

SECTION 3.9

MENTAL HEALTH

3.9 MENTAL HEALTH

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Mental health problems affect young people's psychological growth and development, their health care needs, their educational and occupational attainment, and their involvement with the justice system. Many mental health disorders – such as anxiety, depression, schizophrenia, and eating disorders – have their initial onset in adolescence. Adolescence is also a period marked by increased exposure to risk factors and risk-taking behaviours that may lead to poor mental health outcomes. Early identification and intervention of emerging mental health issues is the key to effective management and treatment and to better health and social outcomes.

Mental health disorders account for the highest burden of disease (almost 50 per cent) among young people in the 16-24 year age group. Around 1 in 4 Australians aged 16–24 experience at least one mental health disorder (AIHW 2011; ABS 2008).

In 2007, 9 per cent of 16-24 year-olds experienced high or very high levels of psychological distress. The most commonly reported disorders are anxiety disorders (15 per cent), substance use disorders (13 per cent), and mood disorders (6 per cent). In 2011, 37% of students aged 12-17 reported psychological distress in the previous 6 months (NSW School Students Health Behaviours Survey).

Overall rates of mental health problems are higher in females than in males: 30 per cent compared to 23 per cent. Behavioural disorders, such as ADHD and Conduct Disorder (CD) are more common among young males than females with around 16 per cent of those with ADHD or CD having both disorders.

The rapid social and emotional changes of adolescence can complicate the presentation and recognition of mental health problems in young people. Behavioural and emotional turmoil is often a part of adolescent development and may be easily dismissed as 'transient'. Mood changes, irritability, poor school performance, or interpersonal conflicts may also mask emotional distress or an underlying mental health problem.

TRAUMA AND MENTAL HEALTH

There is increasing recognition that many mental health problems and disorders are trauma-related (Kezelman and Stavropoulos 2012)

A trauma-informed approach to working with young peoples' mental health problems is widely accepted as best practice.

The landmark Adverse Childhood Experiences (ACE) study conducted in the United States (Felitti et al. 1998; Felitti 2002) found that many problematic symptoms and behaviours stem from coping mechanisms that were initially protective attempts to deal with the adverse experiences associated with complex trauma.

Complex trauma refers to exposure to stressors that are interpersonally generated, ongoing and cumulative, often occurring in childhood or adolescence – such as abuse, neglect or emotional or physical deprivation (Kezelman and Stavropoulos 2012)

In some cases, depression, anxiety, substance abuse, conduct disorders, eating disorders, and self-harming may in fact be symptomatic of the experience of trauma and attempts to cope with it.

For more information about trauma-informed practice, see chapter 3.4.

PRIMARY HEALTH CARE AND SPECIALIST MENTAL HEALTH SERVICES

The first point of contact most people will have with the mental health system is their GP. In Australia, the Better Access Scheme gives GPs a Medicare-supported pathway for referring people to a psychiatrist or psychologist for specialist mental health assessment and/or provision of psychological treatment for a range of mental health problems. Headspace centres are also a first point of contact for mental health care.

However, young people are often reluctant to visit GPs or engage in the mental health system. Youth service providers can play a key role by supporting young people to access a GP. Be sensitive in discussing referral with the young person and explain the reasons why you think they should see a GP. You will also need to explain confidentiality and privacy provisions.

Where possible stay in contact with the young person and support them in practical ways (such as helping them to understand the role of psychiatrists, psychologists and counsellors; accompanying them to appointments; and helping them to adhere to medication and other treatment components).

Approved psychological treatments that can be provided by a psychologist under the Medicare scheme include:

- Cognitive Behavioural Therapy (CBT), including both behavioural and cognitive interventions
- Psycho-education (including MI)

- Relaxation strategies – progressive muscle relaxation; controlled breathing
- Skills training – problem-solving skills and training; anger management; social skills training; communication training; stress management
- Interpersonal therapy (especially for depression)

FINDING OUT MORE...

There are many online resources about mental health. The Head to Health website combines mental health resources and content from the leading health focused organisations in Australia. You can access a range of mental health resources including online programs, fact sheets, audio and video, and online communities as part of the National E-Mental Health Strategy. Visit www.headtohealth.gov.au

DISABILITY AND MENTAL HEALTH

People with a disability exhibit the same range of mental health disorders and problems as general population, however young people with disabilities are more likely than those without a disability to experience mental health problems or disorders early. Fourteen per cent of those with severe or profound disability and mental health problems experienced the onset of mental health issues in childhood or adolescence compared to seven per cent of those without a disability (AIHW 2010).

Children and adolescents with an intellectual disability have a higher risk of developing mental Health problems (Einfeld et al. 2006). Identifying mental health problems and disorders in children and adolescents with an intellectual disability is complex and requires a collaborative approach. Fletcher et al. (2007) provide a clinical guide to diagnosis of mental health problems for people with intellectual disability.

Parents of children with disability may also be at increased risk of mental health problems. Mothers who parent more than one child with a disability, or a child with autism, or have an additional child of preschool age may be more vulnerable to poor mental health (Bourke-Taylor et al. 2012).

FINDING OUT MORE...

Learn more about mental health and young people with a disability in 3.11 Chronic conditions and disability.

SPECIFIC MENTAL HEALTH CONDITIONS

This section provides general guidelines to help you understand and identify some major youth mental health problems. The extent to which particular professionals are able to diagnose and treat mental health disorders will depend on their training, knowledge, experience and work role.

Even if you are not a treating professional, an understanding of common assessment and treatment approaches can help you to know when and how to refer a young person to specialist mental health services.

DEPRESSION

It can be difficult at times to distinguish between the turbulence of adolescent developmental changes and the onset of serious mental health concerns. We all feel down or sad from time to time. Sadness is a reaction to something in particular, like a relationship break-up. Depression means that feelings of sadness last longer than normal, affect most parts of your life, and stop you enjoying the things that you used to.

Adolescence is a key period for the onset of depression. Depression in young people is often masked by other symptoms: anger, irritability, anxiety, poor school performance, marked changes in mood or behaviour may all be hiding depression in a young person. It is important that youth service providers are proactive in enquiring about low mood in young people.

Co-morbidity is common: depression often accompanies other psychosocial or mental health problems, including substance abuse, anxiety, sexual abuse, bullying or family problems.

There are a several different types of depression. Young people often have mood swings (feeling up sometimes as well as down) and may be more irritable and sensitive than usual. This means depression is sometimes hard to diagnose, being mistaken for normal adolescent moods. Major depression usually happens in episodes, when depressed feelings build up slowly over a few weeks.

