5.5 Mental health of Australia's young people and adolescents

Mental health disorders that emerge during the formative years of childhood can have a lasting impact on the health and wellbeing of the individual and on the lives of those around them (Erskine et al. 2015). The development of programs and initiatives for young people who need mental health care and support requires a sound understanding of the scope of the problem, which is best achieved through population-based prevalence studies.

Australia has an epidemiological mental health program, known as the National Survey of Mental Health and Wellbeing, which comprises three surveys: a survey of the adult population, a survey of people living with psychotic mental illness, and a survey of children and adolescents. Together, these surveys provide a detailed national view of the prevalence of mental health issues in Australia and of their impact.

The Australian Child and Adolescent Survey of Mental Health and Wellbeing (known as the Young Minds Matter Survey), conducted in 2013–14, is the second survey to be conducted on the prevalence of mental health disorders in children and adolescents (Telethon Kids Institute 2015), which surveyed households with 4–17 year olds (the methodology is briefly summarised in Box 5.5.1). The survey also examined the health behaviours of young people and their use of the available support services and provided the opportunity to make comparisons against the first survey, conducted in 1998.

Box 5.5.1: The Young Minds Matter Survey methodology

Responses were obtained from over 6,000 households in Australia using two components.

1. A component for parents and carers

Parents and carers were questioned by a trained interviewer on a range of topics, including:

- family structure and sociodemographics
- health of the child and any disabilities
- the child's mental health service usage in the 12 months prior to the survey
- school attendance
- family characteristics.

Survey instrument examples included:

- strengths and difficulties questionnaire in relation to one selected child
- the Diagnostic Interview Schedule for Children Version IV.

(continued)

Box 5.5.1 (continued): The Young Minds Matter Survey methodology

2. A component for young people

A total of 3,000 people aged 11–17 from the participating households completed a self-report questionnaire that included:

- a strengths and difficulties questionnaire
- the Diagnostic Interview Schedule for Children Version IV major depressive disorder module
- the Kessler Psychological Distress Scale.

Questions included information about:

- self-harm and suicidal behaviours
- mental health service usage in the 12 months prior to the survey
- experience of bullying and health risk behaviours
- use of the internet and informal support mechanisms.

Source: Lawrence et al. 2015.

Prevalence of mental health disorders in young people

Results from the 2013–14 Young Minds Matter Survey indicate that the majority of children and adolescents in Australia have good mental health. However, the results also indicate that 1 in 7 (14%, or 560,000) children and adolescents aged 4–17 had a mental disorder in the previous 12 months. Common mental disorders covered in the Young Minds Matter Survey are briefly described in Box 5.5.2. Prevalence rates were higher overall among males (16%) than females (12%) across all disorders except *Major depressive disorder* (Figure 5.5.1). *Attention deficit hyperactivity disorder* (*ADHD*) was the most prevalent disorder for males, and more common in the 4–11 years age group than in the 12–17 years age group. *Anxiety disorders* was the most prevalent disorder group among females, and more common in the 12–17 years age group. The prevalence of *Major depressive disorder* was higher when young people aged 11–17 provided the information themselves (7.7%) than when the information was provided by their parent/carer (4.7%).

Box 5.5.2: Common mental disorders covered in the Young Minds Matter Survey

Major depressive disorder—the key feature is the presence of either depressed mood, loss of interest or pleasure or being grouchy, irritable and in a bad mood. Symptoms of major depressive disorder may include significant weight change, loss of appetite, difficulty sleeping, restlessness, fatigue and loss of energy, feeling of worthlessness and inability to concentrate. The diagnostic criteria for this disorder specify that at least five symptoms of depression must be present for a minimum of a 2-week period; that these symptoms cause clinically significant distress; and that they interfere with normal functions at school, at home or in social settings.

