

2015

The Mental Health of Children and Adolescents

REPORT ON THE SECOND AUSTRALIAN
CHILD AND ADOLESCENT SURVEY
OF MENTAL HEALTH AND WELLBEING



Australian Government

EXHIBIT 662

The Mental Health of Children and Adolescents

Report on the second Australian Child and Adolescent Survey
of Mental Health and Wellbeing

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August 2015

EXHIBIT 662



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ISBN: 978-1-76007-187-5

Online ISBN: 978-1-76007-188-2

Publications approval number: 11097

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Suggested reference: Lawrence D, Johnson S, Hafekost J, Boterhoven De Haan K, Sawyer M, Ainley J, Zubrick SR (2015) The Mental Health of Children and Adolescents. Report on the second Australian Child and Adolescent Survey of Mental Health and Wellbeing. Department of Health, Canberra.

FOREWORD

This report provides compelling reading for everyone interested in the health and wellbeing of Australian children and adolescents. Based on a survey conducted in the homes of over 6,300 families with children and/or adolescents aged 4 to 17 years, the report presents a comprehensive picture of the mental health of young Australians. It documents the prevalence and type of mental health problems, the impact of those problems on families and young people themselves and the role of health and education services in providing assistance. While the primary sources of information were parents and carers, the survey also engaged directly with young people 11 years and older who completed their own survey. This information provides unique insights about aspects of their emotional lives and behaviour that are generally not visible to parents and carers.

Australia has a proud tradition of undertaking mental health surveys of its population. Commencing in 1997 with the first household survey of the adult population, the National Survey of Mental Health and Wellbeing programme has produced six major surveys. Two of these covered the more common mental disorders in adults conducted in 1997 and 2007, two covered people living with less prevalent psychotic illnesses conducted in 1998 and 2010, and now with this report, two surveys have been undertaken of the mental health of children and adolescents. The first child and adolescent survey was conducted in 1998 and released in 2000. It was the first national survey of its type conducted anywhere in the world.

The report on the second child and adolescent mental health survey presents a contemporary update on the next generation of Australian adults that is both reassuring and troubling. Overall prevalence of mental disorders appears to be stable, with approximately one in seven children and young people experiencing a mental disorder in the past year. This is consistent with comparable international studies. The most positive news is that access by families and young people to assistance appears to have increased substantially. The first survey found that only one third of children and adolescents aged 6-17 years with mental disorders used services in 1998 in the previous six months. By contrast the second survey found just over two thirds were able to access services, although this was measured over a 12-month period. The vast majority (95%) used a health service. Despite differences in methodology between the two surveys, the report notes that on balance the data points to a significant increase in service use by children and adolescents with mental disorders in Australia between 1998 and 2014.

It is pleasing that the evidence from this more recent survey shows that those most in need have the best access to services. About nine out of every ten young people with a severe mental disorder accessed assistance from the service systems provided by the health and education sectors, as did about three quarters of those with problems of a moderate impact. This provides reassurance that the policies adopted by governments to lift the known low treatment rates for people with mental illness are achieving results. The Australian Government in particular has had a special focus on improving both prevention and treatment efforts for young Australians, commencing with the introduction of the National Youth Mental Health Initiative in 2005 (now known as *headspace*).

More troubling is the range of information presented in this report that points to the need for refocussed effort by governments and the broader community to develop systems to both prevent mental health problems and to respond early to problems when they emerge. The rates for depression, self-harm and thoughts about suicide in teenagers are particularly worrying, with approximately one in ten indicating that they have engaged in self-harming behaviour. Three quarters did so in the previous 12 months. For

teenage girls aged 16-17 years, nearly one in five were found to meet the clinical criteria for depression based on their own report. Around one quarter of teenage girls in the 16-17 year age range reported deliberately injuring themselves at some point in their lives. The rates for depression in 11-17 year olds were found to be higher when young people provided the information themselves (7.7%) than when their parents and carers did so (4.7%). This is an important signal to all parents who are faced with the challenging task of helping their children navigate the transition from childhood to adulthood.