Typical symptoms of depression include:

- Feelings of unhappiness, moodiness and irritability, and sometimes emptiness or numbness
- Losing interest and pleasure in activities that you once enjoyed
- Loss of appetite and weight (but sometimes people 'comfort eat' and put on weight)
- Either trouble sleeping, or over-sleeping and staying in bed most of the day

- Tiredness, lack of energy and motivation
- Feeling worried or tense
- Difficulty concentrating and making decisions
- Feeling bad, worthless or guilty
- Being self-critical and self-blaming
- Having dark and gloomy thoughts, including thoughts of death or suicide

Dysthymia is a milder type of depression but it is often continuous and can last for months or years. People with dysthymia might still be able to perform their day-to-day tasks, but with less interest, confidence and enjoyment. Dysthymia also interferes with sleep, appetite, energy and concentration. Depression can also occur as part of bipolar disorder.

ASSESSMENT AND DIAGNOSIS

Specialist health providers such as psychologists, psychiatrists, GPs or mental health nurses generally carry out mental health assessment and diagnosis, including the assessment and diagnosis of depression. They conduct an in-depth clinical assessment obtaining a history from the young person, and where appropriate, supporting information from others.

In NSW, mental health clinicians frequently use the NSW Health's Mental Health Outcomes and Assessment Tools (MH-OAT) to assist in the assessment, monitoring and review of mental health care. The tools include diagnostic interviews, self-reporting questionnaires or rating scales that can assist in establishing diagnosis.

Youth service providers can play an important role identifying early signs of depression in a young person and in facilitating access to specialist mental health services. Providers also play an important role in supporting the young person to understand the process of consultation and treatment; collaborating with GPs, psychologists and other providers in implementing a treatment plan; and maintaining connection with the young person.

WHAT TO LOOK FOR

Depressive symptoms (such as low mood and lethargy) are common in young people. The presence of these symptoms alone may not necessarily warrant a diagnosis of depression.

When you are conducting a psychosocial assessment, look for:

- Marked changes in usual mood or behaviour such as sleep/appetite disturbance; persistent irritability; or sleeping too much.
- Underlying risk factors or precipitating events for onset of depression, for example substance use, bullying and victimisation, difficulties in

sexual orientation, issues of loss, family conflict, trauma, stress, or illness.

- Deterioration in functioning in key areas of the young person's life such as a drop in school performance; loss of interest in activities; withdrawal from social contacts; or conflict with peers.
- A family history of depression or other mental illness.

A useful approach to assessment is to ask the young person to rate their own level of depression on a scale from 0 to 10 – where '0' means no depression and '10' means severe depression (Martin 2001). A score of up to 5/10 can usually be considered mild depression. A score above 5 may indicate more severe depression. It is important to ask the young person what that particular score means for them. A score of seven and above demands a careful screening for the risk of suicidality (Martin 2001). A young person who is depressed may be at risk of suicide, and if they are, they need urgent help. If a young person is thinking about suicide, referral to a mental health service is required.

MANAGEMENT APPROACHES

The treatment of depression in young people should ideally involve a collaborative partnership between the young person, a GP and a specialist mental health service provider (e.g. psychiatrist; psychologist; youth mental health worker). Youth service providers play an important role in helping the young person find and access a GP who can prepare a Mental Health Care Plan under the Medicare Better Access scheme.

Youth service providers can also support the young person's journey, listening to their concerns and facilitating referral to other professionals where that is needed.

TREATMENT OPTIONS

Treatment plans should be based on a comprehensive assessment – including the type, severity and duration of the depressive symptoms, related stressors, availability of health services and the skills and experience of workers involved.

In cases of mild depression, there are several specific strategies that can be helpful interventions, including:

- Building problem-solving skills
- Stress management and relaxation techniques
- Activity planning
- Physical exercise
- Psycho-education (in particular about the causes and symptoms of depression and the importance of activity and sleep)

- Social skills training

In more severe cases of depression, more specifically targeted treatment will be required. Current evidence (beyondblue 2010; Hetrick et al. 2013) recommends a stepped approach to treatment, involving:

1. **Establishing support, shared decision-making, multiple visits and the use of psychological therapies.** Evidence-based counselling or psychotherapy is generally considered the first line of treatment for young people (beyondblue 2010; Martin, G. 2001). Evidence-based psychological treatments include CBT, Interpersonal Psychotherapy (IPT), and Family Therapy. GPs can use a Medicare Mental Health Care Plan to refer to a psychologist or other counsellor trained in evidence-based psychological treatments
2. **Prescription of anti-depressant medication.** Available evidence suggests that for selected young people, antidepressants are an effective component of the successful treatment of certain depressive and anxiety disorders in young people (Hetrick, Parker & Purcell, 2013; beyondblue 2010.) Selective Serotonin Reuptake Inhibitors (SSRIs) may be prescribed within the context of comprehensive management of the young person, which includes regular careful monitoring for the emergence of suicidal ideation or behaviour. The key to successful anti-depressant drug treatment in young people is frequent review by a GP or Psychiatrist to monitor response, compliance and side effects.

SUPPORTING A YOUNG PERSON WITH DEPRESSION

Young people who are depressed can benefit from education about the nature of their symptoms and moods, their possible causes and effects on them, and proposed treatments. You can help a young person develop positive coping skills and to learn to manage their depression by helping them to:

- Develop social and interpersonal skills
- Build problem-solving and goal setting skills
- Build self-esteem
- Manage their emotions

Withdrawal from pleasurable or routine activities is a common feature of depression. Set the young person homework tasks to identify and monitor their daily activities over the period of a week. Encourage the young person to re-engage in doing pleasurable activities and to gradually increase the amount of time they spend exercising, playing sport and participating in social and recreational activities.

It is also important to educate and support parents, carers and family members about depression. In some cases, Family Therapy can be an important part of treatment. Specialist family counselling

may be beneficial where family issues are a major contributing factor in the onset and maintenance of the depression.

Ensure that a mental health specialist has assessed the young person before undertaking additional psychological therapies.

FINDING OUT MORE...