(continued)

Box 5.5.2 (continued): Common mental disorders covered in the Young Minds Matter Survey

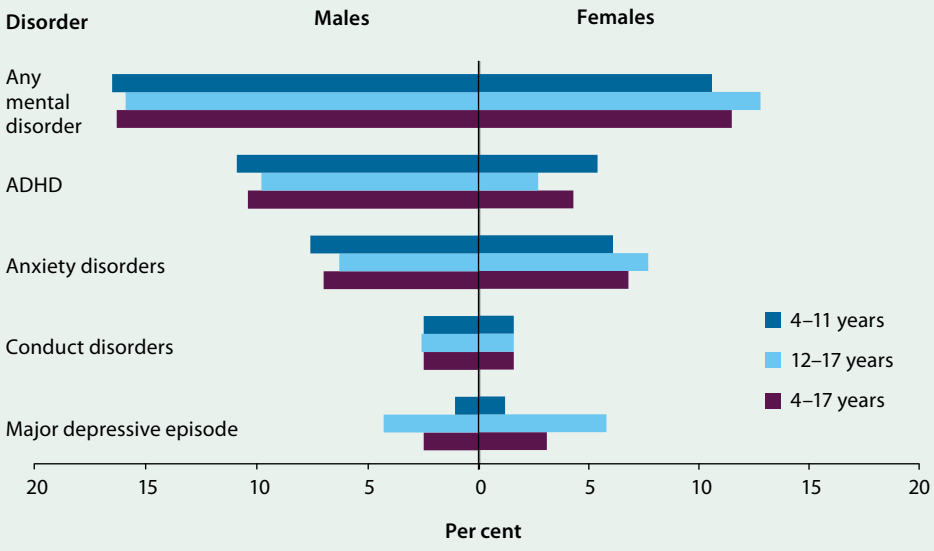
Anxiety disorders—a class of mental disorders defined by the experience of intense and debilitating anxiety. The type of anxiety disorders covered in the survey were social phobia, separation anxiety disorder, generalised anxiety disorder, and obsessive-compulsive disorder.

Attention deficit hyperactivity disorder (ADHD)—a persistent pattern of inattention and/or hyperactivity-impulsivity. Children and adolescents with this condition may find it difficult to pay attention and to see tasks or activities through to the end, or may make careless mistakes with school work or other tasks. Children and adolescents with problems in the area of hyperactivity may talk excessively; have trouble staying still when it is appropriate or expected; and act like they are 'always on the go'.

Conduct disorder—repetitive and persistent behaviour to a degree that violates the basic rights of others, major societal norms or rules—in terms of aggression towards people or animals, destruction of property, deceitfulness or theft, and serious violation of rules.

Source: Lawrence et al. 2015.

Figure 5.5.1: 12-month prevalence of mental health disorders, by disorder type, by age and sex, 2013–14



Comparison of the 2013–14 data with the results of the first survey of young people, conducted in 1998, was limited due to changes in the survey design—most notably differences in the types of disorders that were assessed—and was limited to the 6–17 year old age group. Overall prevalence of any mental health disorder was similar to that indicated in the earlier 1998 survey; however, there were changes in the prevalence of specific disorders between the two surveys. Prevalence rates for *ADHD*

declined over the 15 years between the surveys. By contrast, the rate of *Major depressive disorder* increased. A comparison for *Anxiety disorders* could not be made due to survey design changes.

Social and demographics characteristics

The Young Minds Matter Survey identified associations between household demographics and the prevalence of mental health disorders (Table 5.5.1).

Table 5.5.1: Associations between household demographics and 12-month prevalence of mental disorders, 2013–14

