.[39]

Psychological therapies

There is very good evidence for the following psychological therapies in the treatment of depression:

- ***Cognitive behaviour therapy*** is based on the idea that how we think affects the way we feel. When people get depressed they think negatively about most things. There may be thoughts about how hopeless the person's situation is and how helpless the person feels, with a negative view of themselves, the world and the future. Cognitive behaviour therapy helps the person recognise such unhelpful thoughts and change them to more realistic ones. It also helps people to change depressive behaviours by scheduling regular activities and engaging in pleasurable activities. It can include components such as stress management, relaxation techniques and sleep management. To get the full benefit of cognitive behaviour therapy, it is recommended that a person has 16-20 sessions of treatment.[40]
- ***Interpersonal psychotherapy*** helps people to resolve conflict with other people, deal with grief or changes in their relationships, and develop better relationships. To get the full benefit of interpersonal psychotherapy, it is recommended that a person has 16-20 sessions of treatment.[40]

There is also some evidence to support the helpfulness of the following:

- ***Family therapy*** refers to treatment approaches that regard family relationships as an important factor in depression. The therapist tries to help all family members change their patterns of communication so that their relationships are more supportive and there is less conflict.
- ***Problem solving therapy*** involves meeting with a therapist to clearly identify problems, think of different solutions for each problem, choose the best solution, develop and carry out a plan, and then see if this solves the problem.

Medical treatment

Antidepressant medications have been found to be effective for severe depression in adults, but they have not been shown to be as effective for adolescents. In addition, a small percentage of young people have become suicidal after using them. For these reasons, antidepressants are generally only used when other treatments have failed or for severe depression. When they are used, the doctor and carers need to monitor carefully for any sign of suicidal thoughts.[41]

If depression is severe, long lasting, and treatment resistant, electro-convulsive therapy (ECT) may be used. This treatment is used very rarely with adolescents, but can be helpful as a last resort.[42] It has some negative side effects such as short-term memory loss.



Lifestyle and complementary therapies

There has been very little research carried out on the use of these for adolescents. The only therapies that have some supporting evidence are massage and light therapy.

- ***Massage*** It is not known how massage might work to help depression, but it may be that it reduces the level of stress hormones or tension in the body.
- ***Light therapy,*** which involves bright light exposure to the eyes, often in the morning. This is most useful for seasonal affective disorder (depression that occurs during the darker winter months). This is most useful when used under the guidance of a health professional.

In addition, there are self-help strategies that the majority of Australian health professionals believe are helpful for adolescents with depression. These include exercise, relaxation training, and avoiding alcohol, cannabis and tobacco.[43]

Clinical management of depression in adolescents[41]

'beyondblue: the national depression initiative' has produced new clinical practice guidelines for the treatment of depression in adolescents, based on balancing effective treatment with the risk of doing harm.

The advice takes the form of a stepped-care approach based on severity, which means that initially, simple, less risky approaches are taken to managing the illness. If these don't work, more intensive (and potentially more risky) approaches are used.

The overall recommendations are:

1. Health professionals need to work collaboratively with adolescents to develop an acceptable care plan (for information about shared decision making, see section 1.1 of this manual).
2. If depression is mild, guided self-help, non-directive support and lifestyle advice along with monitoring may be adequate. For example, a young person with mild depression might be encouraged to use a self-help website, offered supportive counselling and encouraged to get regular moderate exercise.
3. Moderate to severe depression requires treatment. Cognitive behavioural therapy (CBT) or interpersonal therapy (IPT) should be used first.
4. For more severe depression, or if psychological treatments are not successful, anti-depressants known as selective serotonin reuptake inhibitors (SSRIs) should be considered.
5. If SSRIs are prescribed, the young person and their carers should be aware of the small risk of an increase in suicidal thinking and the importance of monitoring for this.
6. Treatment should continue for a minimum for six months, even if the symptoms have improved.

Bipolar disorder treatments

There is some evidence that the following treatments help adolescents with bipolar disorder:

- ***Medications*** There are a range of medications that can help.[44] These include mood stabilisers, antipsychotics and antidepressants.
- ***Psychoeducation*** involves providing information to the person and their family about bipolar disorder, its treatment (including the importance of medication compliance to avoid relapse) and managing its effect on their life.[45] Stress reduction, good sleep habits, and a stable social environment can help adolescents with bipolar disorder to stay well.
- ***Psychological therapies*** Two therapies that research has found to be helpful are *cognitive behaviour therapy and interpersonal and social rhythm therapy.*[45] Cognitive behaviour therapy helps people to monitor mood swings, overcome thinking patterns that affect mood, and to function better. Interpersonal and social rhythm therapy covers potential problem areas in the person's life (grief, changes in roles, disputes, and interpersonal deficits), and helps them regulate social and sleep rhythms.
- ***Family therapy*** educates family members on how they can support the person with bipolar disorder and avoid negative interactions that can trigger relapses.[45] The focus of family therapies includes family psychoeducation and developing better family communication.

Importance of early intervention for depression

In adolescents, early intervention is particularly important because depression can potentially have negative effects on a young person's development.[46] Depression in adolescents is associated with delays in social, emotional and cognitive development. Adolescents who have suffered from depression are more likely to have a range of problems in adulthood, including low educational attainment, difficulties at work, unemployment, problems in personal relationships, early pregnancy, and problems with the law.

Crises associated with depression

Two main crises that may be associated with depression are:

- The young person has **suicidal thoughts and behaviours.**
- The young person is engaging in **non-suicidal self-injury.**

Suicidal thoughts and behaviours

Suicidal thoughts and behaviours are all too common in young people. The National Survey of Mental Health and Wellbeing found that in the previous 12 months, in the 16-24 age group, approximately 3.4% seriously thought about suicide and 1.1% attempted suicide.[6] Other data come from the Australian Child and Adolescent Survey of Mental Health and Wellbeing, which found that 7.5% of adolescents aged 12-17 years seriously considered attempting suicide in the previous 12 months, and 2.4% attempted suicide.[13] Depression in adolescents is strongly associated with risk for suicide. Among 12-17 year olds with major depressive disorder, 48.6% had seriously thought about attempting suicide and 19.7% had attempted suicide



in the previous 12 months.[13] A young person may feel so overwhelmed and helpless that the future appears hopeless. They may think suicide is the only way out. Sometimes a young person becomes suicidal very rapidly, perhaps in response to a trigger (e.g. a relationship breakup or failure at school), and acts on their thoughts quickly and impulsively. The risk is increased if they have also been using alcohol. However, not every young person who is depressed is at risk for suicide and nor is every young person who has thoughts of suicide necessarily depressed.

Non-suicidal self-injury

Non-suicidal self-injury is relatively common in young people. An Australian study found that amongst adolescents, 6% of females and 5% of males had engaged in non-suicidal self-injury in the last 12 months[47] and that the median age for the first episode of non-suicidal self-injury was 17 years. Depression is strongly associated with non-suicidal self-injury, with around half of adolescents aged 12-17 years who had major depression injuring themselves in the previous 12 months.[13] Young people who engage in non-suicidal self-injury also report more emotional distress, anger problems, lower self-esteem, more risky health behaviours (including substance use) and more antisocial behaviours. Self-injury is also associated with an increased risk of suicidal ideation and suicide attempts. Adolescents who have emotional difficulties are more likely to engage in non-suicidal self-injury if they have close friends or peers who have engaged in similar behaviours.[48] Few adolescents who engage in self-injury go on to do so in the long term.[49]

The Mental Health First Aid Action Plan for Depression[50, 51]

Mental Health First Aid Action Plan

Approach the young person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give support and information

Encourage the young person to get appropriate professional help

Encourage other supports

Action 1: Approach the young person, assess and assist with any crisis

How to approach

If you think that a young person you care about may be depressed and in need of help, approach them about your concerns. Sometimes a young person may approach you about their feelings, but at other times you will need to take the initiative. When you are making the approach, plan to talk privately about your concerns, at a time and place that is convenient for both of you and free of distractions. You could try asking where they feel most comfortable or safe to talk. Be aware that the young person may not wish to open up to you until they feel that you care enough, are trustworthy and willing to listen. It is also possible that the young person may hide or downplay their problem, particularly if they feel guilty about upsetting or disappointing you. Some young people (especially boys) may fear opening up about their problems in case their vulnerability is perceived as weakness. Let the young person know that you are available to talk when they are ready; do not put pressure on them to talk right away.

There may be times when you are having a private discussion with the young person and other people arrive. In these situations, you should take a private moment to ask them what they would like to do, e.g. continue the discussion in front of others, ask others to leave or schedule another time to continue your discussion.

How to assess and assist in a crisis

As you talk with the young person, be on the lookout for any indications that they may be in crisis.

If you have concerns that the young person may be having **suicidal thoughts**, find out how to **assess** and **assist** them in Section 3.1 *First Aid for Suicidal Thoughts and Behaviours.*

If you have concerns that the young person may be engaging in **non-suicidal self-injury**,



find out how to **assess** and **assist** them in Section 3.2 *First Aid for Non-suicidal Self-injury.*

If you have no concerns that the young person is in crisis, you can ask them about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen and communicate non-judgmentally

If you believe that the young person is not in a crisis that needs immediate attention, you can engage the person in conversation, by asking how they are feeling and how long they have been feeling that way. Listening and communicating non-judgmentally is important at this stage, as it can help the young person to feel heard and understood, while not being judged in any way. This can make it easy for the person to feel comfortable to talk freely about their problems and to ask for help. Although you should encourage the young person to lead the conversation, don't be afraid to ask open, honest questions during the course of discussion. Ask the young person about their experiences and how they feel about them, rather than make your own interpretation.

It is very difficult to be entirely non-judgmental all of the time. We automatically make judgments about people from the minute we first see or meet them, based on their appearance, behaviour, and what they say. **There is more to non-judgmental listening than simply trying not to make those judgments – it is about ensuring that you do not express your negative judgments, as this can get in the way of helping.**

If you have decided to approach a young person with your concerns about them, it is a good idea to spend some time reflecting on your own state of mind first. It is best to talk to the person when you are feeling able to express your concerns without being judgmental.

You can be an effective non-judgmental listener by paying special attention to two main areas:

- Your **attitudes**, and how they are conveyed, and
- Effective **communication skills** – both verbal and non-verbal.

Attitudes

The key attitudes involved in non-judgmental listening are acceptance, genuineness and empathy.

- Adopting an attitude of **acceptance** means respecting the young person's feelings, personal values and experiences as valid, even if they are different from your own, or you disagree with them. You should not judge, criticise or trivialise what the person says because of your own beliefs or attitudes. Sometimes, this may mean withholding any and all judgments that you have made about them and their circumstances, e.g. listen to the person without judging them as weak – these problems are not due to weakness or laziness – the person is trying to cope. An important way to show acceptance is to avoid communicating stigmatising attitudes about mental illness. Be careful in applying labels to the young person that they may find stigmatising, e.g. 'mentally ill' or 'drug addict'. Choose your words carefully so as to avoid causing offence. Also be aware that the young person themselves may hold stigmatising attitudes towards mental illness and that you can model acceptance, making it easier

for them to accept help.

- **Genuineness** means that what you say and do shows the young person that they are accepted. This means not holding one set of attitudes while expressing another. Your body language and verbal cues should reinforce your acceptance of the person. For example, if you tell the person you accept and respect their feelings, but maintain a defensive posture or avoid eye contact, the person will know you are not being genuine. Young people are especially adept at recognising when an adult is not being genuine with them. Being genuine also means not trying to mimic the young person's language, slang and mannerisms if these are not natural for you. It also means that if you find that you have said something in error, you should be upfront and address the error as soon as you can.
- **Empathy** means being able to imagine yourself in the other person's place, showing them that they are truly heard and understood by you. This doesn't mean saying something glib such as "I understand exactly how you are feeling" – it is more appropriate to say that you can appreciate the difficulty that they may be going through. Remember that empathy is different from sympathy, which means feeling sorry for or pitying the person.

Verbal skills

Using the following simple verbal skills will show that you are listening:

- Ask questions that show that you genuinely care and want clarification about what they are saying.
- Check your understanding by re-stating what they have said and summarising facts and feelings.
- Listen not only to what the person says, but how they say it; their tone of voice and non-verbal cues will give extra clues about how they are feeling.
- Use minimal prompts, such as "I see" and "Ah" when necessary to keep the conversation going.
- Be patient, even when the person may not be communicating well, may be repetitive or may be speaking slower and less clearly than usual.
- Do not be critical or express your frustration at the person for having such symptoms.
- Avoid giving unhelpful advice such as "Pull yourself together" or "Cheer up". If this was possible, the person would do it.
- Do not interrupt the person when they are speaking, especially to share your opinions or experiences.
- Avoid confrontation unless necessary to prevent harmful or dangerous acts.

Remember that pauses and silences are okay. Silence can be uncomfortable for many people, but the person may need time to think on what has been said, or may be struggling to find the words they need. Interrupting the silence may make it difficult for them to get back on track, and may damage the rapport you have been building. Consider whether the silence is awkward, or just awkward for you.

Non-verbal skills

Non-verbal communications and body language express a great deal. Good non-verbal skills show that you are listening, while poor non-verbal skills can damage the rapport between you and the young person you are assisting and negate what you say.



Keep the following non-verbal cues in mind to reinforce your non-judgmental listening:

- Pay close attention to what the young person says.
- Maintain comfortable eye contact. Don't avoid eye contact, but do avoid staring; you can do this by maintaining the level of eye contact that the person seems most comfortable with.
- Be aware of the young person's body language, as this can provide clues as to how they are feeling or how comfortable they feel about talking with you. Try to notice how much personal space the adolescent feels comfortable with and do not intrude beyond that.
- Maintain an open body position. Don't cross your arms over your body, as this may appear defensive.
- If it is safe to do so, sit down, even if the young person is standing. This may seem less threatening.
- It is best to sit alongside the person and angled towards them, rather than directly opposite them.
- Avoid distracting gestures, such as fidgeting with a pen, glancing at other things or tapping your feet or fingers, as these could be interpreted as a lack of interest.

Although the focus of your conversation with the young person you are helping is on their feelings, thoughts and experiences, you need to be aware of your own as well. Helping someone who is in distress may evoke an unexpected emotional response in you; you may find yourself feeling fearful, overwhelmed, sad or even irritated or frustrated.

In spite of any emotional response you have, you need to continue listening respectfully and avoid expressing a negative reaction to what the young person says. This is sometimes difficult, and may be made more complex by your relationship with the young person or your personal beliefs about their situation. You need to set aside these beliefs and reactions in order to focus on the needs of the young person you are helping; their need to be heard, understood and helped. Remember that you are providing the person with a safe space to express themselves, and a negative reaction from you can prevent them from feeling that sense of safety.

If you find yourself feeling upset or worn out after listening non-judgmentally to a young person who is depressed, you may need to exercise some good self-care habits. See box 'It is important to care for yourself' in Chapter 1.3 *Mental Health First Aid and Young People.*

Cultural considerations for non-judgmental communication

If you are assisting a young person from a cultural background that is different from your own, you may need to adjust some of your verbal and non-verbal behaviours. For example, the person may be comfortable with a level of eye contact different from what you are used to, or may be used to more personal space.

If these differences are interfering with your ability to be an effective helper, it may be helpful to explore and try to understand the young person's experiences, values or belief systems. Be prepared to discuss what is culturally appropriate and realistic for the young person, or seek advice from someone from their cultural background before speaking to them.

If you are assisting an Aboriginal or Torres Strait Islander young person, see Appendix 1 to this manual for further information about cultural considerations and communication techniques.

More information about communicating effectively with a young person is available in Section 1.3 *Mental Health First Aid and Young People.*

Action 3: Give support and information

Give the young person information about depression. It is important that the resources you give are accurate and appropriate to their age and situation. At the same time, don't assume that the young person knows nothing about depression as they, or someone else close to them, may have experienced depression before.

Treat the young person with respect and dignity

Every young person's situation and needs are unique and it is important to respect their autonomy while considering the extent to which they are able to make decisions for themselves. Equally, you should respect the young person's privacy and confidentiality unless you are concerned that the person is at risk of harming themselves or others.

Do not blame the young person for their illness

Depression is a real health problem and the young person cannot help being affected by depression. It is important to remind them that they have a health problem and that they are not to blame for feeling 'down'.

Have realistic expectations for the young person

You should accept the young person as they are and have realistic expectations for them. Everyday activities like homework and household chores may seem overwhelming to them. You should let them know that they are not weak or a failure because they have depression, and that you don't think less of them as a person. You should acknowledge that the person is not 'faking', 'lazy', 'weak' or 'selfish'.

Offer consistent emotional support and understanding

It is more important for you to be genuinely caring than for you to say all the 'right things'. The young person genuinely needs additional care and understanding to help them through their illness so you should be empathetic, compassionate and patient. People with depression are often overwhelmed by irrational fears; you need to be gently understanding of someone in this state. It is important to be patient, persistent and encouraging when supporting someone with depression. You should also offer the young person kindness and attention, even if it is not reciprocated. Let them know that they will not be abandoned. You should be consistent and predictable in your interactions with the young person.

Give the young person hope for recovery

You need to encourage the young person to maintain hope by saying that, with time and treatment, they will feel better. Offer emotional support and hope of a more positive future in whatever form they will accept.



Provide practical help

Ask the young person if they would like any practical assistance with tasks but be careful not to take over or encourage dependency.

Provide information

Give the young person information about depression. It is important that the resources you give are accurate and appropriate to their age and situation. At the same time, don't assume that the young person knows nothing about depression as they, or someone else close to them, may have experienced depression before.

Discuss options for what to do

Try not to judge a situation on what you would do yourself, but have a discussion with the adolescent about what they think would be helpful. Discuss with and help the adolescent to assess different courses of action and to understand the consequences of each.

What isn't supportive

- There's no point in just telling a young person with depression to get better as they cannot "Snap out of it" or "Get over it."
- Do not be hostile or sarcastic when their responses aren't what you would usually expect of them. Rather accept their responses as the best they have to offer at that time.
- Do not adopt an over-involved or over-protective attitude towards a young person who is depressed.
- Do not nag the young person to try to get them to do what they normally would.
- Do not trivialise their experiences by saying "Put a smile on your face", "Get your act together", or "Lighten up".
- Do not belittle or dismiss the young person's feelings by attempting to say something positive like, "You don't seem that bad to me."
- Avoid speaking with a patronising tone of voice and do not use overly-compassionate looks of concern.
- Resist the urge to try to cure the person's depression or to come up with answers to their problems.
- Do not use scare tactics or threats, e.g. "If you keep thinking like this, you'll end up in big trouble."
- Avoid stereotyping young people, e.g. "Why are people your age always difficult and argumentative?"
- Be careful not to disagree with or minimise the young person's thoughts and feelings as this may appear dismissive of their experience, e.g. "You're not depressed, you're just bored."

Action 4: Encourage the young person to get appropriate professional help

Everybody feels down or sad at times, but it is important to be able to recognise when depression has become more than a temporary experience for someone and when to encourage that person to seek professional help. Professional help is warranted when depression lasts for weeks and affects a young person's functioning in daily life. Many young people with depressive disorders do not seek professional help. According to the National Survey of Mental Health and Wellbeing, only 49% of young people aged 16-24 with depression in the past year received professional help for their problem.[29] However, according to the Australian Child and Adolescent

Survey of Mental Health and Wellbeing, where the diagnosis was based on parent report of symptoms, the rate of getting professional help was much higher (82%) in 12-17 year olds.[13] Young people with depressive disorders may be more likely to seek help if a parent or another adult close to them suggests it.

Discuss options for seeking professional help

You should ask the young person if they need help to manage how they are feeling. If they feel they do need help, discuss the options that they have for seeking help and encourage them to use these options. If the young person does not, help them seek assistance. It is important to encourage the young person to get appropriate professional help and effective treatment as early as possible. For a younger adolescent, you may need to help them to make and attend an appointment with a health professional. Older adolescents may not need the same level of assistance, but this depends on their maturity and the severity of the problem. Depression is not always recognised by health professionals; it may take some time to get a diagnosis and find a healthcare provider with whom the person is able to establish a good relationship. You should encourage the young person not to give up seeking appropriate professional help.

What if the person doesn't want help?

The young person may not want to seek professional help. You should find out if there are specific reasons why this is the case. For example, they might be concerned that their parents can't afford treatment, they may not have a doctor they like, or they might be worried they will be sent to hospital. These reasons may be based on mistaken beliefs and you may be able to help the young person overcome their worry about seeking help. If the young person still doesn't want help after you have explored their reasons with them, let them know that if they change their mind in the future about seeking help they can speak to you. If you think the young person lacks the maturity to understand what is happening to them and refuses help, you need to contact their parents or a health professional.

Action 5: Encourage other supports

Other people who can help

Encourage the young person to consider other supports available to them, such as family, friends and support groups. Some young people who experience depression find it helpful to meet with others who have had similar experiences. Family and friends can also be an important source of support for a young person who is depressed. Recovery from symptoms is quicker for people who feel supported by those around them.[52]

Self-help strategies

Young people who are depressed may benefit from using self-help strategies. Their ability and desire to use self-help strategies will depend on their interests and the severity of their depression. Therefore you should not be too forceful when trying to encourage the person to use self-help strategies.

Self-help strategies may be useful in conjunction with other treatments and may be suitable for people with less severe depression. It is important that severe or long lasting depression be assessed by a health professional. It is a good idea to discuss the appropriateness of self-help strategies with a health professional.



Helpful resources for depression and suicidal thoughts in young people

Telephone and online services

Kids Help Line

1800 55 1800

This web-based and email counselling service is available 24 hours a day, 7 days a week, for young people aged up to 25 years.

www.kidshelp.com.au

Kids Help Line

1800 55 1800

This is a telephone counselling service is available 24 hours a day, 7 days a week, for young people aged up to 25 years. It is free from a landline, but there will be a charge if a call is made from a mobile phone.

Suicide Call Back Service

1300 659 467

This is a telephone counselling service available 24 hours a day, 7 days a week for people who are suicidal.

www.suicidecallbackservice.org.au

Mental Health Crisis Numbers

ACT: Mental Health Triage Service, 24 hours, 7 days, 1800 629 354 or 02 6205 1065

NSW: Ring nearest hospital or the Mental Health Line on 1800 011 511

NT: Northern Territory Mental Health Services on 1800 682 288

QLD: Call the nearest hospital, Emergency Services 000 or Lifeline 13 11 14

SA: Crisis Team 13 14 65

TAS: 1800 332 388 (9am – 11pm) or nearest hospital

VIC: Suicide Helpline Victoria 1300 651 251 or ring nearest hospital for closest crisis team

WA: In Perth, call the Mental Health Emergency Response Team on 08 9224 8888; elsewhere, call RuralLink on 1800 552 002.

Websites

***beyondblue*: the national depression and anxiety initiative**

www.beyondblue.org.au

The *beyondblue* website has screening questionnaires for depression and anxiety. It also has information about depressive disorders, anxiety disorders and professionals who can help. Many resources and fact sheets are available in multiple languages.

For parents and other adults

Parenting Strategies

www.parentingstrategies.net

This website hosts guidelines which consist of strategies that parents can undertake to help prevent depression and anxiety problems in their teenagers. The suggested strategies may also be useful for parents whose child is already experiencing some problems with depression or anxiety.

National Institute of Mental Health (NIMH)

www.nimh.nih.gov

This US government site gives a wealth of excellent, up-to-date information on depression and suicide in the form of downloadable booklets and fact sheets.

For adolescents and young people

youth*beyondblue*: the national depression and anxiety initiative

www.youthbeyondblue.com

This website provides youth-specific information about anxiety and depression including downloadable factsheets, young people's own stories about their experiences of depression and a list of doctors and mental health practitioners with an interest in treating depression. *beyondblue* also has a 24-hour helpline that gives information and referral to services for depression and anxiety and a directory of e-mental health services and therapies.

MoodGYM

http://moodgym.anu.edu.au

This cognitive behaviour therapy website has been evaluated in a scientific trial and found to be effective in preventing and reducing some depression symptoms in young people if they stuck to the program.[53] This site teaches people to use ways of thinking that will help prevent depression.

Books

For parents and other adults

Parker G, Eyers K. *Navigating Teenage Depression: A Guide for Parents and Professionals.* Crows Nest NSW, Australia: Allen and Unwin; 2009.

This book was produced by the Black Dog Institute in Sydney. It includes excerpts from essays submitted by young people describing their experiences of depression. There is information about professional help, treatments and ongoing management.

Johnstone M, Johnstone A. *Living With a Black Dog: How to Take Care of Someone with Depression While Looking After Yourself.* Sydney, NSW, Australia: Pan Macmillan Australia; 2008.

This is another insightful self-help picture book for carers.

Purcell R, Ryan S, Scanlan F, Morgan A, Callahan P, Allen N, Jorm A. *A Guide to What Works for Depression in Young People,* 2nd edition. Melbourne VIC, Australia; beyondblue; 2013.

This booklet looks at what the scientific evidence has to say about a range of treatments for young people with depression. It is designed to help young people and their families make informed choices when seeking treatment. It is available for free from beyondblue.

For adolescents and young people

Johnstone M. *I Had a Black Dog: His Name Was Depression.* Sydney, NSW, Australia: Pan Macmillan Australia; 2005.

This is another insightful self-help picture book.



Agoraphobia

"I suffer from agoraphobia and this is how I felt before I understood my condition and learned to cope with this feeling." **Tammy Hurdle**

2.2 Anxiety in Young People

What are anxiety problems?

Everyone experiences anxiety at some time. When people describe their anxiety, they may use terms such as: anxious, stressed, uptight, nervous, frazzled, worried, tense or hassled. Although anxiety is an unpleasant state, it can be quite useful in helping a person to avoid dangerous situations and motivate the solving of everyday problems. Anxiety is mostly caused by perceived threats in the environment, but some people are more likely than others to react with anxiety when they are threatened. Anxiety can vary in severity from mild uneasiness through to a terrifying panic attack. Anxiety can also vary in how long it lasts, from a few moments to many years. Anxiety problems differ from normal anxiety in the following ways. They are:

- more severe
- longer lasting
- interfere with the person's work, other activities or relationships.

Anxiety can affect someone's thinking, feeling, behaviour and physical well-being, as shown in the box.

Signs and symptoms of anxiety

Thinking

Mind racing or going blank, decreased concentration and memory, indecisiveness, confusion, vivid dreams.

Feeling

Unrealistic or excessive fear and worry (about past and future events), irritability, impatience, anger, feeling on edge, nervousness.

Behaviour

Avoidance of situations, obsessive or compulsive behaviour, distress in social situations, sleep disturbance, increased use of alcohol or other drugs.

Physical

- Heart: pounding heart, chest pain, rapid heartbeat, blushing
- Breathing: rapid, shallow breathing and shortness of breath
- Nervous system: dizziness, headache, sweating, tingling and numbness
- Gastro-intestinal: choking, dry mouth, stomach pains, nausea, vomiting and diarrhoea
- Muscles: aches and pains (especially neck, shoulders and back), restlessness, tremors and shaking.

The symptoms are similar in both adults and adolescents. Some anxiety symptoms are particularly common in adolescents. These include worry in general but particularly worry about what others think of them, fear of social situations and anxiety about past imperfections.[54]

What are anxiety disorders?

People with anxiety problems may be diagnosed with different types of anxiety disorders. These disorders differ from each other by the types of situations or things that the person feels anxious about and by the sorts of beliefs they have that exacerbate their anxiety. The main types of disorders where anxiety is a major feature are post-traumatic stress disorder, social anxiety disorder (social phobia), agoraphobia, generalised anxiety disorder, panic disorder, and obsessive-compulsive disorder. It is not unusual for a person to have more than one of these disorders.

According to the National Survey of Mental Health and Wellbeing, anxiety disorders affect 15% of young people in Australia aged 16-24 in any one year. Anxiety disorders are more common in females (22%) than males (9%). Anxiety disorders frequently start in adolescence. The median age of onset is 15 years,[12] which means that half the people who will ever have an anxiety disorder will have had their first episode by the age of 15. Anxiety disorders often co-occur with depression and substance use disorders.[27]

Other data come from the Australian Child and Adolescent Survey of Mental Health and Wellbeing, which asked parents (but not their children) about symptoms of a number of anxiety disorders in their children.[13] According to parent report, 7.0% of 12-17 year olds had an anxiety disorder in the previous 12 months. However, this figure is likely to be an under-estimate, because the survey did not cover some anxiety disorders (e.g. post-traumatic stress disorder) and parents may not always have been aware of anxiety symptoms in their adolescent children.

Types of anxiety disorders

There are many different types of anxiety disorders.[5] The main ones are generalised anxiety disorder, panic disorder and agoraphobia, phobic disorders including social anxiety disorder, separation anxiety disorder, post-traumatic stress disorder and obsessive compulsive disorder.

While this manual, and the Youth Mental Health First Aid course, are not designed to teach you to diagnose anxiety disorders, it is helpful to understand what some of the symptoms are. There are many symptoms that can indicate the presence of an anxiety disorder and some of them may seem strange to people who do not have an understanding of them. Some behaviours may result in disciplinary actions at home or school and others may result in discrimination or stigmatising attitudes from others.

It is not unusual for a person to have more than one of these anxiety disorders. The table below shows how common each of these is according to the National Survey of Mental Health and Wellbeing (reports from 16-24 year olds) and the Australian Child and Adolescent Survey of Mental Health and Wellbeing (reports from parents of 12-17 year olds).

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder can occur after a person is exposed to actual or threatened death, serious injury or sexual violation. Examples of traumas include involvement in war, accidents, assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, warfare and severe weather events (cyclone, tsunami and bushfire). In a study of

Percentage of Australians aged 16-24 with anxiety disorders in any one year [29]*

Type of anxiety disorder	Males	Female	All
Post-traumatic stress disorder	4%	12%	8%
Social anxiety disorder (social phobia)	4%	7%	5%
Agoraphobia	2%	4%	3%
Panic disorder	2%	3%	2%
Obsessive-compulsive disorder	1%	3%	2%
Generalised anxiety disorder	0.4%	2%	1%
Any of the above anxiety disorders	**9%**	**22%**	**15%**

* The National Survey of Mental Health and Wellbeing included post-traumatic stress disorder and obsessive-compulsive disorder in the types of anxiety disorders. However, since 2013, the American Psychiatric Association has classified them as separate types of disorders, while acknowledging that anxiety is an important factor in both.

Percentage of Australian adolescents aged 12-17 with anxiety disorders in any one year, according to parent report[13]

Type of anxiety disorder	Males	Female	All
Social anxiety disorder (social phobia)	3%	3%	3%
Separation anxiety disorder	4%	3%	3%
Generalised anxiety disorder	2%	3%	3%
Obsessive-compulsive disorder	1%	1%	1%
Any of the above anxiety disorders	**6%**	**8%**	**7%**

Australian adolescents it was found that 9% developed PTSD following a bushfire disaster.[55]

A major symptom is re-experiencing the trauma. This may be in the form of recurrent dreams of the event, flashbacks, intrusive memories or unrest in situations that bring back memories of the original trauma. There is avoidance behaviour, such as persistent avoidance of things associated with the event, which may continue for months or years. Also, persistent symptoms of increased emotional distress occur (constant watchfulness, jumpiness, being easily startled, irritability, aggression, insomnia). The person may also overly blame themselves or others, show reduced interest in others and the outside world, and may not be able to fully remember the event.

It is common for people to feel greatly distressed immediately following a traumatic event. If their distress lasts longer than a month, they may have post-traumatic stress disorder. Only some people who are distressed following a traumatic event will go on to develop a mental illness such as post-traumatic stress disorder or depression.

Social anxiety disorder (social phobia)

This involves extreme discomfort or fear in a variety of social situations. Commonly feared situations include speaking or eating in public, dating and social events. These are situations

where public scrutiny may occur, usually with the fear of behaving in a way that is embarrassing or humiliating. The key fear is that others will think badly of the person. The anxiety about social situations must persist for 6 months or longer. Social anxiety disorder often develops in shy children as they move into adolescence.

Separation anxiety disorder

A young person with separation anxiety disorder shows excessive anxiety about being separated from home or from a parent or caregiver. The person will worry about losing the loved one or about harm happening to them. Young people with separation anxiety may be reluctant to leave home without the loved one or to be left alone, and they may refuse to go to school because of fear of separation. Separation anxiety is most common in young children, but can occur during adolescence as well, often as a result of having lost a parent or other close family member.