There are many evidence-based internet resources to help both professionals working with young people and young people living with depression:

- Beyondblue – the National Depression Initiative has resources for professionals and the public, including a specific site for young people, and a set of Clinical Practice Guidelines: Depression in Adolescents and Young Adults. Visit www.youthbeyondblue.com
- The Black Dog Institute provides assessment tools, resources and management guidelines on the treatment of depression and other mood disorders. Visit www.blackdoginstitute.org.au
- DepressioNet – provides information and resources for health consumers about the causes, symptoms and treatment options for managing depression. Visit www.depressioNet.org.au
- Reachout – provides information, resources and support for young people and professionals. Visit www.reachout.com.au
- Orygen Youth Health (OYH) – provides a range of excellent resources and fact sheets for professionals and young people. Visit www.oyh.org.au

PRACTICE POINTS

- Use the HEEDSSS psychosocial assessment to identify signs of depressed mood in young people
- Refer to a GP, psychiatrist or psychologist, or youth mental health service for more in-depth clinical assessment
- Youth service providers can play a key role in collaborative care by assisting young people to access a GP or mental health professional
- Educate the young person about their depression and help them learn skills to assist in better managing their moods
- Provide follow-up support to the young person and where, appropriate to the family, to assist them in adhering to their treatment plan.

ANXIETY DISORDERS

Anxiety disorders are among the most commonly reported disorders among young people aged 16–24 years (AIHW 2011). Common anxiety disorders in young people include social anxiety, generalised anxiety disorder, obsessive-compulsive disorder (OCD) and post-traumatic stress disorder. Co-morbidity is common: anxiety often occurs with depression, substance abuse and ADHD.

These disorders often have their onset in childhood or early adolescence. Females report considerably higher rates of anxiety disorders than males do (21.7 per cent compared to 9.3 per cent).

ASSESSMENT AND DIAGNOSIS

There are several categories of anxiety disorders that may affect young people:

Generalised anxiety disorder. Generalised anxiety disorder can be diagnosed after an individual has had 6 months or more of anxiety or worry.

Post-traumatic stress disorder (PTSD). A person with PTSD has usually experienced a highly traumatic event in the past, and now re-experiences that event with symptoms of heightened physical and psychological arousal. They are likely to avoid places, people, or situations that they associate with the original trauma.

Social anxiety disorder/phobia. Social anxiety disorder or phobia is characterised by a marked and persistent fear of being embarrassed in social situations. The level or intensity of the fear is usually unreasonable and excessive. Fear of exposure to social or performance situations often leads to avoidance behaviour.

Specific phobia. A phobia is an intense and irrational fear of a specific situation or object (such as fear of traveling on planes). The fear often leads to avoidance behaviour.

Panic disorder. Panic disorder refers to the presence of repeated, unexpected panic attacks compounded by worry about having another panic attack. The fear may relate to losing control or suffering a personal catastrophe.

OCD. OCD is characterised by obsessive thoughts and accompanying compulsive behaviours. A commonly used example is the fear of contamination associated with frequent or continual hand washing. OCD can also involve the fear of catastrophic consequences or events and ritualized behaviours designed to protect against those consequences (for example, stepping over cracks in a specific pattern or counting in particular patterns).

WHAT TO LOOK FOR

Symptoms of anxiety disorders usually fall into three groups:

- Cognitive: including worrying about the future, one's health, one's relationships; and decreased attention and concentration
- Behavioural: avoidance, withdrawal, self-medication with drugs or alcohol
- Somatic: palpitations, increased heart rate, flushing, hyperventilation, tiredness, nausea, sleep difficulties, sweats, shortness of breath, muscular tension

When a person is suffering with an anxiety disorder, the symptoms are usually present at a level that markedly impairs interpersonal, social, academic and occupational functioning

Young people with anxiety often present with physical complaints, school refusal, social avoidance or complex family or interpersonal problems. You can use the HEADSSS psychosocial assessment (see 3.2 Psychosocial assessment) to help identify signs and symptoms of anxiety. Look for:

- Risk factors or precipitating events that may have contributed to the onset and maintenance of anxiety, for example peer conflicts, bullying and victimisation, issues of loss, family difficulties, illness or trauma
- Avoidance behaviour
- Sleep disturbance
- The presence of co-morbid conditions (such as depressed mood or substance use)
- Indicators in the family's background: there is often a strong family history of anxiety or affective disorders.

If you think a young person you are working with may suffer from anxiety, or you're not sure, refer them to a GP or youth mental health service for more in-depth assessment, and possible referral on to a psychologist or psychiatrists for diagnosis and treatment options.

MANAGEMENT APPROACHES

The treatment of depression in young people should ideally involve a collaborative partnership between the young person, a GP and a specialist mental health service provider (e.g. psychiatrist, psychologist; youth mental health worker). Youth service providers play an important role in helping the young person find and access a GP who can prepare a Mental Health Care Plan under the Medicare Better Access scheme.

Youth service providers can also support the young person's journey, listening to their concerns and

facilitating referral to other professionals where that is needed.

TREATMENT OPTIONS

The recommended first line of treatment for young people with anxiety is usually psychological therapies. CBT has proven effective in the treatment of anxiety, particularly in addressing the patterns of negative thinking ('cognitions') that usually contribute to anxiety. CBT exposure and response prevention treatment is the recommended psychological treatment for OCD.

The use of medication for anxiety, while having proven effectiveness, should be used judiciously with young people (as in the treatment of youth depression) and should be based on a comprehensive assessment of the young person's symptoms and circumstances

GPs can facilitate a multidisciplinary approach to treatment by developing a comprehensive Medicare Mental Health Care Plan for referral to a psychiatrist and/or psychologist.

SUPPORTING A YOUNG PERSON WITH ANXIETY

Anxiety can have a debilitating effect on young people (and their families): in particular, they risk become socially isolated, a known precipitator for the onset of other mental health problems like depression.

Young people often don't recognise their anxiety as a problem, or are embarrassed about it. Non-judgemental, informed support from a trusted source can make the experience of seeking help much easier.

Youth service providers can play a vital role in helping to identify young people who may be experiencing anxiety and referring them to a GP or youth mental health service for diagnosis, treatment and professional support.

Your role can extend to supporting treatment plans by helping to address psychosocial factors that may be contributing to the young person's anxiety. Help them to better understand anxiety and to develop positive coping strategies. It may be particularly helpful for the young person to understand how anxiety functions in their brain, including the role that the limbic system and 'primitive' brain (with its fight-or-flight response) plays in the development and maintenance of anxiety. They may also need help to understand and recognise the physiological effects of anxiety – hyper-arousal, increased breathing rate, muscle tension and nausea are common symptoms.

Avoidance behaviour will unfortunately maintain the young person's anxiety. It is helpful to encourage

the young person to overcome their avoidance by gradually and safely exposing themselves to feared situations. You can also teach them skills that might reduce anxiety symptoms and help them regulate their emotions when in an anxiety-provoking situation. These include self-calming skills (e.g. deep breathing, going for a walk), relaxation or meditation techniques to reduce hyper-arousal, and social skills training to increase their confidence in social situations.

FINDING OUT MORE...