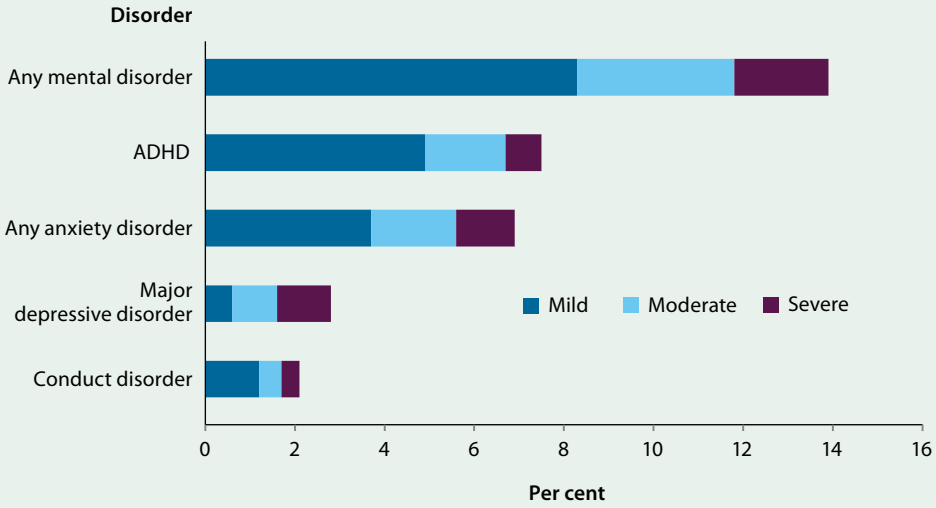
	Lower prevalence	Higher prevalence
Family composition		
	10.4%	18.3–23.7%
	Original family	Step families, blended families and one parent families
Income bracket ($ per year)		
	10.5%	20.5%
	Highest ($130,000+)	Lowest ($52,000 or less)
Parent/carer employment		
	10.8%	21.3–29.6%
	Both parents/ carers employed	Sole parent/carer; neither parent/carer in employment
Family functioning		
	10.9%	35.3%
	Very good	Poor
Location		
	12.6%	16.2%
	Greater capital city	Rest of state

Severity of conditions

Unlike many other health conditions, the experience of a mental health disorder is unique to the individual, meaning that the impact of the disorder on daily life and activities is very different among individuals with the same diagnosis. Four domains relating to impact were assessed by the Young Minds Matter Survey: at school or work; with friends and social activities; on the family; and on the children themselves. These factors were combined to determine the severity profile for each disorder. However, the most severe forms of mental illness (for example, psychotic disorders) were out of scope for the survey.

The prevalence of mental health disorders for 4–17 year olds decreased with increasing severity, with 8.3% having 'mild' disorders, 3.5% 'moderate' and 2.1% 'severe' disorders (Figure 5.5.2). Importantly, the higher prevalence conditions, such as *ADHD* and *Anxiety disorders*, were more likely to be rated as having 'mild' and 'moderate' than 'severe' impact. *Major depressive disorder* was the only condition in which 'mild' impact was less common than 'moderate' and 'severe' impact.

Figure 5.5.2: 12-month prevalence of mental disorders among 4–17 year olds, by disorder type and severity, 2013–14



Self-harm, suicidal ideation and attempted suicide

Suicide, self-harm behaviours, suicidal ideation and attempted suicide have long-lasting impacts on individuals, families and communities. The relationship between suicide and previous self-harm behaviours is strong, with around half of young people who die by suicide having previously engaged in self-harm behaviours (Hawton & James 2005). While suicide is uncommon among young people aged 0–14, it is the leading cause of death for young Australians aged 15–24. In 2013, there was fewer than one suicide death per 100,000 population in young people aged 0–14, increasing to 10 deaths per 100,000 population for the 15–19 age group and 12 deaths per 100,000 population for the 20–24 age group (ABS 2015). Rates have been relatively stable over the last 15 years. (Note: suicide data for children aged under 15 years should be treated with caution because there are difficulties determining a suitable age at which self-inflicted acts can be interpreted as an intentional act of self-harm.)

The Young Minds Matter Survey asked participants questions about self-harm, suicidal ideation and attempted suicide.

