Keynote Session 1　　　　*Navigating Teenage Depression*　　　　**Prof. Gordon Parker**

Professor Gordon Parker is a leading international expert on depression and mood disorders. He is Scientia Professor of Psychiatry at the University of New South Wales and Executive Director of the Black Dog Institute at the Prince of Wales Hospital in Sydney. The Black Dog Institute is a not-for-profit, educational, research, clinical and community-oriented facility offering specialist expertise in depression and bipolar disorder.

Professor Parker provided an overview of mood disorders.

Mood disorders are;
Deadly
Disabling – depression being the most disabling
Discriminating – there is a lack of appreciation / understanding of mood disorders. There has been a destigmatization of mood disorders through prominent people (sportsman, etc.) speaking about their conditions.
Detection problems – risks of under-diagnosis and over-diagnosis

The treatment of mood disorders depends greatly upon the expertise of the practitioner. Different professionals will prescribe different treatments.

Observations of someone who is depressed.
- Asocial
- Loss of 'light' in the eyes
- Changes in sleep pattern

Treatment is given on the basis of severity of the depression. The Black Dog model looks at also treating the cause of the depression.

There are different types and different levels of disorders

- Melancholic depression – typically a loss of 'light' in the eyes, inability to get out of bed, etc., impaired concentration
- Psychotic depression – as for melancholic depression but also delusions and/or hallucinations
- Bi-polar disorders – mania and melancholy. Two types of bi-polar; Type I and Type II. Type II a 'lite' version of Type I.
  2 to 5 out of every 100 kids will be Type II bi-polar
  Years 10 to 12 are at the highest risk.

Stress doesn't come from the objective world – but more from how we perceive things and their impact on us.

Mood disorders can be managed and treated. This is most likely to occur if there is sophisticated diagnosis and management.

The Youth Program by Black Dog   Liza Culleney

Program for schools, which will be ready mid 2010. Program created by Matthew Johnstone

The program makes use of pictures / cartoons and deals with the following issues:

1.   What it's like to be a teenager (Stressors for teens - HSC, peer pressure, bullying, etc.)

2.   Telltale signs of a mood disorder
     - loss of self esteem
     - loss of joy
     - short fuse
     - helplessness of future
     - withdrawal

3.   Different types of mood disorders
     - melancholic
     - bi-polar
     - non-melancholic (stress, personality reactions)

4.   Personality types at risk
     - self critical
     - perfectionsists
     - sensitive

5.   Bi-polar

6.   Fears of seeking help

7.   Navigating the mental health maze

8.   Benefits of good therapy

9.   Touching on medication

10.   Importance of family and school support

11.   Understanding resilience

Nick Newling

Nick Newling was a student at Shore and spoke about his childhood, dealing with a mental illness. He was a very happy child but a perfectionist who put pressure on himself. He was academically strong, receiving a scholarship to Shore. He strated to get treatment in about year 7 and wondered if what he was going through would ever end. He mentioned that he was frequently misdiagnosed and treated for a number of conditions which reflected the area of expertise of the psychologist he happened to be seeing at the time. In Year 8 he went to Rivendell School in Sydney, which is part of the Rivendell Child, Adolescent and Family Mental Health Services. When Nick returend to Shore in Year 9 he made up a story that he had been away from school suffering from chronic fatigure. He felt like an outsider at school. **Nick stated that school was the most important support factor for him.**

Paper 1   *What Schools Need to Know About Boys and Anxiety*   **Jonathan Gaston**

Jonathan Gaston is the Clinic Director of the Macquarie University Anxiety Research Unit. He is responsible for the design of group treatment interventions for anxiety disorders and the day-to-day running of the adult and chiled anxiety clinics.

- What is anxiety?
    - the natural fight or flight response
    - a necessary inbuilt mechanism
    - only a problem when it is switched on at the wrong or inappropriate times

- Anxiety is not necessarily a bad thing. We need a certain level of anxiety to perform optimally.

- How common?
    - 16 % of 6 to 11 year olds
    - 16.5% of 13 to 18 year olds (based on parental reporting) or 10.5% (based on child reporting)
    - 25-50% of 12-18 year olds also present with depression
    - 25-30% of ADHD children also have anxiety issues. Co-morbid problems increase the severity of social and academic problems

- Adolescence is a time of constant change and therefore stress. The highest time for risk is late adolescnce through to early adulthood.

- The Higher School Certificate (State wide exams for Year 12 students in NSW) is a major stressor.