Generalised anxiety disorder (GAD)

Some young people experience long-term anxiety across a whole range of situations and this interferes with their life. These people have generalised anxiety disorder. The main symptoms of generalised anxiety disorder are overwhelming, unfounded anxiety and worry (about things that may go wrong or one's inability to cope) accompanied by multiple physical and psychological symptoms of anxiety or tension occurring more days than not, for at least six months. Young people with generalised anxiety disorder worry excessively about, health, money, appearance, schoolwork, sports and other regular activities, even when there are no signs of trouble. The anxiety appears difficult to control. Other characteristics can include an intolerance of uncertainty, belief that worry is a helpful way to deal with problems and poor problem solving. Generalised anxiety disorder can make it difficult for young people to concentrate at school or work, function at home and generally get on with their lives.

Panic disorder

Some people have short periods of extreme anxiety called a **panic attack**. A panic attack is a sudden onset of intense apprehension, fear or terror. These attacks can begin suddenly and develop rapidly. This intense fear is inappropriate for the circumstances in which it is occurring. Other symptoms, many of which can appear similar to those of a heart attack, can include racing heart, sweating, shortness of breath, chest pain, dizziness, feeling detached from oneself and fears of losing control. Once a person has had one of these attacks, they often fear another attack and may avoid places where attacks have occurred. The person may avoid exercise or other activities that may produce physical sensations similar to those of a panic attack.

It is important to distinguish between a panic attack and a panic disorder. Having a panic attack does not necessarily mean that a person will develop **panic disorder**. A person with panic disorder experiences recurring panic attacks and, for at least one month, is persistently worried about possible future panic attacks and the possible consequences of panic attacks, such as a fear of losing control or having a heart attack. Some people may develop panic disorder after only a few panic attacks, while others may experience many panic attacks without developing a panic disorder. Some people with panic disorder also develop agoraphobia (described below) where they avoid places where they fear they may have a panic attack.

Agoraphobia

A person with agoraphobia avoids situations such as being outside of the home alone, using public transport, being in either open spaces (e.g. a parking lot or bridge) or in an enclosed space (e.g. a shopping mall or a theatre). The focus of the person's anxiety is that it will be difficult or embarrassing to get away from the place if a panic attack or other embarrassing symptoms occur, or that there will be no one present who can help. Some may avoid only a few situations or places, for example parties, enclosed places, or cars. Others may avoid leaving their homes altogether. The younger a person is when they have their first panic attack, the more likely they are to develop agoraphobia.[56] Although agoraphobia can occur without panic attacks, this is less common.

Obsessive-compulsive disorder (OCD)

This disorder is not common but is very disabling. Obsessive-compulsive disorder often begins in adolescence and may be a lifelong illness. Obsessive thoughts and compulsive behaviours accompany feelings of anxiety. **Obsessive thought**s are recurrent thoughts, impulses and images that are experienced as intrusive, unwanted and inappropriate, and cause marked anxiety. Most obsessive thoughts are about fear of contamination, symmetry and exactness, safety, sexual impulses, aggressive impulses and religious preoccupation.

Compulsive behaviours are repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession in order to reduce anxiety. Common compulsions include washing, checking, repeating, ordering, counting, hoarding, or touching things over and over.

Specific phobias

A person with a phobia avoids or restricts activities because of fear. This fear appears persistent, excessive and unreasonable. Specific phobias are common, but are less disabling than other anxiety disorders. The person may have an unreasonable strong fear of specific places, events or objects and often avoid these completely. The most common fears are of spiders, insects, mice, snakes and heights. Other feared objects or situations include an animal, blood, injections, storms, driving, flying, or enclosed places.

Mixed anxiety, depression and substance use problems

Many young people with anxiety problems do not fit neatly into a particular type of anxiety disorder. It is common for people to have some features of several anxiety disorders. A high level of anxiety over a long period will often lead to depression, so that many people have a mixture of anxiety and depression.

People with anxiety disorders frequently use substances as a form of self-medication to help cope. This can lead to substance use problems. Furthermore, heavy use of alcohol and drugs can lead to increased anxiety.[57]

What might a first aider notice if a young person has an anxiety disorder?

When we think of anxiety disorders, we typically imagine someone who is very introverted and perhaps not very communicative. This is certainly an accurate description of some people with anxiety disorders. However, there are other presentations, particularly amongst young people, that may make it difficult to identify anxiety as the underlying problem. This can lead to delayed recognition, unnecessary disciplinary

responses, and difficulties in adolescent development, particularly social and educational development.

A first aider cannot diagnose an anxiety disorder. However, a first aider may be able to recognise the cluster of symptoms that indicate that an anxiety disorder may be the problem. Below are some descriptions of a young person's appearance and behaviour that might indicate that anxiety has become a problem.

At home, an anxious young person may:

- Complain of headaches and other physical problems to avoid going to school
- Be tearful in the morning, saying they don't want to go to school
- Spend more time than necessary doing homework or express a lot of concern that their work isn't good enough
- Demand constant reassurance from parents
- Be touchy and irritable in interactions with family
- Spend a lot of time getting ready for social occasions, worrying about appearance or what they might do, or decide at the last minute not to attend social occasions.

In a school environment, an anxious young person may:

- Be extremely well-behaved and quiet, and fearful of asking questions
- Demand extra time from teachers, asking questions constantly and needing a great deal of reassurance
- Fail to hand in work and assignments on time because the work is perceived as less than perfect
- Complain of sudden, unexplained physical illness such as stomach aches and headaches when exams or presentations have been scheduled.

These presentations can all have an impact on school achievement. A specific phobia of school may result in absenteeism, as well. Some of these behaviours may result in disciplinary responses.

The friends of an anxious young person may notice that they:

- Avoid meeting new people or socialising with groups, spending time with only a few 'safe' friends
- Use alcohol or other drugs at parties to make it easier to talk to people
- Leave social events early
- Avoid speaking up for fear of embarrassment.

In addition, anxiety disorders can make it difficult for some young people to be assertive, make their own decisions and act in accordance with their values.

Risk factors for anxiety disorders

People most at risk are those who:[56, 58]

- Have a more sensitive emotional nature and who tend to see the world as threatening
- Have a history of anxiety in childhood or adolescence, including marked shyness
- Are female
- Abuse alcohol
- Experience a traumatic event.

There are some family factors that increase risk for anxiety disorders:

- A difficult childhood (for example, experiencing physical, emotional, or sexual abuse, neglect, or over strictness)
- A family background that involves poverty or a lack of job skills
- A family history of anxiety disorders

- Parental alcohol problems
- Parental separation and divorce.

Anxiety symptoms can also result from:

- Some medical conditions such as hyperthyroidism, arrhythmias, vitamin B12 deficiency[5]
- Side effects of certain prescription and non-prescription medications
- Intoxication with alcohol, amphetamines, caffeine, cannabis, cocaine, hallucinogens and inhalants
- Withdrawal from alcohol, cocaine, sedatives and anti-anxiety medications.

Some young people develop ways of reducing their anxiety that cause further problems. For example, people with phobias avoid anxiety-provoking situations. This avoidance reduces their anxiety in the short term, but can limit their lives in significant ways. Similarly, people with compulsions reduce their anxiety by repetitive acts such as washing hands. The compulsions then become problems in themselves.

Interventions for anxiety disorders

Professionals who can help

A variety of health professionals can provide help to a young person with an anxiety disorder:

- GPs
- Psychologists
- Mental health nurses
- Counsellors
- Psychiatrists
- Occupational therapists and social workers with mental health training.

More information about how these professionals can help is available in Section 1.1 *Mental health Problems in Australian Youth.*

If the young person is uncertain about what to do, encourage them or their parents to consult a GP first, as the GP can check if there is an underlying physical health problem causing this anxiety and refer the young person to the appropriate specialist help.

Treatments available for anxiety disorders

Research shows that a wide range of treatments can help with anxiety disorders.

Psychological therapies

Various psychological therapies are used for anxiety disorders, but the following have the strongest evidence for effectiveness:[59, 60]

- ***Cognitive behaviour therapy*** is the best all round treatment for anxiety disorders. It involves working with a therapist to look at patterns of thinking (cognition) and acting (behaviour) that are making the person more likely to have problems with anxiety, or are keeping them from improving once they become anxious. Once these patterns are recognised, then the person can make changes to replace these patterns with new ones that reduce anxiety and improve coping. To get the full benefit of cognitive behaviour therapy, a person needs to have sufficient number of sessions. As a guide, it is recommended that a person has 12-15 sessions of treatment for generalized anxiety disorder, 14-16 for social anxiety disorder, 4-14 for panic disorder, 8-12 for post-traumatic stress disorder and 10 for obsessive-compulsive disorder.[40]
- ***Behaviour therapy (also known as exposure therapy)*** is often a component of cognitive behaviour therapy. It involves exposing the person to the things that make them anxious. The person might be exposed to feared situations in real life or in imagination, usually in a gradual way.

This type of therapy teaches the person that their fear will reduce without the need to avoid or escape the situation, and that their fears about the situation often do not come true or are not as bad as they thought.

Many psychological treatments are available over the Internet or in books. While these are often evidence-based treatments for adults, less research has been done with young people. Because a high level of motivation and literacy is required to use such treatments, they may be less suitable for a lot of young people. However, for some young people these approaches will be effective. A clinician may recommend such approaches, and guide the young person through the program.

Medical treatment

Scientific evidence supports the effectiveness of ***antidepressant medications*** for the treatment of severe anxiety disorders such as obsessive-compulsive disorder in young people.[73]

Lifestyle and complementary therapies

Relaxation training has been shown to be effective for young people with anxiety disorders. Relaxation training involves learning to relax by tensing or relaxing specific groups of muscles, or by thinking of relaxing scenes or places. Recorded instructions are available for free on the Internet or can be bought on CDs (see *Helpful resources* at the end of this chapter). Relaxation training is most useful when learned under the guidance of a health professional.[62]

In addition, there are ***self-help strategies*** that the majority of Australian health professionals believe are helpful for young people with anxiety disorders. These include meditation, exercise, relaxation training, and avoiding alcohol, cannabis and tobacco.[62]

Importance of early intervention for anxiety disorders

It is important that anxiety disorders are recognised and treated early because they can have a major impact on a person's subsequent life. Anxiety disorders often develop in childhood and adolescence and, if they are not treated, the person is more likely to have a range of adverse outcomes later in life such as depression, alcohol dependence, drug dependence, suicide attempts, lowered educational achievement and early motherhood.[63] Because of these long-term consequences, it is very important that anxiety disorders are recognised early and people get appropriate professional help.

Crises associated with anxiety disorders

Crises that may be associated with anxiety are:

- The young person experiences an extreme level of anxiety such as a **panic attack.**
- The young person has severe anxiety following a **traumatic event.**
- The young person has **suicidal thoughts and behaviours.**
- The young person is engaging in **non-suicidal self-injury.**

Panic attack

More than one in four people have a panic attack at some time in their lives.[56] Few go on to on to have repeated attacks, and fewer still go on to develop panic disorder or agoraphobia. Although anyone can have a panic attack, people with anxiety disorders are more prone.

Traumatic event

A traumatic event is one that causes an individual or group to experience intense feelings of terror, horror, helplessness, or hopelessness. The person could directly

experience the event, witness it happen to others or learn that it has happened to someone close to them. Most people who experience a traumatic event do not develop a mental illness. Others experience symptoms of severe stress and may go on to develop post-traumatic stress disorder or another anxiety disorder or depression.

Suicidal thoughts and behaviours

Extreme levels of anxiety are the most obvious crisis seen in young people with anxiety disorders. However, there is also the possibility of suicidal thoughts. The risk of suicide in people with anxiety disorders is not as high as for some other mental illnesses.[64] However, the risk increases if the young person also has a depressive or substance use disorder. In any interaction with a young person with an anxiety disorder, be alert to any warning signs of suicide.

Non-suicidal self-injury

Anxiety disorders greatly increase the risk for non-suicidal self-injury.[65] Non-suicidal self-injury may be a coping mechanism for feelings of unbearable anxiety. Almost 60% of people who engage in non-suicidal self-injury have been diagnosed with an anxiety disorder at some time in their lives.[47]

The Mental Health First Aid Action Plan for Anxiety Problems

Mental Health First Aid Action Plan

Approach the young person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give support and information

Encourage the young person to get appropriate professional help

Encourage other supports

Action 1: Approach the young person, assess and assist with any crisis

How to approach

The approach that is helpful to someone with severe anxiety is very similar to that for someone experiencing depression – see Section 2.1 *Depression in Young People*. The key points are:

- Approach the young person about your concerns about their anxiety
- Find a suitable time and space where you both feel comfortable
- If the young person does not initiate a conversation with you about how they are feeling, you should say something to them
- Respect the person's privacy and confidentiality.

How to assess and assist in a crisis

As you talk with the young person, be on the lookout for any indications that the person may be in crisis.

If you have concerns that the young person may be having a **panic attack**, find out how to **assess** and **assist** this person in Section 3.3 *First Aid for Panic Attacks.*

If the young person has experienced a **traumatic event**, find out how to assess and assist this person in Section 3.4 *First Aid for Traumatic Events Affecting Adults* and Section 3.5 *First Aid for Traumatic Events Affecting Children.*

If you have concerns that the young person may be having **suicidal thoughts**, find out how to **assess** and **assist** this person in Section 3.1 *First Aid for Suicidal Thoughts and Behaviours.*

If you have concerns that the young person may be engaging in **non-suicidal self-injury**, find out how to **assess** and **assist** this person in Section 3.2 *First Aid for Non-suicidal Self-injury.*

If you have no concerns that the young person is in crisis, you can ask them about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen and communicate non-judgmentally

See Action 2 in Section 2.1 *Depression in Young People* for more tips on non-judgmental listening. Some main points to remember are:

- Engage the young person in discussing how they are feeling and listen carefully to what they say.
- Do not express any negative judgements about the young person's character or situation.
- Be aware of your body language, including posture, eye contact, and physical position in relation to the young person.
- To ensure you understand what the young person says, reflect back what you hear and ask clarifying questions.
- Allow silences; be patient, do not interrupt the young person, and use only minimal prompts such as "I see" and "Ah".
- Do not give flippant or unhelpful advice, such as "Pull yourself together".
- Avoid confrontation unless necessary to prevent harmful acts.

Action 3: Give support and information

See Action 3 in Section 2.1 *Depression in Young People* for more advice about giving support and information. The support and information that is helpful to someone with an anxiety problem is very similar to that given to someone experiencing depression. You can support the young person in the following ways:

- Treat the young person with respect and dignity
- Do not blame them for their illness
- Have realistic expectations for the young person
- Offer consistent emotional support and understanding
- Give the young person hope for recovery
- Provide practical help
- Offer information.

What isn't supportive

It is important for the first aider to know that recovery from anxiety disorders requires facing situations that are anxiety-provoking. Avoiding such situations can slow recovery and make anxiety worse. Sometimes, family and friends can think they are being supportive by facilitating the young person's avoidance of anxiety-provoking situations, but can inadvertently slow down the recovery process.

Other actions that are not supportive include: dismissing the young person's fears as trivial (e.g. by saying "That is nothing to be afraid of"), telling them "Toughen up" or "Don't be so weak" and speaking in a patronising tone of voice.

Action 4: Encourage the young person to get appropriate professional help

Many people with anxiety disorders do not realise there are treatments that can help them have a better life. According to the National Survey of Mental Health and Wellbeing, only 32% of young people aged 16-24 who had an anxiety disorder in the past year received professional help for their problem.[12] However, according to the more recent Australian Child and Adolescent Survey of Mental Health and Wellbeing, where the diagnosis was based on parent report of symptoms, the rate of getting professional help was much higher (72%) in 12-17 year olds.[13] Young people with anxiety disorders may be more likely to seek help if a parent or another adult close to them suggests it. If a young person does not get help, this can cause serious consequences in their life, limiting social and occupational opportunities and increasing the risk for depression, and drug and alcohol problems.

Discuss options for seeking professional help

Ask the young person if they need help to manage how they are feeling. If they feel they do need help, then respond as follows:

- Encourage the young person to discuss with their parents the anxiety they are experiencing
- Discuss the appropriate professional help and effective treatment options
- Help the young person to use these options
- Encourage the young person not to give up seeking appropriate professional help.

What if the young person doesn't want help?

The young person may not want to seek professional help. You should find out if there are specific reasons why this is the case. For example, the young person might be embarrassed or shy, or be concerned that the doctor will judge them negatively.[21] You may be able to help the young person overcome their worry about seeking help. If the person still doesn't want help after you have explored their reasons with them, let them know that if they change their mind in the future about seeking help they can contact you.

Action 5: Encourage other supports

Other people who can help

Encourage the young person to consider other support available to them, such as family, friends and any services available for them through their school. Young people identify family and friends as their primary sources of support.[21] Friends and family can assist by learning what they can about anxiety disorders in order to offer the best possible support.

Self-help strategies

Some young people who are troubled by anxiety use self-help strategies. The young person's ability and desire to use self-help strategies will depend on their interests and the severity of their symptoms. Therefore you should not be too forceful when trying to encourage the young person to use self-help strategies.

If a young person wishes to use self-help strategies this should be discussed with a professional, and parental support is important. People with more severe anxiety disorders may need to use self-help strategies in conjunction with medical or psychological treatments.

Helpful resources for anxiety problems in young people

Telephone and online support

Kids Help Line

1800 55 1800

This is a telephone, web-based and email counselling service is available 24 hours a day, 7 days a week, for young people aged up to 25 years. It is free from a landline, but there will be a charge if a call is made from a mobile phone

www.kidshelp.com.au

Websites

For parents and other adults

beyondblue: the national depression and anxiety initiative

www.beyondblue.org.au

This website provides questionnaires to allow self-assessment of anxiety and depression, information sheets on anxiety and depressive disorders, and a list of doctors and mental health practitioners with an interest in treating mental illness. *beyondblue* also has a 24-hour helpline that gives information and referral to services for anxiety and depression. There is also a directory of e-mental health services and therapies.

National Institute of Mental Health

www.nimh.nih.gov

This is a US government website which has a wealth of information on anxiety disorders.

For adolescents and young people

BRAVE

www.brave-online.com

BRAVE is an interactive, online and evidence-based[66] cognitive behavioural therapy (CBT) program for the prevention of anxiety for children and teenagers, with complementary programs for their parents. Families complete the program with the guidance of an 'online therapist', who assists them where necessary. There is also a fully self-guided program for adolescents, and fully self-guided programs for parents of children and adolescents.

youthbeyondblue

www.youthbeyondblue.com

This website provides: questionnaires to allow self-assessment of anxiety and depression; downloading information sheets on depression and anxiety disorders; and a list of doctors and mental health practitioners with an interest in treating mental illness.

Books

For parents

Foa EB, Andrews LW. *If Your Adolescent Has an Anxiety Disorder: An Essential Resource for Parents.* New York, NY, USA: Oxford University Press; 2006.

This book incorporates clinical expertise with the experiences of parents of anxious adolescents. It includes information about anxiety disorders in adolescents, treatment options and juggling treatment with school and social activities.

For adolescents and young people

Schab LM. *The Anxiety Workbook for Teens: Activities to Help You Deal with Anxiety & Worry.* Oakland, USA: New Harbinger Publications; 2004.

This self-help book for adolescents teaches relaxation and coping skills, and can help a young person to develop a more positive self-image. Adolescents who are motivated to follow a program of self-help may benefit from using this book, particularly with the assistance of a clinician or parent.

Phillips N. T*he Panic Book.* Concord West, NSW, Australia: Shrink–Rap Press; 2005.

Wever C, Phillips N. *The Secret Problem*. Concord West, NSW, Australia: Shrink–Rap Press; 2006.

These books are suitable for people of all ages, and were written and illustrated by two psychiatrists. They are easy to read and incorporate important information about anxiety disorders, how to cope with them and how to think more realistically about fears and anxiety. *The Panic Book* is about panic attacks, panic disorder and agoraphobia, and *The Secret Problem* is about obsessive-compulsive disorder.

These books can be ordered from the Shrink Rap Press website: www.shrinkrap.com.au.



"It is hard to love yourself the way you are, particularly in such a visual world like today, with increasing amounts of photoshopping and the idealisation of women. It is a sad aspect of many adolescents' struggles. These expectations have really had a major impact on how negatively I have seen myself over the years and I still find it very challenging to view myself the way others see me." **Victoria**

2.3 Eating Disorders in Young People

What are eating disorders?

Eating disorders are not just about food, weight, appearance or will-power but are serious and potentially life threatening illnesses.[67] Most eating disorders occur when a young person has incorrect beliefs about their appearance, body shape and weight, leading to marked changes in eating or exercise behaviours that interfere with their life. Whereas most young people evaluate themselves by achievements in various areas, such as social relationships, school, work or sporting ability, those with eating disorders see their self-worth largely in terms of their body shape and weight and their ability to control these. Most people with eating disorders are very distressed with feeling or appearing overweight or physically unattractive. A young person with an eating disorder can be underweight, overweight or fall within the healthy weight range.

Some young people with eating disorders lose weight, sometimes to the point of starvation. Although they are often seriously underweight, they see this as a success rather than as a problem and have limited motivation to change. This is the pattern in **anorexia nervosa.** Other young people attempt to lose weight but these attempts are undermined by periods of uncontrolled overeating so that 'normal' weight may be maintained, or the person may be somewhat overweight or underweight. This is the pattern in **bulimia nervosa.** Some young people move between these different patterns over time.

Young people with **binge eating disorder** engage in episodes of binge eating (eating a lot of food in a short period of time with a sense of a loss of control), but do not engage in any sustained weight-control behaviours.

Eating disorders are more common in females than in males. The median age of onset for eating disorders is 18 years, i.e. 50% have had their first episode before this age.[68] A high proportion of people with eating disorders also have another mental disorder, particularly anxiety disorders, mood disorders and substance use disorders.[67] However, many do not receive treatment.

Signs and symptoms of eating disorders

It is important to know the signs that indicate that a young person has or is developing an eating disorder. These include behavioural, physical and psychological signs.[69]

Behavioural warning signs

- Dieting behaviours, e.g. fasting, counting calories/kilojoules, avoidance of food groups or types
- Evidence of binge eating, e.g. disappearance or hoarding of food
- Evidence of deliberate vomiting or laxative use, e.g. taking trips to the bathroom during or immediately after meals
- Excessive, obsessive or ritualistic exercise patterns, e.g. exercising when injured or in bad weather, feeling compelled to perform a certain number of repetitions of exercises or experiencing distress if unable to exercise
- Changes in food preferences, e.g. refusing to eat certain 'fatty' or 'bad' foods, or cutting out whole food groups such as meat or dairy, claiming to dislike foods previously enjoyed, a sudden concern with 'healthy eating', or replacing meals with fluids
- Development of rigid patterns around food selection, preparation and eating, e.g. cutting food into small pieces, eating very slowly
- Avoidance of eating meals, especially when in a social setting, e.g. skipping meals by

claiming they have already eaten or have an intolerance/allergy to particular foods
- Lying about amount or type of food consumed or evading questions about eating and weight
- Behaviours focused on food, e.g. planning, buying, preparing and cooking meals for others but not consuming meals themselves, interest in cookbooks, recipes and nutrition
- Behaviours focused on body shape and weight, e.g. interest in weight-loss websites, books and magazines, or images of thin people
- Development of repetitive or obsessive behaviours relating to body shape and weight, e.g. body-checking such as pinching waist or wrists, repeated weighing of self, excessive time spent looking in mirrors
- Social withdrawal or avoidance of previously enjoyed activities.

Physical warning signs

- Weight loss or weight fluctuations
- Sensitivity to the cold or feeling cold most of the time, even in warm temperatures
- Changes in or loss of menstrual patterns
- Swelling around the cheeks or jaw, calluses on knuckles, or dental discoloration from vomiting
- Fainting.

Psychological warning signs

- Pre-occupation with food, body shape and weight
- Extreme body dissatisfaction
- Distorted body image, e.g. complaining of being, feeling or looking fat when a healthy weight or underweight
- Sensitivity to comments or criticism about exercise, food, body shape or weight
- Heightened anxiety around meal times
- Depression, anxiety or irritability
- Low self-esteem, e.g. negative opinions of self, feelings of shame, guilt or self-loathing
- Rigid 'black and white' thinking, e.g. labelling of food as either 'good' or 'bad'.

Some warning signs may be difficult to detect. This is because a young person with an eating disorder:

- May feel shame, guilt and distress about their eating or exercising behaviours and therefore these will often occur in secret
- May use deceit to hide their eating and exercising behaviours
- Will usually deny having a problem
- May find it difficult to ask for help from family and friends.

Types of eating disorders

Health professionals recognise a number of different types of eating disorders, including anorexia nervosa, bulimia nervosa and binge eating disorder.

Anorexia nervosa

If the young person is underweight and using extreme weight-loss strategies, they may have anorexia nervosa. Extreme weight-loss strategies are used in an attempt to control body weight and can include: dieting, fasting, over-exercising, using diet pills, diuretics, laxatives, and vomiting.

The main characteristics of anorexia nervosa are:

- Focussing on body shape and weight as the main measure of self-worth
- Dramatic weight loss
- The person has an intense fear of gaining weight or becoming fat, even if they are underweight.

Anorexia mainly affects young people. Ninety per cent of people with anorexia are female, although in very young adolescents (13 and under) 75% are female. Anorexia is not common. It often starts in adolescence with dieting that becomes out of control. For some people, the disorder is brief, but in others it becomes a long-term problem and there is risk of death. People who get help early in the course of anorexia tend to have a better outcome.[70]

Bulimia nervosa

A young person may have bulimia nervosa if they have recurrent and frequent episodes of eating unusually large amounts of food while feeling a lack of control over their eating, followed by any behaviour that compensates for the binge, such as purging, fasting, and/or excessive exercising.[5] A person with bulimia can be slightly underweight, overweight, or fall within the healthy weight range.

The main characteristics of bulimia nervosa are:[5]

- Focussing on body shape and weight as the main measure of self-worth
- Repeated episodes of uncontrolled overeating (binge eating) for at least twice a week for three months or more
- Extreme weight control behaviour, e.g. extreme dieting, frequent use of vomiting or laxatives to control weight, diuretic and enema abuse, or excessive use of exercise
- Not meeting the characteristics of anorexia.

Bulimia most often starts in adolescence or early adulthood. It is more common than anorexia. It usually starts in the same way as anorexia, but episodes of binge eating prevent the severe weight loss seen in anorexia. For this and other reasons, only a minority of people with bulimia get some form of treatment.

Binge eating disorder

This disorder occurs when a person has recurrent episodes of eating an unusually large amount of food in a short period of time and continues to eat beyond the point of feeling comfortably full. These binges occur at least once per week over 3 months or more. The person has a sense of loss of control over their eating, but does not use extreme weight-loss strategies to compensate. Their body weight may vary from normal to overweight to obese. People with binge eating disorder often feel disgusted, distressed, ashamed or guilty about their actions.

A survey of Australians aged 15 or over found that 16% of the population have either an eating disorder or some symptoms of an eating disorder in the previous 3 months.[11] Diagnosable eating disorders were less common, with anorexia nervosa and bulimia nervosa both affecting less than 1%, although they are much more common in young women. Binge eating disorder affects around 7%.

What might a first aider notice if a young person has an eating disorder?

A first aider cannot diagnose an eating disorder. However, a first aider may be able to recognise the cluster of symptoms that indicate that an eating disorder may be the problem.

When a young person is first developing an eating disorder, the signs may be quite subtle and difficult to interpret. This can lead to delayed recognition. Often first aiders will focus on the young person's weight and appearance, but there are other signs that may be more useful, particularly if the weight change is not very dramatic. Below are some descriptions of a young person's appearance and behaviour that might indicate that an eating disorder is a problem.

At home, a young person developing an eating disorder may:

- Avoid eating with the family by claiming that they have already eaten with friends, ate too much earlier in the day, or that they are not hungry
- Be increasingly pre-occupied with exercise
- Obsessively counting calories or examining food labels for nutritional information
- Complain that the food that they have been given is disgusting, fatty or unhealthy
- Eat more than usual between meals or at mealtimes
- Become angry or defensive when anyone mentions weight changes.

If the young person is binge eating, large amounts of food may go missing periodically (particularly snack foods such as crisps and sweets).

In a school environment, a young person developing an eating disorder may:

- Avoid eating with friends, discard lunches, or spend lunchtimes exercising
- Eat lunch off school grounds to avoid eating in front of peers
- Appear lethargic or struggle to maintain focus on schoolwork
- Not want to be involved in physical education or health classes or change in front of people in change rooms (associated with body shame), or alternatively, may focus intently on physical education and health classes to the point of obsession.

The friends of a young person developing an eating disorder may notice that they:

- Avoid socialising in places where food is a focus, such as cafés and restaurants
- Talk about fat, focus on specific body parts, pinch perceived areas of fat on the body and check their reflection in mirrors, windows and other reflective surfaces
- Change their clothing style to conceal weight changes.

Some young people with anorexia and bulimia spend a lot of time on the Internet talking to other people with eating disorders, rather than spending time with real-world friends who may be concerned or critical about the dieting behaviour.

Health problems caused by eating disorders

A young person with an eating disorder can experience a wide range of physical and psychological health problems. Although rapid weight loss or being very underweight are known to bring about these problems, a person does not need to be underweight for these to occur. Severe weight loss can cause hair and nails to grow brittle, and skin to dry out, become yellow and develop a covering of soft hair. It can also cause the slowing of growth and delay of puberty. There can be muscle and cartilage deterioration, loss of bone density that may lead to osteoporosis and fractures, irregular or slow heartbeat, anaemia, swollen joints, light-headedness and fainting.

Physical signs and symptoms of repeated vomiting include tooth decay (due to the acid in vomit), chronically inflamed and sore throat, severe dehydration, stomach and intestinal ulcers, and inflammation of the oesophagus.

Serious health consequences associated with eating disorders include severe malnutrition, brain dysfunction, and heart or kidney failure. The most common complications that lead to death are cardiac arrest, and electrolyte and fluid imbalances. Suicide also can result. Bulimia is less frequently a cause of death than anorexia, however heart failure and death from other causes can occur in either disorder, and mortality remains high in the long term.

Overweight and obesity are associated with illness and premature death. Although these are less likely to affect people while they are still young, childhood and adolescent overweight and obesity can persist into adulthood. In the long term, there is a risk of cardiovascular disease, Type 2 diabetes, arthritis and many other chronic illnesses.

Eating disorders frequently occur together with depression, anxiety disorders and substance use disorders. When adolescents with eating disorders are followed into adulthood, most individuals recover from the eating disorder but continue to have a high level of depression and anxiety.[71]

Risk factors for eating disorders

As with other mental disorders, there is no single cause. A range of biological, psychological and social factors may be contributing factors. The following factors increase a person's risk of developing an eating disorder:[67, 70]

Life experiences

- Conflict in the home; parents who have little contact with their children, or high expectations of children
- Abuse (physical, psychological or sexual) or neglect
- Family history of dieting
- Parental obesity
- Critical comments from others about eating, weight or body shape
- Pressure to be slim because of occupation (e.g. a model or jockey) or recreation (e.g. ballet, gymnastics, or bodybuilding).

Personal characteristics

- Dieting (see box on 'Dieting in adolescents')
- Low self-esteem
- Perfectionism
- Anxiety
- Obesity (increases risk for bulimia)
- Childhood obesity (increases risk for anorexia and bulimia)
- Early start of periods in girls (≤12 years; increases risk for anorexia and bulimia).

Mental disorders in family members

- Family members with an eating disorder
- Family members with other mental disorders, such as depression, anxiety, or substance use disorders.

Dieting in adolescents[72-74]

For girls, dieting is the single most important risk factor for the development of an eating disorder. This may also be true for boys, but less research is available.

Girls who diet at a moderate level are five times more likely to develop an eating disorder than those who do not diet, while girls who diet at a severe level are 18 times more likely. This risk is even higher if they also have a mental illness such as anxiety or depression.

Investigations of dieting in girls have found that it is common, unnecessary and sometimes dangerous. Australian studies have found that, in girls aged 14-16:

- 57% practice 'unhealthy dieting'
- 47% are currently trying to lose weight
- Of those who are currently trying to lose weight, 56% fall within the healthy weight range and 19% are underweight
- 36% currently use severe dieting methods.

Dieting should not be considered 'normal' adolescent behaviour. If there is concern that a young person is overweight, professional opinion should be sought. If a medical professional feels that weight loss is needed, the focus should be on the young person's health rather than weight or appearance.

Interventions for eating disorders

Professionals who can help

A variety of health professionals can provide help to a person with eating disorders. They are:

- GPs
- Psychologists
- Counsellors
- Psychiatrists
- Mental health nurses
- Dietitians
- Allied health professionals such as occupational therapists and social workers.

Dietitians may be helpful to incorporate education about nutritional needs, and planning and monitoring eating choices. More information about the other professionals can be found in Section 1.1 *Mental Health Problems in Australian Youth.*

Because successful treatment involves both medical and psychological components, eating disorders are best treated by multidisciplinary teams, where different kinds of professionals treat the person at the same time in a coordinated way. Generally, a multidisciplinary team will consist of a GP, a mental health professional and a dietitian or nutritionist. Sometimes allied health professionals who have specific training in managing eating disorders may also be involved. It is best for the person if the professionals can work together and coordinate their treatment plans.

