

WORLD
MENTAL
HEALTH
DAY



YOUNG PEOPLE AND MENTAL HEALTH IN A CHANGING WORLD

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The World Federation for Mental Health (WFMH) is an international membership organization founded in 1948 to advance, among all peoples and nations, the prevention of mental and emotional disorders, the proper treatment and care of those with such disorders, and the promotion of mental health.

The WFMH established World Mental Health Day (WMHDAY) on 10 October 1992. The Deputy Secretary General, Richard Hunter, was instrumental in starting the project, which quickly evolved into a worldwide observance. Each year WFMH provides a different packet of information on a selected topic. People in many countries hold events and use World Mental Health Day to draw attention to the importance of mental health, knowing there is much to be done to increase public education and advocacy.

This year is a new beginning for the World Mental Health Day Campaign!

After 25 years of World Mental Health Day and the 70th Anniversary of the World Federation for Mental Health – we are announcing a new visual identity! This new image shows off the key elements of the project - mental health awareness as a green ribbon and the rays of the sun getting stronger and brighter, representing the way the project has helped the mental health movement and the individual's progress towards recovery.

We will allow people to use the logo for their World Mental Health Day events, with permission from the Secretariat (info@wfmh.com). We hope everyone will help us spread the new image around the world!

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Message from the President

As we watch the news, scroll the internet and talk to family and friends around the world, it's apparent that instability, violence and constant traumatic events are becoming daily occurrences. Discrimination is out of the dark alleys and into the mainstream again and mental illness seems to be on the rise but many young people are not seeking treatment that could inevitably help lessen the severity of their illness and give them the tools to live a more productive and stable life.

Our young people today face constant stressors and challenges – happening in their own lives and in the world around them. Many of the issues facing our young people today, such as, bullying, suicide, the onset of major mental illnesses, the effects of trauma, and gender identity discrimination require our time and attention, global awareness and compassion, as well as new programs and guidelines on how we can protect and empower the next generation.

As we discuss the issues of this year's theme, we have chosen to focus on people in the age ranges of 14-28 – identified as youth, young people and young adults. The information is appropriate for those before and after these general ages but we have tried to focus on the time in life where the most changes – externally and internally – usually happen.

This year, World Mental Health Day will talk about the issues facing young people and cover a small portion of the great research, stories, ideas and programs out there to help the next generations be strong and resilient in the face of hardship, life changes, discrimination and destruction. This information is only the beginning – there is an abundance of great information, organizations and advocates out there fighting for the wellbeing of young people, so follow the links, check out topic specific organizations and authors and learn all you can to help promote the theme.

We ask that you join the 2018 World Mental Health Day campaign and help us create a larger audience, a greater impact and a unified voice for global mental health!

Consider holding a World Mental Health Day event in your community. Use the material in this document to help you educate others and 'spread the word'. Join us on social media to make this year the largest and strongest online gathering of people concerned with mental health! We need to join together on social media and in our homes, communities, schools, and businesses to shine a spotlight on the needs of teens and young adults!

WFMH President
Professor Alberto Trimboli



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The Importance of the 2018 World Mental Health Day Theme

YOUNG PEOPLE AND MENTAL HEALTH IN A CHANGING WORLD

The best path to lifelong wellness is one that starts with good mental health. Young people that grow up with additional stressors due to the effects of trauma, transgender discrimination, major mental illness, bullying and suicide are far more likely to have mental health issues throughout the rest of their lives.

World Mental Health Day 2018 will show the importance of creating more services and better care for our young people, and the issues they are experiencing the most these days. The acts of prevention, early interventions, resilience, available information and services are the key factors in creating a healthy future for our young people.

The United Nations, for statistical purposes, defines those persons between the ages of 15 and 24 as youth without prejudice to other definitions by Member States.

Suicide is the second leading cause of death among 15–29-year-olds.

-World Health Organization

1 in 5 young people suffer from a mental illness, that's 20 percent of our population but yet only about 4 percent of the total health care budget is spent on our mental health.

-teenmentalhealth.org

Every 10 minutes, somewhere in the world, an adolescent girl dies as a result of violence.

-United Nations Children's Fund

83% of young people say bullying has a negative impact on their self-esteem

-ditchthelabel.org

Among nearly 100 transgender youth, ages 12 to 24, 51% reported ever thinking about suicide, while 30% had attempted it at least once in their lives.

-Center for Transyouth Health at Children's Hospital Los Angeles

Bullying

Bullying is widely one of the most negative aspects of youth and young adulthood. This is an issue that transcends culture, religion, economic status – it is a global problem that not only impacts a person's self-esteem, but it harms their education, their physical and mental wellbeing. In the 2016 UNICEF U-Report/SRSG-VAC opinion poll on the experience of bullying to which 100,000 young people in 18 countries responded, among those who had experienced bullying - 25% reported that they had been bullied because of their physical appearance, 25% because of their gender or sexual orientation and 25% because of their ethnicity or national origin.

Sit With Us / Natalie Hampton

In middle school, I went through a severe bullying experience in which I was verbally bullied, cyber bullied, and physically attacked. Apart from the violence, one of the worst things was having to eat lunch alone, and the embarrassment of having others see me eating lunch alone. After I changed schools, and landed in a much more kind community, I would always invite people to join my group whenever I saw someone eating lunch alone. Some of these kids, one girl in particular, are now my best friends, whom I never would have met if I hadn't invited them over. I later learned that one girl who I had invited over had been struggling with self-harm and thoughts of suicide at that time. Finding new friends changed her mind, and changed the course of her high school path for the better. I saw firsthand that one small act of kindness - something that may not have meant much to me at the time -- made a huge difference in her life.

“ I saw firsthand that one small act of kindness - something that may not have meant much to me at the time -made a huge difference in her life.”

I decided that I wanted to affect this kind of change on a larger scale, so I created a free, lunch planning app called *Sit With Us* (<http://www.sitwithus.io>) that helps kids find allies in their schools and safe places to sit at lunch. I believe that every school has up standers like me who want to take an active role in improving their community to make it more warm and wel-

coming. Something as seemingly small as lunch can make huge strides in making a school more inclusive because if kids are more kind to each other at lunch, then they are more likely to be kind in the classroom, and outside of the classroom.

The way *Sit With Us* works is that users download the app and create a profile page with a photo, bio, and list of interests, like any other social network. Users must input their school name and address, so that lunch events are sorted by that geographical location. They are then offered the opportunity to be a *Sit With Us* Ambassador for their schools in which they sign a pledge to post open lunch events from time to time in the app, and to make anyone who joins the table feel welcome. If a kid is looking for a place to sit, he or she can simply open the app, and find a table to join under the “featured events” tab without any fear of rejection. Instead of holding up a sign that says “lonely kids eat here”, it is all very discreet, and no one will know the difference. At my former school, if I had been able to find one ally, I believe I would have had a different experience.

I released the app for IOS in the Apple Store in September 2016, and the Android version in February 2017. Since inception, I have gained over 100,000 users in eight countries worldwide, and it continues to grow every day. *Sit With Us* is the largest club on my school campus, and I see so many smiling faces in the lunch area every day. To my surprise, the app is being used for lunch and meeting planning by adults in colleges, places of worship, conferences, and large work-

spaces (such as nurses in hospitals). The app has been featured by under “New Apps We Love” in the Apple Store, has been covered in international media (print, TV, and radio), has garnered numerous awards, and is included in three museums (including the Smithsonian). For schools that do not allow cell phone use, I created an analog version of the program that achieves the same results.

“ The first lesson is that you are never too young to make a difference. ”

I have been invited to speak at many large conferences, including the UN Youth Assembly (from the podium in the Great Assembly Hall), and TEDxTeen. I also speak at local schools and in public libraries. I receive messages frequently from people all over the world, either saying that the app is helping them make their lives better, or thanking me for providing an effective tool for kids to make their school communities more kind. Recognizing the effectiveness of my solution, six prominent anti-bullying organizations are partnering with me, including PACER's National Bullying Prevention Center, Champions Against Bullying, and United Against Bullying. I formed a non-profit (*Sit With Us, Inc.*) and my company has received grants from Samsung, Disney, Youth Service America, Ryan Seacrest, and others. I am incredibly grateful for the opportunity to have met so many teenagers who have similar stories to mine, and my goal is to help make exclusion a thing of the past for all of them.

“*Second, I want people to know that whatever they are struggling with, they are not alone.*”

This pivotal experience of my life has taught me several important lessons that I try to share with others when I am doing community outreach. The first lesson is that you are never too young to make a difference. When I initially presented the idea to my parents, they looked at me like I was crazy. And yet only one year later, I am running a global non-profit, and a leading a movement to spread kindness. Sometimes what may seem impossible at first is truly very possible if you put in the effort to make it succeed. Second, I want people to know that whatever they are struggling with, they are not alone. When I was being victimized, I thought that nobody else in the world understood what I was going through. But now that I have been able to connect with people through my app, I have found that so many others out there have stories so similar to mine. We are living in a world filled with humans seeking a connection, so no matter what; people need to know that they are not alone.

“*My third and final point is to remind people to choose kindness. It’s up to us to make a difference in our communities - to leave the world a betterplace than how we found it.*”

My third and final point is to remind people to choose kindness. It’s up to us to make a difference in our communities – to leave the world a better place than how we found it. Having been on both sides, the person who was excluded and the person who invites anyone sitting alone to join the lunch table, I know that my app can make a difference. I believe that if we spread kindness out into the world, it comes back to us. Even if you don’t use the app, you can embody the spirit of *Sit With Us* by inviting someone who is sitting alone to join you. You never know – your future best friend might be sitting at the next table and *Sit With Us* can help you take the first step.

Natalie Hampton
CEO/Founder of Sit With Us, Inc.
2017 Global Teen Leader | TEDxTeen

Cyber Bullying / Carol Todd

The 2018 theme for World Mental Health Day is 'young people and mental health in a changing world'. Our world is indeed changing rapidly on a day to day basis, both in the physical world and in the virtual online world.

Bullying and cyberbullying continue to have no boundaries and have confused guidelines in this changing world. These acts of hate and hurt can happen anywhere in the world, at any time and with any ages. The focus of what we see and read is primarily on youth.

Kids want so badly for their peers to accept them and to be their friends. Teenagers want the same thing but show it indifferent ways. They have the group mentality. And when something doesn't go their way, they use the group to fight back because ... that group has made a pact to belong together.

Technology has created a new sense of belonging. It seems to be easier to find a connection online. But is that online connection always the one we want? Is it real? Is it truthful? Is it really belonging if we don't know the person at the other end? Remembering the term - 'a false sense of belonging', does that phrase apply to technology in the 21st century?

Technology plays a vital role today in all our lives and especially in the lives of young people. We only hope that everyone can act appropriately both offline and especially online when using their technology devices. Sadly, this isn't always the case. We need to realize that the ill-natured behaviours of some, deeply affect the lives of another. It is our responsibility as role models, caregivers and bystanders to model appropriate behaviours for all to see.

Amanda was very much afraid to talk about how

she felt. She feared the judgement from others. There was always the constant worrying about what others thought or what they may or may be saying to her or others. There is a feeling of helplessness and hopelessness, and many suffering often feel disconnected to others. Remembering how Amanda struggled with ongoing cyberbullying and personal mental health challenges, reminds us how important to not only share her story, but to continue to talk about the reasons why awareness is needed about mental health and especially how cyberbullying is involved.

AMANDAS STORY

On October 10th, 2012, despite support and help, Amanda took her life. Her death brought attention worldwide to the effects of bullying, cyberbullying and exploitation as she had posted an 8 minute video 5 weeks before her death by suicide chronicling what had happened to her by her peers and others. This in turn, created conversations about bullying, mental health and suicide around the world. This coming October 10th, it will be 6 years since Amanda's death. Her story continues to evolve and has been talked about with governmental agencies, law enforcements, schools and more.

Amanda's Legacy was created with a focus on advocating for increased awareness, education and action on cyberbullying and mental health related issues. Amanda's death coincided with World Mental Health Day on October 10th. With this date in mind, her legacy began a campaign of awareness and we titled it 'Light Up Purple for World Mental Health Day'.

World Mental Health Day is observed on 10 October every year, with the overall objective of raising awareness of mental health issues around the world and mobilizing efforts in

support of mental health. This day provides an opportunity for all stakeholders working on mental health issues to talk about their work, and what more needs to be done to make mental health care a reality for people worldwide.

CYBERBULLYING AND MENTAL HEALTH + SOLUTIONS

As we continue to hear stories about not only cyberbullying but the effects that it has on one's emotional health, we must find the patience and perseverance to include talking about mental health and also ways to promote mental wellness. We can't let those who suffer go through their struggles alone. We have to let them know that there is someone by their side to help, nurture and be with them. As I said in last year's blog post, there is a distinct difference between healthy vs unhealthy and that is also the difference between choosing live vs death.

"Bullying can affect everyone—those who are bullied, those who bully, and those who witness bullying. Bullying is linked to many negative outcomes including impacts on mental health, substance use, and suicide." - stopbullying.gov

We know that young people are affected greatly by the effects of cyberbullying which is 'hate speech via technology use'. How do we get young people to change their behaviours? How do we get parents and schools more involved with this issue of concern? There are many risk factors that arise from cyberbullying. Is it about the social media platforms? Are we doing enough as adults to help find the answers for our young people?

"Our conversations surrounding mental health

have increased in the last five years with more people speaking out about their own personal challenges. These include voices of celebrities, sports figures, and the average person you see walking on the street. When we hear of yet another story of suicide, it creates opportunities to talk about what we are feeling and that it's also okay to ask for help. We know that education and awareness is necessary to bring together the conversations needed to break the cycle of harm to self and others. We must change the discussions and raise the commitment for action. We cannot be afraid to speak out about these issues with words and actions of more honesty and openness. It is important that people know that there is always someone out there who wants to help. The stigma of asking for help is often seen as a sign of weakness, when in fact, it is a sign of strength. It's not easy to ask for help. We must change the discussions and raise the commitment for action. We cannot be afraid to speak out about these issues with words and actions of more honesty and openness. Channelling Amanda's Legacy, I hope that one day our world will be filled with kindness, respect, empathy and compassion."

Where does respect and compassion come into play when we are teaching our young people? We are at the crossroads where there needs to be more of a focus on teaching how to interact both online and offline make a difference in how young people treat each other. Our young people are already growing up in the vulnerable time in their lives with social media, school, peer pressure, etc. We are seeing increased vulnerabilities among our youth. What is needed is for those who see something, need to say something. We have to remember that there can be lasting effects of bullying and cyberbullying that go on in the lives of many.

One of the many things that I have learned is to be able to listen to others and realize that everyone has a story to share. Active listening without judgement can make the biggest difference in someone's life.

LIGHT UP PURPLE

The Light Up Purple campaign for World Mental Health Day was initiated in October 2013. This year marks the 6th year that Amanda's Legacy will be requesting that landmarks, organizations, businesses and people do something significant on October 10th for World Mental Health Day. It continues to be an initiative that has brought about increased global awareness and mental health education into the lives of families and their children of all ages. The short and long term effects of cyber-abusive behaviours with respect to mental health continue to be an ongoing topic of discussion among many.

According to Wikipedia it is defined as "a day for global mental health education, awareness and advocacy." It was first celebrated in 1992 as an initiative of the World Federation for Mental Health, a global mental health organization with members in more than 150 countries. On this day every October, thousands of supporters bring attention to mental illness and its effects on people's' lives worldwide.

Why was purple chosen? One of the reasons for choosing purple includes the combined color of pink (Canada's Pink Shirt initiative) & blue (U.S. anti-bullying + mental health awareness) would be a blended colour to signify unity and change. Structures light up in purple around the world, and people find ways to acknowledge the day in purple ways. Ask people to go find something purple and to show it off to others. When we are asked "what is all the purple about?", then we can share the reason(s). We need to know

and understand that it is okay to talk out loud about mental health and wellness, and to help to de-stigmatize it.

As we move towards October 10th, we must remember to take action and ensure that #MentalHealthMatters. We must do this, not only for one day, but to continue the conversations 365 days a year with a vengeance. We must think about the stories that make us smile and feel good. We must be that person to identify and support others through happiness and pain. We must be able to let others know that it is a sign of strength to ask for help, not weakness.

You can be involved too. Time to think CREATIVELY for October 10th!! You are encouraged to do something that will begin or continue the conversations around cyberbullying and mental health. Think #Purple or any other colour you feels reflects World Mental Health Day. You can: shine a purple light, make your social media profile purple, make purple Jell-O, paint purple eggs, and decorate purple cookies. Just be CREATIVE and UNABASHED and always remember that #MentalHealthMatters and that we need to #EndCyberbullying in whatever ways that matter.

Then be sure to join the conversation on Twitter and Instagram by sharing your images and using #MakeTodayPositive , #WorldMentalHealthDay, #stopbullying.