There are some excellent internet resources with information about anxiety and resources that can be helpful to young people experiencing anxiety.

- Youthbeyondblue has a range of fact sheets for young people, families, and professionals. Visit www.youthbeyondblue.com
- Anxiety Disorders Association of Victoria provides resources and detailed information about panic disorder, social phobia, agoraphobia, generalised anxiety and depression. Visit www.adavic.org
- Headspace – is Australia's National Youth Mental Health Foundation. Visit www.headspace.org.au
- Orygen Youth Health (OYH) – the Orygen website provides a range of resources and fact sheets for professionals. Visit www.oyh.org.au

PRACTICE POINTS

- Use the HEEADSSS psychosocial assessment to identify signs of anxiety in young people.
- Anxiety is often not a 'rational' behaviour, so telling the young person to calm down or relax usually makes things worse – it's not that easy. Be patient and listen to the young person's fears and concerns.
- Refer to a GP, psychiatrist or psychologist, or youth mental health service for more in-depth clinical assessment
- Young people experiencing anxiety can benefit from developing skills in emotional self-regulation, positive coping strategies and relaxation.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Attention Deficit Hyperactivity Disorder is a developmental behavioural disorder characterised by persistent patterns of inattention, poor concentration, hyperactivity and impulsivity. Research suggests the prevalence of ADHD in young people aged

12-17 years is between 5 per cent and 10 per cent (AIHW 2011; ABS 2007). It is much more common in boys than girls.

Symptoms usually appear before the age of seven and cause significant disruption to both home and school environments. If not treated, ADHD is associated with a high risk of future problems, including school difficulties, work difficulties, relationship problems, substance abuse and adult mental health disorders.

ASSESSMENT AND DIAGNOSIS

ADHD can be difficult to diagnose. It frequently co-occurs with anxiety and depressive symptoms, as well as other behavioural disorders such as oppositional-defiant or CDs.

A paediatrician, child psychologist or child psychiatrist can make the assessment. Diagnosis requires a complex and detailed assessment: there is no single test for ADHD. Diagnosis will be based on a range of factors, requiring information from parents and others. Internationally recognised scales and criteria are used to assess and diagnose ADHD.

Assessments include a developmental history of the child's past behaviours. They may also take into account any issues with the child's early attachment to a parent or caregiver, which may contribute to the behaviour.

WHAT TO LOOK FOR

Common symptoms of ADHD include:

- Inattention symptoms – difficulty concentrating and sustaining attention; difficulty organising tasks; easily distracted; not listening when spoken to
- Hyperactivity symptoms – fidgeting; inability to remain seated; poor impulse control
- Not all children or young people displaying these symptoms have ADHD. A paediatrician or psychiatrist will also gather information from the child or young person's school and family before making a diagnosis of ADHD.

MANAGEMENT APPROACHES

A collaborative approach is required for management of ADHD. Treatment is likely to involve medication, psychological support, counselling and learning interventions at school.

GPs can refer the young person to a psychiatrist or paediatrician for specialist diagnosis. They can also develop a comprehensive Mental Health Care Plan for referral to a psychologist as part of a collaborative treatment approach

TREATMENT OPTIONS

Stimulant medications (like Ritalin and Concerta) are usually the first line of treatment for ADHD. There is also growing evidence for the effectiveness of psychological interventions such as CBT, which can help address self-esteem issues, difficulties with impulse control, behavioural management issues, social skills and organisational difficulties.

Counselling interventions can also assist in the treatment of co-morbid conditions such as anxiety and depression.

Young people with ADHD usually also require intensive learning interventions at school to assist them with attention and learning difficulties.

SUPPORTING A YOUNG PERSON WITH ADHD

Youth health and support services can help a young person who they suspect may be showing symptoms of ADHD to see a GP for assessment and diagnosis. ADHD can be severely disruptive in the family environment, so it is important to provide education and support to the family. Family counselling may also be beneficial.

FINDING OUT MORE...

The National Health and Medical Research Council has published Clinical Practice Points on the Diagnosis, Assessment and Management of ADHD in Children and Adolescents which are available at www.nhmrc.gov.au/guidelines/publications/mh26.

The Royal Australian College of Physicians (RACP) has developed the Draft Australian Guidelines on ADHD. You can find the guidelines on the RACP's website www.racp.edu.au.

The Australian Psychological Society (APS) has also published treatment guidelines for ADHD. Visit www.psychology.org.au

PRACTICE POINTS

- Symptoms of ADHD are usually apparent before a child is 7 years old. It is less common for a first diagnosis of ADHD to be made in adolescence or the teenage years.
- A young person with ADHD has three main difficulties: inattention, impulsivity and overactivity. Not all children with these challenges have ADHD.
- Diagnosis is made after consideration of a range of information sources and involves ruling out other causes of symptoms.

EATING DISORDERS

Eating disorders involve issues of body image, dieting and other aspects of life as well as food. They include anorexia nervosa (known as anorexia), bulimia nervosa (bulimia) and eating disorders otherwise not specified (EDNOS).

Eating disorders can lead to serious physical health problems. Malnutrition or repeated cycles of bingeing and purging can cause damaging changes in the body. Starvation, for example, can lead to osteoporosis (weakening of the bones), kidney problems, headaches, constipation or diarrhoea, fainting and heart problems.

Vomiting after eating can expose the teeth to stomach acid and cause decay, and also cause sore throats, heart problems and abdominal pain. Laxatives can cause constipation or diarrhoea, as well as dehydration and bowel disease.

Eating disorders can also lead to difficulties in concentrating causing problems in studying or at work. They also increase the chance of having depression, anxiety, substance misuse, irritability and moodiness.

Eating disorders are estimated to affect approximately 9 per cent of the population. Though they are more common in females, they affect both males and females. Anorexia and bulimia affect between two and four per cent of the population, and it is estimated that a further five per cent of the population is affected by EDNOS. It is estimated that up to 20 per cent of females may have undiagnosed eating disorders with many young women engaging in unhealthy weight loss behaviours.

ASSESSMENT AND DIAGNOSIS

There are specific diagnostic criteria for anorexia, bulimia and EDNOS. If you are working with a young person who you suspect may have an eating disorder, it is important to refer them to a GP or specialist eating disorder clinic or mental health service for support. Support is also available from school counsellors, psychologists and other counselling services.