Self-harm

The survey showed that 11% of young people aged 12–17 had ever self-harmed, which equates to around 186,000 adolescents. However, these figures are likely to be an underestimate, with around 7.5% of survey respondents preferring not to answer questions about self-harm. Females aged 16–17 had the highest prevalence of ever having harmed themselves (23%), over 3 times the rate of males the same age. Self-harm was shown to be most commonly associated with *Major depressive disorder*, with nearly half of all females with the disorder having ever self-harmed. Around half of 12–17 year olds who self-harmed in the 12 months prior to the survey had used support services such as health or school services; however, it is not known if service use was before or after the self-harm event.

Suicidal ideation

One in 20 young people (5.6%) aged 12–15 had thoughts of suicide in the 12 months prior to the survey. The suicidal ideation rate for 16–17 year olds was greater than the 12–15 age group: 1 in 10 (11%) had suicidal thoughts, and 7.8% had made a suicide plan in the 12 months prior to the survey. Rates were higher in females (15%) than males (6.8%) and, similar to self-harm, the strongest association between thoughts of suicide and mental disorders occurred for those with a *Major depressive disorder*.

Suicide attempt

Suicide attempt in the 12 months prior to the survey was highest in females aged 16–17 (4.7%), followed by males aged 16–17 (2.9%); however, 5.3% of 16–17 year olds reported having ever attempted suicide. Suicide attempts in the 12 months prior to the survey in children aged 12–15 (1.7%) were half that of young people aged 16–17 (3.8%). One in 5 females with *Major depressive disorder*, as determined by their own survey response, had attempted suicide. Males (14%) with *Major depressive disorder* were less likely to have attempted suicide than females (23%). The majority of 13–17 year olds who reported a suicide attempt had used support services in the previous 12 months, although it is not possible to establish whether the service use was before or after the suicide attempt.

Services available for people at risk of suicide are:

Lifeline 13 11 14 www.lifeline.org.au

Kids Help Line 1800 55 1800 www.kidshelpline.com.au

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

Health risk behaviours

Behaviours that impact on the overall health and wellbeing of an individual are termed 'health risk behaviours'—that is, they increase a person's risk of developing ill health. For example, smoking, alcohol consumption and drugs use are all considered to be health risk behaviours. Some health risk behaviours are also known risk factors for the development of mental disorders. For example, in young people, risk factors associated with depression include alcohol consumption, drug use, unhealthy diet and negative coping strategies; conversely, maintaining a healthy weight, adequate diet and appropriate levels of sleep have been shown to reduce the risk of depression, and are also known as 'protective health factors' (Cairns et al. 2014). The Young Minds Matter Survey results provide an insight into the prevalence of young people engaging in health risk behaviours.

Alcohol consumption was the most prevalent health-risk behaviour identified in young people by the survey. Nearly 4 in 10 (38%) of all 13–17 year olds reported having ever consumed alcohol, with consumption rates higher for those with a mental disorder, particularly those with *Major depressive disorder* (65%). The self-reported rate for consuming four drinks of alcohol in a row in the last 30 days, by young people with a *Major depressive disorder* (28%), was more than double the rate for young people without a disorder (10%). Three in 10 females (31%) with *Major depressive disorder* (based on self-report) engaged in risky alcohol consumption, compared with 2 in 10 males (19%).

Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

Around 1 in 10 (9.9%) 13–17 year old survey respondents reported having 'ever smoked at least once a week', with 7.2% having smoked in the 30 days prior to the survey. Smoking rates were 4–5 times higher in young people with a mental health disorder than in people without a disorder. Females (8.2%) were more likely than males (6.2%) to report having smoked in the 30 days prior to the survey. The highest smoking rate was in females with a *Major depressive disorder* (27%): 1 in 4 smoked in the 30 days prior to the survey.

Similar usage patterns to alcohol consumption and smoking were observed for cannabis and other drug use. That is, higher usage rates were observed in young people with mental disorders—in particular for young people with *Major depressive disorder*—compared with those who did not have a disorder. Overall, 12% of 13–17 year olds reported having ever used cannabis and 4.5% reported using other drugs. Rates of ever using cannabis by those with *Major depressive disorder* were over 3 times the rate for those without a disorder, and 6–8 times greater for other drugs (based on parent/carer and self-report respectively).