Additionally, this survey has again highlighted the strong relationship between socioeconomic disadvantage and higher rates of mental health problems that has been found in comparable international studies. Children and adolescents in low-income families, with parents and carers with lower levels of education and with higher levels of unemployment had higher rates of mental disorders in the previous 12 months. There was also a strong relationship with where they lived as significantly higher rates of mental disorders were found in non-metropolitan areas.

Overall, the survey highlights the need for continued effort by governments and the broader community to improve the mental health of children and young people and to continue our collaborative work to achieve more effective prevention. A continued focus on suicide prevention and early intervention must be central platforms of the service systems that we build in the health, education and welfare sectors. As this report demonstrates, the health system has a key role to play but the roles of the education and welfare sectors are also critical in responding to the needs of children and young people with mental health problems.

The Australian Government is committed to maintaining a strong focus on prevention and early intervention efforts to reduce the prevalence and impact of mental health problems in our young population. The survey shows that the investment by government in youth mental health is making an impact on service access, however, it also highlights the importance of targeting available resources to focus on emerging need.

This is why the Government tasked the National Mental Health Commission to conduct a comprehensive review of mental health services in Australia. Following the release of this review and its recommendations State, Territory and Commonwealth Governments agreed to recommit to a bipartisan approach to comprehensive mental health reform.

Results from the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing have produced a wealth of information that will guide the development of mental health policy and programmes for young people well into the future. Surveys of this type are highly specialist in nature, expensive and demanding on all involved. I wish to express our gratitude to all who contributed, particularly to the families who willingly gave their time to provide information about areas of their family life that are sensitive and deeply personal. I also wish to thank the team at the Telethon Kids Institute at the University of Western Australia who so ably planned and coordinated the survey, producing this publication.



Sussan Ley
Minister for Health
Minister for Sport

ACKNOWLEDGEMENTS

The authors wish to express their gratitude to the 6,310 families who participated in the survey.

The survey was funded by the Australian Government Department of Health.

The survey was developed and conducted with advice from the Survey Reference Group (membership listed in Appendix 2).

The authors would like to particularly thank Bill Buckingham and Suzy Saw for their advice and support throughout the entire project.

Special thanks to Rajni Walia (Project Director), Gerry Bardsley, Peta McDonald, Mary-Anne Patterson, Caitlin Bennetto and Troy Kohut from Roy Morgan Research and the team of over 100 field interviewers who undertook the fieldwork for the survey.

This survey would not have been possible without help from: Prudence Fisher (Columbia University), Robert Goodman (Institute of Psychiatry, London) and Katherine Stevens (University of Sheffield). Support and assistance from Philip Hazell and Joanna Blades (University of Sydney), Julie Ratcliffe (University of Adelaide), Philip Burgess (University of Queensland), Gavin Stewart and Helen Scales is gratefully acknowledged.

We would also like to thank the following staff of the Telethon Kids Institute who were vital to the success of the project: Allyson Browne, Daniel Christensen, Katherine Hafekost, Monique Robinson, Francis Mitrou, Wayne Rikkers, Kirsten Hancock, Judy Straton, Leanne Scott, Karina Allen, Beth Veitch and Donna Cross.

The survey team would like to thank survey ambassadors Jessica Watson, Fiona Wood, and Fiona Stanley for their support of the survey.

The authors thank PSMA Australia who generously donated access to G-NAF, the geocoded national address file, to support the project.

The authors wish to thank the following people who helped with the cognitive testing of the questionnaire: Caroline Goosens, Margaret Jones, Simon Davies, Adrienne Wills, Jennifer Griffiths, Julie Lambert, Haylee Clark, Vanessa Watson, Shannon McNeair, Naomi D'Souza and Kym Thomas.