CONCLUSION

It is important to keep asking ourselves questions such as - "What can we do to #EndCyberbullying and to promote positive mental health?" and "What things can we do to make a difference":

- Listen to others with care and support
- Build healthy relationships both individually and in the family
- Family communication – built with trust and respect, this will provide another layer of protection and safety within family dynamics.
- Empowering our children to be strong and to be able to walk away and tell someone if something is making them feel uncomfortable
- Most importantly, to establish TECH FREE TIMES for all family members and to spend this time doing something together

I want Amanda to be remembered, not for her death, but for a bigger cause. I don't want her legacy to fade. I want people to remember why this all started. She wanted to help people. She wanted people to treat people with compassion and support them not laugh at them. We are fragile and unique; just like snowflakes and like Amanda. No two are the same. We are ALL different and that's ok.

I can only hope that somewhere, Amanda is able to see what many of us are doing in order to make not only her voice but the voices of others heard. She would have not only wanted us to speak out for cyberbullying and mental health but to also educate on how to use technology in a reputable way.

Just as the gentle snowflake falls from the sky: Delicate. Beautiful. Unique. And fragile. Those are similar qualities to what each of us in this world might feel. That snowflake joins many others to make the landscape (although cold) beautiful. We must embrace the beauty of others and create that harmonious landscape for all of us.

If someone asks you "Why #purple today?", make sure to share why and also take the time to ask back "Have you got a story to share because I would like to listen?"

To learn more about Amanda Todd Legacy and how you can join in the support of making the world a place filled with less bullying, cyberbullying and more mental health supports, go to the

websites for Amanda Todd Legacy and Light Up Purple where you will find more information on how to join in and participate with the campaign for World Mental Health Day 2018.

Carol Todd
Parent, Educator, Advocate
Founder, Amanda Todd Legacy

CYBERBULLYING FACTS

Knowing about bullying and the effects it has on others can be upsetting and life changing. Regardless, they are the facts and we must pay attention to them. It is important to keep informed so that we know what to say to our kids. As adults, we cannot hide from the reality that wrongful behaviours online (otherwise talked about as cyberbullying) hurts others in varying degrees. However much time is needed, we must spend time to learn how to talk with our kids about the repercussions of bullying. We need to teach about RESPECT, COMPASSION, EMPATHY and ultimately KINDNESS!

We must think about the questions that spark the conversations:

- What is cyberbullying? Why does it happen?
- Where does cyberbullying occur?
- How are kids being affected?
- What are the strategies and solutions to make the problem lessen?

Bullying is predatory and antagonistic behavior that contributes to the silent misery of millions of students and puts some at increased risk for suicidal thoughts and behaviors. - Centers for Disease Control and Prevention, n.d.; Hinduja, S., & Patchin, J. W. (2010)

Cyberbullying was defined as threatening or aggressive emails, texts or online posts, embarrassing or threatening pictures posted online, or using someone's identity to send out or post embarrassing or threatening information.

Bullying is any unwanted aggressive behavior(s) by another youth or group of youths who are not siblings or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated. - Cyberbullying.org (2017)

Children have the ability and resiliency to protect themselves and others and to alter their own behaviour once they are effectively informed about the risks. We should be empowering children at an early age to become good digital citizens and make informed and responsible choices when they use online media. - Marvin Bernstein, UNICEF Canada

In the past 4 weeks 42% of Canadian youth have been cyberbullied and 60% of Canadian youth witnessed others being cyberbullied. - Helping our kids deal with cyberbullying. A TELUS Wise parent's guide. -TELUS Wise (May 2018)

1 in 5 girls are cyberbullied, 1 in 10 boys are cyberbullied, 92% of teens ages 13-17 go online daily - StopBullying.org - <https://www.stopbullying.gov/sites/default/files/2017-10/cyberbullying-infographic.pdf>

Childhood Bullying “Damages Adult Life” / BBC NEWS

Bullying in childhood “throws a long shadow” into victims’ adult lives, suggests research indicating long-term negative consequences for health, job prospects and relationships.

The study tracked more than 1,400 people between the ages of nine and 26.

School bullies were also more likely to grow up into adult criminals.

The study, from Warwick University in the UK and Duke University in the US, concludes bullying should not be seen as “a harmless rite of passage”.

The long-term impact of bullying in childhood was examined through the experiences of three different groups - those who had been bullied, those who had carried out the bullying and those who had been both victims of bullying and had also carried out bullying themselves.

Long-term damage

The research, published in Psychological Science, suggests the most negative outcomes were for those who had been both victims and perpetrators of bullying, described in the study as “bully-victims”.

Described as “easily provoked, low in self-esteem, poor at understanding social cues, and unpopular with peers”, these children grew into adults six times more likely to have a “serious illness, smoke regularly or develop a psychiatric disorder”.

By their mid-20s, these former “bully-victims” were more likely to be obese, to have left school without qualifications, to have drifted through jobs and less likely to have friends.

“We cannot continue to dismiss bullying as a harmless, almost inevitable, part of growing up. We need to change this mindset and acknowledge this as a serious problem.”

- Dieter Wolke, University of Warwick

All of those involved in bullying, as victims or aggressors, had outcomes that were generally worse than the average for those who had not been involved in bullying.

Those who had been victims of bullying, without becoming bullies themselves, were more likely to have mental health problems, more serious illnesses and had a greater likelihood of being in poverty.

But compared with “bully-victims” they were more likely to have been successful in education and making friends.

There were also distinctive patterns for those who had been bullies, but who had not been bullied themselves.

These “pure bullies” were more likely to have been sacked from jobs, to be in a violent relationship and to be involved in risky or illegal behavior, such as getting drunk, taking drugs, fighting, lying and having one-night stands with strangers.

They were much more likely to have committed offences such as breaking into property.

However in terms of health and wealth, bullies had more successful outcomes than either the victims of bullying or those who were both bullies and victims.

Such “pure bullies” were identified as often being strong and healthy and socially capable - with their manipulative and aggressive behavior being seen as “deviant” rather than reflecting that they were “emotionally troubled”.

The study included verbal, physical and psychological bullying and the comparisons were adjusted to take into account social background factors, such as family hardship, family stability and dysfunction.

“We cannot continue to dismiss bullying as a harmless, almost inevitable, part of growing up. We need to change this mindset and acknowledge this as a serious problem for both the individual and the country as a whole; the effects are long-lasting and significant,” said Prof Dieter Wolke of the University of Warwick.

“In the case of bully-victims, it shows how bullying can spread when left untreated. Some interventions are already available in schools but new tools are needed to help health professionals to identify, monitor and deal with the ill-effects of bullying. The challenge we face now is committing the time and resource to these interventions to try and put an end to bullying.”

Emma-Jane Cross, founder of the anti-bullying charity BeatBullying, said: “This groundbreaking study shines a light on what has been an overlooked subject for society and the economy. The findings demonstrate for the first time just how far-reaching and damaging the consequences of bullying can be.”

BBC NEWS

By Sean Coughlan

Education Correspondent

<https://www.bbc.com/news/education-23756749>

Preventing Cyberbullying / Top Ten Tips for Teens

1. Educate yourself. To prevent cyberbullying from occurring you must understand exactly what it is. Research what constitutes cyberbullying, as well as how and where it is most likely to occur. Talk to your friends about what they are seeing and experiencing.

2. Protect your password. Safeguard your password and other private information from prying eyes. Never leave passwords or other identifying information where others can see it. Also, never give out this information to anyone, even your best friend. If others know it, take the time to change it now!

3. Keep photos “PG.” Before posting or sending that sexy image of yourself, consider if it’s something you would want your parents, grandparents, and the rest of the world to see. Bullies can use this picture as ammunition to make life miserable for you.

4. Never open unidentified or unsolicited messages. Never open messages (emails, text messages, Facebook messages, etc.) from people you don’t know, or from known bullies. Delete them without reading. They could contain viruses that automatically infect your device if opened. Also never click on links to pages that are sent from someone you don’t know. These

too could contain a virus designed to collect your personal or private information.

5. Log out of online accounts. Don’t save passwords in form fields within web sites or your web browser for convenience, and don’t stay logged in when you walk away from the computer or cell phone. Don’t give anyone even the slightest chance to pose as you online through your device. If you forget to log out of Facebook when using the computer at the library, the next person who uses that computer could get into your account and cause significant problems for you.

6. Pause before you post. Do not post anything that may compromise your reputation. People will judge you based on how you appear to them online. They will also give or deny you opportunities (jobs, scholarships, internships) based on this.

7. Raise awareness. Start a movement, create a club, build a campaign, or host an event to bring awareness to cyberbullying. While you may understand what it is, it’s not until others are aware of it too that we can truly prevent it from occurring.

8. Setup privacy controls. Restrict access of your online profile to trusted friends only. Most

social networking sites like Facebook and Google + offer you the ability to share certain information with friends only, but these settings must be configured in order to ensure maximum protection.

9. “Google” yourself. Regularly search your name in every major search engine (e.g., Google, Bing, and Yahoo). If any personal information or photo comes up which may be used by aggressors to target you, take action to have it removed before it becomes a problem.

10. Don’t be a cyberbully yourself. Treat others how you would want to be treated. By being a jerk to others online, you are reinforcing the idea that the behavior is acceptable.

This Top Ten List specifies how teenagers can keep themselves safe from online harassment and victimization online.

Find more fact sheets and information at Cyberbullying.org

Hinduja, S. & Patchin, J.W. (2012). Preventing Cyberbullying: Top ten tips for teens. Cyberbullying Research Center. Retrieved [August 2018], from <https://cyberbullying.org/Top-Ten-Tips-Teens-Prevention.pdf>

The Effects of Trauma on Young People

In this date in time, young people are in more peril than ever before. The international news carries increasing stories about violence and trauma and it seems to be increasing on a daily basis. While the stories are often about adults, there are always children involved. The refugee population increases with countries being less willing to relocate them. Children are witnessing violence and disasters on a regular basis and can be affected by these events around them, with the consequences lasting a lifetime. A traumatic event can be anything from domestic abuse, neglect, floods, earthquakes, gun violence, war, physical assaults and accidents. Some trauma is common in a lifetime but young people who do not have support systems, years of increased resilience can be affected in ways that can last for months, years or a lifetime.

Children From All Walks of Life Endure Violence, and Millions More Are At Risk / UNICEF

Violence against children takes many forms, including physical, sexual, and emotional abuse, and may involve neglect or deprivation. Violence occurs in many settings, including the home, school, community and over the Internet. Similarly, a wide range of perpetrators commit violence against children, such as family members, intimate partners, teachers, neighbors, strangers and other children. Such violence not only inflicts harm, pain and humiliation on children; it also kills. All children have the right to protection from violence, regardless of the nature or severity of the act and all forms of violence can cause harm to children, reduce their sense of self-worth, affront their dignity and hinder their development. Examining global patterns of violence as well as attitudes and social norms sheds light on an issue that has remained largely undocumented. Using data to make violence against children and its many ramifications more visible will bring about a fuller understanding of its magnitude and nature and offering clues to its prevention.

The protection of children from all forms of violence is a fundamental right guaranteed by the Convention on the Rights of the Child and other international human rights treaties and standards. Yet violence remains an all-too-real part of life for children around the globe – regardless of their economic and social circumstances, culture, religion or ethnicity – with both immediate and long-term consequences. Children who have been severely abused or neglected are often hampered in their development, experience

learning difficulties and perform poorly at school. They may have low self-esteem and suffer from depression, which can lead, at worst, to risk behavior and self-harm. Witnessing violence can cause similar distress. Children who grow up in a violent household or community tend to internalize that behavior as a way of resolving disputes, repeating the pattern of violence and abuse against their own spouses and children. Beyond the tragic effects on individuals and families, violence against children carries serious economic and social costs in both lost potential and reduced productivity.

While all children and adolescents may experience violence, being a girl presents some unique vulnerability. In fact, every 10 minutes, somewhere in the world, an adolescent girl dies as a result of violence.[1] Yet these deaths represent only the most extreme and irrevocable assaults in a long continuum of violence faced by adolescent girls that are often exacerbated by gender discrimination, norms and practices.

Over the last decade, recognition of the pervasive nature and impact of violence against children has grown. Still, the phenomenon remains largely undocumented and underreported. This can be attributed to a variety of reasons, including the fact that some forms of violence against children are socially accepted, tacitly condoned or not perceived as being abusive. Many victims are too young or too vulnerable to disclose their experience or to protect themselves. And all too often when victims do denounce an abuse, the legal system fails to respond and child protection

services are unavailable. The lack of adequate data on the issue is likely compounding the problem by fueling the misconception that violence remains a marginal phenomenon, affecting only certain categories of children and perpetrated solely by offenders with biological predispositions to violent behavior. One of the limitations inherent in any attempt to document violence against children is what it leaves out: the presumably large numbers of children unable or unwilling to report their experiences.

The process of understanding and addressing violence against children will continue to be fraught with difficulties. Nevertheless, as additional strategies to end violence are formulated and carried out, it is also clear that systematic investments in data generation are vital. The evidence that results is essential to monitoring commitments, informing the development of new programs, policies and laws and assessing their effectiveness. Future research should focus on not only documenting the prevalence of violence but also understanding the underlying factors that fuel it and evaluating interventions aimed at preventing and responding to it. Broad dissemination of data in accessible formats will continue to be needed to raise awareness and to foster the political will required to develop and implement effective strategies and action – at all levels of society.

Ending violence against children is in our hands. With reliable data, we will know when this human rights imperative is finally achieved.

“1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programs to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.”

– *Article 19 of the Convention on the Rights of the Child*

“All forms of violence against children, however light, are unacceptable. [...] Frequency, severity of harm and intent to harm are not prerequisites for the definitions of violence. States parties may refer to such factors in intervention strategies in order to allow proportional responses in the best interests of the child, but definitions must in no way erode the child’s absolute right to human dignity and physical and psychological integrity by describing some forms of violence as legally and/or socially acceptable.”

– United Nations Committee on the Rights of the Child, General Comment No. 13 on the Convention on the Rights of the Child

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The Invisible Trauma of War-affected Children /

Millions of children struggle with the physical and psychological traumas of war Robert T. Muller, PhD Robert T. Muller, PhD

Eighteen million children are being raised in the chaos of war. In the past ten years, as a result of armed conflict, over 2 million children have been killed, 6 million have been disabled, 20 million are homeless, and more than 1 million have become separated from their caregivers.

In 1996, Graça Machel, former wife of Nelson Mandela, released a UN report entitled “The Impact of War on Children,” bringing international attention to the subject among policy makers and academics. The 10 recommendations made in the report have become guiding principles to aid war-affected children. Advancements have been made by the international community to address issues of security, displacement, and human rights monitoring, but less support has come to the psychosocial and educational needs of war-affected children.

War vets speak of the images, sounds and smells that continue to haunt them. Many speak of nightmares, flashbacks and periods of crippling grief.

So too, children living in violent, terrorized environments experience such horrors as destruction of their homes, and the death of parents, siblings, neighbors and friends. Many live in circumstances where they make critical survival decisions to hide under deceased remains of others, to kill or be killed, and often live through situations where they believe they will die.

Recent years have seen celebrity and political activists join in the discussion. Following his own recovery from severe post-traumatic stress disorder (PTSD), Canadian Lieutenant-General

Roméo Dallaire, released two books “Shake Hands with the Devil” and “They Fight Like Soldiers, They Die Like Children,” detailing the horrors he witnessed in Rwanda and his mission to stop the use of child soldiers. Hollywood films have included Hotel Rwanda, Blood Diamond, and Machine Gun Preacher.

Despite media attention, response has been limited. Immediate measures for increased protection and security are necessary and being actively pursued, but the more regenerative responses like those of child-focused psychosocial and trauma rehabilitation are not being appropriately supported or implemented despite the demand and need for these interventions among affected communities.

Following the genocide in Rwanda, in psychological interviews, more than 60% of children claimed that they didn’t care if they ever grew up. While the global community struggles to value and prioritize global mental health care, millions of war-affected children around the world are left in the wake of traumatic experiences with little to no support.

Children between the ages of 12-18, having had more years exposed to violent conflict, struggle to recover from years of compounding traumas. Interviews within refugee camps reveal pervasive feelings of depression, anxiety, hopelessness, grief, resentment, anger, and fear among war-affected children.

Graça Machel reports, “The physical, sexual and emotional violence to which they [children] are exposed shatters their world. War undermines

the very foundations of children’s lives, destroying their homes, splintering their communities and breaking down their trust in adults.”

Without the support of the international community, most of these children will carry these heavy emotional burdens into adulthood.

Humanitarian aid generally focuses on the concrete, what we can see, measure, build: Food, medicine, bricks, and mortar. Psychological trauma is invisible.

To address the mental health needs of war-affected children as they relate to future peace building goals, international interventions are being established with a focus on the complex interplay between children’s psychological and social development. These “psychosocial” interventions support not just the emotional healing and development of compassion and empathy, but recognize the important dynamics between children and the social environment in which they form attachments, acquire a sense of belonging, and learn codes of pro-social behavior.