Treatment is best provided by professionals who have had some training and experience in managing eating disorders. If you can't find a professional in your area with such experience, your own GP or mental health professional can liaise with the Eating Disorders Foundation or other eating disorders support organisation in your state for advice on management.

Treatments available for eating disorders

Treatment is often long-term and intensive, depending on the severity of the eating disorder. The following treatments have evidence that they work for eating disorders:[75]

Anorexia

There has been very little research on what treatments work best. The first goal for treatment is to ensure the person's physical health, which involves restoring the person to a healthy weight. If weight loss is severe, or there are health complications, sometimes it is necessary to admit the person to a hospital in order to stabilise their physical health. There are no medications that are proven to work with anorexia. However, one treatment that is known to work for adolescents with anorexia is family therapy in which the parents are encouraged to take control of feeding their child and to prevent severe dieting, purging and over-exercise.

Bulimia and binge eating disorder

Cognitive behaviour therapy is the best treatment. It aims to change eating habits and weight control behaviours, as well as the person's preoccupation with body shape and weight. There are cognitive behaviour therapy programs that target bulimia specifically. These have been shown to be very effective. To get the full benefit of cognitive behaviour therapy for bulimia, it is recommended that a person has 16-20 sessions of treatment.[40]

Other types of *psychological therapy* and *antidepressants* can also help, but the evidence for their effectiveness is not as strong as for cognitive behaviour therapy.

Self-help books and *internet therapy* based on cognitive behaviour therapy have been shown to help adults with bulimia and binge eating disorder when used under the guidance of a health practitioner.[76]

Self-help strategies may help with co-occurring problems such as depression and anxiety. However, while exercise is a useful treatment for depression, care should be taken with any exercise undertaken by people with eating disorders. People who are underweight may be using exercise to lose more weight and maintain their eating disorder. People who are overweight may need to ease into an exercise program more slowly. In either case, exercise should only be done with professional advice and monitoring.

Importance of early intervention for eating disorders

Eating disorders often start in adolescence. If a young person gets to adulthood without treatment, recovery becomes much more difficult and the risk of poor health or premature death increases. For most people with eating disorders, the earlier effective treatment is received, the easier it will be to overcome the problem.[77] A delay in seeking treatment can lead to serious long-term consequences. As with many other types of health problems, early detection and treatment helps to prevent the eating disorder behaviours becoming more entrenched, and to increase the chances of full recovery.

Crises associated with eating disorders

The three main crises that may be associated with eating disorders are:

- The young person is experiencing a **medical emergency** (see box on 'Symptoms that indicate a medical emergency').
- The young person has **suicidal thoughts or behaviours.**
- The young person is engaging in **non-suicidal self-injury.**

Medical emergency

A young person who has an eating disorder is at risk of a medical emergency due to malnutrition and other complications. These include potentially fatal complications such as organ failure, electrolyte imbalances, and bleeding in the digestive tract.

Symptoms that indicate a medical emergency

Emergency help should be sought if the person has any of the following symptoms:

- Disordered thinking and not making any reasonable sense (a person who is malnourished may appear to have psychotic symptoms such as disordered thinking, delusions or hallucinations)
- Disorientation; not knowing what day it is, where they are or who they are
- Throwing up several times a day
- Fainting spells
- Collapsing or being too weak to walk
- Painful muscle spasms
- Chest pain, or difficulty breathing
- Blood in their bowel movements, urine or vomit
- Appears extremely thin
- An irregular heart beat or very low heart beat (less than 50 beats per minute)
- Cold or clammy skin indicating a low body temperature or a body temperature of less than 35 degrees Celsius.

Suicidal thoughts and behaviours

Eating disorders increase the risk of suicide and suicide attempts.[78] However, it is difficult to estimate the percentage of young people with these disorders who have suicidal thoughts or engage in suicidal behaviour.

Non-suicidal self-injury

Eating disorders increase the risk of non-suicidal self-injury.[49] In people with eating disorders and those who engage in non-suicidal self-injury, there appears to be a shared experience of overwhelming feelings that may be relieved by engaging in bingeing, purging or overexercising, or by engaging in non-suicidal self-injury.

The Mental Health First Aid Action Plan for Eating Disorders[69, 79]



Mental Health First Aid Action Plan

Approach the young person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give support and information

Encourage the young person to get appropriate professional help

Encourage other supports

Action 1: Approach the young person, assess and assist with any crisis

How to approach

Before you approach the young person, learn as much as you can about eating disorders. Do this by reading books, articles and brochures, or gathering information from a reliable source, such as an eating disorder support organisation or a health professional experienced in treating people with eating disorders. Make a plan before approaching the young person; pick a place to meet that is private, quiet and comfortable. Avoid approaching them in situations that may lead them to become sensitive or defensive, such as when either you or they are feeling angry, emotional, tired, or frustrated, are drinking, having a meal, or in a place surrounded by food. It is better to approach the young person alone, because having the whole family or a number of people confront the person at the same time could be overwhelming.

What if I don't feel comfortable talking to the young person?

It is common to feel nervous when approaching a young person about their eating and exercising behaviours. Do not avoid talking to them because you fear it might make them angry or upset, or make their problem worse. Speaking to the young person may give them a sense of relief at having someone acknowledge their problems, or they may find it helpful to know that someone cares about them and has noticed that they are not coping.

What should I say?

The way you discuss the young person's problem will depend on their age and the degree to which their problem has developed. Initially, focus on conveying empathy and not on changing the young person or their perspective. Discuss your concerns with them in an open and honest way. Try to use 'I' statements that are not accusing, such as "I am worried about you", rather than 'you' statements such as "You are making me

worried". Try not to just focus on weight or food. Rather, focus on the eating behaviours that are concerning you. Allow the person to discuss other concerns that are not about food, weight or exercise. Make sure you give the person plenty of time to discuss their feelings and reassure them that it is safe to be open and honest about how they feel. Do not comment positively or negatively on the young person's weight or appearance.

How will the person react?

The young person may react in a variety of different ways. For example, they might be positive and receptive, they might be relieved to admit that they have a problem, or they may be denying, defensive, angry or aggressive, even if you have approached them very sensitively. The young person may be relieved that someone has noticed, they may seek to reassure or convince you that they are fine and that there is no problem, or may want time to absorb your comments and concerns.

How to assess and assist in a crisis

If you have concerns that the young person is experiencing a **medical emergency,** call an ambulance or seek medical care immediately.

If you have concerns that the young person may be having **suicidal thoughts**, find out how to **assess** and **assist** them in Section 3.1 *First Aid for Suicidal Thoughts and Behaviours.*

If you have concerns that the young person may be engaging in **non-suicidal self-injury,** find out how to **assess** and **assist** them in Section 3.2 *First Aid for Non-suicidal Self-injury.*

If you have no concerns that the young person is in crisis, you can ask them about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen and communicate non-judgmentally

Listen to the young person's concerns. There may be issues in their life that need to be identified. Depression and anxiety may also be present.

Try to see the young person's behaviour as illness related rather than wilful or self-indulgent. Be aware that you may find it tough to listen to what the person has to say, especially if you do not agree with what they are saying about themselves and food. Don't get drawn into a discussion about their appearance or weight by disagreeing with their beliefs about these. It is important that you try to stay calm.

See Action 2 in Section 2.1: *Depression in Young People* for more tips on non-judgmental listening and communication.

Action 3: Give support and information

Your aim should be to provide support for the young person so that they feel safe and secure enough to seek treatment or to find someone else they can trust to talk to openly about their difficulties, such as a family member, friend or teacher.

Offer consistent emotional support and understanding

When talking with the young person, you need to be non-judgmental, respectful and kind.

Reassure the young person that they are deserving of your love and concern, and let them know you want them to be healthy and happy. Explain that even if there are limits to what you can do for them, you are still going to try and help, and you will be there to listen if they want to talk. To help the young person feel safe, reassure them that you are not going

to take control over their life. There will be times when you don't know what to say. In this instance, just be there for the young person by letting them know you care and are committed to supporting them. Avoid making promises to them that you cannot keep.

Give the young person hope for recovery

Reassure the young person that people with eating disorders can get better and that past unsuccessful attempts do not mean that they cannot get better in the future. Encourage the young person to be proud of any positive steps they have taken. For example, encourage them to take pride when they have acknowledged their disordered eating or exercising habits or agreed to professional help.

Give the young person information

Give the young person some information about eating disorders and the help that is available, but be careful not to overwhelm them with too much information and advice. Remember that you don't have to know all the answers and avoid trying to solve the young person's problems for them. Avoid speculating about the cause of the eating disorder.

If you become aware that the person is visiting 'pro-ana' or 'pro-mia' websites (i.e. websites that promote eating disordered behaviour), you should discourage further visits, as the websites can encourage additional destructive behaviours. If the young person is not already aware of these sites it is important not to mention them.

Supporting a young person who reacts negatively

Understand that the young person may react negatively. If this happens, it is important not to take the negative reaction personally. There are many reasons a young person may react negatively, including that they:

- Are not ready to make a change
- Do not know how to change without losing their coping strategies
- Have difficulty trusting others
- Think you are being pushy, nosey, coercive or bullying
- Do not see their eating habits as a problem.

Try hard not to express disappointment or shock if the young person responds with denial, anger, aggression, tears or defensiveness, and resist the temptation to respond angrily, as this may escalate the situation. Instead be willing to repeat your concerns and remind the young person that even if they don't agree, your support is still offered, and they can come and talk with you again in the future if they want to.

What isn't supportive

- Do not express negative emotion, e.g. don't argue, be confrontational, respond angrily or speak harshly.
- Do not say negative things, e.g. criticising, blaming, expressing disappointment or shock; trying to make the person feel ashamed or guilty; saying that what the person is doing is "Disgusting", "Stupid" or "Self-destructive"; making generalisations such as "You're always moody" or "You never do anything but exercise".
- Do not focus on body shape or food, e.g. commenting positively or negatively on the person's body size or shape, for instance saying "You're too thin" or "Good, you have gained weight"; reinforcing the idea that physical appearance is critically important to happiness or success; making conflict or arguments over food and letting issues of food dominate your relationship

with the person; giving advice about weight loss, exercise or appearance.

- Do not give simple solutions, e.g. such as saying things like "All you have to do is eat".

Action 4: Encourage the young person to get appropriate professional help

Discuss options for seeking professional help

Explain to the young person that you think their behaviours may indicate there is a problem that needs professional attention. Offer to assist them in getting the help they need. If, however, the person is very underweight, they may not be able to take responsibility for getting professional help, as an eating disorder can affect the person's ability to think clearly.

Eating disorders are not always recognised by health professionals. It may take some time to get the right diagnosis and treatment. When the young person sees a GP, it can help if they are told that the young person may have an eating disorder.

What if the young person doesn't want help?

People with an eating disorder may refuse professional help. The resistance may be related to a number of different factors. The young person may:

- Feel ashamed of their behaviour
- Fear gaining weight or fear losing control over their weight
- Be afraid of acknowledging that they are unwell
- Not think that they are ill
- Believe that there are benefits to their disordered eating or exercising behaviours, e.g. controlling their weight may make the person feel better about themselves, or give them a sense of accomplishment.

Don't expect the young person to immediately follow your advice, even if they asked for it. You cannot force the young person to change their attitudes or behaviours. However, even a young person who does not want to change can benefit from professional help, and you need to ensure that they receive it.

Be sensitive towards the young person's fears about help-seeking. You may find it helpful to get advice from an organisation that specialises in eating disorders on how to get a resistant young person to professional help. Eating disorders are long-term problems that are not easily overcome. Although you may feel frustrated by the young person's behaviour, do not threaten to end or alter your relationship with them. Don't give up on the young person.

Instead continue to be supportive, positive and encouraging while waiting for them to accept the need to change. Be encouraging of the young person's strengths and interests that are unrelated to food or physical appearance. Acknowledge the person's positive attributes, successes and accomplishments, and try to view the person as an individual rather than just someone who has an eating disorder.

Action 5: Encourage other supports

Other people who can help

You can suggest that the young person surround themselves with people who are supportive of them. There are organisations that provide information and support for people with eating disorders (see *Helpful resources* at the end of this chapter).

Helpful resources for eating disorders in young people

Telephone and online support

The Butterfly Foundation

www.thebutterflyfoundation.org.au
Phone 1800 33 4673, 8am-9pm
www.thebutterflyfoundation.org.au/web-counselling
Butterfly is a nation-wide advocacy and support organisation for those with eating disorders and their loved ones. The website has excellent resources for parents and carers, and provides support by email or live chat.

Websites

Eating Disorders Foundation of Victoria

www.eatingdisorders.org.au

This website provides comprehensive information to consumers, carers, and professionals in contact with those with eating disorders. It also has links to other relevant organisations. Eating Disorders Victoria also provides an additional site that is very valuable, 'How Far is Too Far?', as described below.

How Far is Too Far?

www.howfaristoofar.org.au

This is an information website divided into sections for young people, families, professionals and schools. It has information about eating disorders as well as body image and exercise.

Feed Your Instinct

www.feedyourinstinct.com.au

This website was developed to assist families when they are concerned a young person may have an eating disorder. This website was created by the Centre for Excellence in Eating Disorders. It uses as interactive checklist you can use to help decide if a young person might need to see a health professional.

beat: beating eating disorders

www.b-eat.co.uk

This is a UK website run by the Eating Disorders Association. It has a special section for young people. There is also advice for parents and other carers.

Books

For parents and other adults

Walsh BT, Cameron VL. *If Your Adolescent Has an Eating Disorder: An Essential Resource for Parents.* New York, NY, USA: Oxford University Press; 2005.
This guide is written for the parents and other caregivers of adolescents with eating disorders. It contains information about treatment and management, addresses myths and includes personal stories from people who are recovering.

Self-help books

Costin C, Schubert, Grabb G. *8 Keys to Recovery From an Eating Disorder: Effective Strategies from Therapeutic Practice and Personal Experience.* New York: W. W. Norton and Company; 2011.

The following books provide self-help cognitive behaviour therapy for bulimia and binge eating. They work best when a clinician guides their use.[76]

Schmidt U, Treasure J, Alexander J. *Getting Better Bite by Bite: A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders.* Abingdon: Taylor and Francis; 2015.

Cooper PJ. *Overcoming Bulimia Self-help Programme.* London: Robinson Publishing; 2006.



Az Steam

"The illness is not a monster, it never is, to say so is absurd demonology. The beast is not the sickness. There is no 'monster' trying to crawl out, the illness is the imaginary clouds of steam and the distress and discomfort s/he feels even when there is NO heat, water or steam."

Veronica Brancato

2.4 Psychosis in Young People

What is psychosis?

Psychosis is a general term to describe a mental health problem in which a person has lost some contact with reality. There are severe disturbances in thinking, emotion and behaviour. Psychosis can severely disrupt a person's life. Relationships, work and other usual activities, and self-care can be difficult to initiate or maintain.

Psychotic disorders are less common than other mental illnesses, affecting around 0.45% of adults in any one year.[10] There are numerous disorders in which a person can experience psychosis, including schizophrenia, psychotic depression, bipolar disorder (which can involve psychotic depression or psychotic mania), schizoaffective disorder and drug-induced psychosis.

People usually experience psychosis in episodes. An episode can involve the following phases, which vary in length from person to person.[80]

- ***Premorbid*** (at risk phase) – the person does not experience any symptoms but has risk factors for developing psychosis.
- ***Prodromal*** (becoming unwell phase) – the person has some changes in their emotions, motivation, thinking and perception or behaviour as described in the box below. The prodrome cannot be diagnosed and is only identifiable in retrospect. During the prodromal phase, it may be unclear whether the person is developing a psychotic disorder or another more common mental illness.
- ***Acute*** (psychotic phase) – the person is unwell with psychotic symptoms such as delusions, hallucinations, disorganised thinking and reduction in ability to maintain social relationships, work or study.
- ***Recovery*** – this is an individual process the person goes through to attain a level of well-being.
- ***Relapse*** – the person may only have one episode in their life or may go on to have other episodes.

Some people have a single episode of psychosis. However, most people have multiple episodes with either full recovery between episodes or partial recovery between episodes. Around a third have a continuous illness.[10]

Common signs and symptoms when psychosis is developing[96]

Changes in emotion and motivation

Depression; anxiety; irritability; suspiciousness; blunted, flat or inappropriate emotion; change in appetite; reduced energy and motivation.

Changes in thinking and perception

Difficulties with concentration or attention; sense of alteration of self, others or outside world (e.g. feeling that self or others have changed or are acting differently in some way); odd ideas; unusual perceptual experiences (e.g. a reduction or greater intensity of smell, sound or colour).

Changes in behaviour

Sleep disturbance; social isolation or withdrawal; reduced ability to carry out studies or social roles.

Although these signs and symptoms may not be very dramatic on their own, when they are considered together, they may suggest that something is not quite right. It is important not to ignore or dismiss such warning signs and symptoms, even if they appear gradually and are unclear. It should not be assumed that the young person is just going through a phase or misusing alcohol or other drugs, or that the symptoms will go away on their own.

The signs and symptoms of psychosis may vary from person to person and can change over time. It is also important to consider the spiritual and cultural context of the person's behaviours, as what is interpreted as a symptom of psychosis in one culture may be considered to be normal in another culture. In some Aboriginal communities, for instance, being visited by spirits or hearing voices of deceased loved ones are normal experiences.[82]

People experiencing the early stages of psychosis often go undiagnosed for some time before receiving treatment. A major reason for this is that psychosis often begins in late adolescence or early adulthood and the early signs and symptoms involve behaviours and emotions that are common in this age group.

For 65% of people with psychosis, their first episode occurs before the age of 25 years.[10]

Many young people will have some of these symptoms without developing a psychosis. Others showing these symptoms will eventually be diagnosed as having one of the following disorders.

Mental illnesses where psychosis can occur

Schizophrenia

The mental illness in which psychosis most commonly occurs is schizophrenia. Contrary to common belief, schizophrenia does not mean 'split personality'. The term 'schizophrenia' comes from the Greek for 'fractured mind' and refers to changes in mental function where thoughts and perceptions become disordered.

The major symptoms of schizophrenia include:

- ***Delusions.*** These are false beliefs, for example of persecution, guilt, having a special mission or being under outside control. Although the delusions may seem bizarre to others, they are very real to the person experiencing them.
- ***Hallucinations.*** These are false perceptions. Hallucinations most commonly involve hearing voices, but can also involve seeing, feeling, tasting or smelling things. These are perceived as very real by the person, but are not actually there. The hallucinations can be very frightening, especially voices making negative comments about the person. The person may hear more than one voice or experience many types of hallucinations. Because their delusions and hallucinations are so real to them, it is common for people with schizophrenia to be unaware they are ill.
- ***Thinking difficulties.*** There may be difficulties in concentration, memory and ability to plan. These make it more difficult for the person to reason, communicate and complete daily tasks.
- ***Loss of drive.*** The person lacks motivation even for self-care. It is not laziness.
- ***Blunted or inappropriate emotions.*** The person does not react to the things around them or reacts inappropriately. Examples

include speaking in a monotone voice, lack of facial expressions or gestures, lack of eye contact or reacting with anger or laughter when these are not appropriate.

- ***Social withdrawal.*** The person may withdraw from contact with other people, even family and close friends. There may be a number of factors that lead to this withdrawal, such as loss of drive, delusions that cause fear of interacting, difficulty concentrating on conversations and loss of social skills.

Approximately 0.4% of the population have been diagnosed with schizophrenia at some point in their life.[85] Most people experience the onset of schizophrenia between the ages of 15 to 30 years, thus coinciding with the main period of social and educational achievement in life. In 77% of all people with schizophrenia, the onset of the disorder was before the age of 30, in 41% before the age of 20 and in 4% before the age of 10.[86] Schizophrenia affects males more than females and males tend to develop it earlier.[87] The onset of the illness may be rapid, with symptoms developing over several weeks, or it may be slow and develop over months or years.

Psychotic depression

Sometimes depression can be so intense it causes psychotic symptoms. For example, the person may experience delusions involving feeling very guilty about something that is not their fault, believing that they are severely physically ill, or that they are being persecuted or observed. Some people may also experience hallucinations, most commonly hearing voices.

Bipolar disorder with psychosis[88]

The depression experienced by a person with bipolar disorder has some or all of the symptoms of depression listed previously in Section 2.1 *Depression in Young People.*

The symptoms of mania have been listed previously in Section 2.1 *Depression in Young People.* A person with **psychotic mania** will have also experience delusions and hallucinations. These involve grandiose beliefs about the person's abilities or invulnerability, e.g. the person has special powers or is an important religious figure. There may also be suspiciousness or paranoia, e.g. about other people doubting their powers. The person will also have lack of insight. They may be so convinced that their manic delusions are real that they do not realise they are ill.

Young people with bipolar disorders may have symptoms that are different to those seen in adults, including more 'mixed' episodes (feeling manic and depressed at the same time), rapid fluctuations of moods, irritability, aggression and high emotional reactivity. Fewer adolescents than adults with bipolar disorder experience the euphoria typically associated with mania.[88] In adolescents, episodes may be less distinct than in adults, lasting longer and with a high level of symptoms seen in between episodes. Adolescents with bipolar disorder are less likely to experience sleep disturbances compared to adults with bipolar disorder. Many young people with bipolar disorder also have attention deficit hyperactivity disorder (ADHD), substance use disorders and anxiety disorders.[44]

Schizoaffective disorder

Sometimes it is difficult to tell the difference between schizophrenia and bipolar disorder as the person has symptoms of both illnesses. A person with schizoaffective disorder has symptoms of psychosis and depression but does not meet criteria for bipolar disorder.

Drug-induced psychosis

This is a psychosis brought on by intoxication with drugs or withdrawal from drugs or alcohol. The symptoms usually appear quickly and last

a short time (from a few hours to a few days) until the effects of the drug wears off. This is not the same as a psychotic illness that develops over time after protracted drug use. The most common symptoms are visual hallucinations, disorientation and memory problems. Both legal and illegal drugs can contribute to a psychotic episode, including marijuana (cannabis), alcohol, cocaine, amphetamine (speed), hallucinogens, inhalants, opioids, sedatives, hypnotics and anxiolytics.[5]

Substance use and psychosis

People with psychotic disorders have very high rates of substance use and dependence. In Australia in 2010, over two-thirds of people with psychotic disorders smoked tobacco daily[10] (compared to about 15% of adults generally in the same year[83]), and also smoked more cigarettes per day than others in the community. However, most people with psychotic disorders who smoke want to quit, and they can be successfully helped by 'quit smoking' programs.[84]

Half of the people with psychotic disorders in Australia have at some time in their lives had harmful use or been dependent on alcohol (compared to 25% in the population as a whole[10]). Similarly, half have at some time had harmful use or been dependent on illicit drugs (compared to 9% in the population as a whole[6]). These contribute to poorer functioning, increased risk of relapse and increased risk of health problems.

Young people with psychotic disorders need to be aware that if they use substances, they are more likely than their peers to develop a problem of abuse or dependence, and that use poses potentially greater problems in terms of greater burden of side effects such as weight gain and associated metabolic disorders. A skilled clinician who the young person trusts may be the best person to have a frank conversation with them about the issue.

What might a first aider notice if a young person is developing a psychotic disorder?

When we think of psychotic disorders, we typically imagine someone who is very out of touch with reality, perhaps talking to themselves or expressing concerns about being observed or persecuted. This is certainly an accurate description of some people with psychotic disorders. However, while the disorder is developing, the signs may be more subtle and difficult to interpret. This can lead to delayed recognition, unnecessary disciplinary responses at school or home, and difficulties with social and educational development.

A first aider cannot diagnose a psychotic disorder. However, a first aider may be able to recognise the cluster of symptoms that indicate that psychosis may be the problem. Below are some descriptions of a young person's appearance and behaviour that might indicate that psychosis is a problem.

Parents are in an ideal position to notice a worrying overall change in their child. At home, a young person developing a psychotic disorder may:

- Become increasingly secretive or avoid answering parents' questions
- Spend more time alone in their bedroom
- Begin expressing strange ideas
- Display sudden outbursts, explosive and highly emotional reactions
- Appear 'changed' in a way that parents can't quite describe. It is important that parents don't dismiss a 'gut feeling' that something 'isn't quite right'.

- Young people experiencing auditory hallucinations for the first time sometimes try to drown them out. For example, they may listen to music on headphones and refuse to take them out when talking to family members or eating a family meal, or turn the television up loud and react angrily when asked to turn it down.

Many school staff have observed hundreds of adolescents over their years working in school, and are in an ideal position to notice distinctly unusual behaviours.

In a school environment, a young person developing a psychotic disorder may:

- Appear unmotivated
- Distance themselves from peers
- Show a decline in school grades due to not completing work, not doing as good a job as they used to, or missing school
- Appear not to react or to react inappropriately to others
- Doing things to drown out auditory hallucinations, e.g. listening to music on headphones in class.

These behaviours can all have an impact on school achievement, and some may result in disciplinary responses.

The friends of a young person developing a psychotic disorder may notice that they:

- Withdraw from friends altogether
- Use alcohol or other drugs, particularly cannabis, to dull unfamiliar feelings and upsetting emotions
- Appear not to react, or to react inappropriately to events and conversations, e.g. getting angry without provocation or laughing at something that isn't funny
- Appear suspicious or accuse friends of acting against them, e.g. talking about them behind their backs, plotting against them.

In the case of drug-induced psychosis, hallucinations and delusions will occur shortly after consuming a drug, and will reduce as the drug wears off.

Risk factors for psychotic disorders

It is believed that psychosis is caused by a combination of factors including genetics, biochemistry and stress. Biological factors could be genetic vulnerability, changes in the brain or a dysfunction in the neurotransmitters in the brain. Stress or drug use may trigger psychotic symptoms in vulnerable people.

Risk factors for schizophrenia[104]

The following are the most significant risk factors:[89]

Having a close relative with schizophrenia. For someone with a parent or sibling with schizophrenia, the risk is around 10-15%. Although the risk is higher, it is important to note that 85-90% will not develop schizophrenia.

Male gender. Males are more likely to develop schizophrenia and tend to have an earlier age of onset.

Urban living. People who are born and grow up in urban areas are at higher risk than people from rural areas. The reason is unknown, but could be related to differences in the health of mothers during pregnancy, cannabis use, or social stressors.

Migration. People who are immigrants or the children of immigrants, have increased risk. The reason is unknown, but social stress from feeling like an outsider could be a factor.

Cannabis use. Cannabis use during adolescence increases risk, particularly in people who have other risk factors.[90]

There are other risk factors that are far less significant and increase risk by only a very small amount. These include events during the mother's pregnancy (such as infections, severe nutritional deficiency, very stressful life events), birth complications, winter/spring birth and older age of father.

While there are a large number of possible risk factors for schizophrenia, these are thought to affect the development of the brain early in life and lead to changes in levels of the neurotransmitter (chemical messenger) dopamine.[91] Antipsychotic medications that are used for schizophrenia work by altering dopamine levels in the brain.

Risk factors for bipolar disorder

The risk factors for bipolar disorder have been listed previously in Section 2.1 *Depression in Young People.*

Interventions for psychotic disorders

Professionals who can help

A variety of health professionals can provide help to a person with psychosis. They are:

- GPs
- Psychiatrists
- Mental health nurses
- Psychologists
- Occupational therapists and social workers with mental health training
- Counsellors
- Case managers.

More information about how these professionals can help is available in Section 1.1 *Mental Health Problems in Australian Youth.*

Early Intervention Services for Psychosis[96]

Early intervention services are services that cater to the needs of young people who are experiencing their first episode of psychosis.[81] Treatments provided typically include medical and psychosocial treatments, group and family programs, and interventions for concurrent substance misuse. Some services also provide monitoring and low-level interventions for young people who are most at risk of developing a psychotic illness (for example, those with mild, transient or occasional symptoms who also have a significant family history of psychosis).

Early intervention services are available in many regions of Australia. Methods of referral and intake vary from service to service – find out what is available near you by speaking to your local mental health service.

Treatments available for psychosis

There are two aspects to professional help for psychosis that need to be considered. The first is medication, and the second is treatments to improve outcomes and maximise quality of life.

Medication is important for the management of a psychotic illness. Different psychotic illnesses require different medications, and are described below. It is not realistic to expect to manage a psychotic illness without medication. A person with a psychotic illness will need to work closely with their doctors to determine the best medications to effectively manage the illness with a minimum of side effects. A young person who is experiencing severe psychosis may benefit from a ***short stay in the hospital*** to get back on track.

Psychiatrists, psychologists, counsellors and other mental health professionals may be able to help improve quality of life by helping the young

person to learn to accept their illness, facilitate good employment or education opportunities and help to maintain good family and social relationships. They may also be able to provide psychoeducation to the young person and their family to promote good understanding and illness management strategies.

The pattern of recovery from psychosis varies from person to person. Some people recover quickly with intervention, while others may require support over a longer period. Recovery from the first episode usually takes a number of months. If symptoms remain or return, the recovery process may be prolonged. Some people experience a difficult period lasting months or even years before effective management of further episodes of psychosis is achieved. Most people recover from psychosis and lead satisfying and productive lives.

There is a range of treatments that have good evidence in the treatment of psychosis:

Schizophrenia treatments[92]

In the past people with schizophrenia were considered to have chronic illnesses with no hope of recovery. It is now known that people who get proper treatment can lead productive and fulfilling lives. In fact, research has demonstrated that recovery is possible for many people who are treated with medications and psychosocial rehabilitation programs. People with schizophrenia and other psychotic disorders need to be treated with optimism for a good outcome and in a spirit of partnership. They need to live in a stable and secure social and family environment. This includes a pleasant home environment, support from family and friends and good educational opportunities[93] There is evidence that the following specific treatments help people with schizophrenia:

- ***Antipsychotic medications.*** These are effective for psychotic symptoms such as delusions and hallucinations. However, they are less effective for other symptoms such as lack of motivation, poor memory and problems with concentration. Antipsychotic medication can sometimes lead to weight gain and associated physical health problems such as diabetes, so a person taking this type of medication needs to have their physical health closely monitored.
- ***Antidepressant medications.*** People with schizophrenia may have depression symptoms as well. Antidepressants are effective for treating these symptoms.
- ***Physical health checks.*** It is important to have ongoing physical health check-ups with a GP to ensure that any side effects from medications (e.g. weight gain) do not cause significant problems in the future.
- ***Psychoeducation*** means education and empowerment of the person and their family about their illness and how best to manage it. This helps to reduce relapses. Family tension, a common result of trying to deal with a poorly understood disability, may contribute to a relapse in the person with schizophrenia, and psychoeducation can help to avoid this.
- ***Cognitive behaviour therapy.*** This type of psychological therapy can help reduce psychotic symptoms by helping the person to develop alternative explanations of schizophrenia symptoms, reducing the impact of the symptoms on their life, and encouraging the person to take their medication.
- ***Social skills training.*** This is used to improve social and life skills.
- ***Assertive community treatment*** is an approach for people experiencing more severe illness. The care of the person is

managed by a team of various kinds of health professionals, such as psychiatrist, nurse, psychologist and social worker. Care is available 24 hours a day and is tailored to the person's individual needs. Support is provided to family members as well. Assertive Community Treatment has been found to reduce relapses and the need for hospitalisation.

Bipolar disorder treatments

The treatments for bipolar disorder have been listed previously in Section 2.1 *Depression in Young People.*

Importance of early intervention for psychosis

Early intervention for people with psychosis is most important. Research has shown that the longer the delay between the onset of psychosis and the start of treatment, the less likely the person is to recover.[96] Other consequences of delayed treatment include:[81]

- Poorer long-term functioning
- Increased risk of depression and suicide
- Slower psychological maturation and slower uptake of adult responsibilities
- Strain on relationships with friends and family and subsequent loss of social supports
- Disruption of study
- Increased use of alcohol and other drugs
- Loss of self-esteem and confidence
- Greater chance of problems with the law.

Shared decision-making about treatment for psychotic disorders

Antipsychotics are important for the management of psychotic disorders, in particular, for controlling hallucinations and delusions. However, they are strong medications that do have side effects.

The most troubling side effects are weight gain and cardiovascular risk (including the onset of metabolic syndrome and diabetes).[94] Other side effects include difficulty moving or difficulty staying still, and sleepiness.

Some of the side effects can be reduced with a change in medication or dose or lifestyle changes (such as healthy diet and exercise), but side effects cannot be eliminated entirely. A recent Australian study showed over three quarters of people using antipsychotic medications had side effects, and three out of five reported that those side effects impacted on daily functioning.[95]

Unfortunately, side effects are the main reason people stop taking medication. Choosing not to take medication is a major factor in relapse. There is some evidence to show that medications become less effective when people stop taking them and start again.