WHAT TO LOOK FOR

People with anorexia might:

- Refuse to eat enough food despite being hungry
- Have a strong fear of gaining weight or becoming fat, even though they are underweight
- Have inaccurate perceptions of their body
- Deny serious weight loss
- Stop having menstrual periods (if female)
- Exercise excessively

- Force themselves to vomit after eating, or use diuretics or laxatives to reduce their weight

People with bulimia might:

- Repeatedly binge eat, consuming large quantities of food that is often high in fat or sugar
- Feel out-of-control when bingeing
- Try to make up for binges and avoid weight gain by making themselves vomit, or by using laxatives or diuretics, fasting, or excessive exercise
- Have a compulsive cycle of binge/purge/exercise/binge
- Manage to keep to a healthy weight making the problem difficult to recognise.

People with EDNOS have many of the symptoms of anorexia or bulimia, but do not meet all the diagnostic criteria for a diagnosis of one of these conditions. A young person with EDNOS may have very disturbed eating habits and a distorted body image and may be extremely anxious about gaining weight.

MANAGEMENT APPROACHES

Eating disorders require specialist assessment and diagnosis and a comprehensive, multidisciplinary approach to treatment. Early referral is important to optimise treatment outcomes

If you suspect a young person may be experience an eating disorder, refer the young person to a GP who can develop a comprehensive Mental Health Care Plan for initiating a collaborative treatment approach. Management of eating disorders is almost always multidisciplinary, involving medical care, dietician support and psychological/psychiatric assistance.

TREATMENT OPTIONS

People with eating disorders will benefit from professional help. Keeping the young person safe is the first priority. If the weight loss is severe or there are serious health complications, then a stay in hospital may be needed.

Treatment starts with developing a good working relationship with the young person, and then moves on to providing information, establishing healthy patterns of eating and exercise, and looking after physical health. Individual counselling, family work and medication (when appropriate) might all be required, usually provided by a treatment team.

SUPPORTING A YOUNG PERSON WITH AN EATING DISORDER

If you are concerned that a young person you are working with has an eating disorder, then first of all let them know that you are concerned about them. Even if they deny there is a problem and do not want to talk about it, gently encourage them to seek professional help.

FINDING OUT MORE...

There are a range of resources and support available to professionals working with a young person with an eating disorder:

- The Eating Disorder Service in the Department of Adolescent Medicine, Children's Hospital Westmead can provide assistance with assessment and treatment. Contact the Service on (02) 9845 2446.
- For more information about eating disorders and factsheets, visit the Eating Disorders Foundation website at www.eatingdisorders.org.au
- The National Eating Disorders Collaboration provides information for professionals on research evidence and treatment approaches – www.nedc.com.au
- Mental Health First Aid Australia also has guidelines on Eating Disorders. Visit www.mhfa.com.au
- The Butterfly Foundation provide support for young people and carers. Visit www.thebutterflyfoundation.org.au or phone 1800 334 673.

PRACTICE POINTS

- Eating or dieting disorders are nutritional, medical and psychological conditions that affect body image, personality and physical health and disrupt family life and relationships.
- Eating disorders can have serious medical complications and lead to long-term social and functional impairment.
- Eating disorders are frequently associated with other psychological and physical disorders such as depression, anxiety disorders, substance abuse and personality disorder.
- Specialist, multidisciplinary support and treatment is essential. The first step is a referral to a GP who can facilitate the involvement of appropriate services.

PSYCHOSIS

Information in this section has been adapted from EPPIC – the Early Psychosis Prevention and Intervention Centre (a specialist program of Orygen Youth Health).

Psychosis describes conditions where there are disturbances of a person's beliefs, thoughts, feelings and behaviours, and/or where there is some loss of contact with reality. Psychotic disorders include schizophrenia, drug-induced psychoses, brief reactive psychosis and bipolar disorder. Schizophrenia is the third leading cause of illness in young men aged 15-24 years, and the fifth in young women of the same age (AIHW 2011).

The peak age of onset of psychotic disorders is in the early to mid-twenties for males and mid to late-twenties for females.

ASSESSMENT AND DIAGNOSIS

If a young person is experiencing significant psychosocial difficulties, and displaying symptoms of depression, anxiety or substance misuse, it is important to consider the possibility that such symptoms are part of a psychotic disorder. Early detection is important as research suggests that the earlier treatment is commenced, the more effective it is in preventing transition to a psychotic disorder or aiding in recovery from a psychotic episode (Yung et al. 2007; EPPIC 2010).

Diagnosis requires in-depth assessment by a mental health professional, usually a psychiatrist or specialist mental health services. A clinical assessment will check for psychosis will check for:

- Thought disorder (trouble with thought processes, thought processes that seem sped up or confused)
- Delusions (concern about any unusual events recently, belief that strange things are occurring around or to them, feeling as if something bad is happening to them, or that people have turned against them)
- Hallucinations (experiencing strange or unpleasant experiences involving senses, for example hearing things or seeing things that others could not)

The assessment will also consider:

- History provided by family and friends, colleagues or others who interact with the young person
- Co-morbid issues requiring treatment – especially substance use
- Suicide risk and whether the person is a risk to others

WHAT TO LOOK FOR

The period before clear psychotic symptoms (such as delusions, thought disorder and hallucinations) emerge is known as the prodromal phase, or prodrome. The prodromal phase is characterised by a gradual change in psychosocial functioning over an extended period of time. Some of these changes may include:

- Anxiety, irritability and depression
- Confused thinking or difficulty in concentration or memory
- Preoccupation with new ideas often of an unusual nature
- Physical changes such as sleep disturbance and loss of energy
- Social withdrawal and impairment of role functioning

The person may also experience some less intense symptoms such as mild thought disorder, suspiciousness, odd beliefs and perceptual disorders that are not quite of psychotic intensity or duration. This can also include changes in their perception of objects (things looking or sounding different) or brief "bursts" of hearing voices or seeing visions. They may also experience unusual or odd thoughts about themselves or people around them (such as worries about mind control or reading personal or special messages into everyday events).

An individual in the acute phase of psychosis experiences psychotic symptoms including thought disorder (a pattern of vague or disordered thinking), delusions (fixed, false beliefs out of keeping with the person's cultural environment) and hallucinations (sensory perceptions in the absence of external stimulus).

MANAGEMENT APPROACHES

Effective management of a young person with psychosis requires a multidisciplinary approach involving primary care and specialist mental health services. GPs can coordinate a collaborative treatment approach by using the Medicare Mental Health Item Numbers to develop a care plan for the young person and to facilitate referral.

TREATMENT OPTIONS

Treatment of psychosis may involve the use of prescribed anti-psychotic medications. Specialist mental health services will generally be responsible for initiating treatment and making significant changes to the medication regime. The initial focus of treatment is the control of positive psychotic symptoms and secondary symptoms such as insomnia and agitation.