For more information on psycho-social and trauma rehabilitation check out Dr Muller’s new book – “Trauma & the Struggle to Open Up” at <https://www.amazon.com/Robert-T.-Muller/e/B0033A-F05A>

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Talking Points: Helping Youth Following Mass Violence

Rutgers University Behavioral Health Care

Mass violence is shocking and disturbing to youth on so many levels. One is that it disrupts the way that they see the world. When threat is minimal, youth see the world as a safe and meaningful place and they feel a sense of control over their environment. When threat is high, youth can feel out of control, unsafe and that the world has lost its meaning. They can begin to worry that dangerous things can befall them or those they love. When violence is perpetrated by adults, the very people youth look to for protection, the impact is powerful. Additionally, venues such as movie theatres and other public places of entertainment are where youth and their families go for fun and relaxation and where they feel safe and free from harm.

Parents and school personnel can be helpful in mitigating the emotional effects of community violence on youth. Below are some strategies for dealing with these tragedies and assisting youth in regaining their sense of safety and security.

Monitor the amount of TV watching.

These kinds of events attract mass media attention. Frightening, dramatic and sad images are often repetitively displayed in newsprint, on television or radio. Watching these kinds of scenes may fixate the images of violent death and increase feelings of vulnerability. It is important to monitor what youth are viewing and limit their exposure to upsetting media coverage.

Ask your children what they have heard or what other kids are saying.

Give youth accurate information and correct any

misinformation. Gear the information to their age and refrain from focusing on the graphic details of the incident. They may ask what homicide means. While it is not necessary to go into detail, you may want to say "It means that someone killed another person on purpose; it was not an accident."

Children often have many developmental issues regarding the integrity of the body. Hearing about the death of someone close to their age, especially a death that was violent can increase anxiety about their own body. Some children may ask specific questions like "What happens when you get shot?" You can answer the question in a more clinical way, avoiding the graphic details. For example: "When you get shot, it can injure the part of the body that got hit. Sometimes the injury can be so serious it can make the heart stop working and the person dies. Sometimes a person is not injured as badly and they can go to the hospital and be taken care of by the doctors and nurses and then go home to their families."

Find out what concerns your child has and take them seriously.

Youth often feel more vulnerable than adults because of their size and their limited physical and emotional resources. Therefore, some of their fears may seem trivial or unrealistic to adults but can occupy the youth's thoughts and dreams just the same. It is important to take their concerns seriously and offer reassurance. You can ask them "After hearing about these kinds of things, what do you think most kids worry about?"

Tackle the tough questions.

Children will ask questions like "why did this happen?" Imbedded in this question are several others: "How could someone get so out of control to do this kind of thing?" and "Could this happen to me or to people I love?"

Why did this happen?

Explain to youth "we may not know the exact reason why this violence occurred, but it is clear that the person that did these things was very troubled and was not able to think clearly about how to deal with their thoughts, feelings and problems. The result was that they were not able to control their impulses or urges to hurt others. They also did not tell anyone about their thoughts, feelings and problems in time for others to help them figure out good ways to fix them without hurting anyone.

This is a good time to teach the importance of help seeking. Explain to children "sometimes people have thoughts and feelings that make them feel hurt, angry, confused, or scared inside. It is important for everyone to have someone to talk to who can help them solve problems and feel better. Ask your child "who would you talk to if you were feeling hurt or scared or confused inside?" Have them name several adults inside and outside the family so their support system is enlarged.

Could this happen to me or to people that I care about?

To balance the enormity of violent acts, it is important to explain to youth that "these kinds

of events are very unusual. Most people do not want to hurt others. You can speculate with them about the number of movie theatres in the United States (or the world for that matter) and compare that number with the number of movie theatres in which this kind of violence has occurred. This is not to minimize the horrific impact of these events but to put them into a perspective that will help youth regain a feeling of safety.

It is important to bring the discussion back to the youth's own experiences and talk about the adults in their life who love them and are there to protect them. It is also helpful to talk about the ways in which the impacted community has come together to help each other cope during this terrible event. Focus on stories that include caring acts of kindness, compassion and resilience even in the face of the tragedy.

Keep the routine.

Routine provides youth with a sense of security. The routine of daily activities including school, after school activities and sports are important to mitigate the feeling that the 'world is out of control'.

Spend time together as a family.

Increase opportunities for play, fun and relaxation. Connecting with friends and family members helps children feel there is a safety net of people around them.

Allow some time for extra comforting.

Youth often need some additional time for soothing and comforting when they are dealing with

upsetting circumstances. Extra hugs, cuddling, and storytelling (even middle school youth enjoy having their parents read to them), are helpful. After these kinds of incidents, children and teens may have nightmares or fears. It might be helpful to allow the child to sleep in close proximity to the parents for a bit of time. Sleeping bags or cots could be used for a few nights.

If you find that your child is having difficulty staying in school because of anxiety, you may want to arrange with the counseling department to allow one phone call to you during lunch. Do all you can to help your child go to school and remain there.

Process your own feelings.

Youth will take their cues from the adults around them. It is important for the adults to take care of themselves and their feelings as well as their child's. If you are feeling upset, anxious or fearful it will be important for you to find a trusted adult to talk to. Avoid talking about your fears in front of your children.

Monitor your child's behavior and seek assistance if necessary.

While the signs and symptoms below can be normal in the early days and weeks following a violent incident, if they do not abate or they increase, additional help may be required. If you have concerns about your child, do not hesitate to contact your school's counseling department or your local community behavioral health center.

- Somatic complaints (stomachaches, headaches and muscle pain)
Changes in eating
- Changes in behavior (increase in irritability, aggression, anger, or becoming more fearful and clinging)
- Changes in school performance
- Withdrawal from friends and family
- Difficulty concentrating
- Nightmares
- Inability to stop thinking about the event
- Refusing to attend school or go into public places
- Worrying excessively about something bad happening to them or someone they love

Rutgers University Behavioral Health Care

<http://ubhc.rutgers.edu/tlc/guidelines/parents/HelpingYouthFollowingMassViolence.html>

Mental Health Responses for Young People Facing Natural or Man-made Disasters / Alan Cohen & Yotam Dagan

After the horrific school shooting that killed 17 in Marjorie Stoneman Douglas High School, Parkland Florida, last February, Carson Abt, a senior year student wrote: "As Albus Dumbledore, the wise headmaster of Harry Potter's Hogwarts, said, "Happiness can be found in the darkest of times, if one only remembers to turn on the light." My teachers are the light. Through a combination of training and determination, they calmed the fear of some and saved the lives of others. When schools across the country lower their flags and share our darkness, they should also share our light. Maybe heroism can't be taught, but preparedness certainly can be. Every teacher should have training for a school shooting like mine did". - My Teachers at Marjory Stoneman Douglas Saved Lives by Carson Abt, New York Times, Feb. 26, 2018

Carson's strong words, and her fellow students' activism, inspired America. She talked about her teachers' active shooter, "code red" alert and preparedness and of how they reacted.

This article stresses that preparing for a school shooting, a fatal accident or a natural disaster, in the sense of knowing what to do and how to act, is only part of the equation. Psychological preparedness is equally if not more important.

Psychological preparedness

The idea of preparing young people to cope psychologically with disaster has been around for some decades (Lahad et al 1993). A comprehensive review of how youngsters have been trained to help each other can be found in Coleman et

al's report (2017) "Peer support and children and young people's mental health". However, the idea that teachers and pupils should be given routine training to enable them to cope with emergency and disaster has still not permeated mainstream teacher training programs and school curricula.

On the one hand, physical training such as fire drills and in some regions earthquake drills are commonplace, on the other psychological training for the aftermath of a disaster is rare. Some places are more prone than others to physical disaster, many places in the world are at risk from threat of violence or currently suffering from ongoing warfare. It is a fact that every educational institution will have to handle the psychological effects of a disastrous event at some stage. It takes an incident such as a mass shooting in a school for the matter to be brought to public attention and often it disappears just as quickly. If ignored, many people will needlessly suffer.

What are the mental health repercussions as a result of disaster?

Notwithstanding the fact that most mental health issues regularly develop in childhood, an emergency or disaster can precipitate the onset of mental illness and stress related ailments. If there is awareness of this and a plan in place, some of the mental health problems resulting from disaster can be prevented. While a peer support system for mental health in general is vital, emphasis is placed here on particular traumatic situations which will exacerbate existing or potential problems and create many new ones. Most people will return to normal following

a disaster or emergency. A significant proportion (depending on the nature of the incident, 5 to 15%) will experience problems in the short term such as sleep problems, loss of appetite, social regression and trouble in concentrating on their studies.

If prevention activities are ready in place then mental and physical health issues can be monitored and stress reduction activities can be implemented and suffering can be alleviated.

Many such programs exist, and are practiced world-wide. We offer here a Youth Stress Intervention Programme consisting of the following categories:

- 1) Personal Identity (what matters to me, what are my values),
- 2) Local patriotism – emotional identification with the region/city,
- 3) Coping with stress, learning ways to handle such situations,
- 4) Rumours and how to handle them, including social media viral posts, preparing youth as helpers,
- 5) Promoting an optimistic versus pessimistic outlook,
- 6) The Meaning of Life - (Suicide prevention),
- 7) "The Morning After", How to deal with getting back to normal.

These programmes are designed for presentation to school counsellors and teachers in five to eight workshop sessions, during which the teachers themselves experience some of the

techniques, receive theoretical background and information on stress, coping and organisational best practices, and offer their own adaptations to the programme. At a teacher's request, a trained professional may help give the class the first few lessons in the course.

Personal Identity

As with most sections, exercises are arranged with attention to the specific characteristics of a class. Teachers are to assess their classes' ability to express themselves abstractly.

One of the programme's most important and basic steps is the establishment of personal identity and the clarification of personal opinions on essential issues. Those students who are initially reluctant to participate are not forced to do so, as often simply hearing their classmates express opinions enables them to clarify their own thoughts. Exercises in this section include drawing up one's own identity card, and designing a family emblem. A values clarification questionnaire is used as well as group and individual activities.

Identification with the city/region

People who identify strongly with their local area will feel less inclined to leave it even in adverse circumstances. Their attachment will help them overcome the fears created by the situation. There are always many positive aspects to region in which one lives, and great significance can be attached to life there. The exercises which include role play, questionnaires, letter writing and the use of structured stories try to

bring out the themes of quality of life in the region, community responsibility, friendship and altruism. Once the youths begin to understand the natural hazards they face or motives of those who wish to harm them, it is possible to help them form positive reasons for living (and hopefully continuing to live) where they do.

Coping with stress

Having an understanding of what stress is and how it affects the individual is vital for mental first aid. Knowing that reactions such as shaking and confusion are normal after a bomb or gun attack will lessen the worry of an individual suffering from this symptom, and enable him or her to return to normal more quickly. In this section theoretical information about stress, practical exercises and methods for gauging individual stress are explained. Sentence completion tasks, role play, problem solving, simulation exercises and structured stories are also used to illustrate certain aspects of coping with stress.

Rumours. Another vital part of stress management is efficient and accurate information flow. It is important to gain some insight into how and why rumours develop and spread and the results of incorrect information. Special emphasis should be placed on WhatsApp, Facebook and other social networks.

Preparing youth as helpers

People who have a function (and are able to carry it out) under stress cope better and have fewer deleterious effects following the stressful event than those without any task to complete. Youth can be mobilised for emergency prepared-

ness, using exercises promoting personal and team development. These can include the organisational and cognitive aspects of preparation through first aid training, firefighting volunteer work, as well as problem solving exercises, simulation games and practical planning of things to do in times of threat when nothing else can be done to alleviate the situation (such as escape).

Optimistic versus pessimistic outlook

The mood of people under stress is very important, both during the preparation for a particular threat and during the actual incident. A positive, optimistic mind set, has shown to facilitate well-being, in the face of adversity. In order to extend the students' repertoire, exercises are used to encourage them to see things from both positive and negative points of view, to understand that the same situation can be seen in many ways.

Meaning of life (Suicide Prevention)

This part concentrates on teaching the educators and then the youth peer counsellors active listening skills and persuasive skills with an emphasis on the early detection of suicidal behaviour and its prevention. Afterwards they are given vital information on relating to someone with suicidal thoughts. Later activities include discussions on the meaning of life and the will to live, expression of emotions, letter writing and problem solving.

The morning after

Here are presented a few guidelines to the teachers on conducting classes immediately following a disaster, emergency or crisis, while

emphasising the importance of adequate advance preparation for any of these events. Many educators have expressed inadequacy in having to face their class immediately following such an incident or they have totally ignored the situation and tried to «continue as normal». Knowing how to bridge the continuity following the disruption of a disaster or emergency will enhance mental health in any framework.

Prior implementation of disaster training with teachers and students in general can only benefit the community at large.

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Alan Cohen is a medical psychologist, EMDR consultant and member of the Community Stress Prevention Centre team.

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For more information: <http://www.eng.icspc.org/>

Major Mental Illness and Young People

Everyone knows how amazing and overwhelming it is to be a teenager or young adult and therefore also knows how incredibly stressful it can be to adapt to all the changes in your body, school and social life, responsibilities, etc. Imagine adding in a mental illness on top of all those changes?

Researchers have determined that at least half of all mental health disorders appear by the age of 14 and about 75% by age 24. Robert Wood Johnson Foundation states that 'serious mental illness incurs huge personal, social, and economic costs.....Early detection and intervention can help reduce the toll of serious mental illnesses'.

Often we see teenagers and young adults dealing with the effects of mental health issues and many of these are serious mental illnesses that need prompt attention. Some of the more serious illnesses that young people have to abruptly deal with are – Major Depression, Bipolar Disorder and Schizophrenia.

Teenager's Guide to Depression

/ Tips and Tools for Helping Yourself or a Friend / Helpguide.org

WHAT IS TEEN DEPRESSION?

Teen depression is much more than feeling temporarily sad or down in the dumps. It's a serious and debilitating mood disorder that can change the way you think, feel, and function in your daily life. When you're depressed, you may feel hopeless and helpless and it can seem like no one understands. But depression is far more common in teens than you may think. You are not alone and your depression is not a hopeless case. Even though it can feel like depression will never lift, there are plenty of things you can do to help yourself start to regain your balance and feel more positive, energetic, and hopeful again.

SIGNS AND SYMPTOMS OF TEEN DEPRESSION:

- Sadness or hopelessness
- Irritability, anger, or hostility
- Tearfulness or frequent crying
- Withdrawal from friends and family
- Loss of interest in activities
- Poor school performance
- Changes in eating and sleeping habits
- Restlessness and agitation
- Feelings of worthlessness and guilt
- Lack of enthusiasm and motivation
- Fatigue or lack of energy
- Difficulty concentrating
- Unexplained aches and pains
- Thoughts of death or suicide

Depression in Teens vs Adults

Depression in teens can look very different from depression in adults. The following symptoms are more common in teenagers than in their adult counterparts:

1. Irritable or angry mood. As noted, irritability, rather than sadness, is often the predominant mood in depressed teens. A depressed teenager may be grumpy, hostile, easily frustrated, or prone to angry outbursts.

2. Unexplained aches and pains. Depressed teens frequently complain about physical ailments such as headaches or stomachaches. If a thorough physical exam does not reveal a medical cause, these aches and pains may indicate depression.

3. Extreme sensitivity to criticism. Depressed teens are plagued by feelings of worthlessness, making them extremely vulnerable to criticism, rejection, and failure. This is a particular problem for “over-achievers.”

4. Withdrawing from some, but not all people. While adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression may socialize less than before, pull away from their parents, or start hanging out with a different crowd.

[Helpguide.org](https://helpguide.org)
<https://helpguide.org/articles/depression/teenagers-guide-to-depression.htm>

SIGNS AND SYMPTOMS OF BIPOLAR DISORDER

Bipolar “mood episodes” include unusual mood changes along with unusual sleep habits, activity levels, thoughts, or behavior. In a child, these mood and activity changes must be very different from their usual behavior and from the behavior of other children. A person with bipolar disorder may have manic episodes, depressive episodes, or “mixed” episodes. A mixed episode has both manic and depressive symptoms. These mood episodes cause symptoms that last a week or two or sometimes longer. During an episode, the symptoms last every day for most of the day.

Children and teens having a manic episode may

- Feel very happy or act silly in a way that’s unusual for them and for other people their age
- Have a very short temper
- Talk really fast about a lot of different things
- Have trouble sleeping but not feel tired
- Have trouble staying focused
- Talk and think about sex more often
- Do risky things

Children and teens having a depressive episode may

- Feel very sad
- Complain about pain a lot, such as stomachaches and headaches
- Sleep too little or too much

- Feel guilty and worthless
- Eat too little or too much
- Have little energy and no interest in fun activities
- Think about death or suicide

SIGNS AND SYMPTOMS OF SCHIZOPHRENIA

Symptoms of schizophrenia usually start between ages 16 and 30. In rare cases, children have schizophrenia too.