For this reason, it is important to negotiate the best treatments with a skilled clinician and discuss the various risks and benefits with them before making decisions about treatment. Choosing the right medication and reaching agreement on the right dose can take time and requires good communication.

Crises associated with psychosis

Crises that may be associated with psychosis are:

- The person is in a **severe psychotic state.**
- The person is showing **aggressive behaviours.**
- The person has **suicidal thoughts or behaviours.**

Severe psychotic states

People with psychotic disorders can have periods when they become very unwell. They can have overwhelming delusions and hallucinations, very disorganised thinking and bizarre and disruptive behaviours. The person will appear very distressed or their behaviours will be disturbing to others. When a person is in this state, they can come to harm unintentionally because of their delusional beliefs or hallucinations, e.g. if the person believes they have special powers to protect them from danger such as driving through red lights, or the person runs through traffic to try to escape from their terrifying hallucinations.

Aggressive behaviours

A very small percentage of people experiencing psychosis may become violent.[97] People with mental illnesses (specifically psychotic illnesses) are often portrayed in the media as possibly unpredictable, violent or dangerous. While there is an increased risk of violence for people who experience psychosis, the use of alcohol or other drugs has a stronger association with violence than do psychotic illnesses.[98-100] The risk of a person with a psychotic illness committing an act of violence is greater if they are not being adequately treated or are using alcohol or other drugs.

Suicidal thoughts and behaviours

Psychotic disorders involve a high risk of suicide. Around 67% of people with a psychotic disorder think about suicide at some time in their life and about 50% attempt suicide.[10] Approximately 5% of people with schizophrenia die by suicide.[101] About 6–19% of individuals with bipolar disorder take their own life.[102] Having a concurrent depression or a substance use disorder increases the risk,[103] as do poor adherence to treatment and the person's fears of the impact of their illness on mental functioning.

The main factors to be taken into account when assessing risk of suicide in people experiencing psychotic symptoms are:[102]

- Depression
- Previous suicide attempt
- Poor adherence to treatment
- Fears of the impact of the illness on mental functioning
- Recent loss
- Family history of suicide
- Younger age of onset
- Drug use problems.

The Mental Health First Aid Action Plan for Psychosis[104, 105]

Mental Health First Aid Action Plan

Approach the young person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give support and information

Encourage the young person to get appropriate professional help

Encourage other supports

Action 1: Approach the young person, assess and assist with any crisis

How to approach

People developing a psychotic disorder will often not reach out for help. Someone who is experiencing profound and frightening changes such as psychotic symptoms will often try to keep them a secret. If you are concerned about a young person, approach them in a caring and non-judgmental manner to discuss your concerns. Let the young person know that you are concerned about them and want to help. The person you are trying to help might not trust you or might be afraid of being perceived as 'different', and therefore may not be open with you.

If possible, you should approach the young person privately about their experiences in a place that is free of distractions. Try to tailor your approach and interaction to the way the young person is behaving, e.g. if they are suspicious and avoiding eye contact, be sensitive to this and give them the space they need. Do not touch the young person without their permission. However, if the young person is unwilling to talk with you about their experiences, do not try to force them. Rather, let them know that you will be available if they would like to talk in the future.

You should state the specific behaviours you are concerned about and should not speculate about the person's diagnosis. It is important to allow the young person to talk about their experiences and beliefs if they want to. As far as possible, let the young person set the pace and style of the interaction. You should recognise that they may be frightened by their thoughts and feelings.

How to assess and assist in a crisis

As you talk with the person, be on the lookout for any indications that the person may be in crisis.

If you have concerns that the young person is in a **severe psychotic state,** find out how to assess and assist this person in Section 3.7 *First Aid for Severe Psychotic States*.

If you have concerns that the person is showing **aggressive behaviour**, find out how to **assess** and **assist** this person in Section 3.9 *First Aid for Aggressive Behaviours.*

If you have concerns that the person may be having **suicidal thoughts and behaviours**, find out how to **assess** and **assist** this person in Section 3.1 *First aid for Suicidal Thoughts and Behaviours.*

If you have no concerns that the person is in crisis, you can ask them about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen and communicate non-judgmentally

The young person may be behaving and talking differently due to psychotic symptoms. They may also find it difficult to tell what is real from what is not.

What you should try to do:

- Understand the symptoms for what they are.
- Empathise with how the person feels about their beliefs and experiences.

Things you should not do:

- Do not confront the person.
- Do not criticise or blame them.
- Do not take their delusional comments personally.
- Do not use sarcasm.
- Do not use patronising statements.
- Do not state any judgments about the content of those beliefs and experiences.

See Action 2 in Section 2.1 *Depression in Young People* for more tips on non-judgmental listening and communication.

Dealing with delusions and hallucinations

It is important to recognise that the delusions and hallucinations are very real to the young person. Because of this you should not do the following:

- Do not dismiss, minimise or argue with the person about their delusions or hallucinations.
- Do not act alarmed, horrified or embarrassed by the person's delusions or hallucinations.
- Do not laugh at the person's symptoms of psychosis.
- Do not encourage or inflame the person's paranoia, if the person exhibits paranoid behaviour.

You can respond to the young person's delusions without agreeing with them by saying something like "That must be horrible for you" or "I can see that you are upset".

Dealing with communication difficulties

People experiencing symptoms of psychosis are often unable to think or communicate clearly.

Ways to deal with communication difficulties include:

- Responding to disorganised speech by communicating in an uncomplicated and succinct manner
- Repeating things if necessary
- Being patient and allow plenty of time for the person to process the information and respond to what you have said
- Being aware that it does not mean that the person is not feeling anything, even if the person is showing a limited range of feelings
- Not assuming the person cannot understand what you are saying, even if their response is limited.

Action 3: Give support and information

Treat the young person with respect and dignity

It is important to respect the young person's autonomy while considering the extent to which they are able to make decisions for themselves. It is important that you are honest when interacting with the person.

Offer consistent emotional support and understanding

Reassure the young person that you are there to help and support them, and that you want to keep them safe.

Give the person hope for recovery

Convey a message of hope by assuring them that help is available and things can get better.

Provide practical help

Try to find out what type of assistance they need by asking what will help them to feel safe and in control. If possible, offer the person options about different ways you can help them so that they feel they are somewhat in control. Do not make any promises that you cannot keep. This can create an atmosphere of distrust and add to the young person's distress.

Offer information

When a person is in a severe psychotic state, it is usually difficult and inappropriate to give information about psychosis. When the person is more lucid and in touch with reality, you could ask the person if they would like some information about psychosis. If they do want some information, it is important that you give them resources that are accurate and appropriate to their situation.

Depending on your relationship with the young person, it may be appropriate to share information with their parents or other caregivers.

Action 4: Encourage appropriate professional help

Discuss options for seeking professional help

Assist the young person to seek professional help, making sure that they (and if needed, their family) are supported both emotionally and practically in accessing services. If the young person or their parents lack confidence in the medical advice received, encourage them to seek a second opinion from another medical or mental health professional.

What if the person doesn't want help?

The person may refuse to seek help even if they realise they are unwell. Their confusion and fear about what is happening to them may lead them to deny that anything is wrong. In this case you should encourage them to talk to someone they trust. It is also possible that a person may refuse to seek help because they lack insight that they are unwell. They might actively resist your attempts to encourage them to seek help. Your course of action should depend on the type and severity of the young person's symptoms, but is essential that the young person does receive a clinical assessment by an appropriate professional.

If the young person's psychosis is not severe, and a clinical assessment does not appear to be urgent, you may wish to seek the advice of a mental health professional with expertise in early psychosis and young people. They may be able to help you to develop a strategy to make sure the young person is seen by an appropriate professional. It is important to remain friendly and patient and maintain a good relationship so that you are in a position to have a positive influence on the young person in the future. Avoid trying to persuade the young person using negative methods such as lecturing, nagging, or threatening.

If the young person's psychosis is severe, they are at risk of harming themselves or others and they are unwilling to engage in treatment, involuntary committal procedures may be necessary. However, never threaten the young person with mental health legislation or hospitalisation.

Action 5: Encourage other supports

Other people who can help

Try to determine whether the person has a supportive social network and, if they do, encourage them to utilise these supports.

Family and friends are an important source of support for a person experiencing a psychotic illness. A person is less likely to relapse if they have good relationships with family.[106] Family and friends can help by:

- Listening to the person without judging or being critical
- Keeping the person's life as stress-free as possible to reduce the chance of relapse
- Encouraging the person to get appropriate treatment and support
- Checking if the person is feeling suicidal and taking immediate action if the person is suicidal
- Providing the same support as they would for a physically ill person – these include sending get-well cards, flowers and other gifts, and phoning, texting or visiting the person
- Helping minimise disruptions to school and other important areas of the young person's life by supporting them to complete homework, attend events and spend time with friends
- Having an understanding of psychosis
- Looking for support from a carers' support group
- Helping the person to develop an Advance Care Directive, wellness plan, relapse prevention plan or personal directive (see box on 'What is an Advance Care Directive?')
- Discouraging unhealthy coping strategies such as the use of alcohol and other drugs.

What is an Advance Care Directive?

An Advance Care Directive is a document describing how the person wants to be treated when they are unable to make their own decisions due to their present state of illness. This is an agreement made between the person, their family, and hopefully their usual healthcare professional. It is not usually a legal document, but this varies between states and territories.

Schools and communities[88]

Young people with psychotic illnesses may experience disruptions in education due to hospitalisations and poor functioning. Schools can help by working with the young person to develop a personal education plan, for example, providing extra assistance to meet deadlines. Older adolescents may benefit for help in gaining employment or vocational training. Parents should contact their adolescent's school to discuss options for extra help.

Support groups can be helpful to a young person experiencing psychosis. Other family members can benefit from joining carers' support groups.

Self-help strategies

People experiencing psychosis should avoid the use of alcohol, cannabis and other drugs. People sometimes take drugs as a way of coping with a developing psychotic illness,

but these drugs can make the symptoms worse, initiate relapse and make the disorder difficult to diagnose.[107] The use of cannabis can also slow down recovery.[108]

Many people experiencing psychosis also have a depressive or anxiety disorder. Self-help strategies recommended for depression and anxiety may also be appropriate for young people with psychosis. However, they should not be used as the main form of assistance. Mental health professionals must be consulted.

Helpful resources for psychosis in young people

Telephone support

SANE Helpline

Information and advice is available by calling the SANE Helpline, 1800 18 SANE (7263), 9-5 weekdays EST.

Mental Health Crisis Numbers

ACT: Mental Health Triage Service, 24 hours, 7 days, 1800 629 354 or 02 6205 1065

NSW: Ring nearest hospital or the Mental Health Line on 1800 011 511

NT: Northern Territory Mental Health Services on 1800 682 288

QLD: Call the nearest hospital, Emergency Services 000 or Lifeline 13 11 14

SA: Crisis Team 13 14 65

TAS: 1800 332 388 (9am – 11pm) or nearest hospital

VIC: Suicide Helpline Victoria 1300 651 251 or ring nearest hospital for closest crisis team

WA: Mental Health Emergency Response Line 1300 555 788 (Metro local call) or 1800 676 822 (Peel free call). Elsewhere, call RuralLink on 1800 552 002.

Websites

Black Dog Institute

www.blackdoginstitute.org.au

The Black Dog Institute provides very good information about bipolar disorder, including a self-assessment test and downloadable fact sheets.

National Institute of Mental Health (NIMH)

www.nimh.nih.gov

This US government site gives a wealth of excellent, up-to-date information on psychosis in the form of downloadable booklets and fact sheets.

Schizophrenia 24x7

www.schizophrenia24x7.com

This website includes information about schizophrenia for people with a recent diagnosis, those who have had the illness for some time, family members and friends of people with the illness and also those whose work brings them into contact with people with schizophrenia. It includes information about treatment, goal setting, returning to study or work and other things that assist with recovery.

Bipolar Caregivers

www.bipolarcaregivers.org

This website provides information on how to support a person with bipolar disorder. The advice on this site is based on the consensus of expert panels of clinicians, caregivers and people with bipolar disorder.

Support and Education Groups

Mental Illness Fellowship of Australia

www.mifa.org.au

The Mental Illness Fellowship of Australia is a not-for-profit, self-help, support and advocacy organisation with branches in every state and territory dedicated to helping people with serious mental illnesses, their families and friends. Such illnesses include schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorders and anxiety disorders.

Mental Health Carers Australia

www.mentalhealthcarersaustralia.org.au

Mental Health Carers Australia supports and promotes the well-being of families and others voluntarily caring for people with mental illness throughout Australia. Details of branches in various sates and territories can be found at the national website above.

Books

Schizophrenia

Compton MT, Broussard B. *The First Episode of Psychosis: A Guide for Patients and Their Families.* England: Oxford University Press; 2009.

This US guide is for people who have had a first psychotic episode and their families. It encourages them to take an active informed role in their care.

Gur RE, Johnson AB. *If Your Adolescent Has Schizophrenia: An Essential Resource for Parents.* New York, NY, USA: Oxford University Press; 2006.

This guide is written for the parents and other caregivers of adolescents with a diagnosis of schizophrenia. It contains information about treatment and management, addresses myths and includes personal stories from people who are recovering.

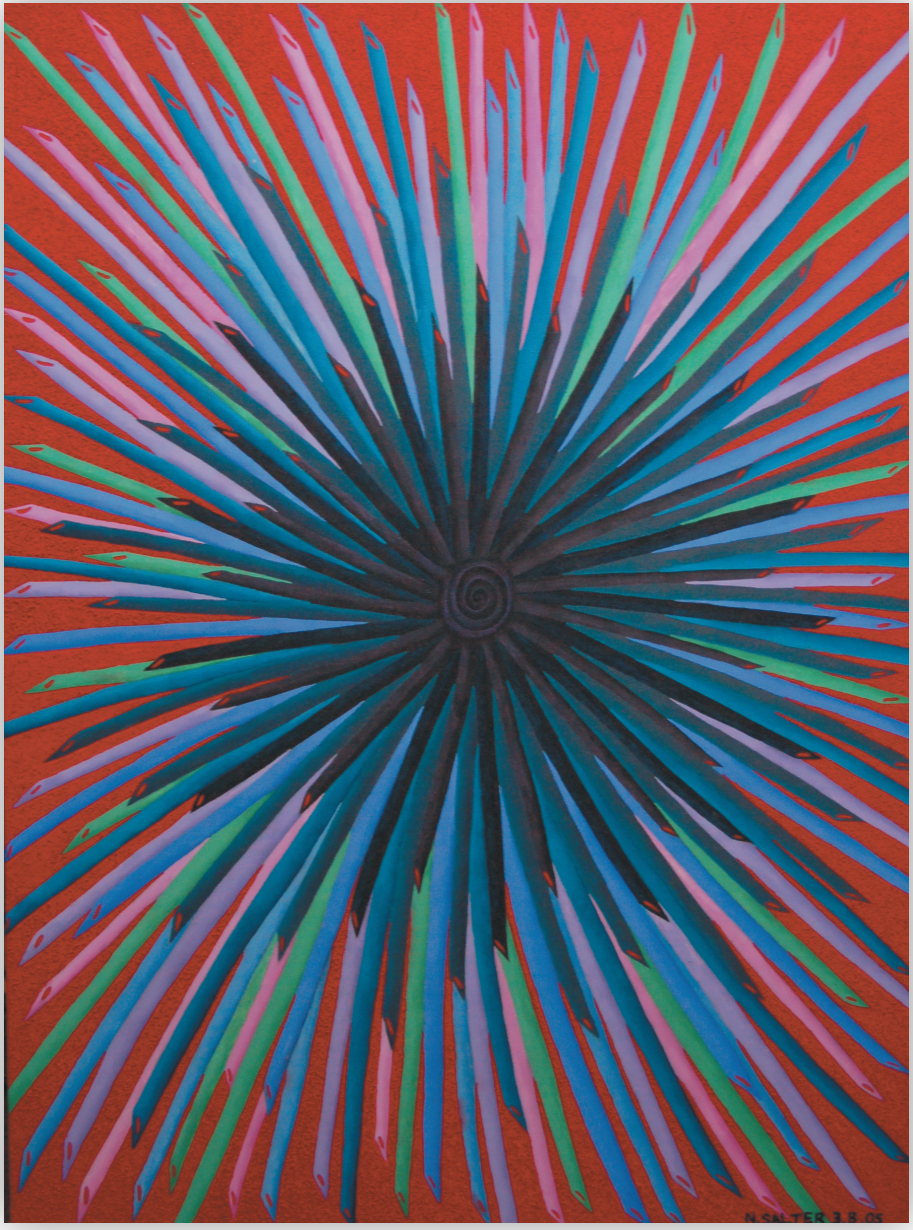
Bipolar disorder

Eyers K, Parker G (eds) (2008). *Mastering Bipolar Disorder: an Insider's Guide to Managing Mood Swings and Finding Balance.* Allen and Unwin, Sydney, NSW, Australia.

This book, produced by the Black Dog Institute, incorporates the latest research on bipolar disorder and personal stories of people with bipolar disorder.

Evans DL, Andrews LW (2005). *If Your Adolescent has Depression or Bipolar Disorder: an Essential Resource for Parents.* Oxford University Press, New York, NY, USA.

This guide is written for the parents and other caregivers of adolescents with a diagnosis of bipolar disorder or depression. It contains information about treatment and management, addresses myths and includes personal stories from people who are recovering.



Escaping the Spiral of Needles
Nicole painted this in 2005 when she was 20 years old. At the time she was overcoming a substance use problem. The middle part of the painting uses dark colours and represents addiction. As she escapes the addiction the colours brighten. At the time she was making a choice between her relationship with her boyfriend or substance abuse. She decided that if she chose the drugs she would still be thinking about her boyfriend, so she chose him instead. **Nicole Salter**

2.5 Substance Use Problems in Young People

What are substance use problems ?

Different substances (alcohol and other drugs) affect the brain in different ways. People use substances because of these effects, which include increasing feelings of pleasure or decreasing feelings of distress. There is a range of levels of use of alcohol and other drugs. Young people may experiment with substances, using only a small amount once or twice during adolescence, or they may develop a pattern of heavy use. **Any substance use by an adolescent should be regarded as a problem.** This is because of potential harmful effects on the developing brain and the young person's mental health, and the strong association with a high level of risk-taking behaviour.[109]

Consequences of substance use in adolescence

Because the brains of adolescents are still developing, alcohol and other drugs have more serious effects in this age group.[110] For example, there is evidence that alcohol use in adolescents affects the development of areas of the brain that control decision-making and memory, and cannabis use in adolescence is associated with lower IQ and poorer memory.

Early and frequent use of alcohol and other drugs increases the risk of developing substance use disorders including substance dependence, and other mental disorders such as depressive, anxiety and psychotic disorders.[27] In addition, any use of alcohol and other drugs by a young person may indicate an underlying mental health problem or emotional distress. Young people may 'self-medicate' for these problems by using substances, but in the long term, this is likely to make the problems worse.

Whilst under the influence of substances, a young person is more likely to engage in risk taking behaviour or get into dangerous situations.[111, 112] These include:

- ***Physical injuries*** due to risk-taking behaviour, such as imitating dangerous stunts seen on television or the Internet, driving or riding a bicycle while intoxicated or getting into a car with an intoxicated driver.
- ***Aggression and antisocial behaviour*** such as getting into fights or engaging in criminal activity such as vandalism or theft.
- ***Sexual risk taking and unplanned sexual contact***. Young people are more likely to engage in unsafe sex practices. Young people may consent to sexual activity that they wouldn't agree to while sober. Sexual risk taking may result in unwanted pregnancy or sexually transmitted infections.
- ***Becoming a victim of crime***. While affected by alcohol and other drugs, young people are also at increased risk of becoming victims of violent crime including physical or sexual assault.
- ***Suicide and self–injury.*** When a person is intoxicated with alcohol, they are more likely to act on suicidal thoughts or injure themselves. Alcohol increases risk in several ways. It acts as a mood amplifier, intensifying feelings of anxiety, depression, or anger, reduces inhibitions, and inhibits the use of more effective coping strategies.

In addition, ongoing substance misuse can interfere with normal functioning in a number of ways. These include:

- ***Educational problems*** including a decline in school performance, increased absenteeism and failure to complete education.
- ***Legal problems*** associated with violence, property damage, theft, vandalism or traffic offences.
- ***Social and family problems*** such as increased conflict.

Long-term substance misuse can lead to physical illnesses and other serious problems. Although these problems typically do not occur until later in life, substance use that starts during adolescence increases the long-term risk.

What are substance use disorders?

People who use more heavily or frequently may have a substance use disorder. For a person to have a substance use disorder, their substance use problems must have an adverse effect on their life during the past year in two or more of the following areas:[5]

- The substance is often taken in larger amounts or for a longer period than intended.
- The person wants to cut down use, but finds this difficult.
- A lot of time is spent obtaining the substance, using it or recovering from its effects.
- Craving (i.e. a strong urge) to use the substance.
- Repeated use that affects their ability to fulfil their work, school or home responsibilities, e.g. repeated absences from work, poor work performance, neglect of children or household.
- Repeated use despite this causing on-going problems with other people, e.g. arguments, fights.
- Other important activities are neglected because of the substance use.
- Repeated use in situations where it is physically hazardous, e.g. driving a car or using machinery while affected by a substance.
- Continued use despite knowing that they have a mental or physical health problem caused by the substance.
- Tolerance for the substance, i.e. the person needs to use increasing amounts to get the desired effect or they get less effect with the same amount of the substance.
- Withdrawal symptoms or the substance is needed to avoid withdrawal symptoms.

Adolescents usually have not been using substances regularly enough or for long enough to have developed a disorder (often because they do not have access or the financial resources to use in sufficient quantities). Substance use disorders are most common in young adults, and those who have substance use problems during adolescence are at highest risk of developing a disorder later on.[112]

Approximately 12.7% of Australians aged 16-24 have a substance use disorder in a given year. This is much higher than the rate of 5.1% in the whole population. More males are affected by substance use disorders than females (in the 16-24 age group, 15.5% of males vs. 9.8% of females).[6] Substance use disorders tend to begin in adolescence or early adulthood with a median age of onset of 18 years,[12] which means that half the people who will ever have a substance use disorder will have misused substances before this age.

Alcohol use problems

Alcohol is the most widely used drug in Australia, for people in all age groups including adolescence. Alcohol makes people less alert and impairs concentration and coordination. In small quantities, alcohol causes people to relax and lower their inhibitions. They can feel more confident and often act more extroverted. However, alcohol use can have serious effects on physical and mental health, particularly if it starts in adolescence.

How much is too much?

In 2009, The National Health and Medical Research Council (NHMRC) made the following recommendations for levels of drinking to help reduce the risk of alcohol-related harm over a person's lifetime:[111]

For children and young people under 18 years of age:

- Not drinking is the safest option.
- Under the age of 15, not drinking is especially important.
- Between the ages of 15-17 years, it is best to delay drinking for as long as possible.
- Any alcohol use under the age of 18 should be at low risk levels (as described below) and supervised by a responsible adult.

For healthy men and women aged 18 years and over:

- Drinking no more than two standard drinks on any day reduces the lifetime risk of harm.
- Drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.

For women who are pregnant, are planning a pregnancy or are breastfeeding:

- Not drinking is the safest option.

Adolescents learn about alcohol from many sources, but for most the biggest influence is their parents. Parents should model responsible alcohol use and healthy attitudes about alcohol

Number of standard drinks in various alcoholic beverages[111]

Alcoholic beverage	Standard drinks
Low strength beer (2.75% alcohol)	
1 can or stubbie	0.8
285 ml glass	0.6
425 ml glass	0.9
Mid strength /light beer (3.5% alcohol)	
1 can or stubbie	1
285 ml glass	0.8
425 ml glass	1.2
Full strength beer (4.9% alcohol)	
1 can or stubbie	1.4
285 ml glass	1.1
425 ml glass	1.6
Wine (9.5%-13% alcohol)	
100 ml glass	1
Average restaurant serving (150 ml)	1.4-1.6
750 ml bottle	7 – 8
Spirits (37%-40% alcohol)	
1 nip (30 ml)	1
700 ml bottle	22
Pre-mixed spirits (5%-7% alcohol)	
1 can (375 ml)	1.5-2.1
1 bottle (275 ml)	1.1-1.5

for their children at all ages. By following the guidelines set down by the NHMRC, parents can have a positive influence on the choices their adolescent children make about alcohol use. Parents who choose to use alcohol can model this more responsibly by measuring their drinks.

Measuring drinks

A standard drink contains about 10 grams of alcohol. The table on the previous page shows different alcoholic drinks that are equal to one standard drink. The average time taken by the human liver to break down 10g of alcohol is one hour.

It is useful to be aware of the terms used to describe different drink sizes. In most parts of Australia, a 285ml glass of beer is called a midi, a half-pint, or a pot. A 425ml glass is usually called a schooner. A pint of beer is 570ml. However, regional differences exist. The size of a wine glass may vary from venue to venue, though many are marked to the point of a standard drink. When drinking alcohol at home, particular care should be taken, as glass sizes vary and many people do not measure the amount of alcohol they put in a glass.

Drug use problems

Although the use of other drugs is less common than the use of alcohol, there are a wide variety of other drugs that are misused by adolescents and other young people.

Cannabis (marijuana)

Cannabis is a mind-altering drug and is a mixture of dried, shredded leaves, stems, seeds, and flowers of the hemp plant. The main active chemical in cannabis is THC (delta-9-tetrahydrocannabinol). The effects of cannabis on the user vary depending on how much THC it contains. The THC content of cannabis has been increasing since the 1970s. Use of cannabis can interfere with performance at work or at school and lead to increased risk of accidents if used whilst driving. Long-term heavy use of cannabis has been found to produce abnormalities in certain parts of the brain.[113]

Cannabis is by far the most commonly used illicit drug in Australia, for adolescents as well as the population as a whole. The 2013 National Drug Strategy Household Survey of Australians aged 14 -19 years found that 14.7% had used cannabis in the past year.[83] Only 1% of Australians aged 16 or over have a cannabis use disorder,[29] although it is more common in young people and amongst males.

People who use cannabis are more likely to suffer from a range of other mental health problems, including anxiety and depression, but it is unclear which comes first. Also, cannabis use by adolescents and young adults has been found to increase the risk of developing schizophrenia, particularly in persons who are vulnerable because of a personal or family history of schizophrenia.[90]

Opioid drugs (including heroin)

Opioid drugs include heroin, morphine, opium, and codeine. Heroin is processed from morphine, which is a naturally occurring substance taken from the Asian poppy plant. Heroin produces a short-term feeling of euphoria and well-being and relief of pain. Heroin is not a widely used drug in Australia. The 2013 National Drug Strategy Household Survey found that only 0.1% of Australians aged 14 and over had used heroin in past year.[83] However, it is a highly addictive drug, and most people who use it develop a substance use disorder. Most people who are dependent on heroin also have associated problems such as depression, alcohol dependence and criminal behaviour. People who use heroin are at higher risk for suicide.

Pharmaceutical drugs used for non-medical purposes

A number of prescription drugs, such as those used to treat anxiety and sleep problems, are used by some people for non-medical purposes. The 2013 National Drug Strategy Household Survey of Australians showed that 4% of people aged 14-19 used prescription drugs for non-medical purposes in the past year, e.g. pain killers, tranquillisers or sedatives.[83] Abuse of these drugs can lead to dangerous situations, such as driving while under the influence.

Cocaine

Cocaine is a highly addictive stimulant drug. Although sometimes thought of as a modern drug problem, cocaine has been abused for more than a century, and the coca leaves from which it is made have been used for thousands of years. Cocaine gives very strong euphoric effects and people can develop dependence after using it for a very short time. The 2013 National Drug Strategy Household Survey of Australians showed that 1.1% of people aged 14-19 had used cocaine in the past year.[83] With long-term use people can develop mental health problems such as paranoia, aggression, anxiety and depression. Cocaine can bring on an episode of drug-induced psychosis.

Amphetamines (including methamphetamine)

Amphetamines belong to a category of stimulant drugs and have the temporary effect of increasing energy and apparent mental alertness. However, as the effect wears off, a person may experience a range of problems including depression, irritability, agitation, increased appetite and sleepiness. Amphetamines come in many shapes and forms and are taken in many ways. They can be in the form of powder, tablets, capsules, crystals or liquid. **Methamphetamine (ice)** has a chemical structure similar to that of amphetamine, but it has stronger effects on the brain. The effects of methamphetamine can last 6-8 hours. After the initial 'rush', there can be a state of agitation, which can sometimes lead to violent behaviour. The 2013 National Drug Strategy Household Survey found that 2% of Australians aged 14-19 had used amphetamines over the past year.[83]

High doses of amphetamine can lead to aggression, intense anxiety, paranoia, and psychotic symptoms. Withdrawal symptoms can include temporary depression. A particular mental health risk is amphetamine psychosis or 'speed psychosis', which involves symptoms similar to schizophrenia. The person may experience hallucinations, delusions and uncontrolled violent behaviour. The person will recover as the drug wears off, but is vulnerable to further episodes of drug-induced psychosis if the drug is used again.

Some types of amphetamines have legitimate medical uses. They are used under prescription to treat attention-deficit disorders and some other medical conditions. Care should be taken to minimise the chances of these medications being sold or passed on to peers for non-medical use.

Hallucinogens

Hallucinogens are drugs that affect a person's perceptions of reality. Some hallucinogens also produce rapid, intense emotional changes. The 2013 National Drug Strategy Household Survey found that 1.3% of people aged 14 and over used hallucinogens in the past year.[83] In Australia the most widely used hallucinogenic drugs are 'magic mushrooms' (psylocibin) and 'acid' (LSD). A particular problem associated with hallucinogens is flashbacks, where the person re-experiences some of the perceptual

effects of the drug when they have not been recently using it.

Ecstasy

Ecstasy (MDMA) (also known as 'E') is a stimulant drug that also has hallucinogenic properties. Some young people use it at dance parties. While intoxicated, ecstasy users report that they feel emotionally close to others. The 2013 National Drug Strategy Household Survey found that 3% of Australians aged 14-19 had used ecstasy in the past year, a decline from previous studies.[83] Users can develop an adverse reaction that in extreme cases can lead to death. To reduce this risk, users need to maintain a steady fluid intake and take rest breaks from vigorous activity. When coming off the drug they often experience depressed mood. The long-term effects of using ecstasy are of particular concern. There is considerable evidence that ecstasy damages nerve cells in the brain that use a chemical messenger called serotonin.[114] Research on people who have used ecstasy regularly shows that they have reduced sexual interest and a range of mental health problems.[115]

It is important to note that while ecstasy refers to the drug MDMA, people buying ecstasy may be buying pills that contain other substances. This means that ecstasy users are risking the use of other drugs and poisonous substances.

Inhalants

Inhalants are breathable chemical vapours that produce mind-altering effects. The effects of inhalants range from an alcohol-like intoxication and euphoria to hallucinations, depending on the substance and the dosage. Use of inhalants also starves the brain of oxygen, causing a brief 'rush'. Inhalants may be solvents (e.g. paint thinners, petrol, glues), gases (e.g. aerosols, butane lighters), nitrites, and other substances. Although people are exposed to volatile solvents and other inhalants in the home and in the workplace, many do not think of inhalable substances as drugs because most of them were never meant to be used in that way. Young people are the most likely to abuse inhalants, partly because inhalants are readily available and inexpensive. In 2013, less than 1% of people aged 14 and over had used inhalants in the past year.[83]

The intentional misuse of common household products used by people to get high can be fatal, as a result of either 'sudden sniffing death' or long-term use. Young people are usually unaware of the serious health risks and those who start using them at an early age are likely to become dependent on them. These agents will destroy the cells in the brain, the liver, and the kidneys.

Tobacco

In 2013, 5% of 12-17 year olds had smoked and 3% were daily smokers.[83] Smoking continues to decrease in adolescents; this rate is less than half what it was in 2004. There is a high rate of mental health problems in people who use tobacco. Smokers are around twice as likely to suffer from a mental illness compared to people who have never smoked.[116] Smoking is particularly high in people with schizophrenia (approximately 66%) and is a significant contributor to their poorer physical health.[10] It is possible that tobacco is used as a type of self-medication by some people with mental illnesses in order to improve mood and cognitive functioning.

What might a first aider notice if a young person is misusing alcohol or other drugs?

If a young person is misusing substances only occasionally, it may be difficult to recognise. If substance use becomes more frequent, the signs may become more noticeable over time.