- Girls show higher levels of stress, anxiety and depression symptoms than boys but girls cope better.

- Anxiety is a disorder when;
    - fear or worry is significant
    - fear or worry appears excessive
    - fear or worry leads to significant avoidance

- Phobias seen most in schools include;
    - social
    - generalised anxiety disorder (feel that the world is dangerous and unsafe plus they feel ill-equipped to deal and cope)
    - obsessive comulsive disorder (OCD)
    - post-traumatic stress
    - separation anxiety disorder

- With school refusers it is important to identify the reason.

- Jonathan outlined the "Stepped Care" model for treatment of anxiety. Each step requires greater intensity of treatment. AT every level you are taking away a percentage of the anxiety.

Paper 2   *Youth Mental Health First Aid for Schools*   **Dr Claire Kelly**

Claire Kelly is the coordinator of the Youth Mental Health First Aid Program at the ORYGEN Research Centre, University of Melbourne.

Mental health first aid is the help provided to a person developing a mental health problem or in a mental health crisis. First aid is given until appropriate professional treatment is received.

The mental health first aid program trains members of the public to give early help to developing mental health.

The program is currently in 17 countries.

Just as conventional first aid courses teach a series of actions under the acronym DRABC, mental health first-aiders use the acronym ALGEE.

1. **A**ssess Risk of Suicide or Harm
2. **L**isten Non-judgmentally
3. **G**ive Reassurance and Information
4. **E**ncourage Person to Get Appropriate Professional Help
5. **E**ncourage Self-Help Strategies

Further information and the mental health first aid manual can be downloaded from the mental health first aid website www.mhfa.com.au

Joint Session *School Management of Self Hard and Suicidal Behaviour* **Lydia Senediak**

Lydia is a Clinical Psychologist who has spent the last 20 years working in the area of mental health – both in private practice and with a Child and Adolescent Mental Health Service in Sydney

- Risk factors for self harm and suicidal behaviour
    - Mental health issues
    - Psychosocial risks (personal, family based, interpersonal such as bullying, environmental)
    - Demographic and physical risks (being male is a significant risk factor)

Add alcohol and drug use to these risk factors and the likely hood of harm increases significantly.

- Protective factors include;
    - Strong family and peer relationships
    - Personal skills (coping, sense of humour, positive involvement in activities)
    - Focus on the future
    - Good physical health
    - Spirituality / faith
    - Minimal family history of family mental health problems

- Deliberate self harm and suicide
    - Vast majority of 'self-harmers' have no suicidal intent, however deliberate self harm is a strong predictor of later suicide and accidental death.
    - Only 10-12% of incidents resul in presentation to Emergency Departments.
    - No such thing as a typical young person who self harms. 60% tell no-one
    - Most parents totally unaware. Boys will mask injuries as 'normal' rough play.
    - Boys more likely to engage in deliberate recklessness.
    - Majority of self-harmers started between 12-15 years. ¼ started in 6th class. The age appears to be dropping.

- Onset of deliberate self harm can be due to;
    - Mental health problems
    - Life stressors such as bullying
    - Certain friends or group cultures eg. 'Goths', 'emo'
    - Internet (self harm sites)

- Factors associated with deliberate self harm
    - Family suicide or self harm
    - Drug use
    - Low self-esteem
    - Friend who suicided or self harmed.

- Self harm serves a function in their lives – an adaptive mechanism that can stop suicide. It is a coping mechanism and other ways need to be found to help children cope.

- School staff need to be supportive, accepting, flexible, tolerant, and focus on strengths of boy.

- Indicators of greater suicide risk:
  - marked problems with sleep
  - appetite and social withdrawal
  - increased risk taking
  - giving away possessions / goodbyes
  - increased alcohol / substance abuse
  - comments on helplessness / suicidal thoughts

- Triggers for suicide
  - disruption to meaningful relationships
  - 40% of cases their was no clear precipitent
  - 30% did not alter their behaviour preceeding the suicide

- Prevention is the most significant target for all schools. Preventative measures include:
  - Universal (well-being) intervention programs across all schools
  - Staff training
  - Clear policies
  - Community (especially parent) awareness
  - Links with service providers

- Identification of at risk students
  - Screening of student cohorts (either universal or targetted)
  - Observation and referral (by staff, peers or family)
  - Self-referral

- Teachers need to;
  - observe for changes
  - communicate concerns
  - notify counsellors, etc.
  - be patient