The symptoms of schizophrenia fall into three categories: positive, negative, and cognitive.

Positive symptoms

“Positive” symptoms are psychotic behaviors not generally seen in healthy people. People with positive symptoms may “lose touch” with some aspects of reality. Symptoms include:

- Hallucinations
- Delusions
- Thought disorders (unusual or dysfunctional ways of thinking)
- Movement disorders (agitated body movements)

Negative symptoms:

“Negative” symptoms are associated with disruptions to normal emotions and behaviors. Symptoms include:

- “Flat affect” (reduced expression of emotions via facial expression or voice tone)
- Reduced feelings of pleasure in everyday life
- Difficulty beginning and sustaining activities
- Reduced speaking

Cognitive symptoms

For some patients, the cognitive symptoms of schizophrenia are subtle, but for others, they are more severe and patients may notice changes in their memory or other aspects of thinking. Symptoms include:

- Poor “executive functioning” (the ability to understand information and use it to make decisions)
- Trouble focusing or paying attention
- Problems with “working memory” (the ability to use information immediately after learning it)

National Institute of Mental Health
<https://www.nimh.nih.gov/health/topics/index.shtml>

Early Intervention Services are Key to Improving the Lives of People Living With Mental Health Disorders / Prof. Patrick McGorry, AO

It is estimated that 50% of people with a mental health disorder currently lack early access to care, prolonging the lifetime and impact of their illness.^{1,6} Originally developed with the intention of early detection and treatment of psychotic disorders, Early Intervention (EI) is a well-established approach, that provides specialist intervention and support to a person who is experiencing any of the early symptoms of a mental health disorder.² EI is delivered through Early Intervention Services (EIS) that combine psychological, social, occupational, and educational interventions, as well as pharmacological treatments.⁴ EI teams are ideally multidisciplinary, and typically consist of a range of mental health professionals such as a psychiatrists, psychologists, psychiatric nurses, occupational therapists and social workers², along with other specialists such as vocational consultants, dieticians and exercise physiologists. The specific benefits of EIS are well-documented, both for the individual and broader society.

A pioneer of early intervention service development and research is Professor Patrick McGorry. He was the Foundation President of the IEPA, Early Intervention in Mental Health Inc. and remains treasurer of the international organisation. With its origins in early intervention in psychosis and previously known as the International Early Psychosis Association, IEPA, Early Intervention in Mental Health aims to enhance awareness of the early phases of mental health disorders more generally, as well as the causes, treatment, prevention and the process of recovery. It aims to provide an international network for those

involved in the study and treatment of the early phases of mental health disorders encompassing a trans-diagnostic approach. Ahead of the 11th International Conference on Early Intervention in Mental Health, to be held in Boston from 7th-10th of October 2018, Professor McGorry answered a few rapid fire questions:

What is early intervention in mental health?

Intervening when there are the first signs of a need for care – that is the first stage of illness according to our staging model. Providing integrated multidisciplinary evidence based care from the first treated episode until remission and recovery is achieved. Then maintaining the remission and recovery over the medium to long term.

How does poor mental health impact young adults?

It has a dose response relationship across a broad range of outcomes from mortality to the fulfilment of potential to economic, social and vocational outcomes.

Why are early interventions important?

They “bend the curve” to improve outcomes across a broad range and result in a dramatic return on investment. EI in mental health represents the very best buy in health care. Reducing delays for treatment and assuring evidence-based treatment during the critical period of the first 5 years post-diagnosis.

What is the value of early interventions (for society, for people with psychosis; for their families)?

There are huge benefits for individuals, families and society on the human, social and economic front.

- Higher recovery rate at 1/3 of the cost of standard public mental health services⁷
- Financial savings in direct health care of approximately €25,000 over a five-year period³
- Improved treatment success rate, including reduced hospital bed days² and decreased relapse rates^{8,9}
- Improvement in social functioning² of people living with psychosis
- Improvement in employment for people with psychosis⁹
- Superior to standard treatment across a wide range of clinically relevant outcomes, including hospitalisation risk, bed-days, symptoms, and global functioning¹²

What should policy-makers do to improve early interventions in young adults?

Invest in early interventions to save lives, save futures and save heaps of money!

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Prevention and Early Intervention in Mental Health

/ Mental Health America

“If only” is a phrase we hear too often in mental health. If only we knew what was going on. If only they knew they weren’t alone. If only we had recognized the signs. If only we had access to treatment. If only. Unfortunately, the conversation tends to be short and after tragedy has already struck – suicides, homelessness, unemployment, and incarceration.

Fortunately, we know how to act early. Studies around the country prove over and over again that we are able to prevent or mitigate the effects of mental illness and allow individuals to live fulfilling, productive lives in the community. From the influence of genetics and prenatal health all the way into early adulthood, we are learning more about the critical points in brain development and life experiences that increase the risk for or provide protection against the development of mental health disorders.

Studies show that half of those who will develop mental health disorders show symptoms by age 14.^[i] We know that the time between prenatal development and early adulthood is crucial for the brain. Despite this knowledge, we continue to fail our children by ignoring problems until they reach crisis levels. Instead of investing in prevention and early intervention programs and providing access to appropriate services, we have unconscionable rates of suicide, school drop-out, homelessness, and involvement in the juvenile justice system.^[ii] While we can work to provide mental health services and supports and to promote recovery for individuals in need, the overwhelming number of those strug-

gling is a reminder of how often we wait too long to take action.

The information below presents a timeline of important factors we know are harmful to mental health throughout the early lifespan, and highlights several programs and policies that address risk factors and increase protective factors in order to promote the prevention and early intervention of mental illness.

Harmful or Helpful?

Risks and protective factors are often used as a framework for addressing issues that impact prevention and early intervention of mental illness. Risk factors are harmful and impede recovery, while protective factors are helpful and support recovery. We have chosen to address harmful or helpful factors in four categories. While there is some overlap among the categories and no exact formula for how much a specific factor will affect an individual, these four categories provide a good framework for exploring the different ways we can support people in reaching their recovery goals. The categories are:

1. Health

Does my brain and body have the ability to do the things I need? Traumatic brain injuries, chronic illnesses, and mental health disorders are common examples of health issues that impact our body and brain’s ability to do the things we would like. Health related issues that influence mental health also include toxic exposure, nutrition, and sleep, among others. Harmful or helpful factors that fall into this category are directly related to

the physical body and brain’s ability to perform functions needed for people to live fulfilling lives.

2. Safety or Security?

Are there environmental or interpersonal factors that affect my ability to attend to or pay attention to the things I need? Trauma like abuse, neglect, experiencing sexual or physical violence, or exposure to violence interferes with our ability to pay attention to what we need. After traumatic experiences, many survivors respond with hypervigilance – a heightened state of fear and attention to one’s surroundings. In this way, many children who experience trauma become like child soldiers, paying close attention to any factor that might bring imminent harm. This change in attention makes it difficult for children when they try to focus on or respond to daily demands such as school or other everyday activities. Harmful or helpful factors in this category refer to external influences that impact how a person can lend *appropriate and required attention* to the things they need and want to do.

3. Resources

Do I have the tangibles or services available to meet my needs? This includes access to resources like adequate housing, nutritious food, finances, and education, as well as mental health services, like school based supports and mental health treatment. As Abraham Maslow understood in his Hierarchy of Needs, physiological needs like air, water, food, and shelter are the most basic requirements for an individual to function and thrive. When youth experience the early signs of mental illness (typically around

puberty), having access to needed mental health resources like therapy, peer services, supported education, case management, integrated school and community care, and sometimes medication is crucial to prevent mental illness from getting worse. Harmful or helpful factors in this category refer to goods or services that support an individual's physical and mental health and overall well-being.

4. Relationships

Do I have interpersonal supports that help me meet my needs? This includes healthy and appropriate relationships with others, including caregivers, family, friends, or classmates. This also includes the extent to which the individual feels like a valued member of his or her community. While relationships can be a resource and contribute to whether we feel safe or insecure, they are given a separate category because of the special role healthy or unhealthy relationships can have for individuals. The negative effects of isolation are an all too common experience for individuals with mental illness. Programs and policies that address isolation or family and peer support deserve extra attention. Harmful or helpful factors in this category refer to the support a person needs and receives from those around him or her that impact health and well-being.

In addition to the four categories of harmful (risk) or helpful (protective) factors, we divided early lifespan into three distinct periods where specific social, emotional, and biological changes occur: the prenatal period to early childhood, early childhood to puberty, and puberty to early

adulthood. These periods are critical times where we can take action to support children and young adults before they reach a crisis or when recovery becomes more difficult. For each stage, we provide research on important risk or protective factors and offer several policy and program options that have been shown to remove harmful factors or increase helpful factors. The hope is that support for these policy changes and implementation of prevention and intervention programs will reduce the number of families who will reflect on "if only" as well as decrease the over reliance on hindsight and reactionary practices that are used now to address mental illness.

Genetics and Brain Development

While many of the helpful and harmful factors discussed below address environmental factors, it is important to acknowledge the influence of genetics and brain development. Like many physical health problems, genes and brain development play a role in mental illness, and an individual has an increased likelihood for developing a specific disorder if others in his or her family have been diagnosed with that disorder.^[vii] However, having a genetic predisposition to mental illness does not necessarily mean an individual will develop a mental illness. It does imply that there is an increased risk, which, when combined with other harmful factors, increases the possibility that someone will suffer with mental health problems. To further complicate, sometimes random mutation in brain development occurs such that even people born into safe and supportive environments, with access

to needed resources, can continue to struggle with mental health problems.

Luckily, we know that genes and physical characteristics of the brain do not operate outside of influence from the environment. While we cannot yet change the genetic code someone is born with, by influencing the environment they live in we can have a positive influence on how a brain works and continues to grow (called neuroplasticity). This is not unlike how physical or occupational therapy supports a person following any physical injury.

There are critical periods during brain development where the brain goes through rapid growth and change. At birth, an infant will have almost all the neurons (nerve cells) it will ever have in its lifetime. However, within the first few years of life, the brain will develop twice the amount of synapses (structures that allows a neuron to transmit chemical and electrical signals to another neuron) as it will in adulthood.^[viii] This process, called blooming, makes infancy a sensitive time for learning and engaging with outside information. Synapses that are engaged and used repeatedly become stronger. Blooming is followed by pruning – the elimination of unnecessary connections between neurons and strengthening of important connections. The pruning process has been especially tied to important brain development and mental health issues in adolescent years.^{[ix],[x],[xi]} The timing of these changes (from infancy through puberty) provide additional evidence for why focusing on mental health problems among youth is critical,

and why waiting until someone reaches adulthood is harmful. If we truly want to address mental illness, we must *address all of the factors* we know play a role in its development and we must *address these factors early*.

PREVENTION AND EARLY INTERVENTION IN MENTAL HEALTH - PUBERTY TO EARLY ADULTHOOD

Puberty to Early Adulthood

Puberty to early adulthood is the final critical stage of blooming and pruning cells in the brain, similar to that seen in the early years of life. Rapid growth in the brain's gray matter before puberty is met by a strengthening of pathways that are used most often and a weakening of those that are not used often as the brain refines itself through pruning.[i] Research has started to explore the connection between brain changes such as an abnormal pruning of the brain (exacerbated by disruptions in sleep and increased stress) with the onset of various mental health problems including schizophrenia, substance use, mood disorders, anxiety disorders, and eating disorders.[ii][iii][iv][v][vi] The brain changes are combined with changes in friendships, social roles, self-esteem, hormones, and challenging expectations. Most students will be advancing to high school, which can be massively stressful, particularly for vulnerable students. This is also a time when many mental health disorders become more apparent or when teens start showing symptoms of mental health disorders. With so many transitions and new stressors, puberty to early adulthood is an especially vulnerable time for teens' mental health.

Health

- **Sleep:** The rapid changes in the brain and body that occur during puberty make it a crucial time for sleep. As a child hits puberty, the body's relationship with sleep begins to change. The circadian rhythm, or the combination of internal influences that determine the body's schedule of wakefulness and sleep, leads those in this age group to begin feeling tired about two hours later than they did in childhood.[vii] They also begin to require an increased amount of sleep each night. Current pressures on kids, teens, and young adults emphasize success in academics and sports or clubs, in addition to dealing with peer pressure and part-time jobs. For many, overscheduling, early school start times, and other concerns take priority over sleep at a time when sleep increasingly important. Disruptions in sleep can result in trouble concentrating, mood swings, hyperactivity, nervousness, and aggressive behavior.[viii] One study showed that adolescents who slept fewer than six hours a night were three times more likely to experience psychological distress than those who slept a healthy amount.[ix]
- **Substance Use:** Substance use during this time may also be associated with later mental health problems.[x] In particular, studies have found a potential causal relationship between the amount of marijuana used during this time and likelihood of later experiencing psychotic symptoms.[xi] Studies show the clearest link between

marijuana use and later symptoms of psychosis among heavy users with preexisting vulnerability. For example, one study showed daily users with a specific gene variant were seven times as likely to develop psychosis than infrequent or non-users with the same gene.[xii]

- **Physical Activity:** Regular physical activity in childhood and adolescence has been associated with improved mental health, while screen time has been associated with poorer mental health.[xiii]

Safety or Security

- **Intimate Partner Violence:** For many, puberty to early adulthood is when romantic relationships become more common and important. While these relationships can be a healthy part of growing up, this is also when people young people may begin experiencing intimate partner violence, including physical, emotional, psychological, and sexual abuse. 10 to 30% of teens report being physically abused by their romantic partner. Anywhere from 20 to 50% report being psychologically or emotionally abused. 10 to 13% report sexual coercion or assault by their partner.[xiv] Those that experience intimate partner violence are more likely to show symptoms of depression and anxiety, abuse substances, and report thoughts of suicide, in addition to being at an increased risk for victimization during college.[xv]

Resources

- **Supports:** For students who are struggling, it can be challenging to get help, especially with fears of talking about mental health or asking for help. Even when one asks for help, access to supports might be influenced by insurance coverage, cost of treatment, and availability of providers in the area. Schools are mandated to provide Individualized Education Programs (IEPs), which are designed to give children with mental health problems the supports and accommodations they need to be successful in school. However, funding for IEPs is limited so many children with mental health problems will not receive an IEP or receive inadequate support from their IEP. As a result, children that are considered to have an emotional disturbance qualifying them for an IEP have a high school graduation rate of 43.3%, the lowest of all disabilities.[xvi] In addition to difficulties in obtaining treatment and supports at schools, community providers and IEP teams are not often coordinated to ensure that they are working effectively together. Care needs to be integrated between school and community treatment and supports to best support children.

Relationships

- **Bullying:** The [2014–2015 School Crime Supplement - PDF](#) (National Center for Education Statistics and Bureau of Justice Statistics) indicates that, nationwide, about 21% of students ages 12-18 experienced bullying. The 2015 Youth Risk Behavior

Surveillance System (Centers for Disease Control and Prevention) also indicates that an estimated 16% of high school students were bullied electronically in the 12 months prior to the survey.[xvii] With Mental Health America's Bullying Survey, over 60% of respondents in seventh through twelfth grade reported being cyberbullied. When it comes to bullying in schools, a 2013 report by the Bureau of Justice Statistics stated that 28% of students age 12-18 reported being bullied in the past year.[xviii] A report by the Centers for Disease Control and Prevention in 2013 stated 7.2% of students report not going to school due to personal safety concerns.[xix] The same study highlighted the dramatically increased risk for bullying among students who self-identify, are identified by others, or are questioning their identification as LGBT. 12 to 28% of students in this group reported being threatened or injured with an object on school property within the past year.[xx] Those that experience bullying are at an increased risk for depression, anxiety, substance abuse, poor school performance, and suicidal behavior. Conversely, students, regardless of sexual orientation, who reported a positive school climate and were not experiencing homophobic teasing, had the lowest levels of depression, suicidal feelings, substance use, and unexcused absences.[xxi]

- **Isolation:** Puberty into early adulthood is a time when relationships with peers are especially important, as young people are form-

ing their identities and navigating their transition to adult roles. Adolescents who report high levels of social isolation also report more depressive symptoms, lower self-esteem, and are at a higher risk for suicide or suicide attempts than those who do not feel isolated.[xxii] This demonstrates that socially inclusive environments are important for ensuring adolescents get the support they need during this time.