At home, a young person who is misusing substances may:

- Become increasingly secretive or avoid answering parents' questions, particularly when it comes to where they go and what they do with friends
- Take alcohol from their parents' liquor cabinets or other sources in the home
- Appear to suffer from a hangover some mornings
- Eat a lot of snack food, as a result of increased appetite from cannabis use
- Spend money more quickly than they used to, or be unable to explain what they are spending their money on.

In a school environment, a young person who is misusing substances may:

- Show a decline in school grades due to not completing work, not doing as good a job as they used to, or missing school
- Have difficulty maintaining focus and concentration
- Decrease the time spent in healthy extracurricular activities such as sport.

These behaviours can all have an impact on school achievement, and some may result in disciplinary responses.

The friends of a young person who is misusing substances may notice that they:

- Spend increased amounts of time with friends who also use substances, rather than those who do not
- Use more substances than what is considered usual in the social group, or starts to suggest bringing substances to parties or other social events
- Use substances to become intoxicated rather than to experiment
- Seem to have a 'different personality' when using substances compared to their usual selves, or experience distress as a result of their behaviour when intoxicated.

Risk factors for adolescent substance use problems[117]

Most of our knowledge about the risk factors for substance use problems relates to alcohol, but the risk factors for other drug use problems are likely to be similar.

There are many factors that may influence an adolescent's *decision to drink*:

- Many adolescents associate alcohol use with becoming an adult
- Drinking may be considered normal within their peer or cultural groups
- Portrayal and marketing of alcohol in the media may encourage drinking
- Parents' use of and attitudes about alcohol also influence drinking.

A number of factors increase the risk of an *adolescent drinking heavily:*

- Experiencing emotional or psychological problems
- Not feeling connected to family, school or community
- Behaviour problems
- Family history of alcohol problems.

Some adolescents who drink heavily will go on to develop an *alcohol use disorder.* Factors that increase the risk include:[118]

- Early use of alcohol

- Availability and tolerance of alcohol in society
- Alcohol use in the family
- Social disadvantage and negative life events
- Biological factors such as genetic predisposition and alcohol sensitivity
- Enjoyment from drinking
- Other mental health problems.

Interventions for substance use problems

Professionals who can help

A variety of health professionals can provide help to a young person who is misusing substances. If the young person is uncertain about what to do, encourage them or their parents to consult a GP first. The GP may be able to provide treatment themselves, might refer the young person to a drug or alcohol service, or to a mental health professional if there are other mental health problems.

Treatments available for substance use problems

The treatments for substance use problems depend on the severity of the problem, how motivated the person is to change, and what other physical and mental health problems they also have.

If a young person is substance dependent, detoxification and withdrawal management will be needed. This can involve a stay in a treatment facility, medication and ongoing therapy.

For young people who are not substance dependent, the main treatments are:[119, 120]

Brief intervention. If a person is drinking at a level that could damage their health or using drugs, then brief counselling by a GP can help them reduce or stop using. If they have a substance use disorder, it can help to motivate them to enter long-term treatment. This type of intervention generally takes 4 or fewer sessions, each lasting from a few minutes up to an hour. The professional looks at how much the person is using, gives information about risks to their health, advises them to cut down, discusses the pros and cons of changing and options for how to change, motivates the person to act by emphasising personal responsibility, and monitors progress. In doing these things, the GP adopts an empathic rather than a coercive approach.

Psychological treatments. These include:

- **Cognitive behaviour therapy** teaches the person how to cope with craving and how to recognise and cope with situations that might trigger relapse. To get the full benefit of cognitive behaviour therapy, a person needs to have a sufficient number of sessions. As a guide, around 12 sessions is recommended.[40]
- **Motivational enhancement therapy** helps motivate and empower a person to change. It allows the person to consider the gains they receive from using substances, while helping to improve their awareness of the negative aspects and consequences of their use, and helps them to identify reasons to choose not to use.
- **Contingency management** involves offering the person incentives such as shopping vouchers or privileges, for negative drug test results or for harm reduction actions such as having a hepatitis or HIV test. For adults with substance use disorders this therapy is usually clinician directed, but for adolescents parents can use similar strategies effectively. This may be one component of family based therapy.

Treatment for any underlying mental health problems. Young people with a substance use problem often have another mental illness. Use of the substance may have started as a way to deal with emotional difficulties. This means that it is important that any other mental illness is treated as well, preferably at the same time.

The importance of early intervention for substance use problems

Substance use problems typically begin in adolescence and early adulthood, so this is the critical time for early intervention. There is evidence that the brains of adolescents and young adults are still developing and are more sensitive to the effects of alcohol and other drugs than the brains of older adults.[36] Substance use during this period of life can affect brain development and lead to cognitive impairments. Early intervention will also prevent many of the long-term ill effects on a person's physical health, social relationships, educational progress, financial status and job prospects. It will also reduce the possibility of serious problems with the law.

Crises associated with substance use

The main crises that may be associated with substance use are:

- The person has **severe effects from alcohol use.**
- The person has **severe effects from drug use.**
- The person is showing **aggressive behaviours.**
- The person has **suicidal thoughts and behaviours.**

Severe effects from alcohol misuse

If the person is using alcohol heavily, it is possible they will experience severe effects from alcohol intoxication, alcohol poisoning or alcohol withdrawal.

Alcohol intoxication substantially impairs thinking and behaviour. When intoxicated the person may engage in a wide range of risky activities, such as having unprotected sex, getting into arguments or fights, or driving a car. The person may also be at higher risk of attempting suicide.

Alcohol poisoning is a dangerous level of intoxication that can lead to death. The amount of alcohol that causes alcohol poisoning is different for every person.

Alcohol withdrawal refers to the unpleasant symptoms a person experiences when they stop drinking or drink substantially less than usual. It is not simply a hangover. Unmedicated alcohol withdrawal may lead to seizures.

Severe effects from drug misuse

If the person is using drugs, it is possible they will experience severe effects from drug intoxication, drug overdose, or overheating or dehydration.

Drug intoxication can lead to impairment or distress e.g. the person may have poor judgement, engage in risky behaviours or become aggressive. The effects vary depending on the type and amount of drug and also vary from person to person. It can be difficult to make a distinction between the effects of different drugs. Illicit drugs can have unpredictable effects as they are not manufactured in a controlled way.

Overdose occurs when the intoxication level leads to risk of death.

Overheating or dehydration can occur with prolonged dancing in a hot environment (such as a dance party) while on some drugs (e.g.

ecstasy) without adequate water intake. This causes the person's body temperature to rise to dangerous levels.

Sudden sniffing death may occur with inhalant use, due to heart failure. This is more likely if the person becomes agitated or engages in physical exertion, e.g. the person gets a fright and runs away.

Aggressive behaviours

There is an increased risk of aggression towards others for people who experience substance use problems.[100] Many crimes are committed by people who are intoxicated with alcohol or other drugs.

Suicidal thoughts and behaviours

There is also increased risk of suicide. Of all persons who die by suicide, 26% have a substance use disorder.[64] People are more likely to act on suicidal thoughts when they are intoxicated.

The Mental Health First Aid Action Plan For Substance Use Problems[121-124]



Mental Health First Aid Action Plan

Approach the young person, assess and assist with any crisis

Listen and communicate non-judgmentally

Give support and information

Encourage the young person to get appropriate professional help

Encourage other supports

Action 1: Approach the young person, assess and assist with any crisis

How to approach

If you are concerned about someone's substance use, talk to the person about it openly and honestly. Before speaking with the person, reflect on their situation, organise your thoughts and decide what you want to say. Arrange a time to talk with the person. Talk with them in a quiet, private environment at a time when there will be no interruptions, when both of you are sober and are in a calm frame of mind. Express your concerns non-judgmentally in a supportive, non-confrontational way. Be assertive, but do not blame or be aggressive.

Consider the following when making your approach:

- ***The young person's own perception of their using.*** Try to understand the person's own perception of their using. Ask the person about their substance use (for example, about how much of the substance the person is using) and if they believe their substance use is a problem.
- ***The person's readiness to talk.*** Consider the young person's readiness to talk about their substance use problem by asking about areas of their life that it may be affecting, for example, their mood, performance and school and relationships. Be aware that the person may deny that they are using at all, or might not recognise that they have a substance use problem, and that trying to force the person to admit to substance misuse may cause conflict.
- ***Use 'I' statements.*** Express your point of view by using 'I' statements, for example, "I am concerned about how much you've been drinking lately" rather than 'you' statements such as "You have been drinking too much lately".
- ***Rate the act, not the young person.*** Identify and discuss the person's behaviour rather than criticising their character, for example, "Your drug use seems to be getting in the way of your friendships"

rather than "You're a pathetic druggie".

- ***The person's recall of events.*** When discussing the person's substance use, bear in mind that the young person may recall events that occurred while they were using in a different way to how they actually happened, or that they may not recall events at all.
- ***Stick to the point.*** Focus on the person's substance use and do not get drawn into arguments or discussion about other issues.

How to assess and assist in a crisis

As you talk with the person, be on the lookout for any indications that the person may be in crisis.

If you have concerns that the young person has **severe effects from alcohol misuse** (intoxication, alcohol poisoning or severe withdrawal), find out how to **assess** and **assist** this person in Section 3.7 *First Aid for Severe Effects from Alcohol Use.*

If you have concerns that the young person has severe **effects from drug misuse** (drug intoxication, overdose, overheating or dehydration), find out how to **assess** and **assist** this person in Section 3.8 *First Aid for Severe Effects from Drug Use.*

If you have concerns that the young person is showing **aggressive behaviours**, find out how to **assess** and **assist** this person in Section 3.9 *First Aid for Aggressive Behaviours*.

If you have concerns that the young person may be having **suicidal thoughts and behaviours**, find out how to **assess** and **assist** this person in Section 3.1 *First Aid for Suicidal Thoughts and Behaviours.*

If you have no concerns that the person is in crisis, you can ask them about how they are feeling and how long they have been feeling that way and move on to Action 2.

Action 2: Listen and communicate non-judgmentally

See Action 2 in Section 2.1 *Depression in Young People* for more tips on non-judgmental listening and communication. It can be hard for an adult to listen non-judgmentally to a young person who is using substances. These substances are often illegal and because of the high risk of injury or other harms, adults can be fearful of what might happen. Some of the main things to keep in mind in order to listen non-judgmentally are:

- Treat the young person with respect and dignity.
- Interact with the young person in a supportive way, rather than threatening, confronting or lecturing them.
- Listen to the young person without judging them as bad or immoral.
- Avoid expressing moral judgments about their substance use.
- Do not criticise the young person's substance use. You are more likely to be able to help them in the long term if you maintain a non-critical but concerned approach.
- Do not label the young person, e.g. by calling them a "Pothead" or "Drunk".
- Try not to express your frustration at the young person for having a substance use problem.

Action 3: Give support and information

Give the young person information about substance misuse and associated risks. Try to find out whether the young person feels they need help to change their substance misuse and discuss what you are willing and able to do. Have a helpline phone number or the address of a reputable website with you to give them (see *Helpful resources* at the end of this chapter).

Have realistic expectations for the person

Do not expect a change in the person's thinking or behaviour right away. Bear in mind that:

- Changing substance use habits may not be easy.
- A person's willpower and self-resolve is not always enough to help them stop using substances.
- Giving advice alone may not stop the young person using substances.

The stages of change[125]

A young person who is misusing substances may not be ready to change. Major behaviour changes take time to be achieved and often involve the person going through a number of stages. There are five 'stages of change', and the person may move back and forth between the stages at different times. The information and support you offer to the young person can be tailored to their level of readiness as shown below:

Stage 1: Pre-contemplation – the person does not think they have a problem

Give the young person information about the drug and how it might be affecting them, discuss less harmful ways of using the drug and how to recognise overdose.

Stage 2: Contemplation – the person thinks their drug use might be a problem

Encourage the young person to keep thinking about quitting, talk about the pros and cons of changing, give information and refer them to a professional.

Stage 3: Preparation – the person has decided to make a change

Encourage the young person and support their decision to change, and help them plan how they will stop using substances (e.g. talk to a substance use counsellor or GP).

Stage 4: Action – making the change

Provide support by helping the young person develop strategies for saying 'no' and avoiding people who use substances, practicing doing other things when they feel like using substances and finding other ways to cope with distress. Encourage the young person to get periodic health checks.

Stage 5: Maintenance – keeping up the new habits

Support the young person to keep up the new behaviour. Focus on the positive effects of not using substances and praise the young person's achievements.

A person may relapse once or several times before making long-term changes to their substance use.

- A person may try to change or stop their substance use more than once before they are successful.
- If the young person finds it very difficult to give up their substance use altogether, cutting down is still worthwhile.

Supporting the young person who wants to change

Tell the person what you are willing and able to do to help. This may range from simply being a good listener to organising professional help. If you are assisting an adolescent and you are not their parent, support them to talk to their parents about what is going on. Discuss with their parents what a good response might be; rather than parents getting angry and the young person being disciplined, encourage them to find more useful ways of talking through the problem.

During adolescence, friends and 'fitting in' become very important. Young people may use substances as a way to obtain acceptance from peers. The young person may find themselves in situations where they experience peer pressure to use substances. Tell the young person that the decision whether or not to use alcohol or other drugs is theirs, and not their friends'. Help them to prepare for this by talking about specific situations that may occur and helping them to develop different refusal techniques.

Help the young person to develop strategies for handling or removing themselves from situations involving substance misuse. Talk about the ways in which you will support them. If appropriate, tell them to call you if ever faced with a situation where other people are using substances, and assure them that whatever the circumstances, you will pick them up. Talk to them about ways to minimise any embarrassment this may cause them.

Helping the young person who does not want to change

If a young person wants to continue using substances, you may need to take extra steps to help them change. However, it is important that you maintain a good relationship. Let the person know how important it is for their health that they stop using alcohol and other drugs during adolescence. Provide them with information about substance misuse, e.g. reputable websites or pamphlets. Encourage them to question any assumptions they may have that most adolescents use substances and help them realise that many of their peers are not using.

You can speak with a health professional who specialises in substance misuse to determine how best to help the young person or you could consult with others who have dealt with such problems about effective ways to help.

While working to encourage the young person to change their substance use, you should set boundaries around what behaviour you are willing and not willing to accept from them. If you are the young person's parent, it can be helpful to set rules such as: being home by a particular time, informing you about where they are and who they are with when unsupervised and having a plan to get home safely. Adults supervising adolescents' recreational activities such as sports, youth groups or drama may enforce a rule that the adolescent may not participate if they have been using alcohol or other drugs. School professionals need to know their policies and procedures for managing students who use substances at school.

If the young person continues to use substances:

- Do not use negative approaches (e.g. lecturing or making them feel guilty) as these are unlikely to promote change

- Do not try to control them by bribing, nagging, threatening or crying
- Do not make excuses for them or cover up their substance use or related behaviour
- Do not make them move out from the family home.

Action 4: Encourage the young person to get appropriate professional help

Many people with alcohol and drug problems do not receive health or other services for these problems. In Australia, only 11% of young people aged 16-24 who had a substance use disorder in the past year received such help.[27] A failure to seek help can cause problems with family and education, damage physical health and increase the risk of developing other mental illnesses such as depression and anxiety disorders.

Assist the young person to access professional help

Seek information about local services, particularly those that are tailored to the needs of young people. Help the young person or their parents to access these services. Ensure that the young person is supported to make and keep appointments. E-counselling (counselling by email or live internet chat) and telephone counselling are a good option if other professional help is unavailable or difficult to access (see *Helpful resources* at the end of this chapter).

What if the person doesn't want professional help?

Be prepared for a negative response when suggesting professional help. The young person may not want such help when it is first suggested to them and may find it difficult to accept. Continue to suggest professional help to the person. However, don't pressure the person or use negative approaches as these may be counter-productive. Discuss with the young person their reasons for not wanting help. Their reasons may be based on mistaken beliefs about treatment that you may be able to correct. Reassure the person that professional help is confidential.

Remember that the person cannot be forced to get professional help except under certain circumstances, e.g. if a violent incident results in the police being called or following a medical emergency. If the young person is substance dependent or otherwise severely impaired by their use, a doctor or the young person's parents or guardians may seek involuntary treatment for them. However, this is very rare in this age group.

Action 5: Encourage other supports

Talk to the young people about available supports and help them to choose the ones they feel they will find most helpful.

Peer pressure can be a positive rather than a negative influence. Encourage the young person to develop friendships with peers who have healthy, positive lifestyles and good coping strategies, rather than those who misuse substances. Talk to the young person about qualities that really count in a friend, such as being kind and trustworthy, rather than popular and 'cool'. Encourage them to turn to friends who are supportive of the decision not to use alcohol or other drugs.

If you are the young person's parent or guardian, get to know their friends. Encourage your adolescent child to invite their friends over when you are at home, and invite their friends to join in family activities.

People are more likely to start using substances again if there is an emotional upset in their life. Parents can try to reduce this possibility by offering additional support and recommending good coping strategies when negative events occur.

Helpful resources for substance use problems in young people

Telephone and online support

Quitline

National smoking quitline, 24 hours a day
phone 131 848
www.quit.org.au

Counselling Online

www.counsellingonline.com.au
Counselling Online is a service that provides free online text-based counselling to alcohol and other drug users, their family members, relatives and friends. It is provided by Turning Point, a substance use treatment centre. Counselling Online is available 24 hours a day, 7 days a week, across Australia.

Alcohol and Drug Information Services (ADIS)

These services are available across Australia, 24 hours a day and will try to answer any questions about alcohol, tobacco or other drugs.

ACT: phone (02) 6207 9977

NSW: phone (02) 9361 8000,
rural NSW freecall 1800 422 599

NT: phone (08) 8922 8399 (Darwin),
(08) 8951 7580 (Alice Springs),
statewide freecall 1800 131 350

QLD: Statewide freecall 1800 177 833

SA: (08) 8363 8618 (Adelaide),
statewide freecall 1300 131 340

TAS: phone: (03) 9416 1818
(Hobart), statewide freecall 1800 811 994

VIC: phone (03) 9416 1818,
statewide freecall 1800 888 236

WA: phone (08) 9442 5000, statewide freecall 1800 198 024

National: phone 1300 368 186 (Family Drug Support)

http://www.fds.org.au

Telephone and online support

Screening for substance use disorders

Check Your Drinking

www.checkyourdrinking.net

Research has shown that this website is effective for motivating people with alcohol abuse problems to change their drinking.[126] Website users can check their drinking against the rates in other people in the same age group.

For parents and other adults

Parenting Strategies

www.parentingstrategies.net

This website includes guidelines for parents who wish to help their children avoid alcohol misuse now and in their adulthood. A survey allows parents to receive tailored messages about which areas of their parenting could be more effective, or the guidelines can be accessed in full.

The Other Talk

www.theothertalk.org.au

This website is designed for Australian parents. It can guide parents through having a conversation with their children about alcohol use. It also discusses secondary supply laws, which are important for parents who choose to allow their children to drink at home or at parties.

Youth Drug and Alcohol Advice service (YoDAA)

yodaa.org.au

YoDAA is a site that provides information specifically targeted to four groups: young people, workers, families and carers, and schools. It includes information as well as interactive tools.

Australian Drug Foundation

http://www.adf.org.au

The Australian Drug Foundation (ADF) is an independent, non-profit organisation working to prevent and reduce alcohol and drug problems in the Australian community. Its website is a good source of factual information on most types of drugs used illegally or unsafely.

Australian Drug Information Network (ADIN)

http://www.adin.com.au

This site is funded by the Australian Department of Health to provide a central point of access to Australian drug and alcohol information.

For young people

Somazone

www.somazone.com.au

This website has information about alcohol and other drugs, mental illness, relationships and family issues. Young people post stories about their own lives and can get feedback from other visitors to the site, and can ask questions that are answered by health professionals and other volunteers with good knowledge of the relevant issues.

OxyGen (tobacco)

www.oxygen.org.au

The name of this website refers to its slogan: 'Be part of the tobacco free OxyGeneration'. It provides information about tobacco and interactive activities for young people.

Reduce Your Use

www.reduceyouruse.org.au

This is a free, interactive, online program that uses a variety of self-help approaches to reducing or quitting cannabis use.

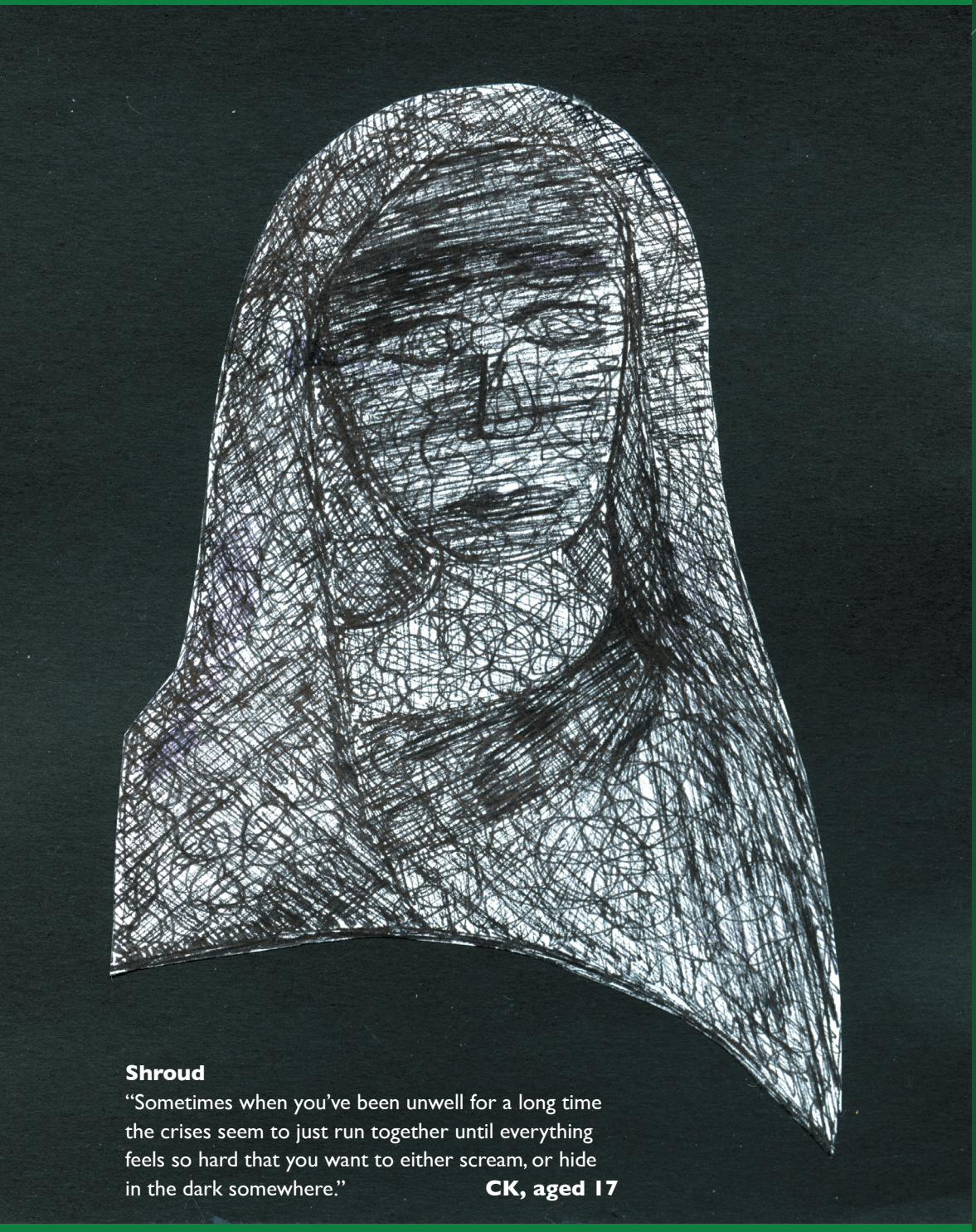
Book

Dillon P. Teenagers, *Alcohol and Drugs: What Your Kids Really Want and Need to Know About Alcohol and Drugs.* Sydney, NSW, Australia: Allen and Unwin; 2009.

This book was written by an Australian expert on alcohol and other drugs, for the parents of adolescents. This guide can help parents to talk to their adolescent children about the risks of substance use, how to resist peer pressure and harm reduction.

First Aid for Mental Health Crises

3



Shroud
"Sometimes when you've been unwell for a long time the crises seem to just run together until everything feels so hard that you want to either scream, or hide in the dark somewhere." **CK, aged 17**

Section 3: First Aid for Mental Health Crises

Introduction

This section contains recommendations for members of the public on how to assess and assist in a number of mental health crisis situations. Some of these crises can occur in people with various mental illnesses or those who are in emotional distress. Others may precipitate the onset of a mental illness, or may be related to substance use. The role of the first aider is to assist the person until appropriate professional help is received or the crisis resolves.

The first aid advice in this section is based on international guidelines that have been developed using the expert consensus of panels of mental health consumers, carers and clinicians. These experts came from a range of developed English speaking countries: Australia, Canada, Ireland, New Zealand, the UK and the USA.

These guidelines were not developed for use by adolescents themselves, and they were not developed specifically for helping adolescents. However, the advice presented here will be of use in most situations where an adolescent is in crisis.

Each individual is unique and it is important to tailor your support to that person's needs. These recommendations therefore may not be appropriate for every person who may be in crisis. Crises vary in severity and the first aid given also varies. If the crisis is severe enough to require emergency professional help, then your role as a first aider finishes when you hand over to the professional. If the crisis is less severe, the first aid can continue with other actions from the Mental Health First Aid Action Plan after the crisis resolves.

First aid recommendations are provided for the following crisis situations:

- Suicidal thoughts and behaviours
- Non-suicidal self-injury
- Panic attacks
- Adults affected by a traumatic event
- Children affected by a traumatic event
- Severe psychotic states
- Severe effects from alcohol use
- Severe effects from drug use
- Aggressive behaviours.



For me this time

"The collage text says 'I've decided not to die, for me this time'. I did this in the ward in 2008 after I tried to kill myself again. I always tried to stay alive because I was scared my brother and mum wouldn't cope without me but I realised that's not enough and the pressure just made me feel so guilty (even though it was from me and not them). Instead I have to live for me." **EM, aged 16**

3.1 First Aid for Suicidal Thoughts and Behaviours[127, 128]

An important note

Self-injury can indicate a number of different things. Someone who is hurting themselves may be at risk of suicide. Others engage in a pattern of self-injury over weeks, months or years and are not necessarily suicidal. This advice can be of use to you only if the person you are helping is suicidal. If the person you are assisting is injuring themselves, but is not suicidal, please refer to Section 3.2 *First Aid for Non-suicidal Self-injury.*

Facts on suicide in Australia

Although this age group does not have the highest rate of suicide, among 15-19 and 20-24 year olds, suicide is the single most common cause of death. Across all age groups, males account for around three quarters of suicides.[129] Approximately 87% of people who die by suicide have a mental illness.[64]

Suicidal thoughts and suicide attempts are also a major problem for young people. The National Survey of Mental Health and Wellbeing, which covered adults aged 16-85, found that the 16-24 year age group had the highest rate of suicidal thoughts in the past year (3.4%) and also the highest rate of suicide attempts (1.1%).[130] Other data come from the 2013-14 Australian Child and Adolescent Survey of Mental Health and Wellbeing, which found that 7.5% of 12-17 year olds had seriously considered attempting suicide in the past year and 2.4% had made a suicide attempt over this period.[13]

The main reasons people give for attempting suicide are:[131]

1. Needing to escape or relieve unmanageable emotions and thoughts. The person wants relief from unbearable emotional pain, feels their situation is hopeless, feels worthless and believes that other people would be better off without them.

2. Desire to communicate with or influence another individual. The person wants to communicate how they feel to other people, change how other people treat them or get help.

People are at greater risk of suicide if they have:[132]

- A mental illness
- Poor physical health and disabilities
- Attempted suicide or harmed themselves in the past
- Had bad things happen recently, particularly with relationships or their health
- Been physically or sexually abused as a child
- Been recently exposed to suicide by someone else.

Suicide is also more common in certain groups, including males, indigenous people, the unemployed, prisoners and LGBTIQ people.

How to assess

Important signs that a young person may be suicidal are:[133]

- Threatening to hurt or kill themselves
- Looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Talking or writing about death, dying or suicide
- Hopelessness
- Rage, anger, seeking revenge
- Acting recklessly or engaging in risky activities, seemingly without thinking
- Feeling trapped, like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic changes in mood (including sudden improvement in mood following an episode of depression)
- No reason for living, no sense of purpose in life.

People may show one or many of these signs, and some may show signs not on this list.
If you are concerned that a young person may be at risk of suicide, you need to approach them and have a conversation about your concerns.

Preparing yourself to approach the young person

Be aware of your own attitudes about suicide and the impact of these on your ability to provide assistance, e.g. a belief that suicide is wrong or that it is a rational option. If the young person is from a different cultural or religious background to your own, keep in mind that they might have beliefs and attitudes about suicide that differ from your own. Be aware that it is more important to genuinely want to help than to be of the same age, gender or cultural background as the person. **If you feel unable to ask the person about suicidal thoughts, find someone else who can.**

Making the approach

Act promptly if you think a young person is considering suicide. Even if you only have a mild suspicion that they are having suicidal thoughts, you should still approach them. Tell the person your concerns about them, describing behaviours that have caused you to be concerned about suicide. However, understand that the person may not want to talk with you. In this instance, you should offer to help them find someone else to talk to.

Asking about thoughts of suicide

Anyone could have thoughts of suicide. If you think a young person might be having suicidal thoughts, you should ask them directly. Unless someone tells you, the only way to know if they are thinking about suicide is to ask. For example, you could ask:

- **"Are you having thoughts of suicide?"** or
- **"Are you thinking about killing yourself?"**

While it is more important to ask the question directly than to be concerned about the exact wording, you should not ask about suicide in leading or judgmental ways, e.g. "You're not thinking of doing anything stupid, are you?"

Sometimes people are reluctant to ask directly about suicide because they think they will put the idea in the person's head. This is not true. Similarly, if a person is suicidal, asking them about suicidal thoughts will not increase the risk that they will act on these. Instead, asking the person about suicidal thoughts will allow them the chance to talk about their problems and show them that somebody cares.

Although it is common to feel panic or shock when someone discloses thoughts of suicide, it is important to avoid expressing negative reactions. Do your best to appear calm, confident and empathic in the face of the suicide crisis, as this may have a reassuring effect for the suicidal young person.

How can I tell how urgent the situation is?

Take all thoughts of suicide seriously and take action. Do not dismiss a young person's thoughts as 'attention seeking' or a 'cry for help'. Determine the urgency of taking action based on recognition of suicide warning signs.

Enquire about issues that affect their immediate safety by asking the suicidal young person:

- Whether they have a plan for suicide
- How they intend to suicide, i.e. ask them direct questions about how and where they intend to suicide
- Whether they have decided when they will carry out their plan
- Whether they have already taken steps to secure the means to end their life
- Whether they have been using drugs or alcohol. Intoxication can increase the risk of a person acting on suicidal thoughts
- Whether they have ever attempted or planned suicide in the past.

If the suicidal young person says they are hearing voices, ask what the voices are telling them. This is important in case the voices are relevant to their current suicidal thoughts.

It is also useful to find out what supports are available to the person. Ask the person:

- Whether they have told anyone about how they are feeling
- Whether there have been changes in their employment, social life or family
- Whether they have received treatment for mental health problems or are taking any medication.

Be aware that those at the highest risk for acting on thoughts of suicide in the near future are those who have a specific suicide plan, the means to carry out the plan, a time set for doing it, and an intention to do it. However, the lack of a plan for suicide is not sufficient to ensure safety.

How to assist

How should I talk with a young person who is suicidal?

It is more important to be genuinely caring than to say 'all the right things'. Be supportive and understanding of the suicidal person, and listen to them with undivided attention. Suicidal thoughts are often a plea for help and a desperate attempt to escape from problems and distressing feelings.

Do not avoid using the word 'suicide'. It is important to discuss the issue directly without dread or expressing negative judgment. Demonstrate appropriate language when referring to suicide by using the terms 'suicide' or 'die by suicide', and avoiding use of terms to describe suicide that promote stigmatising attitudes, e.g. 'commit suicide' (implying it is a crime or sin) or referring to past suicide attempts as having 'failed' or been 'unsuccessful' (implying death would have been a favourable outcome).

Ask the suicidal person what they are thinking and feeling. Reassure them that you want to hear whatever they have to say. Allow them to talk about these thoughts and feelings, and their reasons for wanting to die and acknowledge these. Let the suicidal person know it is okay to talk about things that might be painful, even if it is hard. Allow them to express their feelings,

e.g. allow them to cry, express anger, or scream. A suicidal person may feel relief at being able to do so.

Remember to thank the young person for sharing their feelings with you and acknowledge the courage this takes (see boxes on 'Listening tips' and 'What not to do').