These results suggest that while *Major depressive disorder* was less prevalent across the total youth population than other disorders, it was more prevalent in 16–17 year olds and more often associated with risky health-related behaviours that may impact on the overall health and wellbeing of the individual. However, it is important to note that these data only illustrate the association between risk behaviours and mental health conditions. They cannot identify cause and effect—that is, whether the health behaviours occur before or after the development of a mental health condition.

Emotional and behavioural support for young people

Young people often need support for emotional and behavioural issues in their formative years that may not be due to a diagnosable mental disorder. That is, support is often required to help young people negotiate 'normal' childhood/adolescent issues that are part of the transition to adulthood (Zimmerman et al. 2013). The lives of young people are dominated by family relationships, peer relationships and the school environment. Each of these elements provides a critical gateway through which support for young people can be delivered. Support at critical times may ease the transition to adulthood and prevent the onset and/or severity of mental health issues.

Family, friends and school staff—informal support

Young people most often rely on those close to them for informal support. Informal support for emotional or behavioural issues is often provided by relatives, friends and school staff. The Young Minds Matter Survey found that, in 2013–14, nearly two-thirds (63%) of young people aged 13–17 received informal help from their family members, friends or school staff in the 12 months prior to the survey. While males (52%) were less likely to receive informal support, they were equally likely to receive support from a parent (38%) or a friend (35%). By contrast, females (74%) reported receiving more informal support than males but were more likely to receive support from a friend (62%) than from a parent (55%). Four in 5 (80%) young people aged 13–17 with a mental health disorder received informal support (based on the parent report), compared with 3 in 5 of those without a disorder (58%). These data suggest that the majority of young people receive support from a range of sources, regardless of their mental health status.

Support services

Support services and clinical care options specifically designed for young people are provided by governments through various portfolios, including education and health. Support services are also provided by the non-government sector. The first Australian Child and Adolescent Survey of Mental Health and Wellbeing, conducted in 1998, estimated that only around one-third of 6–17 year olds with mental health issues sought and received care in the 6 months prior to the survey, suggesting that more needed to be done for young people requiring care (Sawyer et al. 2000). The 2013–14 Young Minds Matter Survey results provide a timely update on the use of services by all children and adolescents, as well as those with mental health disorders.

Service use by all 4–17 year olds

Health and school services were the most common services used by 4–17 year olds in 2013–14.

- One in 10 young people who received support for their emotional and behavioural issues did not have a diagnosable mental disorder, as measured by the survey.
- A further 40% of service users had symptoms of a mental disorder but did not meet the threshold for a 'mental disorder'.
- The remaining 50% of service users were assessed as having a mental disorder.

Data imply that many young people with emotional and behavioural issues are seeking and receiving support regardless of whether they have a diagnosable mental health illness.

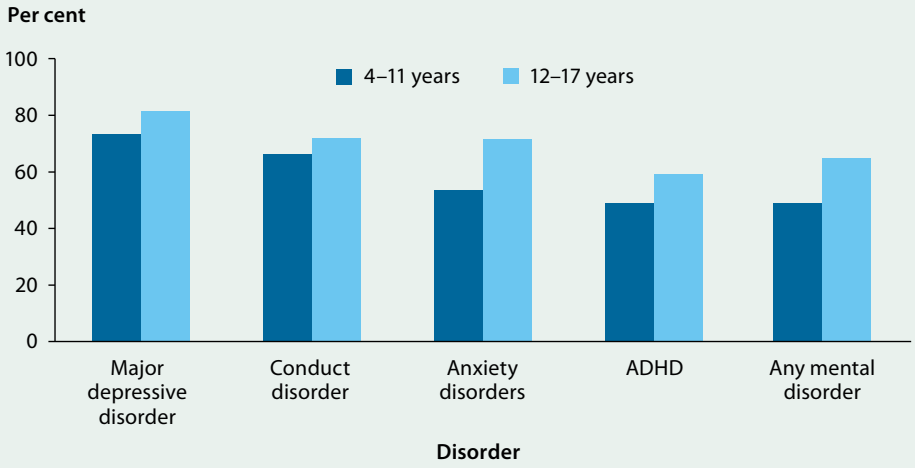
Service use by 4–17 year olds with a mental health disorder