Interventions

Prevention and early intervention at this stage take into account the unique challenges of high school and transition to adulthood. Many of the universal prevention programs focus on managing high-risk behaviors, like substance abuse, which can be linked to later mental health. Life Skills Training is an example of a middle school curriculum that reinforces self-esteem and resilience to social pressures. This program demonstrates decreased substance use in adolescents and the Washington State Institute of Public Policy calculated that it has a return on investment of \$13 for every \$1 spent.[xxiii]

Because puberty into adulthood is a time when symptoms of specific disorders become more apparent, three key steps are important in getting youth the care they need to stop the progression of worsening problems. First, providing universal mental health screenings is a necessary and critical first step for intervention. Screening for mental health problems should be as ubiquitous as vision or hearing screenings and provided during puberty. A positive screen should be

followed by a comprehensive mental health assessment. Secondly, universal education about early signs is important to bring in key community members who are mostly likely to catch problems when they occur. A commitment to funding outreach and education to individuals including teachers, mentors, churches, pediatricians and hospitals is necessary to identifying youth who are often tentative about sharing their mental health problems. Finally, once a youth has received a full psychosocial assessment, we must provide access to specialized services that have been proven effective. Examples of evidenced based specialty mental health care should include wraparound services like those included in Family-Aided Assertive Community Treatment or Coordinated Specialty Care for First Episode Psychosis.[xxiv] Currently, getting early care often comes down to a combination of resources, knowledge of the mental health system, location, and timing, since even with adequate resources and insurance coverage, getting help can still come down to whether or not good treatment is available in your area. For those that do not have access to specialty care during this critical time, focusing on reducing stress, increasing sleep, and proper nutrition has been shown to help build protective factors. For example, in one study, adolescents deemed ultra-high risk for developing psychotic disorders who took 1200 mg of fish oils were four times less likely to develop a psychotic disorder 2 years later.[xxv] For adolescents who might be showing early signs of mental illness, it is crucial for us to provide them treatment to keep them in school and engaged in the community, with supports that allow them to reach their personal recovery goals.

“ Those that experience bullying are at an increased risk for depression, anxiety, substance abuse, poor school performance, and suicidal behavior. Conversely, students, regardless of sexual orientation, who reported a positive school climate and were not experiencing homophobic teasing, had the lowest levels of depression, suicidal feelings, substance use, and unexcused absences. ”

Mental Health America
<http://www.mentalhealthamerica.net/issues/prevention-and-early-intervention-mental-health>

Suicide and Young People

It seems like every day you turn on the news, someone else has taken his/her life. Famous people, young, old, rich, poor, healthy and sick – suicide doesn't discriminate.

For young people, suicide is the 2nd leading cause of death – and completely preventable. The facts are clear, the research done – so why are so many people still choosing to end their lives prematurely? We have to bring mental health awareness into the spotlight, make it as normal as having the flu or a cavity. No one should feel alone or afraid to talk about how they feel and no one should get to the point that nothing matters. Education, advocacy and prevention measures would go a long way to helping people step back from the edge. We must, as a global society, learn all we can, beyond the illnesses and the situations and understand why people take the last step and what we can do to reverse that decision, before it's too late.

KEY FACTS

Close to 800.000 people die due to suicide every year.

For every suicide there are many more people who attempt suicide every year. A prior suicide attempt is the single most important risk factor for suicide in the general population.

Suicide is the second leading cause of death among 15-29-year-olds.

78% of global suicides occur in low - and middle-income countries.

Ingestion of pesticide, hanging and firearms are among the most common methods of suicide globally.

Every year close to 800 000 people take their own life and there are many more people who attempt suicide. Every suicide is a tragedy that affects families, communities and entire countries and has long-lasting effects on the people left behind. Suicide occurs throughout the lifespan and was the second leading cause of death among 15–29-year-olds globally in 2015. Suicide does not just occur in high-income countries, but is a global phenomenon in all regions of the world. In fact, over 78% of global suicides occurred in low- and middle-income countries in 2015.

Suicide is a serious public health problem; however, suicides are preventable with timely, evidence-based and often low-cost interventions. For national responses to be effective, a comprehensive multi-sectoral suicide prevention strategy is needed.

Who is at risk?

While the link between suicide and mental disorders (in particular, depression and alcohol use disorders) is well established in high-income countries, many suicides happen impulsively in moments of crisis with a breakdown in the ability to deal with life stresses, such as financial problems, relationship break-up or chronic pain and illness.

In addition, experiencing conflict, disaster, violence, abuse, or loss and a sense of isolation are strongly associated with suicidal behavior. Suicide rates are also high amongst vulnerable groups who experience discrimination, such as

refugees and migrants; indigenous peoples; lesbian, gay, bisexual, transgender, intersex (LGBTI) persons; and prisoners. By far the strongest risk factor for suicide is a previous suicide attempt.

Methods of suicide

It is estimated that around 30% of global suicides are due to pesticide self-poisoning, most of which occur in rural agricultural areas in low- and middle-income countries. Other common methods of suicide are hanging and firearms.

Knowledge of the most commonly used suicide methods is important to devise prevention strategies which have shown to be effective, such as restriction of access to means of suicide.

Prevention and control

Suicides are preventable. There are a number of measures that can be taken at population, sub-population and individual levels to prevent suicide and suicide attempts. These include:

- reducing access to the means of suicide (e.g. pesticides, firearms, certain medications);
- reporting by media in a responsible way;
- introducing alcohol policies to reduce the harmful use of alcohol;
- early identification, treatment and care of people with mental and substance use disorders, chronic pain and acute emotional distress;

- training of non-specialized health workers in the assessment and management of suicidal behavior;
- follow-up care for people who attempted suicide and provision of community support.

Suicide is a complex issue and therefore suicide prevention efforts require coordination and collaboration among multiple sectors of society, including the health sector and other sectors such as education, labour, agriculture, business, justice, law, defense, politics, and the media. These efforts must be comprehensive and integrated as no single approach alone can make an impact on an issue as complex as suicide.

CHALLENGES AND OBSTACLES

Stigma and taboo

Stigma, particularly surrounding mental disorders and suicide, means many people thinking of taking their own life or who have attempted suicide are not seeking help and are therefore not getting the help they need. The prevention of suicide has not been adequately addressed due to a lack of awareness of suicide as a major public health problem and the taboo in many societies to openly discuss it. To date, only a few countries have included suicide prevention among their health priorities and only 28 countries report having a national suicide prevention strategy.

Raising community awareness and breaking down the taboo is important for countries to make progress in preventing suicide.

Data quality

Globally, the availability and quality of data on suicide and suicide attempts is poor. Only 60 Member States have good-quality vital registration data that can be used directly to estimate suicide rates. This problem of poor-quality mortality data is not unique to suicide, but given the sensitivity of suicide – and the illegality of suicidal behavior in some countries – it is likely that under-reporting and misclassification are greater problems for suicide than for most other causes of death.

Improved surveillance and monitoring of suicide and suicide attempts is required for effective suicide prevention strategies. Cross-national differences in the patterns of suicide, and changes in the rates, characteristics and methods of suicide highlight the need for each country to improve the comprehensiveness, quality and timeliness of their suicide-related data. This includes vital registration of suicide, hospital-based registries of suicide attempts and nationally representative surveys collecting information about self-reported suicide attempts.

WHO response

WHO recognizes suicide as a public health priority. The first WHO World Suicide Report “Preventing suicide: a global imperative” published in 2014, aims to increase the awareness of the public health significance of suicide and suicide attempts and to make suicide prevention a high priority on the global public health agenda. It also aims to encourage and support countries to develop or strengthen comprehensive suicide

prevention strategies in a multi-sectoral public health approach.

Suicide is one of the priority conditions in the WHO Mental Health Gap Action Programme (mhGAP) launched in 2008, which provides evidence-based technical guidance to scale up service provision and care in countries for mental, neurological and substance use disorders. In the *WHO Mental Health Action Plan 2013–2020*, WHO Member States have committed themselves to working towards the global target of reducing the suicide rate in countries by 10% by 2020.

In addition, the suicide mortality rate is an indicator of target 3.4 of the Sustainable Development Goals: by 2030, to reduce by one third premature mortality from non-communicable diseases through prevention and treatment, and promote mental health and well-being.

World Health Organization

<http://www.who.int/en/news-room/fact-sheets/detail/suicide>
31 January 2018

Suicide Prevention Fact Sheet

The National Institute of Mental Health Information Resource Center

KEY FACTS

Suicide is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.

A **suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.

Suicidal ideation refers to thinking about, considering, or planning suicide.

SIGNS AND SYMPTOMS: The behaviors listed below may be signs that someone is thinking about suicide.

- Talking about wanting to die or wanting to kill themselves
- Talking about feeling empty, hopeless, or having no reason to live
- Making a plan or looking for a way to kill themselves, such as searching online, stockpiling pills, or buying a gun
- Talking about great guilt or shame
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable pain (emotional pain or physical pain)
- Talking about being a burden to others
- Using alcohol or drugs more often
- Acting anxious or agitated
- Withdrawing from family and friends
- Changing eating and/or sleeping habits
- Showing rage or talking about seeking revenge
- Taking great risks that could lead to death, such as driving extremely fast
- Talking or thinking about death often
- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
- Giving away important possessions
- Saying goodbye to friends and family
- Putting affairs in order, making a will

RISK FACTORS

Suicide does not discriminate. People of all genders, ages, and ethnicities can be at risk. Suicidal behavior is complex and there is no single cause. In fact, many different factors contribute to someone making a suicide attempt. But people most at risk tend to share certain characteristics. The main risk factors for suicide are:

- Depression, other mental disorders, or substance abuse disorder
- Certain medical conditions
- Chronic pain
- A prior suicide attempt
- Family history of a mental disorder or substance abuse
- Family history of suicide
- Family violence, including physical or sexual abuse
- Having guns or other firearms in the home
- Having recently been released from prison or jail
- Being exposed to others' suicidal behavior, such as that of family members, peers, or celebrities

Many people have some of these risk factors but do not attempt suicide. It is important to note that suicide is not a normal response to stress. Suicidal thoughts or actions are a sign of extreme distress, not a harmless bid for attention, and should not be ignored.

The National Institute of Mental Health Information Resource Center
<https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>

Self-harm and Suicide in Young People

/ Dr. Rohan Borschmann, Dr. Shilpa Aggarwal, Prof. George Patton

INTRODUCTION

Self-harm and suicide in young people (i.e., those aged <25 years^{1,2}) are major global public health problems. Whilst suicide results in the tragic loss of life of young people, self-harm often has profound effects on the young people engaging in this behavior, as well as their families, health services and the wider community^{3,4}. 'Self-harm' refers to any intentional behavior that causes damage, mutilation or destruction of the body without suicidal intent. This can include cutting, overdosing, burning, scalding, swallowing dangerous objects or substances, picking or scratching, biting, hair pulling, head-banging or bruising.

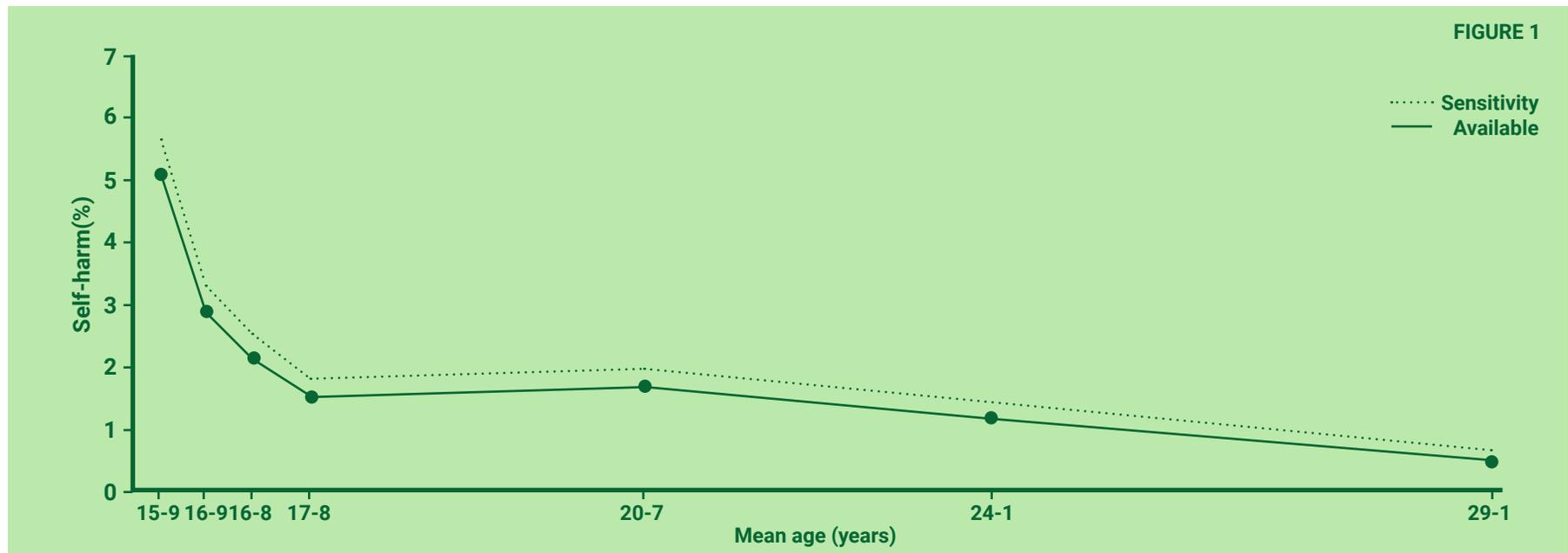
Many other terms are used interchangeably with the term 'self-harm'; these include 'self-mutilation', 'self-injury', 'deliberate self-harm', 'non-suicidal self-injury', 'non-fatal deliberate self-harm', 'self-poisoning', 'self-injurious behavior', 'self-inflicted violence', 'self-wounding', 'non-fatal suicidal behavior' and 'para-suicide'⁵⁻⁷. In this article, 'self-harm' refers to all behaviors captured by the above definition. A suicide attempt, conversely, is any act in which a person attempts to kill themselves, but survives. Suicidal ideation refers to thinking about suicide, and ideation can range from a passing thought to making a plan to conducting a 'dry run' of the plan.

HOW COMMON ARE SELF-HARM AND SUICIDE?

Self-harm

Self-harm is rare before puberty and becomes more common in early adolescence⁸, with the first episode of self-harm typically occurring between the ages of 12 and 16^{6,7}. Rates of self-harm fall in the later teenage years and continue dropping until at least the end of the twenties (see Figure 1)⁹.

Figure 1. The proportion of young people reporting recent self-harm from the age of 15 to 29 years (from Moran et al.⁹).



Community studies in high-income countries consistently report that approximately 10% of young people report having self-harmed at least once in their lives¹⁰. It is more commonly reported by females than males^{9, 10}, and cutting is the most commonly reported form of self-harm, followed by poisoning or overdosing^{11, 12}. Only a small proportion of young people who self-harm (about one in eight) present to health services for treatment¹⁰, meaning the majority of this behavior is omitted from official statistics. Despite this, in the United Kingdom self-harm is one of the five most common reasons for acute admission to hospital¹³. It accounts for 120,000 admissions annually, of which almost half are repeat episodes and 90% involve medication overdoses.

Self-harm in young people has been studied less in low- and middle- income countries (LMICs), but the available evidence suggests that it might be equally - if not more - common than it is in high-income countries. A recent systematic review of self-harm in young people in LMICs reported that approximately 15-31% of 12-to-25-year-olds reported self-harming¹⁴. Some self-harm may take place in a response to acute distress with little further risk to the young person. Often, however, it is an indicator of underlying mental health problems and an increased risk of suicide¹⁵. In the general population it has been reported that approximately 4% of adults¹⁶, 13-45% of adolescents¹⁷⁻¹⁹ and 14-35% of college students²⁰⁻²² have a recent history of self-harm. It is more common amongst vulnerable or marginalized subpopulations such as gay and bisexual

people^{6, 23} and in certain adolescent subcultures such as 'goths'^{24, 25}. It is particularly common among young people, a group in whom rates of repetitive and medically serious self-harm appear to be rising^{9, 11, 26-32}. Long-term studies have found that most young people who self-harm during adolescence no longer self-harm by the time they enter their young adult years⁹. However, this group often experiences ongoing difficulties in adulthood^{23, 33}, including higher rates of drug and alcohol use^{34, 35}, common mental disorder³⁴ and problems maintaining intimate relationships³⁶.

Suicide

Each year it is estimated that there are 800,000 suicide deaths worldwide, and in young people it is the second leading cause of death globally³⁷. For every death, there are many more who attempt to take their own lives. Unlike self-harm, dying by suicide is more common in males than females¹⁰. More than three quarters (78%) of all suicide deaths globally occur in low- and middle-income countries³⁷. Although male suicides outnumber female suicides in European countries and the United States by approximately four-to-one, the gender ratio in Asian countries is much lower at around two-to-one^{56, 57}. Swallowing pesticide, hanging and guns are among the most common methods of suicide globally.

Is there a link between self-harm and suicide?