How can I keep the young person safe?

Once you have established that a suicide risk is present, you need to take action to keep the young person safe. A person who is suicidal should not be left on their own. If you suspect there is an immediate risk of the young person acting on suicidal thoughts, act quickly, even if you are unsure. Work collaboratively with the young person to ensure their safety, rather than acting alone to prevent suicide.

Remind the young person that suicidal thoughts need not be acted on. Reassure them that there are solutions to problems or ways of coping other than suicide.

Listening tips

- Be patient and calm while the suicidal person is talking about their feelings.
- Listen to the suicidal person without expressing judgment, accepting what they are saying without agreeing or disagreeing with their behaviour or point of view.
- Ask open-ended questions (i.e. questions that cannot be simply answered with 'yes' or 'no') to find out more about the suicidal thoughts and feelings and the problems behind these.
- Show you are listening by summarising what the suicidal person is saying.
- Clarify important points with the person to make sure they are fully understood.
- Express empathy for the suicidal person.

What not to do

- Do not argue or debate with the young person about their thoughts of suicide.
- Do not discuss with the young person whether suicide is right or wrong.
- Do not use guilt or threats to prevent suicide, e.g. do not tell the person they will go to hell or ruin other people's lives if they die by suicide.
- Do not minimise the suicidal young person's problems.
- Do not give glib 'reassurance' such as "Don't worry", "Cheer up", "You have everything going for you" or "Everything will be alright".
- Do not interrupt with stories of your own.
- Do not communicate a lack of interest or negative attitude through your body language.
- Do not 'call their bluff' (dare or tell the suicidal person to "Just do it").
- Do not attempt to give the suicidal young person a diagnosis of a mental illness.

When talking to the suicidal young person, focus on the things that will keep them safe for now, rather than the things that put them at risk. To help keep them safe, develop a safety plan with them (see box on 'Safety plan'). Engage them to the fullest extent possible in decisions about a safety plan. However, do not assume that a safety plan by itself is adequate to keep the suicidal young person safe.

Although you can offer support, you are not responsible for the actions or behaviours of someone else, and cannot control what they might decide to do.

Safety plan

A safety plan is an agreement between the suicidal young person and the first aider that involves actions to keep the person safe. The safety plan should:

- Focus on what the suicidal person should do rather than what they shouldn't.
- Be clear, outlining what will be done, who will be doing it, and when it will be carried out.
- Be for a length of time that will be easy for the suicidal person to cope with, so that they can feel able to fulfil the agreement and have a sense of achievement.
- Include contact numbers that the person agrees to call if they are feeling suicidal, e.g. the person's doctor or mental health care professional, a suicide helpline or 24 hour crisis line, friends and family members who will help in an emergency.

Find out who or what has supported the person in the past and whether these supports are still available. Ask them how they would like to be supported and if there is anything you can do to help, but do not try to take on their responsibilities.

What about professional help?

Encourage the young person to get appropriate professional help as soon as possible. Find out information about the resources and services available for a person who is considering suicide, including local services that can assist in response to people at risk of suicide such as hospitals, mental health clinics, mobile outreach crisis teams, suicide prevention helplines, specialty youth mental health services and local emergency services. Provide this information to the suicidal young person and discuss help-seeking options with them. If they don't want to talk to someone face-to-face, encourage them to contact a suicide helpline.

National Emergency Help Lines

Kids Helpline
24-hour counselling 1800 55 1800

Suicide Call Back Service
1300 659 467

Mental Health Crisis Numbers

ACT: Mental Health Triage Service
1800 629 354 or 02 6205 1065

NSW: Mental Health Line 1800 011 511

NT: Northern Territory Mental Health Line
1800 682 288

QLD: 13 43 25 84 (13 HEALTH)

SA: Mental Health Assessment and Crisis Intervention Service 13 14 65

TAS: Mental Health Services Helpline
1800 332 388 (9am–11pm) or nearest hospital

VIC: SuicideLine 1300 651 251

WA: Mental Health Emergency Response Line, 1300 555 788 (Metro local call) or 1800 676 822 (Peel, free call).
Elsewhere, call RuralLink 1800 552 002.

Call the nearest hospital if you cannot reach a number above.

Don't assume that the young person will get better without help or that they will seek help on their own. People who are feeling suicidal often don't ask for help for many reasons, including stigma, shame and a belief that their situation is hopeless and that nothing can help.

If the suicidal young person is an adolescent, a more directive approach may be needed. If an adolescent is reluctant to seek help, make sure someone close to them is aware of the situation (i.e. a close friend or family member). If the adolescent refuses professional help, also get assistance from a mental health professional.

If the suicidal young person is reluctant to seek help, keep encouraging them to see a mental health professional and contact a suicide prevention hotline for guidance on how to help them. **If the suicidal person refuses professional help,** call a mental health centre or crisis telephone line and ask for advice on the situation.

For people at more urgent risk, additional action may be needed to facilitate professional help seeking. **If you believe the suicidal young person will not stay safe,** seek their permission to contact their regular doctor or mental health professional about your concerns. If possible, the health professional contacted should be a professional the suicidal person already knows and trusts. **If the person has a specific plan for suicide, or if they have the means to carry out their suicide plan,** call a mental health centre or crisis telephone line and ask for advice on the situation.

If the suicidal person has a weapon, contact the police. When contacting the police, inform them that the young person is suicidal to help them respond appropriately. Make sure you do not put yourself in any danger while offering support to the suicidal person.

Be prepared for the suicidal young person to possibly express anger and feel betrayed by your attempt to prevent their suicide or help them get professional help. Try not to take personally any hurtful actions or words of the suicidal person.

What if the young person wants me to promise not to tell anyone else?

You must never agree to keep a plan for suicide or risk of suicide a secret. If the person doesn't want you to tell anyone about their suicidal thoughts, you should not agree but give an explanation why, e.g. "I care about you too much to keep a secret like this. You need help and I am here to help you get it". Treat the young person with respect and involve them in decisions about who else knows about the suicidal crisis.

If the young person refuses to give permission to disclose information about their suicidal thoughts, then you may need to breach their confidentiality in order to ensure their safety. In doing so, you need to be honest and tell the person who you will be notifying.

Keep in mind that it is much better to have the young person angry at you for sharing their suicidal thoughts without their permission, in order to obtain help, than to lose the person to suicide.

What should I do if the person has acted on suicidal thoughts?

If the suicidal person has already harmed themselves, administer first aid and call emergency services, asking for an ambulance.

Keep in mind that despite our best efforts, we may not be successful in preventing suicide.

The person I am trying to help has injured themselves, but insists they are not suicidal. What should I do?

Some people injure themselves for reasons other than suicide. This may be to relieve unbearable anguish, to stop feeling numb, or other reasons. This can be distressing to see. See Section 3.2 *First Aid for Non-suicidal Self-injury* to help you understand and assist if this is occurring.

Take care of yourself

After helping someone who is suicidal, make sure you take appropriate self-care. Providing support and assistance to a suicidal person is exhausting and it is therefore important to take care of yourself.

Three key actions for helping a suicidal person

1. **If you think someone is suicidal, ask them directly.**
2. **Work together to keep them safe for now.**
3. **Connect them to professional help.**



Lonely

"Self-injury started in response to something bad that happened. In my visual diary it says 'I wanted to cut but I made this instead'."

CK, aged 17

3.2 First Aid for Non-suicidal Self-injury[134, 135]

An important note

This first aid advice applies only if the person is injuring themselves for reasons other than suicide.

Some people engage in non-suicidal self-injury even when suicidal. This means that even though they are having thoughts of suicide, their self-inflicted injuries are not intended to result in death. Some people say that engaging

Facts on non-suicidal self-injury[56]

Many terms are used to describe self-injury, including self-harm, self-mutilation, cutting and parasuicide. There is a great deal of debate about what self-injury is and how it is different to suicidal behaviour. Here the term non-suicidal self-injury is used to refer to situations where the self-injury is not intended to result in death. It is not always easy to tell the difference between non-suicidal self-injury and a suicide attempt. The only way to know is to ask the person directly if they are suicidal.

How common is non-suicidal self-injury?

The Australian National Epidemiological Study of Self-Injury (ANESSI), carried out in 2008, found that 2.4% of people aged 10-17 had engaged in non-suicidal self-injury in the past month and 9.4% had done so at some point in their life.[47] Other data come from the 2013-14 Australian Child and Adolescent Survey of Mental Health and Wellbeing, which found that 8% of 12-17 year olds had engaged in non-suicidal self-injury in the past year and 5.9% had harmed themselves 4 or more times over this period.[13]

According to the ANESSI study, 61% of people who self-injured in the past month had a depressive or bipolar disorder and 58% an anxiety disorder. Non-suicidal self-injury is also common amongst people who have been diagnosed with borderline personality disorder.

Although it can occur at any age, self-injury was most common in adolescents and young adults. The median age of onset of self-injury in the ANESSI study was 17 years. Self-injury was slightly more common in females than in males.

Why do people engage in non-suicidal self-injury?

People self-injure for many reasons. The main ones are:[47]

- To manage feelings of distress
- To punish themselves
- To communicate personal distress to others.

What are the physical and mental health risks of self-injury?

Injuries to the skin often go untreated (e.g. people may be unwilling to seek sutures for wounds or may not undertake good wound care to keep injuries from becoming infected), meaning they can take a long time to heal, and there may be complications from infection. Hitting body parts against hard surfaces may result in small fractures that may become complicated if untreated.

Over time, self-injury can become the central strategy for coping with problems, making it very hard to use more adaptive ways of coping. For some people, self-injury can be a very difficult habit to break.

in non-suicidal self-injury helps them to avoid acting on suicidal thoughts. If the young person you are helping is engaging in non-suicidal self-injury and is also suicidal, you will also need to refer to Section 3.1 *First Aid for Suicidal Thoughts and Behaviours.*

How to assess

If you suspect that a young person you care about is deliberately injuring themselves, you need to discuss it with them. Do not ignore suspicious injuries you have noticed on the person's body. Take all self-injuring behaviour seriously, regardless of the severity of the injuries or the intent.

The most common methods of self-injury are:[47]

- Cutting (41%)
- Scratching (40%)
- Deliberately hitting body on hard surface (37%)
- Punching, hitting or slapping self (34%)
- Biting (15%)
- Burning (15%)

How to assist

What should I do if I suspect someone is injuring themselves?

If you suspect that a young person who you care about is deliberately injuring themselves, you need to discuss it with them. Before talking to the person, acknowledge and deal with your own feelings about self-injuring behaviours. If you feel you are unable to talk to the person who is self-injuring, try to find someone else who can talk to them.

Choose a private place for the conversation. Directly express your concerns that the young person may be injuring themselves. Ask about self-injury in a way that makes it clear to the person that you understand a bit about self-injury, e.g. "Sometimes, when people are in a lot of emotional pain, they injure themselves on purpose. Is that how your injury happened?"

Self-injury is a very private thing and is hard to talk about. Do not demand to talk about things the young person is not ready to discuss. You should avoid expressing a strong emotional response of anger, fear, revulsion or frustration.

If the young person is receiving psychiatric care, ask if their treating professional knows about the injuries.

What should I do if I find someone deliberately injuring themselves?

If you have interrupted someone who is in the act of self-injury, intervene in a supportive and non-judgmental way. Although it is natural to feel upset, helpless and even angry upon finding out someone self-injures, try to remain calm and avoid expressions of shock or anger. Tell the person that you are concerned about them and ask whether you can do anything to alleviate the distress. Ask if medical attention is needed.

When is emergency medical attention necessary?

Avoid over-reacting; medical attention is only required if the injury is severe. Contact emergency services if a wound or injury is medically serious. Any cut that is gaping requires medical attention, as it may need stitches. Any burn that is two centimetres or larger in diameter, and any burn on the hands, feet or face requires medical attention.

If the young person has harmed themselves by taking an overdose of medication or consuming poison, call an ambulance, as the risk of death or permanent harm is high. Deliberate overdose is more frequently intended to result in death, but is sometimes a form of self-injury. Regardless

of a young person's intentions, emergency help must be sought.

How should I talk with someone who is deliberately injuring themselves?

Keep in mind that 'stopping self-injury' should not be the focus of the conversation. Instead, look at what can be done to make the person's life more manageable, or their environment less distressing. Understand that self-injury cannot be stopped overnight, and people will need time to recover and learn healthy coping mechanisms.

Behave in a supportive and non-judgmental way. Understand that self-injury makes the person's life easier and accept their reasons for doing it. Be supportive without being permissive of the behaviour. Be aware of what your body language is communicating about your attitudes.

Use a calm voice when talking to the person. Avoid expressing anger or a desire to punish the person for self-injuring. Be comfortable with silence, allowing the person time to process what has been talked about. Be prepared for the expression of intense emotions.

Express concern and actively listen

When talking with the young person, use 'I' statements instead of 'you' statements, e.g. "I feel worried/angry/frustrated when you…" instead of "You make me feel worried/angry/frustrated…". Ask the person questions about their self-injury, but avoid pressuring them to talk about it. Reflect what the person is saying by acknowledging their experience as they are describing it.

Give support and reassurance

Express empathy for how the young person is feeling. Validate their emotions by explaining that these emotions are appropriate and valid.

Let them know they are not alone and that you are there to support them. Work collaboratively

Things to avoid when talking with a young person about non-suicidal self-injury

- Do not minimise the young person's feelings or problems.
- Do not use statements that don't take the person's pain seriously, e.g. "But you've got a great life" or "Things aren't that bad".
- Do not try to solve the person's problems for them.
- Do not touch (e.g. hug or hold hands with) the young person without their permission.
- Do not use terms such as 'self-mutilator', 'self-injurer', or 'cutter'.
- Do not accuse the young person of attention seeking.
- Do not make the person feel guilty about the effect their self-injuring is having on others.
- Do not set goals or pacts, such as "If you promise not to hurt yourself between now and next week, you're doing really well", unless the person asks you to do this.
- Do not try to make the person stop self-injuring (e.g. by removing self-injury tools) or giving them ultimatums, e.g. "If you don't stop self-injuring, you have to move out".
- Do not offer drugs, prescription pills or alcohol to the person.

with the person in finding solutions, i.e. by finding out what they want to happen, and discussing any possible actions with them.

Reassure the young person that there are sources of help and support available. Tell the person that you want to help, and let them know the ways in which you are willing to help them.

Don't promise the person that you will keep their self-injury a secret. If you need to tell somebody about the young person's self-injury to keep them safe, speak to them about this first. Avoid gossiping or talking to others about it without their permission.

What do I do if the person is not ready to talk?

Respect the person's right not to talk about their self-injuring. If the person doesn't want to talk right away, let them know that you want to listen to them when they are ready. Ask the person what would make them feel safe enough to be able to discuss their feelings. Do not force the issue unless the injury is severe. If the person still doesn't want to talk, ask a health professional for advice on what to do.

Seeking professional help

Self-injury is often a symptom of a mental health problem that can be treated. Encourage the person to seek professional help. Let them remain in control over seeking help as much as possible. Suggest and discuss options for getting help rather than directing the person what to do. Help the person map out a plan of action for seeking help. Talk about how you can help them to seek treatment and who they can talk to, e.g. a mental health service or a mental health professional.

Provide praise for any steps the person takes towards getting professional help. Follow up with the young person to check whether they have found professional help that is suitable for them.

You should seek mental health assistance on the young person's behalf if:

- The person asks you to
- The injury is severe or getting more severe, such as cuts getting deeper or bones being broken
- The self-injurious behaviour is interfering with daily life
- The person has injured their eyes
- The person has injured their genitals
- The person has expressed a desire to die.

Keep in mind that not all people who self-injure want to change their behaviour. Even though you can offer support, you are not responsible for the actions or behaviour of someone else, and cannot control what they do.

If the young person is an adolescent, a more directive approach may be needed. Help the adolescent map out a plan of action for seeking help and offer to go along with them to an appointment.

Encouraging alternatives to self-injury

Encourage the young person to seek other ways to relieve their distress. Help them to use their coping strategies that do not involve self-injuring, and help them to make a plan about what to do when they feel like self-injuring. Suggest some coping strategies and discuss with the person what might be helpful for them. These may include:

- Encouraging the person to share their feelings with other people, such as a close friend or family member, when they are feeling distressed or have the urge to self-injure.
- Helping the young person think of ways to reduce their distress, e.g. having a hot bath, listening to loud music, or doing something kind for themselves.
- Offering the young person information materials (e.g. a website or fact sheet) about alternatives to self-injury.

3.3 First Aid for Panic Attacks[136,137]

Facts on panic attacks

More than one in four people have a panic attack at some time in their lives.[56] Few go on to on to have repeated attacks, and fewer still go on to develop panic disorder or agoraphobia. Although anyone can have a panic attack, people with anxiety disorders are more prone.

Some panic attacks do not appear to be triggered by anything specific. These are called 'uncued' panic attacks. Other panic attacks may be associated with a feared situation. For example, a person with social anxiety disorder may experience a panic attack in a social setting.

How to assess

Signs and symptoms of a panic attack

A panic attack is a distinct episode of high anxiety, with fear or discomfort, that develops abruptly and has its peak within 10 minutes. During the attack, several of the following symptoms are present.[5]

- Palpitations, pounding heart, or rapid heart rate
- Sweating
- Trembling and shaking
- Shortness of breath, sensations of choking or smothering
- Chest pain or discomfort
- Abdominal distress or nausea
- Dizziness, light-headedness, feeling faint or unsteady
- Feelings of unreality or being detached from oneself
- Fears of losing control or going crazy
- Fear of dying
- Numbness or tingling
- Chills or hot flushes.

If a young person is experiencing the above symptoms and you suspect that they are having a panic attack, you should first ask them if they know what is happening and whether they have ever had a panic attack before.

How to assist

What should I do if I think someone is having a panic attack?

If the young person says that they have had panic attacks before, and believe that they are having one now, ask them if they need any kind of help, and give it to them. If you are helping someone you do not know, introduce yourself.

What if I am uncertain whether the person is really having a panic attack, and not something more serious like a heart attack?

The symptoms of a panic attack sometimes resemble the symptoms of a heart attack or other medical problem. It is not possible to be totally sure that a person is having a panic attack. Only a medical professional can tell if it is something more serious. If the young person has not had a panic attack before, and doesn't think they are having one now, you should follow physical first aid guidelines. The first step is to help the person into a supported sitting position, e.g. against a wall.

Ask the young person, or check to see, if they are wearing a medical alert bracelet or necklace. If they are, follow the instructions on the alert or seek medical assistance. If the young person loses consciousness, apply physical first aid principles. Check for breathing and pulse, and call an ambulance.

What should I say and do if I know the person is having a panic attack?

Reassure the person that they are experiencing a panic attack. It is important that you remain calm and that you do not start to panic yourself. Speak to the person in a reassuring but firm manner, and be patient. Speak clearly and slowly and use short sentences. Invite the person to sit down somewhere comfortable. Rather than making assumptions about what the young person needs, ask them directly what they think might help.

Do not belittle the person's experience. Acknowledge that the terror feels very real, but reassure them that a panic attack, while very frightening, is not life threatening or dangerous. Reassure them that they are safe and that the symptoms will pass.

What should I say and do when the panic attack has ended?

After the panic attack has subsided, assist the young person to get information about panic attacks. Tell them that if the panic attacks recur, and are causing them distress, they should speak to an appropriate health professional. Assist the young person or their parents to access professional help if they feel they need it.

You should be aware of the range of professional help available for panic attacks in your community. Reassure the young person that there are effective treatments available for panic attacks and panic disorder.

Note:

It has been widely believed for many years that focussing on breathing during a panic attack can help, either by distracting the person or to bring about a state of calm. Many people still find this to be helpful, and you should not try to stop someone from focussing on their breathing.

However, many experts now say that it is not a good idea to actively encourage a person to focus on their breathing, as this can become an emotional crutch, leading to difficulty with treatments later on.[138] Instead, simply support the person as described above, and if they feel distressed encourage them to seek professional help.



Vacant

"I have often likened my life to a smashed mirror: so many pieces they are either forever lost or impossible to put back together. This fact makes me feel so utterly empty… (this picture actually had broken mirrored glass in it, but my school made me take it out due to safety issues)." **Kiri Smith**

3.4 First Aid for Adults Affected by a Traumatic Event[139,140]

Note:

Separate guidelines are provided for assisting children (see Section 3.5 *First Aid for Children Affected by a Traumatic Event*). If you are assisting an adolescent, consider their age and their reaction to the event when choosing which guidelines to use. For younger adolescents and those who seem to regress (behave in a child-like way) in response to the event, the child guidelines may be the most appropriate. For older adolescents and those who are responding to the event in a somewhat mature manner, the adult guidelines may be the most appropriate. Use your best judgement and consider how the adolescent responds, adjusting your approach as necessary.

How to assess

A person who has experienced a traumatic event may react strongly right away, showing you that they need immediate assistance. Others may have a delayed reaction. This means that if you are helping someone you know and see on a regular basis, you may be continually assessing them for signs of distress over the next few weeks.

Facts on traumatic events

A **traumatic event** is one that causes an individual or group to experience intense feelings of terror, horror, helplessness, or hopelessness. Examples of traumas include involvement in war, accidents, assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, warfare and severe weather events (cyclone, tsunami and bushfire).

The traumatic event is not necessarily directly experienced by the person. The person might witness it happening to someone else, learn about a traumatic event that has occurred to someone close to them, or they are exposed to repeated or extreme details of the event.

Mental health first aid might not always occur immediately after the traumatic event. For instance, there are other sorts of traumas that are not single discrete incidents:

- Common examples of recurring trauma include sexual, physical or emotional abuse, or torture. In these cases, the first aid recommendations here will be used when the first aider becomes aware of what has been happening.
- Sometimes the memories of a traumatic event suddenly or unexpectedly return, weeks, months or even years afterwards. Again, the first aid recommendations here will be used when the first aider becomes aware of this.

It is important to know that people can differ a lot in how they react to traumatic events:

- Particular types of traumas may affect some individuals more than others.
- A history of trauma may make some people more susceptible to later traumatic events, while others become more resilient as a result.

How to assist

What are the first priorities for helping someone after a traumatic event?

If relevant, you need to ensure your own safety before offering help to anyone. Check for potential dangers, such as fire, weapons, debris, or other people who may become aggressive, before deciding to approach a person to offer your help.

If you are helping someone who you do not know, introduce yourself and explain what your role is. Find out the person's name and use it when talking to them. Remain calm, and do what you can to create a safe environment, by taking the person to a safer location or removing any immediate dangers.

If the person is injured, it is important that their injuries are attended to. If you are able to, offer the person first aid for their injuries, and seek medical assistance. If the person seems physically unhurt, you need to watch for signs that their physical or mental state is declining, and be prepared to seek emergency medical assistance for them. Be aware that a person may suddenly become disoriented, or an apparently uninjured person may have internal injuries that reveal themselves more slowly.

Try to determine what the person's immediate needs are for food, water, shelter or clothing. However, if there are professional helpers nearby (police, ambulance, or others) who are better able to meet those needs, don't take over their role.

If the person has been a victim of assault, you need to consider the possibility that forensic evidence may need to be collected (e.g. cheek swabs, evidence on clothing or skin). Work with the person in preserving such evidence, where possible. For example, they may want to change their clothes and shower, which may destroy forensic evidence. It may be helpful to put clothing in a bag for police to take as evidence and suggest to the person that they wait to shower until after a forensic exam. Although collecting evidence is important, you should not force the person to do anything that they don't want to do.

Do not make any promises you may not be able to keep. For example, don't tell someone that you will get them home soon, if this may not be the case.

What are the priorities if I am helping after a mass traumatic event?

Mass traumatic events are those that affect large numbers of people. They include severe environmental events (e.g. fires and floods), acts of war and terrorism, and mass shootings. In addition to the general principles outlined above, there are a number of things you need to do.

Find out what emergency help is available. If there are professional helpers at the scene, you should follow their directions.

Be aware of and responsive to the comfort and dignity of the person you are helping, for example by offering the person something to cover themselves with (such as a blanket) and asking bystanders or media to go away. Try not to appear rushed or impatient.

Give the person truthful information and admit that you lack information when this is the case. Tell the person about any available sources of information that are offered to survivors (for example, information sessions, fact sheets and phone numbers for information lines) as they become available. Do not try to give the person any information they do not want to hear, as this can be traumatic in itself.

How do I talk to someone who has just experienced a traumatic event?

When talking to a person who has experienced a traumatic event, it is more important to be genuinely caring than to say all the 'right things'. Show the person that you understand and care, and ask them how they would like to be helped. Speak clearly and avoid clinical and technical language, and communicate with the person as an equal, rather than as a superior or expert. If the person seems unable to understand what is said, you may need to repeat yourself several times. Be aware that providing support doesn't have to be complicated; it can involve small things like spending time with the person, having a cup of tea or coffee, chatting about day-to-day life or giving them a hug.

Behaviour such as withdrawal, irritability and bad temper may be a response to the trauma, so try not to take such behaviour personally. Try to be friendly, even if the person is being difficult.

The person may not be as distressed about what has happened as you might expect them to be, and this is fine. Don't tell the person how they should be feeling. Tell them that everyone deals with trauma at their own pace. Be aware that cultural differences may influence the way some people respond to a traumatic event; for example, in some cultures, expressing vulnerability or grief around strangers is not considered appropriate.

Should we talk about what happened? How can I support someone in doing so?

It is very important that you do not force the person to tell their story. Remember that you are not the person's therapist.

Only encourage the person to talk about their reactions if they feel ready and want to do so. If the person does want to talk, don't interrupt to share your own feelings, experiences or opinions. Be aware that the person may need to talk repetitively about the trauma, so you may need to be willing to listen on more than one occasion.

Avoid saying anything that might trivialise the person's feelings, such as "Don't cry" or "Calm down", or anything that might trivialise their experience, such as "You should just be glad you're alive."

Be aware that the person may experience survivors' guilt; the feeling that it is unfair that others died, or were injured, while they were not.

How can I help the person to cope over the next few weeks or months?

If you are helping someone you know after a traumatic event, you can help them to cope with their reactions over the next few weeks or months. You may be helping a family member, perhaps a spouse, sibling or parent who you are living with. If you are helping someone you don't know, unless you are responsible for them in some professional capacity, it is not expected that you will have further contact with them.

Encourage the person to tell others when they need or want something, rather than assume others will know what they want. Also encourage them to identify sources of support, including loved ones and friends, but remember that it is important to respect the person's need to be alone at times.

Encourage the person to take care of themselves; to get plenty of rest if they feel tired, to do things that feel good to them (e.g. take baths, read, exercise, watch television), and to think about any coping strategies they have successfully used in the past and use them again. Encourage

them to spend time somewhere they feel safe and comfortable.

Be aware that the person may suddenly or unexpectedly remember details of the event, and may or may not wish to discuss these details. If this happens, the general principles outlined above can help you to assist the person.

Discourage the person from using negative coping strategies such as working too hard, using alcohol or other drugs, or engaging in self-destructive behaviour.

When should the person seek professional help?

Not everyone will need professional help to recover from a traumatic event. Research has shown that, in an attempt to prevent PTSD, providing psychological help to everyone within three months following a traumatic event is not helpful and may even have an adverse effect on some individuals.[141] However, if the person wants to seek help, you should support them to do so. Be aware of the sorts of professional help that are available locally, and if the person does not like the first professional they speak to, you should tell them that it is okay to try a different one. If the person hasn't indicated that they want professional help, the following guidelines can help you to determine whether help is needed.

If at any time the person becomes suicidal, you should seek professional help. Section 3.1 *First Aid For Suicidal Thoughts and Behaviours* may be useful in helping you to do this. Also, if at any time the person abuses alcohol or other drugs to deal with the trauma, you should encourage them to seek professional help.

After 4 weeks, some return to normal functioning is expected. You should encourage the person to seek professional help if, for 4 weeks or more, after the trauma:

- They still feel very upset or fearful.
- They are unable to escape intense, ongoing distressing feelings.
- Their important relationships are suffering as a result of the trauma, e.g. if they withdraw from their family or friends.
- They feel jumpy or have nightmares because of or about the trauma.
- They can't stop thinking about the trauma.
- They are unable to enjoy life at all as a result of the trauma.
- Their post-trauma symptoms are interfering with their usual activities.



No Future Ever

"*From my visual diary:* 'Weird looking, ugly, I deserved this. The girls I draw always look stupid. I guess because I am'.

A couple of days later: 'Why did I scribble over her? I don't remember doing that. My subconscious mind telling me not to make plans I guess'." **CK, aged 15**

3.5 First Aid for Children Affected by a Traumatic Event[142,143]

Facts on traumatic events

A **traumatic event** is one that causes an individual or group to experience intense feelings of terror, horror, helplessness, or hopelessness. Examples of traumas include involvement in war, accidents, assault (including physical or sexual assault, mugging or robbery, or family violence), and witnessing something terrible happen. Mass traumatic events include terrorist attacks, mass shootings, warfare and severe weather events (cyclone, tsunami and bushfire).

The traumatic event is not necessarily directly experienced by the person. The person might witness it happening to someone else, learn about a traumatic event that has occurred to someone close to them, or they are exposed to repeated or extreme details of the event.

Mental health first aid might not always occur immediately after the traumatic event. For instance, there are other sorts of traumas that are not single discrete incidents:

- Common examples of recurring trauma include sexual, physical or emotional abuse, or torture. In these cases, the first aid recommendations here will be used when the first aider becomes aware of what has been happening.
- Sometimes the memories of a traumatic event suddenly or unexpectedly return, weeks, months or even years afterwards. Again, the first aid recommendations here will be used when the first aider becomes aware of this.

It is important to know that people can differ a lot in how they react to traumatic events:

- Particular types of traumas may affect some individuals more than others.
- A history of trauma may make some people more susceptible to later traumatic events, while others become more resilient as a result.

Note:

Separate guidelines are provided for assisting adults (see Section 3.4 *First Aid for Adults Affected by a Traumatic Event*). If you are assisting an adolescent, consider their age and their reaction to the event when choosing which guidelines to use. For younger adolescents and those who seem to regress (behave in a child-like way) in response to the event, the child guidelines may be the most appropriate. For older adolescents and those who are responding to the event in a somewhat mature manner, the adult guidelines may be the most appropriate. Use your best judgement and consider how the adolescent responds, adjusting your approach as necessary.

How to assess

A child who has experienced a traumatic event may react strongly right away, showing you that they need immediate assistance. Others may have a delayed reaction. This means that if you are helping a child you know and see on a regular basis, you may be continually assessing them for signs of distress over the next few weeks.

How to assist

What are the first priorities for helping a child after a traumatic event?

If relevant, you need to ensure your own safety before offering help to anyone. Determine whether it is safe to approach the child. Before deciding to approach a child to offer your help, check for potential dangers (for example, from fire, weapons, or debris), including any person who may become aggressive.

If you are helping a child who you do not know, introduce yourself and explain that you are there to help. Find out the child's name

and use it when talking to them. Remain calm. Do what you can to protect the child (whether by taking them to a safer location or removing any immediate dangers). Reassure the child that they won't be left alone, so far as this is possible, and ensure that you, or another adult (such as a professional helper), are available to take care of the child. If you have to leave the child alone for a few minutes to attend to others, reassure the child that you will be back soon. However, try not to behave towards the child in such a way that they feel they are still in danger.

If the child is injured, it is important that their injuries are attended to. If you are able to, give the child first aid for their injuries, and seek medical assistance. If the child seems physically unhurt, you need to watch for signs that their physical or mental state is declining, and be prepared to seek emergency medical assistance for them. Be aware that a child may suddenly become disoriented, or an apparently uninjured child may have internal injuries that reveal themselves more slowly.

Try to determine what the child's immediate needs are for food, water, shelter or clothing. However, if there are professional helpers nearby (police, ambulance, or others) who are better able to meet those needs, don't take over their role.

Don't make any promises you may not be able to keep. For example, don't promise the child that you will get them home soon, when this may not be the case.

What are the priorities if I am helping after a mass traumatic event?

Mass traumatic events are those that affect large numbers of people. They include severe environmental events (such as fires and floods), acts of war and terrorism, and mass shootings. In addition to the more general guidelines in the previous section, there are a number of things you need to do.

Try to keep the child together with any loved ones and carers who are present. If they are not present, or have been separated from the child in the course of the event, ensure that the child is reconnected with them as soon as possible. Ask the child what would make them feel better or safer. Direct the child away from traumatic sights and sounds (including media images), people who are injured, and very distressed people, e.g. anyone who is screaming, agitated or aggressive. Ask bystanders and the media to stay away from the child.

How do I talk to a child who has experienced a traumatic event?