SUPPORTING A YOUNG PERSON EXPERIENCING PSYCHOSIS

Early recognition and intensive intervention in early psychosis has been shown to increase the likelihood of positive outcomes for young people and their families (Yung et al. 2007; EPPIC 2010). Youth services can help by supporting a young person to seek professional treatment as early as possible for psychotic symptoms.

If a young person you are working with is showing acute symptoms of psychosis, contact your local district mental health service by calling the Mental Health Line – 1800 011 511. Alternatively, the young person can be accompanied, with an appropriate escort, to the Emergency Department of your local hospital, or call 000 in an emergency.

FINDING OUT MORE...

For more information on the signs and symptoms of psychosis and the "at risk" mental state for psychosis, Orygen's website has factsheets on "Psychosis and Young People", "At Risk Mental State and Young People" and "Medication for psychosis". Visit www.oyh.org.au

To learn more about the treatment of psychosis in young people, see the Australian Clinical Guidelines for Early Psychosis on EPPIC's website. Visit www.eppic.org.au

PRACTICE POINTS

- Psychosis is usually preceded by a period of decreased psychosocial functioning.
- It is characterised by disturbances of a person's beliefs, thoughts, feelings and behaviours and includes disorders such as schizophrenia, drug-induced psychoses, brief reactive psychosis and bipolar disorder.
- Psychosis requires diagnosis and treatment by specialist mental health services but you can support a young person who is showing signs of disordered thinking by referring them to a GP or mental health service for evaluation and assessment.

BIPOLAR DISORDER

This section has been developed based on information from the Black Dog Institute. Visit their website at www.blackdoginstitute.org.au

Bipolar disorder is the name used to describe a set of 'mood swing' conditions. Bipolar disorder is associated with high rates of morbidity and mortality, high suicide rates and high levels of social disruption to employment and relationships. It is characterised by swings between mania (or hypomania) and

depression. Mania refers to a state of heightened energy and euphoria - an elevation of mood. Mania can vary in its intensity from hypomania (elevated mood and energy, with mild impairment of judgement and insight) to severe mania with delusions. Severe mania can be so exhausting for an individual experiencing it that hospitalisation maybe required to control the episode.

Unfortunately, bipolar disorder is commonly misdiagnosed: it can be difficult to distinguish between bipolar disorder and other conditions such as anxiety, schizophrenia and personality disorders. Bipolar disorder commonly emerges in mid to late adolescence (15-18 years old).

There are two main forms of the disorder. Bipolar 1 disorder (BP-1) affects around 1 per cent of the population (Parker 2007). A young person with BP-1 is likely to experience mania, have long highs and be more likely to experience psychosis. Individuals with BP-1 are also more likely to be hospitalised. Bipolar 2 disorder (BP-2) is milder in terms of its symptoms; however, the impairment associated with it may be as serious as it is for a person with BP-1. A young person with BP-2 experiences the symptoms of a high but does not experience symptoms of psychosis present for individuals with BP-1. Hypomanic episodes tend to last a few hours or days.

Anxiety disorders and substance abuse are common in people with bipolar disorder.

ASSESSMENT AND DIAGNOSIS

Most health professionals can identify the manic phase of bipolar disorder. However, because many patients only seek help when they are in the depressed phase, it can take a long time for a diagnosis of bipolar to be made. It can be helpful to consider the possibility of bipolar disorder when a young person presents with depression, as early detection will lead to better health and wellbeing outcomes.

Some of the factors that would lead a health professional to consider a diagnosis of bipolar disorder include:

- History of recurrent depression with melancholic features
- History of depression with psychotic features
- Positive family history of a mood disorder
- Onset of melancholic or psychotic depression at a young age (before 40).

Structured screening tools assist health professionals to make the diagnosis, but most of these require specialist training and are often only used in specialist psychiatric research settings. The Black Dog Institute has developed a self-rating tool, which

can be completed online or downloaded and printed by health professionals who are screening for bipolar disorder. Visit www.blackdoginstitute.org.au

WHAT TO LOOK FOR

People experiencing bipolar disorder may exhibit a range of symptoms. Remember that you may only see them in the depressive phase of an illness, which is why screening by a mental health professional is essential before any diagnosis is made.

Nevertheless, you may notice symptoms including:

- High energy levels (feeling wired or hyper), racing thoughts, talking more and talking over people; racing from plan to plan and being constantly on the go; and describing the need for less sleep without feeling tired.
- Positive Mood. A positive or hedonistic mood is characteristic. People with bipolar disorder describe it as feeling confident and capable, being extremely optimistic, feeling that they can succeed in everything, being more creative, and perhaps feeling 'high as a kite'. Any general anxiety disappears.
- Irritability. An individual may exhibit: irritable, impatient and angry behaviour.
- Inappropriate behaviour. An individual in the manic phase of bipolar disorder may be over-involved in other people's activities. They may also exhibit increased risk-taking behaviour; saying and doing outrageous things; spending more money; an increased libido; lack of discernment in relationships; and dressing more colourfully and without inhibition.
- Creativity. People with bipolar disorder experience heightened creativity, often 'seeing things in a new light', vividly or with great clarity. Their senses are heightened and they experience a feeling of being able to achieve great things creatively.
- Mystical experiences: An individual may believe that events are connected and that there is a higher rate of coincidences occurring. They often feel at one with nature and believe that events hide signs or symbols of special significance.

MANAGEMENT APPROACHES

Correct diagnosis is crucial in providing effective treatment for bipolar disorder. Referral to a psychiatrist is recommended to assist with diagnosis and treatment. GPs can refer the young person to a psychiatrist and/or psychologist for assessment, counselling and treatment under a Medicare Mental Health Care Plan. Treatment involves a mix of both medication and psychological therapies.

Bipolar disorder is not a curable condition and requires long-term management.

TREATMENT OPTIONS

Bipolar disorder can require long-term treatment. Medications are used to treat acute episodes of mania and depression and other medications (mood stabilisers) are used to prevent episodes from occurring. While counselling can be beneficial to support a person with bipolar disorder, psychological therapies alone are ineffective.

SUPPORTING A YOUNG PERSON WITH BIPOLAR DISORDER

If you are concerned that a young person you are working with may be exhibiting symptoms of bipolar disorder, referral to a GP or specialist youth mental health services is essential. Early engagement with mental health professionals can improve the health and wellbeing outcomes for individuals with bipolar disorder.

If a young person you work with has been diagnosed with bipolar disorder, you can support them by helping them learn more about the condition, attend appointments and consultations and follow treatment plans.