Self-harm is strongly associated with subsequent suicide³⁸⁻⁴¹. The risk of suicide is highest in the first six months after an episode of self-harm and self-harm is also associated with an

increased risk of accidental death or permanent disability^{6, 13}. For every young person who dies by suicide, approximately 30 acts of self-harm occur⁴². Following an act of self-harm, the rate of suicide in young people increases to 50-100 times the rate of suicide observed in the general population^{26, 40, 58}. Approximately 1% of young people presenting to emergency departments following self-harm die by suicide within the following year. This figure rises to 4% within ten years, 9% within 22 years and 10% across the entire lifespan^{43, 44}. Approximately half of all people who die by suicide have a history of self-harm, with approximately 25% having self-harmed within the previous year⁴⁴. In light of this association between self-harm and suicide, by intervening effectively to reduce self-harm in young people, it is likely that the number of suicide deaths will also be reduced.

Why do young people self-harm?

Most young people who self-harm do so in response to intense emotional pain or a sense of being overwhelmed by negative feelings, thoughts or memories⁴⁵. For some, it may seem there is no other way of dealing with what they are experiencing, or expressing what they are feeling. It can sometimes be a means of escape from intolerable social situations, or eliciting a caring response from others¹⁴. Although it may seem to offer some temporary relief, self-harm does little to help overcome emotional problems. There are many other emotional functions of self-harm, including punishing oneself, expressing anger, relieving tension, distracting from an intolerable situation, asserting their autonomy or

establishing a boundary between self and other, and generating excitement^{6, 24, 46-56}.

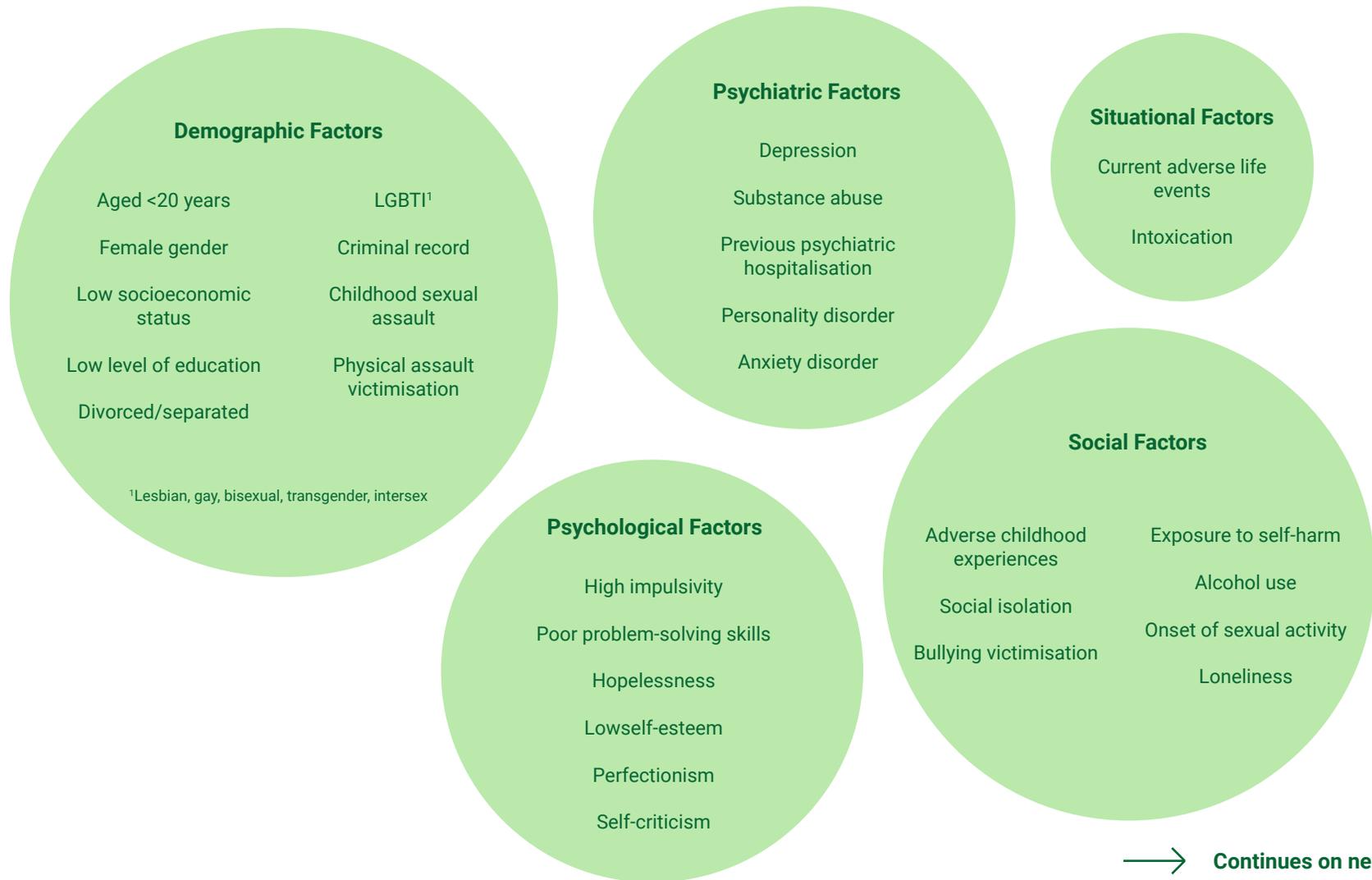
What should we target to prevent self-harm and suicide?

Self-harm and suicide in young people are the end products of an interaction between biological, psychiatric, psychological, social and cultural factors¹⁰. Table 1 lists the main factors associated with adolescent self-harm^{6, 11, 57-60} and suicide^{10, 61}. Although these factors do not necessarily *cause* self-harm or suicide, each has been independently associated with self-harm and/or suicidal behavior in several research studies. While the link between suicide and underlying mental disorders (in particular, depression and alcohol use disorders) is well established in high-income countries, many suicides happen impulsively in moments of crisis, such as financial problems, relationship breakdowns or chronic pain and illness³⁷. The risk of suicide is higher amongst groups of vulnerable young people who experience discrimination, such as refugees and migrants; Indigenous young people; lesbian, gay, bisexual, transgender, intersex (LGBTI) persons; and young people in contact with the youth justice system³⁷. Importantly, by far the strongest risk factor for suicide is a previous suicide attempt³⁷.

The link between mental disorders and suicide is less well established when it comes to LMICs⁵⁷. There are many family-, peer- and school-related factors that have been identified as having important associations with adolescent self-harm and suicide in LMICs. Family risk factors are

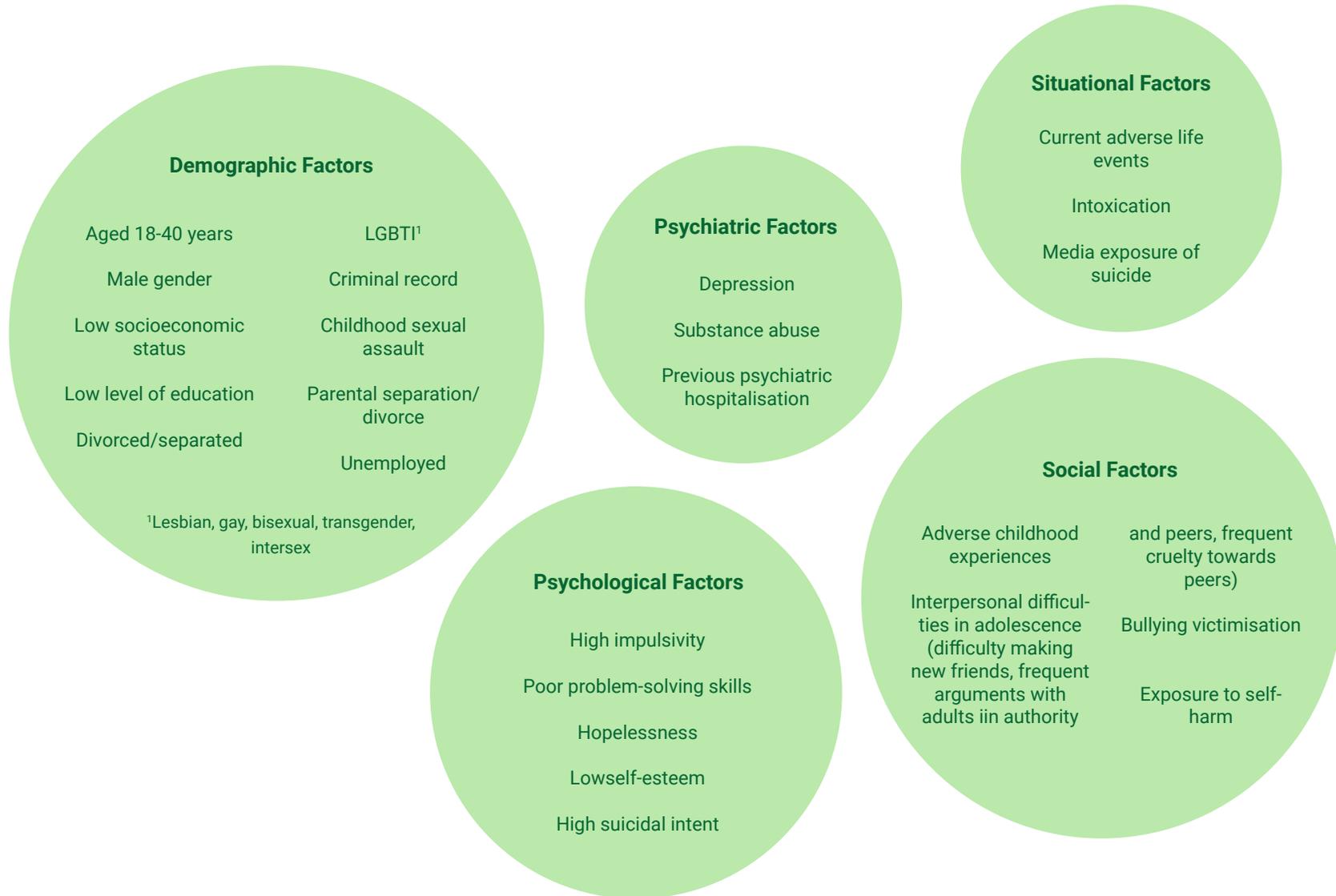
similar to those in high-income countries and include a history of childhood abuse or maltreatment, conflicting family relationships, and divorced parents introducing new partners into the family structure. Conversely, higher family functioning and having more understanding parents appears to be protective against suicide. This could be due to the dense family networks and greater reliance of young people on their families in LMICs¹⁴. Peer-related risk factors include self-harm by a young person's best friend, and a negative opinion of one's family members. In addition, below average school performance, truancy, school absenteeism and dropping out of school or college are associated with self-harm in LMICs¹⁴.

Factors associated with self-harm



→ Continues on next page

Factors associated with suicide



Treatments for self-harm and suicidal ideation in young people:

The research evidence demonstrating effective treatments for self-harm and suicide attempts is limited, with more evidence supporting a reduction in acts of self-harm than suicide attempts⁶². Only small advances have been made in prevention and there is a lack of evidence for effective treatment interventions. Outside of structured clinical treatment in community settings, most treatment of adolescent self-harm is likely to take place in a school counsellor's office. There is limited evidence for the effectiveness of some talking therapies (such as dialectical behavior therapy for adolescents [DBT-A] and mentalization-based treatment [MBT]), however these findings need to be replicated in other studies before they can be accepted as truly beneficial.

There is also limited evidence supporting the usefulness of engaging families in the management of adolescent self-harm, and they can be considered as partners in providing care and promoting engagement with treatment services⁵⁹. The overall evidence is not encouraging, however, with the authors of one large-scale study in 2018 concluding that clinicians are still unable to recommend a clear, evidence-based intervention to reduce repeated self-harm in adolescents⁶³. The development and assessment of new psychosocial and pharmacological interventions to reduce self-harm and suicide in young people should be considered a major priority, and should include internet-based interventions. The improvement of mental health care in adolescents in terms of both access to and quality of services is essential, especially in LMICs¹⁰.

How can I help someone who has self-harmed or might be at risk of suicide?

Most young people who self-harm do not seek help beforehand; concerns about confidentiality and stigma have been reported by adolescents as barriers to seeking help for self-harm or suicidal ideation¹⁰. Elements of providing support include letting the young person know that they are not alone and encouraging them to ask for professional help. Being as open as possible and ensuring safety in discussing feelings are important. Assessment should include asking a young person directly if she/he is considering suicide and, where relevant, calling the local hospital or mental health service. While this may be challenging, calling an ambulance or taking a young person to the nearest hospital emergency department may be appropriate if they need urgent medical attention⁴⁵. The available evidence tells us that a young person's risk of suicide remains elevated for at least a decade after an emergency department presentation with self-harm³³. Therefore, self-harm during adolescence should be considered by friends, family members and health professionals as more than just a passing phase⁶⁴.

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Gender Identity and Mental Wellbeing

Many young people explore their gender identity during their youth, sometimes resulting in major changes in their reality, their relationships and their stability. It is real, it is not a choice and we must consider the person underneath it all and create an environment of acceptance and support to allow that child to grow up healthy and resilient. Education, advocacy and basic human rights for the thousands of young people considering their identities right now are crucial to help them achieve their long term wellbeing.

Supporting the Mental Health of Sexual and Gender Minority (LGBTI) Adolescents / Elizabeth M. Saewyc, PhD, RN, FSAHM, FACHS, FAAN

Adolescence is a time of tremendous growth and change, physically, intellectually, and socially. It is during these years that young people most often develop their romantic and sexual attractions, as well as consolidating their gender identity. Most adolescents will identify as one of only two genders, boys or girls, and that gender will tend to align with the sex they were assigned at their birth based on observation (cisgender youth). However, a small proportion of young people will identify as the other of the two main genders, or as a different, non-binary option; this group is sometimes referred to as transgender youth. Another 1% to 2% of the population will have differences in their bodies that are not clearly aligned as male or female, boys or girls, also known as intersex people.

Similarly, most but not all adolescents will develop heterosexual romantic and sexual attractions (boys attracted solely to girls, girls solely attracted to boys). Between 2% and 10% of young people will develop same-gender attractions (gay, lesbian, or queer) or attractions to more than one gender (also called mostly heterosexual, bisexual or pansexual), or no attractions at all (asexual). Given the many different terms and labels for sexual and gender minority people in different languages, the United Nations, WHO and other UN agencies use the acronym LGBTI, which stands for lesbian, gay, bisexual, transgender, and intersex people.

As a small minority of the population, in most countries throughout the world LGBTI people are marginalized, and face stigma and discrimination, family rejection, and even violence. In more than 70 nations it is still illegal to identify as LGBTI, and

in some of those countries, LGBTI people can face arrest, prison, or the death penalty. Even in places where they are fully protected by human rights laws, such as in Canada, LGBTI young people may face social disapproval and stigma, and they may be harassed or bullied in school.

This stigma and discrimination contributes to stress and mental health challenges for LGBTI adolescents. In nearly every country where their health has been studied, including countries in North and South America, Europe, and Asia, LGBTI youth face higher rates of anxiety, depression, and emotional distress. They report 2 to 8 times the risk of self-harm, suicidal thoughts, and suicide attempts than their heterosexual and cisgender peers in the same communities.

This higher risk is not universal. There are a number of ways that communities, schools and families can support LGBTI young people and promote positive mental health. The first and perhaps most wide-reaching are to ensure the laws and policies in regions and local communities protect the human rights of all people, including LGBTI youth. As the UN noted in the Joint Statement on *Ending Violence and Discrimination Against Lesbian, Gay, Bisexual, Transgender and Intersex People* issued in September 2015, they remain “seriously concerned that around the world, millions of LGBTI individuals, those perceived as LGBTI and their families face widespread human rights violations. This is cause for alarm – and action.” Advocating for the enforcement of international human rights laws in your local community is one way to create a safer environment to promote mental health for

LGBTI youth. Research has shown in communities that have both human rights law and more supportive attitudes towards LGBTI people, suicide attempts are lower than in communities without such supports.

Schools can be another important place for supporting the mental well-being of LGBTI adolescents. Safe School and anti-bullying policies that specifically identify sexual orientation and gender identity and expression among other characteristics, such as ethnic or racial background or physical disabilities, are more effective in creating safe and welcoming schools, and are linked to lower odds of suicidal thoughts and attempts among LGBTI youth. Social clubs or supportive groups, called gay/straight alliances or gender & sexuality alliances (GSAs) during or after school can be another strategy to support LGBTI young people, even if they do not actually participate in the group itself. Having a GSA in a school has been shown to alter the school climate, reducing discrimination and mental health challenges. School policies and GSAs do not only benefit LGBTI youth; anti-LGBTI bullying and discrimination can be targeted to others who are perceived or suspected to be LGBTI, even if they are not, with similar results in mental health challenges. In research in Canada, we found that in schools that had Safe Schools policies and/or GSAs, the odds of suicide attempts among heterosexual boys were half the odds in schools without such inclusive policies.