This section of the guidelines may be used to help you support a child after they have experienced a traumatic event. If you know the child, then you can use these guidelines to offer the child ongoing support. If you don't know the child, then you can use these as a guide for talking to the child at anytime that you come into contact with them following their traumatic experience, e.g. at the scene of a trauma, or later on, at home, in a classroom, or elsewhere.

Remember, when talking to a child who has experienced a traumatic event, that it is more important to be genuinely caring than to say all the 'right things'. Show the child that you understand and care, be patient, and tell the child you will do your best to keep them safe.

Talk to the child using age-appropriate language and explanations. Allow the child to ask questions and answer them as truthfully as possible. Be patient if the child asks the same question many times, and try to be consistent with answers and information. If you can't answer a question, admit to the child that you don't know the answer. If the child knows accurate, upsetting details, don't deny these.

When someone has died, it can be tempting to soften this news by telling a child that the person has "gone to sleep", but this is best avoided, as it may result in the child becoming fearful of sleep.

A child may stop talking altogether after a trauma, and if this happens, you should not try to force or coerce the child to speak. Equally, you should never coerce a child to talk about their feelings or memories of the trauma before they are ready to do so.

If the child wants to talk about their feelings, you should allow them to. Some children prefer to express their feelings through writing, drawing, or playing with toys.

Never tell the child how they should or shouldn't be feeling. Don't tell the child to be brave, or not to cry, and don't make judgments about their feelings. Don't get angry if the child expresses strong emotions; instead tell them it is okay to feel upset when something bad or scary happens.

A child has told me that they are being abused. What should I do?

Remain calm and reassure the child that they have done the right thing by telling you, and that what happened was not their fault. Tell the child that you believe them.

You need to know the local laws or regulations about reporting suspected child abuse and follow these. Contact the appropriate authorities and work with them to ensure the child's safety. Do not confront the perpetrator.

I am a parent/guardian and the child I am helping lives with me. How should I behave at home?

Try to keep your behaviour as predictable as possible, and tell the child that you (and their other loved ones) love and support them. Encourage the child to do things they enjoy, such as playing with toys or reading books. You can help the child to feel in control by letting them make some decisions, e.g. about meals, or what to wear.

Dealing with temper tantrums and avoidance behaviours

Be aware that the child may avoid things that remind them of the trauma (such as specific places, driving in the car, certain people, or separation from their parents or guardians). Try to figure out what triggers sudden fearfulness or regression in the child. If the child has temper tantrums or becomes fearful, crying and clingy in order to avoid something that reminds them of the trauma, ask them what they are afraid of. Don't get angry or call the child 'babyish' if they appear to regress, for example by bedwetting, misbehaving, or sucking their thumb.

If the child avoids things that remind them of the trauma, but does not appear very distressed, ask what they are afraid of and assure them that they are safe.

The symptoms associated with trauma may suddenly or unexpectedly appear months or years after the event. If this occurs, professional help may need to be sought.

Should the child receive professional help?

Not all children will need professional help to recover from a traumatic event. The following guidelines can help you to determine whether help is needed.

If at any time the child becomes suicidal, you should seek immediate professional help.

You should seek professional help for the child if, for 2 weeks or more after the trauma:

- The child is unable to enjoy life at all.
- The child displays sudden severe or delayed reactions to trauma.
- The child is unable to escape intense ongoing distressing feelings.
- The child's post-trauma symptoms are interfering with their usual activities.
- The child's important relationships are suffering, e.g. if they withdraw from their carers or friends.

You should seek professional help for the child if, for 4 weeks or more after the trauma:

- The child has temper tantrums or becomes fearful, crying and clingy in order to avoid something that reminds them of what happened.
- The child still feels very upset or fearful.
- The child acts very differently compared to before the trauma.
- The child feels jumpy or has nightmares because of or about the trauma.
- The child can't stop thinking about the trauma.

You should be aware of the types of professional help that are available locally for children. Clinical child psychologists, psychiatrists, paediatricians and family doctors can all be helpful. If you are not the child's parent or guardian, do not seek professional help for them unless it is an emergency; instead assist the child's parent or guardian to seek professional help for them.

3.6 First Aid for Severe Psychotic States[104,105]

Facts on severe psychotic states

If someone has a psychotic illness, they may at times experience severe psychotic states. Some people experience a severe psychotic state only rarely, perhaps every few years; others more frequently and some may experience these states several times a year.

A severe psychotic state can occur without an apparent cause or may be triggered by something specific. Possible triggers include extra stresses or life events (even positive life events such as a new job or a holiday). Forgetting to take medication, or choosing not to, can also trigger a psychotic episode and this is one of the reasons that it is best for people to continue using their medication as prescribed.

A severe psychotic state may develop gradually over a few days or it may seem to come on very suddenly. For this reason, early signs of a psychotic state should be addressed as quickly as possible.

How to assess

A young person in a severe psychotic state can have:

- Overwhelming delusions and hallucinations
- Very disorganised thinking
- Bizarre and disruptive behaviours.

The person will appear very distressed or their behaviours will be disturbing to others. When a young person is in this state, they can come to harm unintentionally because of their delusions or hallucinations, e.g. the person believes they have special powers to protect them from danger such as driving through red lights, or they may run through traffic to try to escape from terrifying hallucinations.

How to assist

When helping a young person in a severe psychotic state, you should try to remain as calm as possible. It is important to communicate to in a clear and concise manner and use short, simple sentences. Speak quietly in a non-threatening tone of voice and at a moderate pace. If the young person asks you questions, answer them calmly. You should comply with requests unless they are unsafe or unreasonable. This gives the person the opportunity to feel somewhat in control.

If the young person has an Advance Care Directive or relapse prevention plan, you should follow those instructions. You should also assess whether it is safe for the person to be alone and, if not, should ensure that someone stays with them. Try to find out if the young person has someone they trust (e.g. close friends, family) and try to enlist their help. If the young person says they have no one they trust, you may need to contact their parents or another caregiver against their wishes. If this becomes necessary, tell the young person who you are calling, explain that it is for their own safety, and that you care about them.

It is possible that the young person might act upon a delusion or hallucination. Remember that your primary task is to de-escalate the situation and therefore you should not do anything to further agitate the person. Try to maintain safety and protect yourself, the young person and others around you from harm. It may help to invite the young person to sit down. Make sure that you have access to an exit.

Sometimes it is not possible to de-escalate the situation and if this is the case, you should be prepared to call for help from emergency services. If this becomes necessary, convey specific, concise observations about the young person's behaviour and symptoms. When any unfamiliar helpers arrive, explain to the person who they are and how they are going to help. However, if your concerns about the young person are dismissed by the services you contact, you should persevere in trying to seek support for them.



Under the Bridge

"Most of the really big mistakes I've ever made in my life I've made while drunk. This was done after the boy I was seeing said he couldn't handle it any more."

CK, aged 17

3.7 First Aid for Severe Effects from Alcohol Use[121, 124]

Facts on alcohol intoxication, poisoning and withdrawal

Alcohol intoxication refers to significantly elevated levels of alcohol in a person's blood stream substantially impairing the person's thinking and behaviour.

Alcohol poisoning means the person has a toxic level of alcohol in the blood stream. This can lead to the person's death. The amount of alcohol that causes alcohol poisoning is different for every person.

Alcohol withdrawal refers to the unpleasant symptoms a person experiences when they stop drinking or drink substantially less than usual. Unmedicated alcohol withdrawal may lead to seizures.

How to assess

Common signs and symptoms of ***alcohol intoxication*** include:

- Loss of coordination
- Slurred speech
- Staggering or falling over
- Loud argumentative or aggressive behaviour
- Vomiting
- Drowsiness or sleepiness.

Signs and symptoms of ***alcohol intoxication and poisoning*** that may lead to a medical emergency are:

- Continually vomiting
- Cannot be woken
- Unconsciousness
- Signs of a possible head injury, e.g. they are vomiting and talking incoherently
- Irregular, shallow or slow breathing
- Irregular, weak or slow pulse rate
- Cold, clammy, pale or bluish coloured skin.

Signs and symptoms of ***severe alcohol withdrawal*** that may lead to a medical emergency are:

- Delirium tremens (a state of confusion and visual hallucinations)
- Agitation
- Fever
- Seizures
- Blackouts (when the person forgets what happened during the drinking episode).

How to assist

If the young person is intoxicated:

- ***Stay calm.***
- ***Communicate appropriately.*** Talk with the young person in a respectful manner and use simple, clear language. Do not laugh at, make fun of, or provoke the person.
- ***Monitor for danger.*** While intoxicated, the young person may engage in a wide range of risky activities (such as having unprotected sex, vandalising property or driving a car). Assess the situation for potential dangers and ensure that the person, yourself and others are safe. Monitor the young person and their environment to prevent tripping or falling. Ask the person if they have taken any medications or other drugs, in case their condition deteriorates into a medical emergency.
- ***Ensure the person's safety.*** Stay with the young person or ensure they are not left alone. Be aware that they may be more intoxicated than they realise. Keep them away from machines and dangerous objects. If they attempt to drive a vehicle (or ride a bike), you should try to discourage them, e.g. by telling them about the risks to both

themselves and others. Only prevent the person from driving if it is safe to do so. If it is unsafe, call the police. Arrange for the young person to go to a hospital if you think the person is a risk to themselves; otherwise organise a safe mode of transport to get them home. If you are not the young person's parent, you will need to inform the parents about what has occurred. Alcohol intoxication, poisoning and withdrawal may lead to medical emergencies.

When to call an ambulance

Call an ambulance or seek medical help in any of the following circumstances:

- The person is unconscious, i.e. cannot be woken.
- The person has irregular, shallow or slow breathing.
- The person has an irregular, weak or slow pulse rate.
- The person has cold, clammy, pale or bluish coloured skin
- The person is continuously vomiting.
- The person shows signs of a possible head injury, e.g. they are vomiting and talking incoherently.
- The person has a seizure.
- The person has delirium tremens – a state of confusion and visual hallucinations.
- The person has blackouts, i.e. when the person forgets what happened during the drinking episode.
- Drink spiking is suspected.

Tips about calling an ambulance

- Do not be afraid to seek medical help for the young person. Be aware that ambulance officers and hospital staff are there to help the person and not to enforce the law. The police will only be called if the person becomes aggressive toward ambulance officers.
- When you call for an ambulance, it is important that you follow the instructions of the telephone operator.
- When asked, describe the young person's symptoms and explain that they have been drinking alcohol.
- Have the address of where you are ready to give to the telephone operator and stay with the person until the ambulance arrives.
- It is beneficial for a friend or family member to accompany the person to hospital, as they may be able to provide relevant information. If the young person's parents are not present, they will need to be informed.

What to do while waiting for the ambulance

Be aware that alcohol consumption can mask pain from injuries. Ensure that:

- The young person is not left alone.
- No food is given to the person, as they may choke on it if they are not fully conscious.
- The person's airway, breathing and circulation are monitored.
- If the person is hard to wake, put them in the recovery position (see *Helping an unconscious person*).

- If the person is vomiting and conscious, keep the person sitting. Alternatively, put them in the recovery position. If necessary, clear the person's airway after they have vomited.

Can I help the young person sober up?

Only time will reverse the effects of intoxication. The body metabolises approximately one standard drink of alcohol an hour. It is a myth that drinking black coffee, sleeping, walking or taking a cold shower will speed up this process.

What do I do if the intoxicated person becomes aggressive?

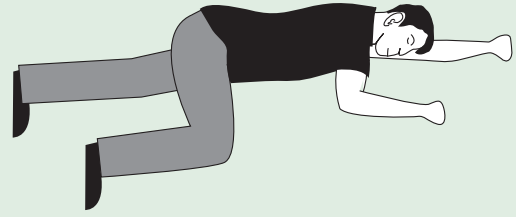
If this occurs, follow the advice in Section 3.9 *First Aid for Aggressive Behaviours.*.

Helping an unconscious person

Do not leave the young person lying on their back, as they could suffocate on their vomit or their tongue could block their airway. Putting the young person in the recovery position will help to keep the airway open. Before placing them in the recovery position, check for sharp objects, e.g. broken glass or syringes on the ground. If necessary, clear the person's airway after they have vomited by using their own fingers to clear vomit from their mouth. Keep the person warm without allowing them to overheat.

The person should be placed on a firm surface — the ground, or on a bed, not on a couch. On a couch, the person may roll forward or back and suffocate.

If the person is alcohol or drug affected, they may not be quite unconscious and may react to being physically touched by lashing out, or they may be afraid. Nudge their foot gently with your own and speak to them before placing them in the recovery position, and explain to them throughout the whole process what you are doing.



3.8 First Aid for Severe Effects from Drug Use[122, 123]

Facts on drug-affected states

Drug-affected states are short-term changes in a person's state of mind or behaviour as a result of drug use. These states distress the person or impair their ability to function. The effects of drugs on behaviour can vary from person to person depending on the sort of drug that has been used and the amount that is taken. Illicit drugs can have varying effects, as they are not manufactured in a controlled way. It is often difficult to make a distinction between the effects of different drugs. **Overdose** refers to use of an amount of a drug that could cause death, most typically opioid drugs. Overdose leads quickly to a loss of consciousness.

How to assess

Some drugs have ***stimulating effects*** ('uppers' such as cocaine and amphetamines) including making the person feel energetic and confident. Signs of more acute intoxication include becoming frustrated or angry, having a racing heart, and overheating or dehydration.

Some drugs have ***hallucinogenic effects*** ('trips' such as magic mushrooms and LSD) including hallucinations and delusions and feelings of affection for others. Signs of more acute intoxication include having more negative hallucinations and delusions and becoming fearful or paranoid.

Some drugs have ***depressant effects*** ('downers' such as cannabis and tranquilisers) including fatigue, slurred speech and slowed reflexes. Signs of more acute intoxication include feelings of having trouble moving, vomiting and loss of consciousness. Some drugs (such as ecstasy and cannabis) may have multiple effects. This is why it can be hard to tell what sort of drug has been used.

Overheating or dehydration from drug misuse can also lead to a medical emergency. Prolonged dancing in a hot environment (such as a dance party) while on some drugs (e.g. ecstasy) without adequate water intake, can cause the person's body temperature to rise to dangerous levels. This can lead to symptoms of overheating or dehydration, such as:

- Feeling hot, exhausted and weak
- Persistent headache
- Pale, cool, clammy skin
- Rapid breathing and shortness of breath
- Fatigue, thirst and nausea
- Giddiness and feeling faint.

If the young person has been ***sniffing***, you may notice inhalants such as glue, paint or petrol nearby, a strong smell of fumes, and the person may be euphoric, dizzy, slurring or uncommunicative.

How to assist

If the person is in a drug-affected state:

- ***Stay calm.***
- ***Communicate appropriately.*** Talk with the young person in a respectful manner and use simple, clear language. Be prepared to repeat simple requests and instructions, as the person may find it difficult to comprehend what has been said. Do not speak in an angry manner. Do not laugh at, make fun of, or provoke the person.
- ***Monitor for danger.*** While in a drug-affected state, the person may engage in a wide range of risky activities (such as having unprotected sex, vandalising property or driving a car). Assess the situation for potential dangers and ensure that the person, yourself and others are safe. Monitor the person and their environment to prevent tripping or falling.

- ***Ensure the person's safety.*** Stay with the young person or ensure they are not left alone. Be aware that they may be more affected than they realise. Encourage the person to tell someone if they start to feel unwell or uneasy, and to call emergency services if they have an adverse reaction. Keep them away from machines and dangerous objects. If the person attempts to drive a vehicle (or ride a bike), you should try to discourage them, e.g. by telling them about the risks to both themselves and others. Only prevent the person from driving if it is safe to do so. If it is unsafe, call the police. Arrange for the person to go to a hospital if you think the person is a risk to themselves; otherwise organise a safe mode of transport to get the person home. If you are not the young person's parent, you will need to ensure that the parents are informed of what has occurred. Drug use can lead to a range of medical emergencies.

When to call an ambulance

Call an ambulance or seek medical help if the young person:

- The person is unconscious, i.e. cannot be woken.
- The person has irregular, shallow or slow breathing.
- The person has an irregular, weak or slow pulse rate.
- The person has cold, clammy, pale or bluish coloured skin.
- The person is continuously vomiting.
- The person shows signs of a possible head injury, e.g. they are vomiting and talking incoherently.
- The person has a seizure.
- The person has delirium tremens – a state of confusion and visual hallucinations
- The person has blackouts, i.e. when the person forgets what happened during the drinking episode.
- Drink spiking is suspected.

Tips about calling an ambulance

- Do not be afraid to seek medical help for the person, even if there may be legal implications for the person. Be aware that ambulance officers and hospital staff are there to help the person and not to enforce the law.
- When you call for an ambulance, it is important that you follow the instructions of the telephone operator.
- When asked, describe the young person's symptoms and explain that the person has been using drugs. Try to get detailed information about what drugs the person has taken by either asking the person, their friends or visually scanning the environment for clues.
- Have the address of where you are to give to the telephone operator and stay with the person until the ambulance arrives.
- It is beneficial for a friend or family member to accompany the person to hospital as they may be able to provide relevant information.
- Drink spiking is suspected.

What to do while waiting for the ambulance

Ensure that:

- The young person is not left alone.
- No food is given to the person as they may choke on it if they are not fully conscious.
- The person's airway, breathing and circulation are monitored.
- If the person is hard to wake, put them in the recovery position (see Helping an unconscious person on the following page).
- Give first aid for any overheating or dehydration.

Helping a person who is overheated or dehydrated

If the young person is showing symptoms of overheating or dehydration, you must keep them calm and seek medical help immediately. Encourage them to stop dancing and to rest somewhere quiet and cool. While waiting for help to arrive, reduce the young person's body temperature gradually. Do this by loosening any restrictive clothing and removing any additional layers, and encourage the person to sip non-alcoholic fluids (e.g. water and soft drinks). Prevent the young person from drinking too much water at once, as this may lead to coma or death. Do not allow them to drink any alcohol, as this will further dehydrate them.

Helping a person who has been sniffing

Deliberately concentrating and inhaling the fumes of paint, glue, petrol, and other substances, often from a container or a plastic bag, is called sniffing, chroming, or huffing.

If a young person has been sniffing, stay with them or make sure they stay somewhere safe until the effects have worn off. Medical help should be sought if the effects are not wearing off after the person has stopped sniffing.

Be aware of the risk of sudden sniffing death (i.e. the person's heart and breathing are affected and sudden exercise or a shock can cause their heart to stop). To reduce the risk of sudden sniffing death, do not threaten or chase the young person, and tell any other people around that it is dangerous to chase or overexcite them. Also, there is a high risk that inhalants may catch on fire and cause severe burns. Keep the young person away from anything that could cause inhalants to catch on fire, e.g. a lit cigarette, a cigarette lighter or a campfire.

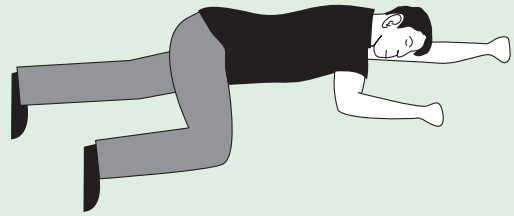
Try to create a calm environment for the young person by asking any onlookers to move. If possible, move the young person to a safe place with plenty of fresh air or open any doors and windows. If the young person is not willing to hand over their inhalants, try to keep them talking or doing something with their hands so they are not actively sniffing.

What do I do if the young person becomes aggressive?

If this occurs, follow the advice in Section 3.9 *First Aid for Aggressive Behaviours.*

Helping an unconscious person

Do not leave the young person lying on their back, as they could suffocate on their vomit or their tongue could block their airway. Putting the young person in the recovery position will help to keep the airway open. Before placing them in the recovery position, check for sharp objects (e.g. broken glass or syringes on the ground). If necessary, clear the person's airway after they have vomited by using their own fingers to clear vomit from their mouth. Keep the person warm without allowing them to overheat.



The person should be placed on a firm surface — the ground, or on a bed, not on a couch. On a couch, the person may roll forward or back and suffocate.

If the person is alcohol or drug affected, they may not be quite unconscious and may react to being physically touched by lashing out, or they may be afraid. Nudge their foot gently with your own and speak to them before placing them in the recovery position, and explain to them throughout the whole process what you are doing.

3.9 First Aid for Aggressive Behaviours[121,122]

Facts on aggressive behaviours

The vast majority of people with mental illnesses are not dangerous to others. Only a small proportion (up to 10%) of violence in society is due to mental illness.[97-99]

Depression and anxiety disorders have little or no association with violent behaviour towards others. However, there is an increased risk of violence for people who experience substance use disorders, personality disorders or psychosis.[100]

The use of alcohol or other drugs has a stronger association with violence than do mental illnesses. Many crimes are committed by people who are intoxicated with alcohol or other drugs.

When a violent act is committed be a person having an episode of psychosis, it is generally done out of fear, with the person believing they are acting out of self-defence.

How to assess

Aggression has different components to it – verbal (e.g. insults or threats), behavioural (e.g. pounding, throwing things, violating personal space) and emotional (e.g. raised voice, looking angry). What is perceived as aggression can vary between individuals and across cultures. It is best to prevent aggression and therefore take de-escalation action as soon as you perceive it. If you are concerned that the young person is becoming aggressive, you need to take steps to protect yourself and others.

How to assist

If the young person becomes aggressive, ensure your own safety at all times. Remain as calm as possible and try to de-escalate the situation.

How to de-escalate the situation

- Speak to the person slowly and confidently with a gentle, caring tone of voice.
- Do not respond in a hostile, disciplinary or challenging manner.
- Do not argue with the person.
- Do not threaten them, as this may increase fear or prompt aggressive behaviour.
- Avoid raising your voice or talking too fast.
- Be aware that the young person may overreact to negative words; therefore, use positive words (such as "Stay calm") instead of negative words (such as "Don't fight").
- Stay calm and avoid nervous behaviour, e.g. shuffling your feet, fidgeting, making abrupt movements.
- Do not restrict the young person's movement, e.g. if he or she wants to pace up and down the room.
- Remain aware that the person's symptoms or fear causing their aggression might be exacerbated if you take certain steps, e.g. involve the police.
- Consider taking a break from the conversation to allow the young person a chance to calm down.
- Consider inviting the young person to sit down if they are standing.

Take any threats or warnings seriously, particularly if the person believes they are being persecuted. If you are frightened, seek outside help immediately. You should never put yourself at risk and you must always ensure you have access to an exit. Similarly, if the person's aggression escalates out of control at any time, you should remove yourself from the situation and call for emergency assistance, e.g. the mental health crisis team or the police.

If you believe that the aggression is related to a mental health problem, you may need to call the ***mental health crisis team***. If you do so, it is best to describe the person's symptoms and behaviours rather than trying to make a diagnosis of your own. Be aware that the crisis team may not attend without a police presence.

If the situation becomes unsafe, it may be necessary to involve the ***police.*** If you suspect that the person's aggression is related to a mental health problem, to assist the police in their response, you should tell them that this is the case and that you need their help to obtain medical treatment and to control the young person's aggressive behaviour. If the young person is intoxicated, and it becomes necessary to call the police, tell them that you believe the young person is intoxicated, and what substances you believe have been used. In either case, you should tell the police whether or not the person is armed.

Appendix 1

Cultural Considerations and Communication Techniques when Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Young Person



Development of these guidelines

The following guidelines are based on the expert opinions of Aboriginal mental health professionals from across Australia, who have extensive knowledge of, and experience in, the mental health of Aboriginal youth.

How to use these guidelines

It is important to acknowledge that Aboriginal and Torres Strait Islander communities are not all the same; they may differ in their understanding, interpretations, approaches and treatment of mental illness. Be aware that the community that the adolescent lives in may not view mental illness in the same way that you do.

In these guidelines the word *Aboriginal* is used to represent all Australian Aboriginal and Torres Strait Islander people. In these guidelines the word adolescent refers to an Aboriginal or Torres Strait Islander adolescent. There are a number of ways of defining adolescence and this may differ between communities. Here adolescence is defined as those aged between 12 and 18. However, adolescence can start earlier than 12 years and can continue through to the early 20s, so items in these guidelines could be relevant when helping people who are a little younger or older. When providing mental health first aid to an adolescent, first aiders need to use good judgment about whether the information is going to be appropriate for helping a person outside of the age range specified.

These guidelines are a general set of recommendations about how you can best communicate with an Aboriginal adolescent who may be experiencing a mental illness or developing a mental health crisis. Each individual is unique and it is important to tailor your support to the adolescent's needs. These recommendations therefore may not be appropriate for every adolescent. Be aware that these guidelines are not exhaustive and simply reading them will not equip you to be competent in providing assistance to Aboriginal adolescents.

Understanding cultural influences

Be aware of the impacts of culture and history

Social, cultural and historical factors all have an impact on the health and wellbeing of Aboriginal and Torres Strait Islander people. You should be aware of the adolescent's cultural background, local cultural norms and the hierarchy of decision-making power within their community. It is important to recognise that there are cultural differences among Aboriginal and Torres Strait Islander communities.

You should have a basic awareness of the historical invasion of Australia by Europeans and an understanding of the ongoing impact on the health and wellbeing of Aboriginal and Torres Strait Islander people. If you are providing mental health first aid outside your own culture or community you should be culturally competent and practice cultural safety (see boxes below). You should not express any negative opinions about the adolescent's culture.

It is important to recognise that no one is ever entirely culturally competent, as culture changes and evolves with time. Even if you have not undertaken cultural awareness training (see box below), you should still provide mental health first aid to the Aboriginal adolescent, because any support, especially in a crisis, is better than none.

Cultural awareness

Cultural awareness involves recognising that we are all shaped by our cultural background, which in turn influences how we interpret the world around us, perceive ourselves and relate to other people. It includes acknowledging past histories, policies and practices.

Cultural competence

Cultural competence focuses on the capacity of a person to apply cultural awareness and knowledge to their behaviours and attitudes. Being culturally competent involves behaviours and attitudes that reflect an awareness about:

- How a person's culture shapes their behaviour and how they understand health and ill-health
- The specific cultural beliefs that surround mental illness in a person's community
- How mental illness is described in a person's community, e.g. knowing what words and ideas are used to talk about the symptoms or behaviours
- Which concepts, behaviours or language are taboo and may cause shame (see the definition of 'shame' next).

Cultural safety

Practicing **cultural safety** involves:

- Respecting the culture of the community by using appropriate language and behaviour
- Never doing anything that causes the person to feel shame
- Supporting the person's right to make decisions about seeking culturally based care.

Shame

The feeling of **shame** for an Aboriginal or Torres Strait Islander person is not easily defined and bears little or no resemblance to a dictionary definition. Shame can occur when a person is singled out or in a circumstance that directly targets a person's dignity. Shame may be felt as a result of:

- a lack of respect
- embarrassment
- self importance/self promotion
- rudeness
- a breach of accepted Aboriginal "norms" and/or taboos

A **shame job** is an event that causes a person shame or embarrassment.

The concept of shame is very important within many Aboriginal and Torres Strait Islander communities. Shame can be overwhelming, disempowering and can also act as a barrier to seeking help.

Learn about the adolescent's cultural beliefs and concept of mental illness

A person's culture plays a very important role in the way they understand and talk about mental health and mental illness, and how they go about seeking help from friends, family or professionals. There are also differences in the way that communities and individuals think about mental health. In providing mental health first aid, you should be aware that your concept of mental health may differ from the adolescent's and, therefore, you should learn about the specific cultural beliefs that surround mental illness in the adolescent's community. This includes being aware of the concept of mental illness within the adolescent's community, including symptoms and behaviour, and the terminology

used. You should consider that the adolescent might understand mental health within a wider context of health and wellbeing, which includes how the adolescent functions socially and emotionally in their community. The adolescent may see behavioural signs of mental illness as part of a person's spirit or personality and may not think of these as symptoms of a mental illness

When assisting the adolescent you should be aware that certain cultural experiences of Aboriginal people (such as seeing spirits or hearing voices of recently deceased loved ones) may be misdiagnosed or mislabelled as symptoms of mental illness.

Previous misdiagnosis of a mental health problem within the Aboriginal adolescent's community could be a barrier to help seeking. For these reasons, you should take into consideration the spiritual and cultural context of the adolescent's behaviours.

On the other hand, you should not assume that unusual or out-of-character behaviours are a part of the adolescent's culture, as they may be signs of mental health problems. Before acting on any assumptions it is important to explore these signs.

Be aware of challenges the adolescent might be experiencing

When providing mental health first aid to the adolescent you should be aware that they may have additional challenges because of social problems such as racism and discrimination. The adolescent may carry a lot of anger from past injustices that they or their family have endured and you should consider this in your approach.

If the adolescent appears angry, irritable or frustrated, you should not automatically assume it is a sign of an underlying mental health problem. The adolescent might be expressing these feelings due a range of other factors, e.g. transgenerational trauma, social disadvantage, racism and discrimination.

Be aware that the adolescent is likely to have experienced the death of a family member, community member or friend. In fact, the adolescent may have experienced the death of more than one loved one in a short space of time, making the recovery process from each loss very difficult. It is important to be aware of how the adolescent's family deals with death and grieving because this will vary between regions and families, e.g. some communities believe that mentioning the names of the deceased or displaying their photograph will call the person's spirit back and not let them pass on.

Address the death of a person in a sensitive manner and be prepared to be led by the adolescent when discussing loss and any deceased relatives or friends. Also, when discussing death and a loss experienced by the adolescent, be aware that suppressed emotions may come to the surface.

Think about the impact that family may have on the adolescent

Recognise the cultural significance of family and the importance to the adolescent of strong family ties. Do not criticise members of the adolescent's extended family. Be aware that, because of the significance of family within Aboriginal communities, problems within the family can have a greater impact on the adolescent.

Understand what might cause the adolescent to feel shame

Be aware of the cultural concept of shame within the adolescent's community. You should understand what might cause the adolescent to

feel shame, such as topics or behaviours that may be considered 'mad', abnormal, unusual or embarrassing, and do your best to avoid these. You should also know how an Aboriginal adolescent might feel community shame. For example, do not talk about the adolescent's mental health problems in front of other community members. In some communities the stigma around mental health is strong, so you need to be sensitive and careful when approaching an adolescent and their family who may be uninformed about mental health issues.

Although it is important to be aware of the historical factors that may lead to shame, you should approach the adolescent with an open mind and be careful not to push this previous trauma upon them.

Making the approach

Approach the adolescent in a sensitive and appropriate manner

An introduction may be needed between yourself and the adolescent. If this is the case, you should be aware that when Aboriginal people introduce themselves, they may do this in relation to their land/country, cultural background or origin. If you are Aboriginal yourself, you should introduce yourself in this way. Whether or not you are Aboriginal, you should offer your first name to create a less formal atmosphere. Using titles such as 'doctor' or 'mister' creates a hierarchy, and the adolescent may perceive you as wanting power over them. Do not be overly assertive or 'big-note' yourself when talking with the adolescent because it is not considered polite in many Aboriginal communities.

You should make sure that you approach the adolescent privately about their experiences, at a time and place that is convenient and free of distractions, and when you have plenty of time for the discussion. Consider that the adolescent may feel more able to discuss their problems when no one else is listening. Find out where the adolescent feels comfortable or safe to talk, as they are more likely to engage with you in a setting that is within their comfort zone, e.g. in a café or at home.

You could ask the adolescent if they wish to do a mutual activity whilst talking. If you do this, you should ensure that you inform the adolescent that it is for the purpose of having a chat (so they don't feel pressured or hemmed in), e.g. "Would you like to go for a walk with me so that we can talk?"

Remember that building a trusting relationship where the adolescent feels comfortable is more important than other factors e.g. how you introduce yourself or the place of discussion.

Know how to handle concerns about cultural or gender differences

Although some adolescents prefer confiding in people of their own cultural background, don't assume that this is always the case; ask if they would prefer this. Be aware that gender and cultural differences between yourself and the adolescent might be exacerbated by discussing private issues, such as commenting on the quality of family relationships, discussing intimate relationships, and, most particularly, topics that include any issues of a sexual nature. If the adolescent shows any concern about a cultural or gender difference between the two of you, you should explore the possibility of getting help from someone the adolescent feels more comfortable with.

Ask the adolescent who they wish to involve in discussions

Because family and friends are a very big part of Aboriginal and Torres Strait Islander cultures, you should anticipate that family or friends may expect to be involved in caring for the adolescent. If family or friends express that they wish to be involved, you should make sure the adolescent is okay with this. Allow the adolescent to choose who they talk to and who is present in these discussions.

If the family of the adolescent are present, avoid asking the adolescent questions that might cause the adolescent embarrassment. You should also ensure the adolescent has the opportunity to answer any questions, even though the family may answer for them.

If you can't help, ensure someone else does

You may find yourself in the situation where the adolescent asks you for help and you do not know much about the problem. In this instance, you should still try to support the adolescent and assist them to get other help. If you do suggest that the adolescent speak to someone else about their problem, you should find a suitable replacement, rather than leaving this task for the adolescent, e.g. "I don't know if I can offer the best advice on X, but I can help you find someone else to talk to."