If a young person you are working with is showing acute symptoms, contact your local district mental health service by calling the Mental Health Line – 1800 011 511. Alternatively, the young person can be accompanied, with an appropriate escort, to the Emergency Department of your local hospital, or call 000 in an emergency.

FINDING OUT MORE...

The Black Dog Institute's website has extensive information about bipolar disorders, their presentation, assessment, diagnosis and treatment. Visit www.blackdoginstitute.org.au

PRACTICE POINTS

- Diagnosis can be difficult and must be undertaken by a mental health professional.
- Symptoms of bipolar disorder often emerge in the late teens or early twenties. If you suspect that a young person you are working with or supporting may be experiencing mood swings, mania or severe depression help them to find a GP or access specialist youth mental health services.
- Support the young person to comply with treatment plans. Bipolar disorder is a life-long condition and requires ongoing treatment to reduce and manage mood swings and symptoms.

SELF-HARM AND SUICIDE

This section is based on information from Mental Health First Aid (MHFA) Australia's *Non-suicidal self-injury: first aid guidelines and Suicidal thoughts and behaviours: first aid guidelines*. Visit www.mhfa.com.au

Self-harming and suicidal behaviour are maladaptive solutions to emotional, psychological and interpersonal problems. Deliberate self-harm is common in Australian young people, especially in females: research suggests that 6-7 per cent of young Australians (aged 15-24) have self-harmed in any 12-month period, while over 12 per cent report having done so at some point in their life (De Leo and Heller 2004).

Self-harming behaviour involves directly and deliberately inflicting bodily harm or injury. It includes cutting, scratching, burning and abrading. The act or experience alters the person's mood state and reduces psychological tension. A young person may self-harm to cope with overwhelming feelings and situations. Conversely, some young people self-harm in an attempt to feel emotion.

In most cases, self-harm is not a suicide attempt: many young people use self-harm as a way to stay alive rather than end their life. Suicidal behaviour, however, is intended to end life. It consists of threats and actions that involve the intention to kill oneself and that, if carried out, may lead to serious injury or death. Suicidal ideation refers to conscious thoughts about ending one's life.

While more young females are hospitalised for suicide attempts than young males, young men have a death rate from suicide that is three to four times higher than the rate amongst females. Males tend to use more lethal methods than females. Suicide rates amongst Indigenous young people are four times the rate for non-Indigenous young people. Prevalence rates of suicide attempts in same-sex attracted young people are 4 to 6 times higher than the general population, with those in rural areas particularly at risk.

ASSESSMENT AND DIAGNOSIS

Self-harming behaviour indicates a high level of psychological stress. It is often repetitive in nature and, in some cases, may be associated with a personality disorder. A young person who is self-harming needs professional mental health support, so refer the young person to a GP or a psychiatrist for a comprehensive assessment.

Some self-harming behaviour may need urgent medical attention – because of the risk of accidental death or injury (for example, if the young person has taken an overdose or there is bleeding that is rapid or pulsing). If any of these situations occur, call

an ambulance (dial 000) or accompany the young person to the Emergency Department of your local hospital

Young people who are self-harming should be screened for depression and suicide risk. A psychosocial risk assessment using the HEEADSSS screening tool can help to identify presence of suicidal ideation and behaviour. It also allows you to determine risk and protective factors in the young person's life.

If you think the young person may be depressed or he or she discloses suicidal thoughts, it is important to enquire directly about suicidal thoughts or behaviour. Asking about suicide does not put the idea of suicide in someone's mind. Most young people feel relieved to have their distress acknowledged – it allows them to express their worries and to feel heard and understood.

If the young person has been having suicidal thoughts, it is important to conduct a more systematic assessment to identify whether the young person is at low, moderate or high risk of suicide.

In NSW, the Mental Health Line is a statewide, 24-hour mental health telephone access service. Anyone with a mental health issue can use the Mental Health Line to speak with a mental health professional and be directed to the right care for them. Carers, other health professionals and emergency service workers can also use the Mental Health Line for advice about a person's clinical symptoms, the urgency of the need for care and local treatment options.

The Mental Health Line can be contacted on 1800 011 511.

The Suicide Callback Service, a national support service for individuals and health professionals, has factsheets and guidance to support you in assessing risk. Visit www.suicidecallbackservice.org.au

If you do not feel confident to conduct a suicide risk assessment, refer the young person to a GP, psychologist, psychiatrist or a youth mental health service for an in-depth assessment.

WHAT TO LOOK FOR

Some of the factors that may indicate an increased suicide risk include:

- Previous suicide attempts or intentional self-harm
- History of previous attempts in family/friends
- Mental illness combined with harmful drug use
- Depression or hopelessness
- Concrete suicide plan
- Recent stressful life events

- Relationship breakdown
- Loss, disappointment or humiliation
- School or work difficulties
- Withdrawal from friends, family or society
- Victim of bullying
- GLBTIQ identification

The main contributing factors in youth suicide are depression and loss of hope. Empathise with the young person and show your concern and interest – use reflective listening to encourage them to express their thoughts and feelings about their current situation. Common thoughts and feelings include:

- Sense of hopelessness and/or helplessness
- Persistently thinking things will never get better and no-one can help
- Feeling overwhelmed by the expectations of others
- Loneliness, fear, feelings of abandonment and not being heard consistent high levels of anxiety and/or anger

MANAGEMENT APPROACHES

Self-harming behaviours and thoughts of suicide are indicators for referral for specialist mental health support. Young people may be reluctant to engage with the mental health system, so it is important to address concerns about referral openly. Of course, you will also need to deal with the situation of confidentiality sensitively but firmly. **It is important not to agree to secrecy.**

Example:

"Mark, you've said that you don't want anyone to know about this. However, I'm very concerned about you at the moment and my first duty really is to make sure that you are safe. In order to make sure you are safe, I need to contact some other people who can help you so that we can get you through this difficult time."

In the case of a young person who you believe may be suicidal, let them know that suicidal thoughts are common and don't have to be acted on. Refer the young person to the local youth mental health service or to a GP who can facilitate referral to psychiatrist or psychologist. Be prepared to support the young person to attend appointments and to facilitate contact between the young person and a mental health service or GP.

TREATMENT OPTIONS

Treatment for self-harming behaviours may include a range of psychological supports, including:

- CBT, including both behavioural and cognitive interventions
- Psycho-education (including MI)
- Relaxation strategies – progressive muscle relaxation; controlled breathing
- Skills training – problem-solving skills and training; anger management; social skills training; communication training; stress management
- Interpersonal therapy (especially for depression)

The treatment approach taken to support a young person at risk of suicide or who has attempted suicide will vary from case to case, but should always involve a mental health professional or team. Medication may be required, as may other therapies. Hospitalisation may also be necessary in medium-to-high risk cases, particularly where a young person has little or no social support.