Schools that are supportive of LGBTI teachers and other staff and include accurate and positive information about LGBTI people in their school

curriculum, also provide important supports for LGBTI youth mental health. Young people need role models to guide and inspire them. The knowledge that some of the famous people they are learning about in school are LGBTI like them can create a sense of pride and hope. And LGBTI teachers and staff who are visible in the school convey the message that the school welcomes students like them. Ensuring all teachers and staff have professional development opportunities to learn how to be inclusive of LGBTI students also helps create a safe and supportive school environment.

Finally, families are a key support for LGBTI young people, just as they are for all other adolescents. Young people generally need the love and support of parents or other family members to grow and thrive. Even when society is hostile, or school is not safe, LGBTI youth who have families who love and accept them report much better mental health. It can be difficult for parents and family members to go against the cultural or spiritual beliefs and attitudes they have been raised with or are widespread in their community, but it can make all the difference to LGBTI adolescents to have parents and other family members who accept them, understand them, protect them, and speak up for them in their community.

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Answers to Your Questions About Transgender People, Gender Identity and Gender Expression

What does transgender mean?

Transgender is an umbrella term for persons whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth. Gender identity refers to a person's internal sense of being male, female or something else; gender expression refers to the way a person communicates gender identity to others through behavior, clothing, hairstyles, and voice or body characteristics. "Trans" is sometimes used as shorthand for "transgender." While transgender is generally a good term to use, not everyone whose appearance or behavior is gender-nonconforming will identify as a transgender person. The ways that transgender people are talked about in popular culture, academia and science are constantly changing, particularly as individuals' awareness, knowledge and openness about transgender people and their experiences grow.

What is the difference between sex and gender?

Sex is assigned at birth, refers to one's biological status as either male or female, and is associated primarily with physical attributes such as chromosomes, hormone prevalence, and external and internal anatomy. Gender refers to the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for boys and men or girls and women. These influence the ways that people act, interact, and feel about themselves. While aspects of biological sex are similar across different cultures, aspects of gender may differ.

Various conditions that lead to atypical develop-

ment of physical sex characteristics are collectively referred to as intersex conditions. For information about people with intersex conditions (also known as disorders of sex development), see APA's brochure *Answers to Your Questions About Individuals With Intersex Conditions*.

Have transgender people always existed?

Transgender persons have been documented in many indigenous, Western, and Eastern cultures and societies from antiquity until the present day. However, the meaning of gender nonconformity may vary from culture to culture.

What are some categories or types of transgender people?

Many identities fall under the transgender umbrella. The term *transsexual* refers to people whose gender identity is different from their assigned sex. Often, transsexual people alter or wish to alter their bodies through hormones, surgery, and other means to make their bodies as congruent as possible with their gender identities. This process of transition through medical intervention is often referred to as sex or gender reassignment, but more recently is also referred to as gender affirmation. People who were assigned female, but identify and live as male and alter or wish to alter their bodies through medical intervention to more closely resemble their gender identity are known as transsexual men or transmen (also known as female-to-male or FTM). Conversely, people who were assigned male, but identify and live as female and alter or wish to alter their bodies through medical intervention to more closely resemble their gender

identity are known as transsexual women or transwomen (also known as male-to-female or MTF). Some individuals, who transition from one gender to another, prefer to be referred to as a man or a woman, rather than as transgender.

People who *cross-dress* wear clothing that is traditionally or stereotypically worn by another gender in their culture. They vary in how completely they cross-dress, from one article of clothing to fully cross-dressing. Those who cross-dress are usually comfortable with their assigned sex and do not wish to change it. Cross-dressing is a form of gender expression and is not necessarily tied to erotic activity. Cross-dressing is not indicative of sexual orientation. (See *Answers to Your Questions: For a Better Understanding of Sexual Orientation and Homosexuality* for more information on sexual orientation.) The degree of societal acceptance for cross-dressing varies for males and females. In some cultures, one gender may be given more latitude than another for wearing clothing associated with a different gender.

The term *drag queens* generally refer to men who dress as women for the purpose of entertaining others at bars, clubs, or other events. The term *drag king* refers to women who dress as men for the purpose of entertaining others at bars, clubs, or other events.

Genderqueer is a term that some people use who identify their gender as falling outside the binary constructs of "male" and "female." They may define their gender as falling somewhere on a

continuum between male and female, or they may define it as wholly different from these terms. They may also request that pronouns be used to refer to them that are neither masculine nor feminine, such as “zie” instead of “he” or “she,” or “hir” instead of “his” or “her.” Some genderqueer people do not identify as transgender.

Other categories of transgender people include *androgynous*, *multigendered*, *gender nonconforming*, *third gender*, and *two-spirit people*. Exact definitions of these terms vary from person to person and may change over time, but often include a sense of blending or alternating genders. Some people who use these terms to describe themselves see traditional, binary concepts of gender as restrictive.

Why are some people transgender?

There is no single explanation for why some people are transgender. The diversity of transgender expression and experiences argues against any simple or unitary explanation. Many experts believe that biological factors such as genetic influences and prenatal hormone levels, early experiences, and experiences later in adolescence or adulthood may all contribute to the development of transgender identities.

How prevalent are transgender people?

It is difficult to accurately estimate the number of transgender people, mostly because there are no population studies that accurately and completely account for the range of gender identity and gender expression.

What is the relationship between gender identity and sexual orientation?

Gender identity and sexual orientation are not the same. Sexual orientation refers to an individual’s enduring physical, romantic, and/or emotional attraction to another person, whereas gender identity refers to one’s internal sense of being male, female, or something else. Transgender people may be straight, lesbian, gay, bisexual, or asexual, just as non-transgender people can be. Some recent research has shown that a change or a new exploration period in partner attraction may occur during the process of transition. However, transgender people usually remain as attached to loved ones after transition as they were before transition. Transgender people usually label their sexual orientation using their gender as a reference. For example, a transgender woman, or a person who is assigned male at birth and transitions to female, who is attracted to other women would be identified as a lesbian or gay woman. Likewise, a transgender man, or a person who is assigned female at birth and transitions to male, who is attracted to other men would be identified as a gay man.

How does someone know that they are transgender?

Transgender people experience their transgender identity in a variety of ways and may become aware of their transgender identity at any age. Some can trace their transgender identities and feelings back to their earliest memories. They may have vague feelings of “not fitting in” with people of their assigned sex or specific wishes to be something other than their assigned sex. Others become aware of their transgender

identities or begin to explore and experience gender-nonconforming attitudes and behaviors during adolescence or much later in life. Some embrace their transgender feelings, while others struggle with feelings of shame or confusion. Those who transition later in life may have struggled to fit in adequately as their assigned sex only to later face dissatisfaction with their lives. Some transgender people, transsexuals in particular, experience intense dissatisfaction with their sex assigned at birth, physical sex characteristics, or the gender role associated with that sex. These individuals often seek gender-affirming treatments.

What should parents do if their child appears to be transgender or gender nonconforming?

Parents may be concerned about a child who appears to be gender-nonconforming for a variety of reasons. Some children express a great deal of distress about their assigned sex at birth or the gender roles they are expected to follow. Some children experience difficult social interactions with peers and adults because of their gender expression. Parents may become concerned when what they believed to be a “phase” does not pass. Parents of gender-nonconforming children may need to work with schools and other institutions to address their children’s particular needs and ensure their children’s safety. It is helpful to consult with mental health and medical professionals familiar with gender issues in children to decide how to best address these concerns. It is not helpful to force the child to act in a more gender-conforming way. Peer support from other parents of gender-nonconforming children may also be helpful.

How do transsexuals make a gender transition?

Transitioning from one gender to another is a complex process and may involve transition to a gender that is neither traditionally male nor female. People who transition often start by expressing their preferred gender in situations where they feel safe. They typically work up to living full time as members of their preferred gender by making many changes a little at a time. While there is no “right” way to transition genders, there are some common social changes transgender people experience that may involve one or more of the following: adopting the appearance of the desired sex through changes in clothing and grooming, adopting a new name, changing sex designation on identity documents (if possible), using hormone therapy treatment, and/or undergoing medical procedures that modify their body to conform with their gender identity.

Every transgender person’s process or transition differs. Because of this, many factors may determine how the individual wishes to live and express their gender identity. Finding a qualified mental health professional that is experienced in providing affirmative care for transgender people is an important first step. A qualified professional can provide guidance and referrals to other helping professionals. Connecting with other transgender people through peer support groups and transgender community organizations is also helpful.

The World Professional Association for Transgender Health (WPATH), a professional organi-

zation devoted to the treatment of transgender people, publishes *The Standards of Care for Gender Identity Disorders*, which offers recommendations for the provision of gender affirmation procedures and services.

Is being transgender a mental disorder?

A psychological state is considered a mental disorder only if it causes significant distress or disability. Many transgender people do not experience their gender as distressing or disabling, which implies that identifying as transgender does not constitute a mental disorder. For these individuals, the significant problem is finding affordable resources, such as counseling, hormone therapy, medical procedures and the social support necessary to freely express their gender identity and minimize discrimination. Many other obstacles may lead to distress, including a lack of acceptance within society, direct or indirect experiences with discrimination, or assault. These experiences may lead many transgender people to suffer with anxiety, depression or related disorders at higher rates than non-transgender persons.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), people who experience intense, persistent gender incongruence can be given the diagnosis of “gender dysphoria.” Some contend that the diagnosis inappropriately pathologizes gender noncongruence and should be eliminated. Others argue that it is essential to retain the diagnosis to ensure access to care. The International Classification of Diseases (ICD) is under revision and there

may be changes to its current classification of intense persistent gender incongruence as “gender identity disorder.”

What kinds of discrimination do transgender people face?

Anti-discrimination laws in most U.S. cities and states do not protect transgender people from discrimination based on gender identity or gender expression. Consequently, transgender people in most cities and states face discrimination in nearly every aspect of their lives. The National Center for Transgender Equality and the National Gay and Lesbian Task Force released a report in 2011 entitled *Injustice at Every Turn*, which confirmed the pervasive and severe discrimination faced by transgender people. Out of a sample of nearly 6,500 transgender people, the report found that transgender people experience high levels of discrimination in employment, housing, health care, education, legal systems, and even in their families. The report can be found at <http://endtransdiscrimination.org>.

Transgender people may also have additional identities that may affect the types of discrimination they experience. Groups with such additional identities include transgender people of racial, ethnic, or religious minority backgrounds; transgender people of lower socioeconomic statuses; transgender people with disabilities; transgender youth; transgender elderly; and others. Experiencing discrimination may cause significant amounts of psychological stress, often leaving transgender individuals to wonder whether they were discriminated against because of

their gender identity or gender expression, another sociocultural identity, or some combination of all of these.

According to the study, while discrimination is pervasive for the majority of transgender people, the intersection of anti-transgender bias and persistent, structural racism is especially severe. People of color in general fare worse than White transgender people, with African American transgender individuals faring far worse than all other transgender populations examined.

Many transgender people are the targets of hate crimes. They are also the victims of subtle discrimination—which includes everything from glances or glares of disapproval or discomfort to invasive questions about their body parts.

How can I be supportive of transgender family members, friends, or significant others?

- Educate yourself about transgender issues by reading books, attending conferences, and consulting with transgender experts.
- Be aware of your attitudes concerning people with gender-nonconforming appearance or behavior.
- Know that transgender people have membership in various sociocultural identity groups (e.g., race, social class, religion, age, disability, etc.) and there is not one universal way to look or be transgender.

- Use names and pronouns that are appropriate to the person's gender presentation and identity; if in doubt, ask.
- Don't make assumptions about transgender people's sexual orientation, desire for hormonal or medical treatment, or other aspects of their identity or transition plans. If you have a reason to know (e.g., you are a physician conducting a necessary physical exam or you are a person who is interested in dating someone that you've learned is transgender), ask.
- Don't confuse gender nonconformity with being transgender. Not all people who appear androgynous or gender nonconforming identify as transgender or desire gender affirmation treatment.
- Keep the lines of communication open with the transgender person in your life.
- Get support in processing your own reactions. It can take some time to adjust to seeing someone you know well transitioning. Having someone close to you transition will be an adjustment and can be challenging, especially for partners, parents, and children.
- Seek support in dealing with your feelings. You are not alone. Mental health professionals and support groups for family, friends, and significant others of transgender people can be useful resources.

- Advocate for transgender rights, including social and economic justice and appropriate psychological care. Familiarize yourself with the local and state or provincial laws that protect transgender people from discrimination.

Where can I find more information about transgender health, advocacy and human rights?

Please check the website of the American Psychology Association to find more information, resources and organizations. www.apa.org

<http://www.apa.org/topics/lgbt/transgender.pdf>

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The teen years are an important period for mental health. Many mental health disorders appear for the first time during those years. Unfortunately, the suicide rate is high among all people between the ages of 10 to 24. Lesbian, gay, bisexual, transgender, and queer (LGBTQ) teens and young adults are at an even greater risk for poor mental health.

Mental health issues can include depression and mood disorders, anxiety, and post-traumatic stress. There is also a risk of alcohol use and abuse and risky behaviors (such as unprotected sex). Much of this is due to the stigma associated with being LGBTQ. LGBTQ teens and young adults fear not being accepted by family, friends, teachers, co-workers, their religious community, and the community overall. There also is a fear of being bullied or not being able to achieve certain things because of bias. This is called “minority stress.”

Path to improved wellness

The majority of LGBTQ teens and young adults are happy, confident individuals. They thrive in every area of their life. Often, this is thanks to a safe, loving, and supportive home and school environment. If you are the parent or educator of a LGBTQ teen, there are two areas you can improve your LGBTQ teen’s social, emotional, and physical wellness:

- Most LGBTQ teens are fearful of telling their parents they are homosexual, bisexual, or transgender. Children fear losing their par-

ents’ love, support, and even being kicked out of the house. As a parent, the best thing you can do for your child is offer unconditional love and support. To help your teen, offer your support by:

- Talking calmly and honestly about your child’s feelings.
- Encouraging your child to talk with you at any time.
- Inviting your child to talk with a counselor or therapist.
- Resisting passing judgment based on your own choices.
- Holding your child to the same values as you would your heterosexual children.
- Staying involved in your teen and young adult’s life.
- Being resourceful. Help your child find the medical, educational, and emotional resources they need to thrive.

- If your child decides to tell friends and classmates that he or she is LGBTQ, make sure they are in a safe school environment. Talk to your child about his or her view of the school culture, see if they celebrate diversity, and look into their policies related to bullying and violence. Additionally, watch how your child’s school:

- Identifies “safe spaces,” such as counselors’ offices or classrooms, where
- LGBTQ youth can go for support from administrators, teachers, or other

school personnel.

- Encourages school clubs that promote a safe, welcoming, and accepting environment (e.g., gay-straight alliances or gender and sexuality alliances. These are school clubs open to youth of all sexual orientations and genders).
- Ensures health education about HIV and sexually transmitted diseases (STDs) that is relevant to LGBTQ youth.
- Trains and requires school staff on how to create safe and supportive school environment for all students, regardless of sexual orientation or gender identity.
- Facilitates access to community-based providers who have experience providing health services, including HIV/STD testing and counseling, social, and psychological services to LGBTQ youth.

The American Academy of Family Physicians (AAFP) believes mental health professionals are valuable for people struggling with emotional wellness. Many people continue to see their primary care physician for help. Promoting emotional wellness is an important part of family medicine. Early detection of mental health problems is more likely to happen through regular visits with your family doctor. Family physicians treat the whole family. They are often better able to recognize problems and provide interventions in the family system. Family physicians are also able to treat people who would not have access

to traditional mental health services. Many times this is because of the social stigma associated with mental illness.

Things to consider

If you are concerned about your LGBTQ teen or young adult's emotional wellness, here are things you can monitor to assess their mental health:

- Sudden changes in your child's personality, such as withdrawing from friends and social activities they have enjoyed in the past.
- Unexplained drops in grades or school absences.
- Unplanned weight loss. This could be the result of an eating disorder.
- Signs of substance abuse (alcohol and drugs).
- Signs of self-injury, such as cutting (sometimes a person will wear long sleeves and pants during warm weather to hide the marks).
- Signs of bullying, both physically and emotionally (bruises, cuts, fear, avoidance).
- Headaches and stomach aches. These are common symptoms related to stress.
- Giving away personal treasures (which could be a sign your child is considering suicide).

Questions to ask your doctor

- If I suspect my son or daughter is LGBTQ, should I discuss it with him or her?
- Can my child's depression or anxiety be treated with medicine alone?
- What should I do if I support my son or daughter but my spouse does not?
- What are the signs that a teen is considering suicide?

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The Way Forward

- Prevention, Resilience and Support

We all know that a young person with support, stability and the information will usually lead to a positive, healthy adult. So, how do we make sure our young people have all the skills and support they need to achieve that? Early interventions, prevention, resilience support and programs to educate young people and the world around them. Following are just a few examples of ways we can help create an environment that leads to resilience and happiness.