Similarly, if the adolescent doesn't feel comfortable talking to you, you should help them to find a more suitable person to talk to.

Engage the adolescent before discussing personal issues

Before discussing personal issues with the adolescent, you should take the time to engage with them first (e.g. getting them to talk about their interests and social life). If you don't know what the adolescent is interested in, you should try to learn more from them. Be aware that your reactions to the adolescent's 'everyday problems' may influence what else the adolescent decides to share.

Keep in mind that some adolescents (especially boys) may fear opening up about their problems in case their vulnerability is labelled as a weakness. You should avoid pressuring the adolescent to talk. Tell them they don't have to talk until they are ready to do so, but that you will listen to them when they are. Also let them know that the conversation will remain private unless they talk about harming themselves or someone else.

Be aware that sometimes adolescents struggle to ask for assistance, or reject help when offered, even if they feel that a situation is out of control. The adolescent may hide or play down their problem if they are worried about upsetting or disappointing you. It is also possible that the adolescent does not like being the focus of attention. Do not presume that the adolescent doesn't want your help, even if their initial reaction is negative. The adolescent may need more than one conversation to open up about what is bothering them. You should not give up on trying to engage with the adolescent if they are finding it difficult to open up, but rather try again another time.

Because the adolescent may not wish to open up until they feel you care enough, are trustworthy and are willing to listen, make sure that you take the time to build rapport and trust with them. Be prepared for this process to take longer if you are not Aboriginal or if the adolescent has disengaged from other people. Once you have the adolescent's trust, you should tell them that you want to support them.

Tips for good communication

Make the adolescent the focus of the interaction

When communicating with the adolescent, give them your full attention. Set aside your own issues and try to focus on the adolescent's concerns. Ask the adolescent to explain their experiences and how they feel about them rather than making your own interpretation. Be sure to talk 'with', not 'at', the adolescent and avoid sounding condescending or patronising.

Be warm and non-judgmental

Be warm, caring and non-judgmental toward the adolescent. Offer the adolescent consistent emotional support and understanding and help them feel more positive about themselves. Avoid stereotyping them, e.g. "Teenagers are always so difficult." You should treat the adolescent with respect and fairness, and avoid confronting, criticising or blaming them. Do not contradict or minimise the adolescent's feelings by using statements such as "You're not depressed, you're just bored." Instead, acknowledge the adolescent's expertise about their own life and try to empathise with how they feel.

Offer positive feedback to the adolescent, as this may encourage them to communicate with you, e.g. "I think it's great that you are willing to talk to me about this." Convey a message of hope to the adolescent by assuring them that help is available and things can get better.

Be honest, reliable and consistent

Be honest during the interaction. It is important to be reliable and consistent in your behaviour with the adolescent. Adolescents are very good at reading an adult's attitude and are particularly tuned in to anyone who is faking it. Therefore, it is important that you are genuine by being yourself. Do not make any promises to the adolescent that you can't keep.

If you find that you have said something in error to the adolescent, you should be upfront and address the error as soon as you can.

Adapt your communication style

It is important that you are aware of respectful ways to communicate with the adolescent, including body language, seating position and use of certain words. This may differ between communities and regions. You should recognise that each adolescent's situation and needs are unique. Rather than automatically adopting communication styles based on assumptions, you should pay attention to what the adolescent feels comfortable with and use this to guide your communication.

Talk to the adolescent in a calm and confident manner

You should show a confident manner when interacting with the adolescent. Use a calm voice and steady tone. Never raise your voice if you can help it.

Use clear and simple language

When talking with the adolescent, you should use simple and clear language. If you realise you are using language that the adolescent does not understand (e.g. metaphor or humour), you should change your approach and use direct language.

Be aware that some adolescents do not communicate well verbally, and it is important to adapt to the adolescent's preferred communication style, e.g. using art if they do not feel comfortable with spoken language. If the adolescent has difficulties with communication (e.g. vision impairment, cognitive impairment, poor literacy), you should do your best to adapt your communication to meet these needs. Try to be aware of when the adolescent is not listening to you and respond by changing the way you say or do things.

Let the adolescent tell their story

As far as possible, you should let the adolescent set the pace and style of the interaction. Listen to the adolescent without interrupting them. Allow the adolescent the opportunity to 'have a yarn' or 'tell the story' as this may work better than asking 'yes' or 'no' questions. The adolescent may not respond to a question with a direct answer. Asking for a clear response to a question of a personal nature may result in the adolescent feeling shame.

You should make sure you actively listen and ask relevant questions to check your understanding and acknowledge that you have heard what the adolescent has said. Additionally, make a conscious effort to listen for the feelings and meaning behind the adolescent's words, and respond to this. For example, if an adolescent says, "There's no point in going to school anymore", it could mean that they feel that the future is hopeless.

Allow periods of silence while the adolescent considers their response to a question. After speaking, you should be patient and allow plenty of time for the adolescent to collect their thoughts, reflect on their feelings, and decide what to say next. If you often use long silent pauses yourself, you should explain that you are just thinking about the adolescent's options, as the adolescent may otherwise misinterpret this negatively.

If a parent or guardian is present during the conversation, you should encourage turn-taking and courteous silence when another person is speaking. If you are having a private discussion with the adolescent and other people arrive, you should take a moment to ask the adolescent in private what they would like to do, e.g. continue the discussion in front of others, ask others to leave or make another time to continue your discussion.

Be aware of body language

Be conscious of your body language and what this conveys when communicating with the adolescent, e.g. posture, facial expressions and gestures. You should use cues like nodding to keep a conversation going with the adolescent and avoid negative body language such as crossing your arms, putting your hands on your hips or looking uninterested. Also avoid distracting gestures, such as fidgeting with a pen, glancing at other things or tapping your feet or fingers, as these could be interpreted as lack of interest. Consider that the adolescent may be uncomfortable with direct eye contact. Be conscious of the adolescent's body language as well, as this can provide clues to how they are feeling or how comfortable they feel talking with you. If the adolescent appears defensive, you should make your body language as open as possible, e.g. by appearing relaxed, sitting alongside the adolescent but angled toward them and keeping your voice calm and low.

Provide a comfortable and appropriate amount of personal space

When talking with the adolescent, you should notice how much personal space they feel comfortable with and not intrude beyond that. Consider the possible consequences of physical contact with the adolescent, as it may cause problems with personal boundaries and may lead to legal troubles. If you represent an organisation (e.g. if you are a teacher), you should consider your employer's guidelines on physical contact with an adolescent before giving the adolescent a brief hug or touch of the hand.

Discussing mental illness with the adolescent

Let the adolescent tell you about their experiences and beliefs

Talk openly with the adolescent about mental illness, adapting your language to their age and maturity. You should be aware that the adolescent may not use mental health terms when communicating that they are feeling mentally unwell, e.g. "I feel like crap" rather than "I feel depressed" or "I'm feeling anxious". When acknowledging the adolescent's illness or discomfort, use the words that they use to describe their problems.

Be aware that the adolescent may hold stigmatising attitudes towards mental illness and be careful not to communicate such attitudes yourself. Don't use labels the adolescent may find stigmatising, e.g. 'mentally ill', 'drug addict'.

Allow the adolescent to talk to you about their experiences and beliefs about mental illness if they want to. Ask the adolescent's permission before asking questions about sensitive topics, e.g. "I would like to talk about something important, but I'm aware it might be painful for you. Is that okay?" Let the adolescent speak and tell their story first, and then help them after they have said their piece. Tell the adolescent that they have done the right thing in talking to someone about their problems.

Do not use scare tactics or threats when talking to the adolescent, e.g. "If you keep thinking like this, you'll end up in big trouble." Never tell the adolescent to "Snap out of it" or "Stop thinking that way".

Eating disorders in Aboriginal adolescents

Although some people believe that Aboriginal adolescents are not affected by eating disorders and body dissatisfaction, you should be aware that this is a myth. Therefore, you should not ignore signs of eating disorders in Aboriginal adolescents.

Know how to share your own experiences of mental illness

If you choose to share your own experience of a mental health problem that is similar to the adolescent's, do not allow this to dominate the conversation. Do not compare the adolescent's life to your own experiences at that age. If you talk about what worked for you to overcome a mental health problem (e.g. depression), you should emphasise that everyone is different and that your experience may not apply to them. On the other hand, if there have been difficulties in your recovery, you should be careful not to convey a bleak attitude towards recovery to the adolescent.

If you represent an organisation, you should also consider your employer's guidelines before disclosing your own personal experience of a mental health problem to the adolescent.

Discussing options and getting help

Offer the adolescent options and assistance in finding a solution to their problems

You should not imply to the adolescent that simply talking to you about their mental health problems will make these problems go away. Try to help the adolescent find solutions without trying to fix their problems for them.

Offer options for actions that could help with their problems and allow for compromise to give the adolescent a sense of control. You should discuss with and help the adolescent to assess different courses of action and to understand the consequences of each.

Listen attentively and sensitively to the adolescent's problems in full before you suggest possible courses of action. Otherwise you could be offering ill-considered or inappropriate advice based on only 'half the picture', or you might appear to be minimising or dismissing their problems. You should try not to offer a solution based on what you would do yourself, but have a discussion with the adolescent about what could be done.

If you are concerned about the adolescent's safety (e.g. they are experiencing abuse or bullying), you should ask them directly about this and reassure them that you want to keep them safe. If you are worried about the adolescent causing harm to self or others, you should seek immediate professional help.

Recommend that the adolescent talk to a professional as soon as possible

If the adolescent appears distressed by what they are experiencing, you should reassure the adolescent that help is available. You should recommend that the adolescent talk about what they have been experiencing to a relevant professional (e.g. doctor, counsellor) as early as possible. When you encourage the adolescent to seek professional help, you should ask them what they prefer. You might also consider finding out which mental health professionals have been recommended by other people in the adolescent's community.

Be aware that the adolescent may distrust formal organisations or non-Aboriginal services. For example, the adolescent might prefer not to use mainstream health services because of the way shame affects the behaviour of Aboriginal people. Some may be afraid of attending a mainstream hospital because, historically, being admitted to a hospital with a mental illness caused shame on family and community. Another possibility is that the adolescent feels uncomfortable using these services because of fear, language or literacy difficulties, or the racist attitudes of the first contact staff.

On the other hand, you should also be aware that some adolescents are not comfortable using Aboriginal-controlled health services because of concerns about confidentiality and shame jobs.

You should also be aware that the adolescent might feel shame in engaging in personal discussions with people of a different gender. Ask the adolescent if they would prefer someone of the same gender and culture, if this is possible.

If the adolescent resists seeing someone about their problem, you should offer the adolescent phone numbers to Lifeline or Kids Help Line, or website addresses, as these are anonymous and may be less confronting.

Encourage the use of other supports in the adolescent's community

You should find out what informal supports exist in the adolescent's community and encourage use of these where appropriate. Try to find out who has the most positive influence on the adolescent and who the adolescent will respect and listen to. Ask the adolescent who their primary carer is and whether they could be contacted if help is needed.

You should have the adolescent's permission before you seek help from other members of the community, unless you are worried about the adolescent's risk of harm to self or others.

Similarly, you should uphold the adolescent's right to confidentiality, unless you are worried about the adolescent's risk of harm to self or others.

Encourage the adolescent to participate in positive activities in their community. In order to help them find suitable activities, you should ask about their interests.

In a crisis

If you are worried about the adolescent's safety or if the adolescent is experiencing a crisis, then you should be persistent in trying to get the adolescent help and support from others. Be aware that establishing a network of support for the adolescent is a very important step in helping them resolve their mental health crisis, especially if access to professional support or mental health services is limited.

Handling difficulties in the interaction

You may have problems engaging and communicating with the adolescent or they may not want to talk about their problems. If this is the case, you should respect this and not take it personally. You may have to consider finding someone else to help the adolescent. Ask whether they would like some help to find someone else to talk to, e.g. a person of a different age or gender. If you are going to recommend the adolescent talk to someone else, then you should explain that you are doing this because you think the other person will be of greater help to them and that you are still available to help if needed.

You should note any topic the adolescent finds distressing and give them time to think and the opportunity to continue the conversation after a pause. If the adolescent is being antagonistic or argumentative, you should not respond in a hostile, disciplinary or challenging manner.

If you feel startled or disturbed by what the adolescent says, you should remain neutral, e.g. in your phrasing, vocal tone and body language.

Exercise self-care

Following a discussion with the adolescent you may be left feeling bewildered or distressed. If this occurs you should confide your feelings to a trusted friend or health professional, while maintaining the adolescent's privacy.

Appendix 2

Considerations When Providing Mental Health First Aid to a Young LGBTIQ Person

Purpose of these guidelines

These guidelines describe how members of the public should tailor their approach when providing mental health first aid to a young LGBTIQ person who may be developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis.

How to use these guidelines

These guidelines are a general set of recommendations. Each individual is unique and it is important to tailor your support to that person's needs. Therefore, these recommendations may not be appropriate for every person.

Understanding LGBTIQ experiences

So that you can better support a young LGBTIQ person with mental health problems, learn as much as you can about the LGBTIQ community, including the way culture and religion impact on LGBTIQ people, e.g. shame due to cultural or religious norms.

Sexuality and gender lie on a spectrum, rather than falling within rigid categories, e.g. not everybody identifies as male or female. Sexuality and gender may also change over time. There is great diversity among people using any particular LGBTIQ label and an LGBTIQ person may hold a range of identities, e.g. queer and transgender.

There are some things you should avoid:

- Do not make assumptions about the young person's sexuality or gender identity based on the way they look, act, talk, dress or who their friends are
- Do not make assumptions about the way the person is likely to behave or think based on your knowledge of the person's LGBTIQ experience
- Do not make assumptions about the person's sexuality based on their gender identity, and vice versa.

If you are interacting with a same-sex attracted person who is of the same gender as you, do not assume that the person is sexually attracted to you, just as you would not assume that all heterosexual members of the opposite gender are attracted to you.

If you are an LGBTIQ person yourself, you should not make assumptions based on your own experience or understanding of being LGBTIQ.

Definitions used in these guidelines

The definition of terms and the way they are used changes over time, and can vary depending on location and culture. While acknowledging this, the terms used in these guidelines are defined below.

LGBTIQ traditionally stands for lesbian, gay, bisexual, transgender, intersex, and queer or questioning. In these guidelines, it is expanded to include the full range of sexual and romantic attractions (e.g. asexual, polysexual, pansexual), and all gender identities.

LGBTIQ experience refers to the way an LGBTIQ person experiences sexual or romantic attraction, sexual behaviours, gender identity or intersex variation.

Gender identity describes someone's own understanding of who they are with regards to their gender-related identity (e.g. woman, genderqueer, man, no gender, etc.), as distinct from their physical characteristics. This includes the way people express or present their gender and recognises that a person may not identify as either a woman or a man.

- ***Transgender*** is a broad term for people whose gender identity, expression or behaviour is different from those typically associated with their assigned sex at birth. 'Trans' is shorthand for 'transgender'. Transgender is correctly used as an adjective, not a noun, thus 'transgender people' is appropriate, but 'transgenders' or 'transgendered' is often viewed as disrespectful. A person with a transgender experience may not identify as 'transgender', but rather as male, female, binary, etc.
- ***Transsexual*** is an older term for transgender.
- ***Transvestite*** (or cross-dresser) is a term for people who dress in clothing traditionally or stereotypically worn by the other sex, but who generally have no intent to live full-time as the other gender. The term 'transvestite' may be considered derogatory.
- ***Cisgender*** refers to people whose gender identity is typically associated with their biological sex at birth.

Sexuality describes a person's emotional, romantic, or sexual attractions towards others, often describing the gender of people with whom someone builds sexual or romantic relationships, e.g. lesbian, gay, etc. Some people experience sexuality as fluid and changing across the lifespan, therefore we choose not to use the term 'orientation'.

- ***Asexual*** is used to describe a person who does not experience sexual attraction.
- ***Bisexual*** is sexual attraction to both males and females. It is a sexuality in its own right, and should not be viewed as 'a phase' or 'on the way to being gay'.
- ***Pansexual*** is derived from the Greek prefix 'pan', which means 'all'. Pansexual people may be attracted to a person of any gender.
- ***Polysexual*** is used to describe a person who is attracted to some, but not all genders.

Intersex variation is an umbrella term for people with physical characteristics that are seen as different from what is typically thought of as 'female' and 'male' bodies. These physical characteristics are present at birth and may become more noticeable during physical development. Intersex variation is distinct from sexuality and gender identity. Therefore, intersex people may identify as male, female or another gender; and gay, lesbian, bisexual, heterosexual, etc.

Queer is an umbrella term used by some people who are sexual or gender minorities to describe themselves.

Definitions based on those from MindOut and the National Centre for Transgender Equality.

How common are LGBTIQ experiences in the community?

Around 1-2% of people in the community identify as lesbian or gay, and a similar percentage identify as bisexual. A much higher percentage (6-13%) have had a same sex experience in their lifetime, but may not identify as LGBTIQ. Approximately 1% of people identify as asexual and up to 2% have an intersex variation. There is no reliable data about transgender experiences.

Mental health problems in LGBTIQ people

LGBTIQ experiences and identities are not mental illnesses. However, young LGBTIQ people are at an increased risk of depression, anxiety, substance use problems, suicidal thoughts and behaviours, and non-suicidal self-injury. You should also know that:

- Bisexual people are at an increased risk of mental health problems as compared to gay men and lesbians.
- Transgender people are at an increased risk of eating and body image disorders.
- Men who are attracted to other men are at an increased risk of eating and body image disorders.

LGBTIQ experiences do not, in themselves, cause mental health problems, rather they may be associated with specific stressors. There are a number of risk factors for mental health problems that are specific to or more common for young LGBTIQ people. These include:

- Being in a minority group
- Discrimination, prejudice and abuse
- Actual or anticipated insensitive treatment or violence
- Intersex people receiving 'corrective' surgery they did not consent to, often in infancy (see box on 'Surgical interventions on sex characteristics and risk of mental health problems').

However, not all young people experience distress about their LGBTIQ experience. Therefore, do not assume that LGBTIQ experiences are related to any mental health problems a young person may have or distress they are experiencing.

Surgical interventions on sex characteristics and risk of mental health problems

Gender affirmation surgery aims to align a transgender person's physical body to their gender identity. This is not the same as 'corrective' surgery that is intended to assign one gender to a person with an intersex condition, where genitalia may be mixed or ambiguous. You should know that:

- 'Corrective' surgery is not necessary in order to prevent mental health problems in intersex people.
- Intersex people may experience distress due to 'corrective' surgery that they did not consent to (e.g. in infancy), and the related shame and secrecy.
- Gender affirmation surgery is not necessary in order to prevent mental health problems in transgender people.

Talking with an LGBTIQ person

Language and terminology

It can be difficult for a young person to disclose that they are LGBTIQ because of the language people use to ask questions, especially when language assumes heterosexuality and cisgender experiences, e.g. asking a young woman if she has a boyfriend, or asking someone if they are male or female. By using appropriate and inclusive language you can help the person to feel safe and comfortable about disclosing information that may be relevant to their distress. Any attempts to get language and terminology correct are likely to be appreciated by the young LGBTIQ person.

Use the same terms that the person does to describe themselves, their sexual or romantic partners, relationships, and identity. If you are uncertain about what terms to use, you should ask the person. Make your questions as open as possible, to give the young person room to describe and express themselves in a way they are comfortable with, e.g. instead of asking "are you straight, gay or bisexual?" ask "how do you describe your sexuality?"

There are some things you should avoid:

- Do not use the term 'homosexual' unless the young person refers to themselves in this way, as this term can carry negative connotations for some people.
- Do not use the term 'hermaphrodite' or 'disorders of sex development' (DSD) to refer to intersex people, because these terms are misleading and stigmatising.
- Do not use terms such as 'tranny', 'transsexual', 'transvestite', or 'cross-dresser' when referring to a transgender person, as this may be offensive.

Be aware that the young person may use terms to describe themselves or others that have historically been derogatory (this is called 'reclaimed language'), e.g. 'fag' or 'dyke'. However, do **not** assume that it is acceptable for you to use these terms.

Pronouns

Using the wrong gender pronouns when interacting with an LGBTIQ person can be very embarrassing or humiliating for them. Some people choose not to use gendered pronouns to refer to themselves, as they may identify themselves as having a gender other than male or female, having more than one gender identity, or having no gender at all.

If the young person you are assisting is not familiar to you and you are unsure of the person's gender identity, you should:

- Communicate in terms that are gender and relationship neutral, e.g. using 'partner' rather than 'boyfriend' or 'girlfriend'.
- Use non-gendered pronouns (i.e. 'they', 'them', 'their', even though referring to an individual) or use the person's name in place of a gendered pronoun (i.e. instead of saying, "That belongs to her", say "That belongs to Sam").
- Ask about this in a respectful and inclusive way, e.g. "I use feminine pronouns to refer to myself. Can I ask what pronouns you use?"

Talking and asking questions about LGBTIQ experience

Unless it is relevant to assisting the young person, do not ask the person if they are LGBTIQ. However, if it is relevant and you are in doubt about how to talk with the person about their LGBTIQ experience, ask them. If you have questions for the person about their LGBTIQ experience, seek permission from the person to ask these questions. Watch for subtle cues that indicate that the person may

be uncomfortable with the questions you are asking. Do not focus only on their LGBTIQ experience, e.g. if a young transgender person is undergoing gender affirmation, try not to focus only on this.

Do not ask any questions of the person that you would not ask a non-LGBTIQ person. For example, no one would think to ask a cisgender person, "Do you think this is just a phase?" Similarly, do not ask a transgender person what their 'real' name is (i.e. the name they were given at birth), as this may be offensive. Do not make jokes about sexuality, gender identity or intersex variation or say things that involve stereotyping, e.g. "Gay people are so…"

Do not ask questions about sex, sexuality, sexual partners, genitals or similar, unless it is relevant to assisting the young person. However, you should make it clear that you are open to discussing any issue without asking for personal disclosure from the person, e.g. "I am not going to ask you to give me details of your LGBTIQ experience, but I am open to discussing anything you need to".

Difficulties you may encounter when talking to the young person

If the young person doesn't feel comfortable talking to you or vice versa, you should help them find someone more suitable to talk to, unless it is a crisis and you are the only person available. Try not to take it personally if the young person does not feel comfortable talking to you.

Ask the young person to tell you if you do or say anything that makes them uncomfortable and apologise if you do. After you apologise, move on, rather than focusing on the mistake or on what you have learned. Do not let the fear of saying the wrong thing prevent you from offering to help the person. It is more important to be genuinely caring than to say 'all the right things'.

Be aware that young LGBTIQ people who have been marginalised may express anger and hostility. Try not to take this personally.

Supporting the LGBTIQ Person

Treat the young LGBTIQ person as a person first and foremost, rather than defining them by their LGBTIQ experience.

Although no one is obligated to share their LGBTIQ experience, helping the person to feel comfortable in your presence may go a long way toward open exchange of feelings and thoughts. You can do this by:

- Appropriately and correctly acknowledging the person's LGBTIQ experience, which can also improve the person's sense of wellbeing
- Asking the person what they think would help them, irrespective of the possible causes of their distress
- Asking what help the person needs, rather than making assumptions about what they need based on their LGBTIQ experience
- Showing your support in a concrete way by respecting the choices the person makes about clothing, name and pronouns, even if you don't understand or feel comfortable with it
- Listening to the person and not feeling that you need to have answers or provide advice.

Sexuality and gender identity are not a choice, and any attempts to convince the young person that they can change these can be harmful. It is also important that you:

- Do not offer your opinion on the young person's LGBTIQ experience unless it is invited
- Do not express judgement about the person's LGBTIQ experience when interacting with them

- Do not refer to your own religious or moral beliefs about LGBTIQ people
- Do not give the person the impression that being LGBTIQ is a 'deviation from the norm'
- Do not say things that are intended to reassure but are mostly not helpful or patronising, e.g. "Some of my best friends are gay".

Some of the supports that non-LGBTIQ people use may not be appropriate for a young LGBTIQ person. For example, if the person's family of origin has rejected them because of their LGBTIQ experience, encourage the person to seek support from other sources.

However, do not assume that the LGBTIQ community will be supportive of the person you are helping. Transgender or intersex young people who identify as heterosexual may not feel part of either the LGBTIQ or straight communities, leading to reduced support. Similarly, a young bisexual person may not feel part of either the LGBTIQ or straight communities, because they can face prejudice from both, leading to reduced support.

When the person experiences discrimination and stigma

All LGBTIQ people, even those who have grown up with supportive family and friends, will most likely have experienced some degree of discrimination or prejudice. They may also experience discrimination and prejudice from others with LGBTIQ experience. Young LGBTIQ people can even begin to believe these negative attitudes about themselves, absorbed from the world around them (internalised stigma), which can cause them distress.

If the young person is experiencing mental health problems due to bullying, harassment or discrimination related to their LGBTIQ experience, you should let the person know that they can:

- Report it to authorities, if it is safe to do so
- Pursue their rights
- Contact a support service for LGBTIQ people
- Seek help from an LGBTIQ advocacy organisation.

You should also:

- Let them know they have a right to be safe at all times.
- Ask them what support they would like from you.
- Let them know of any available services where they can report it anonymously.
- Direct them to services that can help them pursue their rights.
- Encourage them to seek professional help.

However, you should not push the young person to take action, but rather support them if they choose to.

When the person comes out or discloses

In these guidelines, the term **coming out** refers to the situation where a young LGBTIQ person tells others with whom they have an ongoing relationship about their sexuality, gender identity or intersex variation for the first time. Coming out may refer to the first time a person shares their sexuality, gender identity or intersex variation with anyone, or it could be the process by which they begin to share this with others in their life. Be aware that not all transgender and intersex people will go through a 'coming out' process.

The term **disclosure** refers to the situation where a young LGBTIQ person who is generally open about their sexuality, gender identity or intersex variation tells a new person for the first time. This might include telling the first aider or a mental health professional.

In these guidelines, this distinction is made because the emotional cost of coming out may be greater than for disclosure.

Coming out

Be aware of the factors that may affect the risk of mental health problems during the coming out process, e.g. possibility of rejection, discrimination or abuse by family, friends, teachers, etc. However, you should know that coming out may have a positive effect on the young person's mental health and wellbeing.

If the young person comes out to you, be aware that it may be the first time the person has ever told anyone about their LGBTIQ experience. You should not express surprise or concern. Acknowledge that coming out may have been difficult and taken a lot of courage. If you ask the young person follow-up questions, these should be to indicate support and care, rather than to satisfy your curiosity.

If the young person wants to come out, but is distressed about how others may react, discuss strategies that will help to reduce the chance of negative reactions from others. This may include:

- Identifying the best person or people to come out to first, so that the likelihood of a positive first experience is optimised
- Identifying two or more trusted people who can support the person during the coming out process
- If there is no one available to support the young person during the coming out process, you should help them to connect with a relevant organisation.

If the person has experienced negative reactions in response to their coming out that are contributing to their mental health problems, you should:

- Listen to the person non-judgmentally rather than offer advice.
- Validate the person's feelings, e.g. "It's understandable that you are upset by your parent's reaction".
- Reassure the person that you accept and support them.
- Tell the person that it may take time for others to accept their LGBTIQ experience.
- Know about and inform the person of online resources that share others' experiences of coming out.
- Encourage the person to contact a support service for LGBTIQ people.

Disclosure

Some young people may not want to disclose their LGBTIQ experience to you, or may not want to disclose until a good connection has developed. This may be due to actual or anticipated negative experiences that have led to a fear of discrimination or being treated insensitively.

If the young person does disclose to you that they are or may be LGBTIQ, you should ask them:

- If they feel that their LGBTIQ experience is contributing to their distress
- If they are experiencing bullying or discrimination related to this
- Whether they want other people to know
- Who else knows about their LGBTIQ experience, so that you do not unintentionally 'out' them.

There are things you should **not** do:

- Do not express a negative reaction, because this may exacerbate the person's distress
- Do not tell the person that this was obvious or that you already knew, as this can be impolite or offensive.

Unless there is a risk of harm to the person or others, you should keep confidential anything they have told you. They may not wish to tell others or they may wish to tell others in their own way.

When the person is an adolescent

Some of the changes that occur during adolescence can be particularly challenging for an adolescent who is intersex, or questioning their sexuality or gender identity. Furthermore, adolescents who are gender diverse may have additional stressors around age of consent to seek treatment, cost of treatment and restrictive laws.

An adolescent may be uncertain about their sexuality or gender identity and, while these may change over time, this does not invalidate their current experience. If this is the case, you should not tell the young person that they have to be an adult before they can know they are LGBTIQ. Nor should you pressure the adolescent to commit to a sexuality or gender identity.

If an adolescent tells you about their LGBTIQ experience, you should be aware that how you react may influence their future decisions to seek help for mental health problems. Do not pressure the adolescent to 'come out' in order to deal with their distress.

You are not obliged to tell the adolescent's parents. You should not tell their parents, or other people, without the adolescent's permission, because to do so would be a breach of confidentiality and could possibly place the adolescent at risk. For example, LGBTIQ adolescents are at increased risk of isolation and homelessness if their family is not accepting of their LGBTIQ experience. Do not assume that the adolescent's friends or school are aware of their sexuality or gender identity.

When talking with the adolescent, let them know that you will not share anything they say with anyone else, except in the case of significant risk of harm to self or others. If you are going to breach confidentiality due to risk of harm, you should only share the information necessary to keep the adolescent safe, and not their LGBTIQ experience. Follow any local mandatory reporting laws concerning mistreatment of minors, where applicable.

Treatment seeking for mental health problems

You should know about sources of information and resources relevant to the mental health of LGBTIQ people, including local services and professionals that specialise in the mental health of LGBTIQ people or are LGBTIQ-friendly. However, do not assume that all 'LGBTIQ-friendly' services are really appropriate for the person's specific LGBTIQ experience. Help the person find resources and services specific to their LGBTIQ experience, where available, e.g. transgender- or intersex-friendly services. Even if there is an LGBTIQ-specific service, the young person may be reluctant to attend. If this is the case, help the person find a 'mainstream' service that is sensitive to the needs of young LGBTIQ people.

You should be aware of the potential barriers limiting access to professional help for young LGBTIQ people, e.g. actual or anticipated discrimination. If the young person lives in a rural area, they may face additional challenges, such as geographical isolation, rural culture, limited access to culturally competent mental health services, and greater exposure to discrimination. You should ask the person about any barriers preventing them from receiving the support they need.

If appropriate services are not available, or the young person is not comfortable accessing

face-to-face services because of their LGBTIQ experience, consider recommending online resources, e.g. online counselling.

If the young person is in a mental health crisis situation (e.g. if they are suicidal), you can enlist the help of others without sharing the person's LGBTIQ experience. You should also be aware of the possibility of family (family of origin or family of choice) or intimate partner violence and, if needed, offer contacts for appropriate services.

Helpful resources for young LGBTIQ people with mental health problems

QLife

www.qlife.org.au

Telephone: 1800 184 527

(3pm-midnight local time, 7 days)

QLife is Australia's first nationally-oriented counselling and referral service for LGBTIQ people. QLife provides nation-wide, early intervention, peer supported telephone and web-based services to people of all ages, sexualities and genders. The website also hosts some useful guides.

Touchbase

www.touchbase.org.au

This website includes a lot of resources about mental health and substance use relevant to LGBTIQ Australians. This includes harm minimisation practices for decreasing risk associated with substances. It also has a section on sexual health.

Appendix 2

Mandatory Reporting of Abuse in Australia

Mandatory Reporting refers to the responsibility of certain professionals to report potential cases of abuse. Each state and territory has different laws.

What should be reported?

Mandatory Reporting guidelines may require the reporting of abuse (physical, sexual, psychological or emotional), neglect, exposure to family violence (i.e. spousal abuse that does not extend to abuse against the young person) or exploitation.

Do I require proof?

Proof is not required, but the degree of certainty required in different states varies. This can vary from an allegation by a child to the suspicion of any reasonable adult.

Who is required to report?

Again, this varies from state to state. Commonly, professionals who work primarily with minors (school and daycare professionals) are required to report, along with health professionals and emergency services personnel.

Who should I make my report to?

The system for reporting abuse varies from state to state. If you are not sure, the police can advise.

I am not subject to Mandatory Reporting laws. Does this mean that I can't report suspected abuse?

You can still report your suspicions, but may be subject to a different process. Again, the police can advise you on what to do.

More information is available from the Australian Institute of Family Studies website:

bit.ly/aifsmandrep

All laws are subject to change. This information should not be considered legal advice. Do not act on this advice without confirming that the described laws are current and relevant to you.

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