Over half (56%) of 4–17 year olds with a mental health disorder had used services for emotional or behavioural issues in 2013–14 (Figure 5.5.3). Service use comparisons with the 1998 estimates can only be made for those aged 6–17 years with either *Major depressive disorder*, *ADHD* or *Conduct disorder*. Service use in this group was 68% in the 12 months prior to the 2013–14 survey compared with 31% in the six months prior to the 1998 survey.

Service use for all disorders in 2013–14 was greater for the 12–17 years age group than for the corresponding 4–11 years age group. The service-use profiles for each of the mental health disorders (Figure 5.5.3) largely reflect the severity profile of each disorder: that is, disorders with a greater proportion of severe impact (see Figure 5.5.2) were associated with greater service usage rates. When severity is considered, regardless of disorder, 88% of young people with a mental disorder that severely affected their daily lives accessed services, compared with 73% of those with moderate disorders and 41% with mild disorders.

Australian Institute of Health and Welfare 2016. *Australia's health 2016*. Australia's health series no. 15. Cat. no. AUS 199. Canberra: AIHW.

Figure 5.5.3: Service use in the 12-months prior to the survey among 4–17 year olds with mental disorders, by disorder type and age, 2013–14



Types of support services

School-based services

School-based services—such as counsellors, welfare officers and support resources—provide support for young people as they negotiate challenges in their school-based social environment, since social connectedness has been shown to be a predictive factor for substance abuse, mental health disorders and school outcomes (Bond 2007).

Almost all (96%) of survey respondents aged 4–17 reported attending school or another educational institution. Of these, 1 in 9 students had used a school service for emotional or behavioural problems in the 12 months prior to the survey. Students with a mental health disorder used school services at a higher rate, with 40% receiving school-based services for their emotional and behavioural issues. The most common school service received was individual counselling followed by special class or school; group counselling or support program; and school nurse services. Similar to the overall usage profile, severity of the impact of the disorder was associated with much higher service-usage rates.

Headspace

Headspace is an early intervention service model aimed at providing mental health services to 12–25-year-olds (National Youth Mental Health Foundation 2015). More than one-third (37%) of all Young Minds Matter Survey participants had heard of headspace, and 7.4% had accessed one or more of headspace's services —for example, accessed online information, spoken to a headspace professional, or visited a headspace site.

The online environment

Online services were accessed by nearly 3 in 10 (30%) of young people aged 13–17 with any mental disorder. The most common service accessed by this group was information about mental health issues, followed by assessment tools. One in 5 young people without any disorder also accessed online services, mostly seeking information about mental health issues.

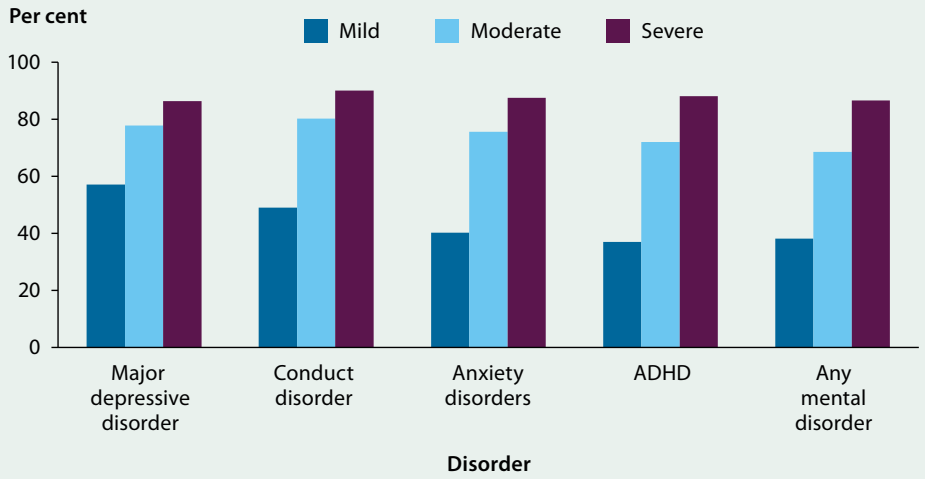
Health services

Health services are most commonly clinical in nature: that is, they treat patients. Available mental health services are diverse and include:

- primary care services—that is, the first point of contact with the health system (for example, general practitioners)
- community-based care, including psychologists and psychiatrists and community-based specialised mental health teams operated and managed by state and territory health departments
- specialised mental health care facilities in hospitals.

The Young Minds Matter Survey results showed that mental health-related services were used by around half of all 4–17 year olds with a mental health disorder. As would be expected, given the predominantly clinical nature of health services, usage was greater for young people with disorders that had a severe impact on the individual, regardless of the disorder type (Figure 5.5.4).

Figure 5.5.4: Mental health-related health service use in past 12 months among 4–17 year olds with mental disorders, by disorder type and severity of impact, 2013–14



Barriers to seeking and receiving care

The survey results indicate that around one-third (31%) of parents of 4–17 year olds with mental health disorders reported accessibility issues as the main reason for not seeking help or not having their needs met. Accessibility issues, such as inability to afford a service, are a continuing challenge for the mental health care system.

There are many reasons why children and adolescents with mental health disorders might not seek or receive the care they need. The Young Minds Matter Survey provides some insight into this issue.

Parents and carers of 4–11 year olds with mental health disorders who reported they did not seek help for their child, or that their child's needs were not met by services, most commonly reported that they could not afford it (41%), were not sure where to get help (40%), and that they would prefer to handle the issues by themselves or with

family/friends (37%) (note that more than one response was allowed). Parents of 12–17 year olds were most likely to report that their child/adolescent refused help (48%), that they were not sure where to get help (39%), or that they could not afford it (33%). Three out of 10 (29%) parents of 4–17 year olds with mental disorders reported that they could not get an appointment.

What is the AIHW doing?

The program of population surveys and the National Survey of Mental Health and Wellbeing, is supplemented by AIHW's administrative mental health data sets. These latter data provide detailed information on the response of governments to the mental health needs of Australians, including children and adolescents. These data—published on the AIHW's *Mental health services in Australia* website—monitor the support services provided by Australia's specialised mental health care services.

What is missing from the picture?

National mental health prevalence studies require rigorous survey design and data analysis and hence are costly exercises. However, the surveys afford the opportunity to obtain additional valuable information about other aspects of children's and adolescents' mental health and wellbeing, including service usage (of both health and non-health services); self-reported problems, behaviours and risk factors in young people; and self-harm and suicidal behaviours. Although a range of health administrative data sets are available to provide information about mental health service usage by children and adolescents, there is a paucity of national data on the support provided by other sectors, for example by education and welfare. Development of alternative data sources/methodologies to supplement the cycle of prevalence surveys, providing more regular information about these other aspects of children and adolescents' mental health and wellbeing, would be valuable.

The Young Minds Matter Survey's design did not enable representative data to be collected on Indigenous status; therefore, no comparisons can be made between the prevalence of mental health disorders for Aboriginal and Torres Strait Islander people and non-Indigenous Australians (see Chapter 5.7 'How healthy are Indigenous Australians?').

Where do I go for more information?

The Young Minds Matter website (Telethon Kids Institute 2015) provides a range of information about the study, including an online data portal for interrogation of some aspects of the data.

There are a number of *Australian & New Zealand Journal of Psychiatry* articles either in press or published which supplement the survey report and supplementary tables.

More information about mental health is available at the *Mental health services in Australia* website, which provides a comprehensive picture of the national response of the health and welfare service system to the mental health care needs of Australians.

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