International Suicide Hotlines

Argentina: +5402234930430

Australia: 131114

Austria: 017133374

Belgium: 106

Bosnia & Herzegovina: 080 05 03 05

Botswana: 3911270

Brazil: 212339191

Canada: 5147234000 (Montreal);
18662773553 (outside Montreal)

Croatia: 014833888

Denmark: +4570201201

Egypt: 7621602

Estonia: 3726558088;
in Russian 3726555688

Finland: 010 195 202

France: 0145394000

Germany: 08001810771

Holland: 09000767

Hong Kong: +852 2382 0000

Hungary: 116123

India: 8888817666

Ireland: +4408457909090

Italy: 800860022

Japan: +810352869090

Mexico: 5255102550

New Zealand: 045861048

Norway: +4781533300

Philippines: 028969191

Poland: 5270000

Portugal: 21 854 07 40/8 .
96 898 21 50

Russia: 0078202577577

Spain: 914590050

South Africa: 0514445691

Sweden: 46317112400

Switzerland: 143

United Kingdom: 08457909090

USA: 18002738255

Veterans' Crisis Line: 1 800 273
8255/ text 838255

Imagine a World Without Stigma / Amy Molloy, MSW

The word *stigma* is derived from the Latin term *stigmata*, meaning a mark of shame. Throughout history, stigmas were imposed on individuals who exhibited unfavorable characteristics or engaged in behaviors that were not typical. When stigma associated with a specific condition becomes rooted in societal norms it manifests in attitudes and behaviors that are difficult to change. For centuries, society did not possess the skills or knowledge to identify and treat mental health problems. Thus the gap in understanding was filled with misinformation and fear.

Like most disorders, mental health disorders can be prevented and treated. Unfortunately, people experiencing a mental health problem often feel embarrassed and fearful due to persistent stigma. In the case of youth, they may dismiss signs and symptoms as typical adolescent development and may delay getting help or not reach out for help at all. In fact, the median age of onset between the time when symptoms first appear and when a person gets appropriate professional help is 10 years. In the case of a young person, the age of onset for anxiety disorder is as young as eight years old. Imagine if you would, that a child begins to exhibit symptoms in third grade but doesn't get help until they around the time they graduate high school. Now think about the growth that typically occurs between those years – the development of social skills, learning and career exploration, and psychological maturation. When mental illness goes undiagnosed or treatment is delayed, the results are lower academic achievement, higher rates of absenteeism and discipline problems, lower graduation

rates and less engagement in higher education, employment or other gainful activities. Most alarming, unrecognized or untreated mental health problems can lead to suicidal thoughts or behaviors and non-suicidal self-injury.

New York State's Mental Health Education in Schools Law

This past July, a law took effect in New York State requiring schools to teach about mental health as part of the health curricula. The Mental Health Association in New York State, Inc. (MHA-NYS) led the advocacy efforts, making New York the first state in the US to legislate mental health education for all students from kindergarten to twelfth grade. NYS Education Law § 804 reads, in part, "All schools shall ensure that their health education programs recognize the multiple dimensions of health by including mental health and the relationship of physical health and mental health so as to enhance student understanding, attitudes and behaviors that promote health, well-being and human dignity."

Consistent with research in mental health literacy, MHANYS believes that a systematic approach to promoting youth understanding of prevention and recognition, as well the development of coping strategies and help-seeking behaviors can reduce stigma now and for future generations. The Mental Health Association in New York State, Inc. recommends a public health approach to mental health education – one that provide the entire school community with the knowledge and life-long skills to promote mental health and wellness for students, families, edu-

cators and other school personnel. Furthermore, mental health instruction should include:

- 1) The concept of wellness including self-care and personal responsibility for one's own mental health and wellness.
- 2) The concept of mental health as an integral part of health.
- 3) The recognition of signs and symptoms of developing mental health problems.
- 4) Instruction in the awareness and management of mental health crises, such as the risk of suicide, self-harm and other mental health crises.
- 5) The relationship between mental health, substance use and other negative coping behaviors
- 6) The negative impact of stigma and cultural attitudes toward mental illness on treatment seeking behavior and as a contributing factor in discrimination against people with mental illnesses.
- 7) The concept of recovery from mental illness.
- 8) The implications of risk factors, protective factors and resiliency on wellness, mental health and recovery.
- 9) Instruction in identifying appropriate professionals, services and family/social supports for treating and maintaining recovery from mental illness.

A Comprehensive Approach to Implementation

The law only applies to instruction in health education (a K-12 requirement in NYS) but many schools are using this opportunity to develop a plan to support and promote the mental health

and wellness of the entire school community. The focus is not on instruction but rather on creating a climate of well-being and social connectedness in which the mental health of everyone is valued and supported, including students, families and staff.

At the Elementary level, school-wide social emotional learning (SEL) initiatives are quickly becoming a preferred approach to affecting school climate and building the foundation for mental health instruction. Applying the core components of SEL programs to concepts related to mental health, schools are taking a skills-based approach to mental health instructions, using:

- 1) self-awareness skills to support the identification and express of feelings,
- 2) self-management strategies to promote the development of positive coping skills,
- 3) social awareness to build empathy and social connections,
- 4) relationship skills to encourage social connectedness and supportive relationships, and
- 5) responsible decision-making to promote healthy lifestyle choices.

The general consensus is that teaching about mental health as part of the health education curriculum is simply not enough, and that learning is best accomplished when we support the whole child, not just their academic development. In New York State, students typically receive one half year of health education in either 7th or 8th grade, and one half year in high school. Consider this: a student learns about mental

health in the Fall of seventh grade and then not again until the Spring of eleventh grade. Given what we know about untreated mental health problems, the years in between are critical for recognition and prevention of mental health problems. What value do we apply to mental health if we are limiting our discussions to a few classes in middle school and a few classes in high school?

We talk openly and often about the importance of sleep, hand-washing, good nutrition and exercise because all of these things support physical health. Why wouldn't we do the same for mental health? MHANYS is encouraging schools to develop strategies for promoting mental health and wellness everyday by integrating the conversation into other subjects, such as English Language Arts, History and Biology. In addition, school-wide initiatives can also provide opportunities to continue the conversation of mental health outside of the health classroom. For example, schools can select a week or a month to promote mental health through activities that raise awareness and encourage prevention strategies. Alternatively, schools might opt for a more regular approach by instituting "Wellness Wednesdays" to promote wellness tips on morning announcements. Such tips do not have to be limited mental health but can include everything from wearing sunscreen and staying hydrated to practice deep breathing or mindfulness strategies.

Finally, remember that a public health approach is best – so consider ways to educate families, communities and school staff about mental

health and wellness. Professional development for school staff is undoubtedly an important part of implementing mental health instruction. As much as young people value their independence and the support of their peer network, they remain connected all day to adults – teachers, administrators and coaches during the school day, supervisors and co-workers at their jobs, and parents and caregivers at home.

The Mental Health Association in New York State has received funding from the NYS Legislature and Executive to establish the School Mental Health Resource and Training Center; visit us at www.mentalhealthEDnys.org to learn more. The Resource Center provides technical assistance to schools to support implementation of the school mental health law, including lesson plans, resources and professional development. In addition, information is available to promote mental health awareness for students, families and communities. It is imperative that we strive to enhance a better understanding of mental health for the entire community, not just schools. If we are to imagine a world without stigma, it will require a systematic, comprehensive approach that involves all of us regardless of age, race, occupation or the country we call home.

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Resilience in Young People / Dr Stanley Kutcher, Dr Yifeng Wei

Resilience at its core means the ability to successfully engage with the challenges and opportunities that life brings and through that engagement, develop the competencies necessary to take on future and more complex existential confrontations. The development of resilience is a life-long activity and involves the complex interplay of environment, genetics and epigenetic processes. In young people it is a necessary component of normal development, in particular the growth of independence. What has emerged from the now robust literature on resilience is that active engagement with both the challenges and opportunities that life presents is foundational for its development. Resilience does not mean that individuals do not suffer emotional and cognitive distress when faced with life circumstances, it means that they are both able to apply competencies they have learned to deal

with those circumstances and that they are able to develop new skills as a result of dealing with those circumstances – skills that they will apply in future situations. Having supportive personal relationships, good problem solving skills, the ability to manage emotions and knowing when, where and from whom to obtain needed help are some of the competencies that contribute to the building of resilience.

Mental Health and Resilience

It is perhaps not well appreciated that mental health is the foundation for resilience and that it is the same existential engagement drives their mutually dependent development. At its core, mental health is the ability to successfully address the challenges and opportunities of life. People do this by all those activities that we know are key to the development of resilience:

engaging with adversity; establishing and improving our human connections; helping others and applying life-style activities that are well established to help facilitate the enhancement of developmentally appropriate emotional, cognitive and behavioral capacities that promote this engagement.

Key to understanding this dialectic is the consideration that mental health is a capacity we all have, and that we build this capacity through active involvement in the challenges and opportunities that life brings. It is helpful to consider this within the following schematic (Figure 1).

Figure 1: the inter-relationship of mental health states



While mental health exists across all the different states illustrated above, how it is expressed may differ. With mental distress, mental health both provides the solution to and is developed from, dealing with the exigencies of life. Learning how to overcome the usual challenges of life and how to best take advantage of the opportunities that life may bring is fundamental to enhancing mental health and the development of the competencies needed to adapt and become resilient. Person's addressing these do not need medical or psychological treatment; they need the support, care and guidance of others. Avoidance of these challenges and opportunities can have the opposite effect.

With a mental health problem, the challenges and opportunities of life are of a much greater magnitude – such things as: the death of a loved one; losing a job; facing personal/family displacement; etc. These situations are also part of the existential challenges of life but are of much greater magnitude and require additional assistance and support. Globally, community institutions or religious organizations often provide this support with additional help from socially sanctioned healers such as counselors, traditional healers and others. Medical and psychological treatments are not usually required. With a mental illness, in addition to the supports described above, best available evidence based treatments applied by trained providers are often needed.

What is key is the understanding that mental health and mental illness are not exclusive and separate from each other. A person can have a

mental illness, be dealing with a mental health problem and be experiencing mental distress concurrently. Each of these components builds on and is built from resilience. Our task as global citizens and civil societies is to work together to create the social, economic and institutional structures that optimize everybody's outcomes and engage all people equally and without discrimination in the opportunities to build resilience and enhance mental health.

This must be done in a developmentally appropriate manner – and requires a whole of society approach. This is the meaning of the well-known proverb: “it takes a village to raise a child”. This also requires the development and application of mental health literacy, which is foundational for mental health promotion, prevention and care for those who need it.

School Based Mental Health Literacy

Mental Health Literacy (MHL) is an essential part of health literacy, (http://www.euro.who.int/__data/assets/pdf_file/0008/190655/e96854.pdf) and is comprised of four separate but related components. These are: 1) understanding how to obtain and maintain good mental health; 2) understanding mental disorders and their treatments; 3) decreasing stigma; 4) enhancing help-seeking efficacy (Kutcher et al., 2016a; Kutcher et al., 2016b). For young people, this should ideally be provided from and embedded into educational institutions, should demonstrate significant, substantial and sustained impact on all aspects of MHL, should be able to be frugally applied and demonstrate global appli-

cation. Such an approach is consistent with the Education for All initiative promoted by UNESCO (<https://en.unesco.org/gem-report/report/2015/education-all-2000-2015-achievements-and-challenges>) and when applied in the school setting can reach many more young people than any alternative delivery method.

A recently developed classroom ready school mental health literacy resource (the Guide), developmentally appropriate for youth ages 12 – 16, has been created, successfully delivered and found to demonstrate highly positive results for both young people and their teachers. The Guide is freely available at (<http://teenmentalhealth.org/schoolmhl/school-mental-health-literacy/mental-health-high-school-curriculum-guide/download-the-guide/>) and an online teacher preparation course to help educators learn how to apply the Guide in their classrooms can be readily accessed at (<http://pdce.educ.ubc.ca/mentalhealth/>). Research on the application of this frugal and freely available resource on improving MHL for both students and teachers has demonstrated its impact and utility in countries as diverse as Canada, Nicaragua, Malawi and Tanzania (Kutcher et al., 2015; Ravindran et al., 2018; Kutcher et al., 2017; Milin et al., 2016) and it is currently being studied or applied in upper income, middle income and lower income countries alike (for example: England; Wales; Portugal; Bangladesh; China; USA and others).

Numerous peer reviewed publications have demonstrated significant, substantial and sustained positive outcomes in MHL (Table 1 and 2) and evaluations of its impact are easily found.

(<http://teenmentalhealth.org/schoolmhl/research/evaluations/>). It has also been demonstrated to positively impact the MHL of pre-service teacher candidates, thus making it ideal for implementation into existing higher education for educators (Carr et al., 2017).

Now, this freely and easily available education resource (<http://www.mhinnovation.net/innovations/mental-health-literacy-students-and-educators-mental-health-high-school-curriculum-guide>) can be used globally as part of our common commitment to working collaboratively and using best available evidence based resources to help improve the lives and outcomes of young people everywhere.

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Table 1

Location	Research type	Numbers of teachers	Improved Knowledge		Reduced Stigma	
Nova Scotia	Pre- and posttest	228	Yes	p<.0001 d=1.85	Yes	p<.0001 d=.51
British Columbia	Pre- and posttest	91	Yes	p<.0001 d=1.03	Yes	p<.05 d=.35
Newfoundland	Pre- and posttest	124	Yes	p<.0001 d=2.65	Yes	p<.001 d=.39
Alberta	Pre- and posttest	325	Yes	p<.0001 d=2.03	Yes	p<.05 d=.21

Table 2

Province	Study type	Year	Participants	Increased Knowledge		Improved Attitudes		Improved helpseeking	
				Yes		Yes		Yes	
Ontario	RCT	2011-2012	362 Studens	Yes	p=0.0001, d=0.46	Yes	p=0.0001, d=0.30	Yes	p=0.01; d=0.18
	Cross-sectional study	2012	409 Studens	Yes	p<0.001, d=0.9; p<0.001*, d=0.73*	Yes	p<0.001, d=0.25; p<0.007*, d=0.18*	Yes	
	Program evaluation	2013	74 Educators	Yes	p<0.001, d=1.48	Yes	p<.0.03 d=1.26	Yes	
	Cross-sectional study	2013	175 Students	Yes	p<0.0001, d=1.11; p<0.001*, d=0.91*	Yes	p<0.001, d=0.66; p<0.001*, d=0.52*	Yes	

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The Impact of School Violence and Bullying

- The Response / UNESCO, School Violence and Bully Global Status Report

The education sector, working with other sectors and other stakeholders, has a responsibility to protect children and young people from violence and to provide safe and inclusive learning environments for all students. School is also a place where attitudes to violence can be changed and non-violent behavior can be learned; both the learning environment and the content of education can instill an understanding of human rights, gender equality, values of respect and solidarity and skills to communicate, negotiate and resolve problems peacefully. In addition, violence-free schools can also promote non-violence in the wider community.

This section provides an overview of the key elements of a comprehensive education sector response to school violence and bullying and highlights examples of initiatives and actions to prevent and respond to school violence and bullying in a range of countries. Available evidence shows that responses that take a comprehensive sector (and whole-school) approach and that involve interventions to both prevent and respond to school violence and bullying can make a difference. Such an approach can not only reduce violence and bullying, but can also contribute to reducing truancy, improving academic achievement and enhancing children's social skills and well-being. An effective and comprehensive education sector approach to school violence and bullying encompasses all of the following elements:

Leadership - This includes: developing and enforcing national laws and policies that protect

children and adolescents from violence and bullying in schools; and allocating adequate resources to address school violence and bullying.

School environment - This includes: creating safe and inclusive learning environments; strong school management; and developing and enforcing school policies and codes of conduct, and ensuring that staff who violate these are held accountable.

Capacity - This includes: training and support for teachers and other staff to ensure they have the knowledge and skills to use curriculum approaches that prevent violence and to respond to incidents of school violence and bullying; developing the capacity of children and adolescents; and developing appropriate knowledge, attitudes and skills to prevent violence among children and adolescents.

Partnerships - This includes: promoting awareness of the negative impact of school violence and bullying; collaboration with other sectors at national and local level; partnerships with teachers and teachers' unions; working with families and communities; and the active participation of children and adolescents.

Services and support - This includes: providing accessible, child-sensitive, confidential reporting mechanisms; making available counselling and support; and referral to health and other services.

Evidence - This includes: implementing com-

prehensive data collection; rigorous monitoring and evaluation to track progress and impact; and research to inform the design of programs and interventions.

Specific examples of actions taken in different countries related to the different elements of an effective and comprehensive response to school violence and bullying are available within the UNESCO's global status report "School Violence and Bullying".

Please follow the link and read this informative global report - <http://unesdoc.unesco.org/images/0024/002469/246970e.pdf>



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