SUPPORTING A YOUNG PERSON WHO SELF-HARMS

Remember that a young person who self-harms does so to relieve overwhelming feelings or perhaps to reconnect with feelings and relieve a sense of numbness. They are often experiencing high levels of anxiety and/or depression.

Talk openly and calmly to the young person about their self-harming, in a supportive and non-judgemental way. It is important to manage your own reactions to the self-harming behaviour – stay calm and avoid expressing a strong negative judgement.

Explore the triggers to their self-harming and its function in their life:

- When and in what situations do they self-harm?
- How does self-harming help to regulate their moods?

Help the young person to identify their strengths and goals for how they would like to be able to react to these triggers. You can also help them to explore other ways of managing their anxiety and coping with emotions.

Talk with the young person about how counselling can assist them to develop positive self-soothing and emotional self-regulation techniques, problem-solving skills and communication skills. You can then refer them to a GP for referral on to a psychologist or psychiatrist for assessment and counselling under a Medicare Mental Health Care Plan. Alternatively, in NSW, you can refer the young person to a local mental health service through the Mental Health Line on 1800 011 511.

SUPPORTING A YOUNG PERSON AT RISK OF SUICIDE

If the young person is in immediate danger:

- Call 000 and ask for an ambulance.
- Go with the young person to the local hospital's Emergency Department.
- In NSW, you can contact the Mental Health Line, which provides 24-hour access to mental health service support. Call 1800 011 511.

If the young person is at moderate-to-high risk, consider:

- What steps can I do to increase the young person's safety?
- Who else does the young person trust?
- What services can I draw on to support this young person?
- What options are available when I am not here? Provide contact details for telephone crisis services.
- Which GP, mental health service or mental health professional can I refer this young person to? You may need to be proactive in facilitating contact and accompanying the young person to appointments.

You can also help by:

- Developing a safety plan with the young person. You can learn more about safety planning at www.youthbeyondblue.com
- Contacting and mobilising family and/or social supports
- Removing or limiting access to the means of self-harm if possible
- Affirming the person, affirming the problem but negating the maladaptive solution (i.e. suicide)

FINDING OUT MORE...

There are many online resources about managing self-harming behaviour and about identifying, assessing and managing suicide risk in young people.

Mental Health First Aid (www.mhfa.com.au) provides guidelines on mental health first aid for both self-harming and suicidal behaviours.

Reachout (www.reachout.com.au), headspace (www.headspace.org.au), and youthbeyondblue (www.youthbeyondblue.com 1300 22 4636) provide information and resources for young people, their families, friends and health professionals about managing mental health including self-harm and suicide.

Kids Helpline (www.kidshelp.com.au 1800 551 800) provides a free and confidential telephone and online counselling service specifically for young people aged between 5 and 25.

Lifeline (www.lifeline.org.au 13 11 14) provides free online, phone and face-to-face crisis support and suicide prevention service.

The Black Dog Institute also provides a range of resources including screening tools, factsheets and guidelines on its website. Visit www.blackdoginstitute.org.au. The Institute has a website specifically for young people (www.biteback.org.au) and also offers a training program specifically for professionals working with young people.

Headspace helps young people who are going through a tough time. 12-25 year-olds can get health advice, support and information. With centres all around Australia, headspace can help with: general health, mental health and counselling, education, employment and other services, alcohol and other drug services. Headspace also provide an online counselling service (www.eheadspace.org.au 1800 650 890). Visit www.headspace.org.au.

Suicide Call Back Service (www.suicidecallbackservice.org.au 1300 659 467) provides a free professional telephone and online counselling service for anyone affected by suicide.

QLife provides phone and online support ([www.qlife.org.au](http://www qlife.org.au) 1800 184 527) for lesbian, gay, bi, trans and intersex communities.

PRACTICE POINTS

- Self-harming behaviour and suicide both represent maladaptive responses to emotional and psychological distress.
- Self-harm may occur in individuals who are not suicidal (as a coping mechanism to relieve feelings of anxiety or to “get in touch” with feelings), but it can also be an indicator of a suicide risk (where the harming behaviour becomes more lethal in nature).
- Both suicidal ideation and suicidal behaviour must be treated as serious. Referral for professional mental health assessment and treatment is necessary, but an initial risk assessment should be carried out to determine whether the young person is in imminent danger of harming their self.
- There are a number of referral options:
 - » Community Mental Health Services provide free, specialist mental health services for children and adolescents up to the age of 18yrs and their families (CAMHS). You can access these services is through the Mental Health Line on 1800 011 511. Calls to the line are answered by a mental health professional who can advise whether or not a person is in need of mental health services and provide referral to the local CAMHS.
 - » Mental Health Crisis Teams operate across NSW, 24 hours a day. The team responds to mental health emergencies such as suicidal behaviour or psychosis. You can contact the team through the Mental Health Line on 1800 011 511.
 - » GPs can facilitate referral to a psychiatrist or psychologist by under a Medicare Mental Health Care Plan. A psychologist or counsellor can assist with assessment and diagnosis and specialised counselling. Referral to a Psychiatrist is recommended for in-depth assessment and diagnosis and the provision of treatment, including the prescription of medication.
 - » The NSW Transcultural Mental Health Centre is a statewide resource centre offering clinical and consultation services including assessment, short-term intervention and telephone advice on cross-cultural mental health issues. The centre can be contacted on 1800 648 911.

CHAPTER SUMMARY - WHAT TO REMEMBER

Around 25 per cent of young Australians (aged 16–24) experience at least one mental health disorder.

Many mental health issues including anxiety, depression, eating disorders, schizophrenia and bipolar disorder begin to emerge in adolescence.

The best outcomes for a young person's mental health and wellbeing occur when issues are identified early and management and treatment is implemented collaboratively. Health and youth support workers who are not qualified to diagnose and treat mental health disorders can learn the early signs of psychological distress and understand the processes and supports that need to be put in place to support the young person's mental health.

Young people with intellectual disability may have specific mental health service needs.

In NSW, advice, support and referral is available through the Mental Health Line on 1800 011 511.

In a mental health emergency, call 000.

REFLECTION QUESTIONS

How confident are you in identifying the signs and symptoms of psychological distress in the young people you work with?

Does your organisation have a protocol for referring young people who may be experiencing psychological distress to specialist support?

Can you identify opportunities to improve your organisation's response to mental health issues?

Supporting people with a mental illness can take its toll on workers. What self-care do you undertake?

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