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Highlights

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2 The Mental Health of Children and Adolescents

SECOND AUSTRALIAN CHILD AND ADOLESCENT SURVEY OF MENTAL HEALTH AND WELLBEING HIGHLIGHTS

A second national survey of the mental health and wellbeing of Australian children and adolescents was conducted by the Telethon Kids Institute at The University of Western Australia in partnership with Roy Morgan Research in 2013-14.

- The second national child and adolescent survey was a household survey of parents and carers of 4-17 year-olds in the general population and 11-17 year-olds themselves.

Aims of the survey

- The main aims were to determine:
 1. How many children and adolescents had which mental health problems and disorders.
 2. The nature and impact of these.
 3. How many children and adolescents had used services for mental health problems.
 4. The role of the education sector in providing these services.

Diagnostic assessment of mental disorders

- The Diagnostic Interview Schedule for Children Version IV (DISC-IV) was used to assess young people against the Diagnostic and Statistical Manual of Mental Disorders Version IV (DSM-IV) criteria.
- Disorders that were most common and had the greatest impact on children and adolescents were assessed. These were:
 1. Anxiety disorders
 - Social phobia
 - Separation anxiety disorder
 - Generalised anxiety disorder
 - Obsessive-compulsive disorder
 2. Major depressive disorder
 3. Attention-Deficit/Hyperactivity Disorder (ADHD)
 4. Conduct disorder.

What participants were asked

- Parents and carers took on average 60 minutes to complete a questionnaire with a trained interviewer. This included the following:
 - Family structure and socio-demographics;
 - General health of child and disabilities;
 - DISC-IV modules and functional impairment;
 - Strengths and Difficulties Questionnaire;
 - Service use in past 12 months and perceived need for help;
 - School attendance and performance; and
 - Family characteristics, life stressor events, and parent/carer mental health measures.
- Young people aged 11-17 years completed a questionnaire in private on a tablet computer, taking on average 35 minutes to do so. This included the following:
 - DISC-IV Major depressive disorder module;
 - Strengths and Difficulties Questionnaire;
 - Kessler Psychological Distress Scale;
 - Service use in past 12 months and perceived need for help;
 - Use of internet and informal supports;
 - Self-harm and suicidal behaviours;
 - Experience of bullying; and
 - Health-risk behaviours, including substance use and problem eating behaviours.

Who participated

- In total 76,606 households were approached and visited up to 6 times each between June 2013 and April 2014.
- This resulted in 6,310 or 55% of eligible households and 2,967 or 89% of eligible young people responding.

PREVALENCE OF MENTAL DISORDERS IN AUSTRALIAN CHILDREN AND ADOLESCENTS

The Australian Child and Adolescent Survey of Mental Health and Wellbeing provides information on the prevalence of mental disorders in children and adolescents in Australia. The prevalence of mental disorders is the proportion of children and adolescents in the population who meet DSM-IV criteria for a diagnosis of a mental disorder within the 12 months prior to the survey.

- Almost one in seven (13.9%) 4-17 year-olds were assessed as having mental disorders in the previous 12 months. This is equivalent to 560,000 Australian children and adolescents.
- Males were more likely than females to have experienced mental disorders in the 12 months prior to the survey (16.3% compared with 11.5%).
- ADHD was the most common mental disorder in children and adolescents (7.4%), followed by anxiety disorders (6.9%), major depressive disorder (2.8%) and conduct disorder (2.1%).
- Based on these prevalence rates it is estimated that in the previous 12 months 298,000 Australian children and adolescents aged 4-17 years would have had ADHD, 278,000 had anxiety disorders, 112,000 had major depressive disorder and 83,600 had conduct disorder.
- Almost one third (30.0% or 4.2% of all 4-17 year-olds) of children and adolescents with a disorder had two or more mental disorders at some time in the previous 12 months.
- Prevalence did not differ significantly with age for males (16.5% for 4-11 year-olds and 15.9% for 12-17 year-olds), but was slightly higher in older females than younger females (10.6% for 4-11 year-olds and 12.8% for 12-17 year-olds).

Figure 1: Prevalence of mental disorders in 4-17 year-olds in the past 12 months

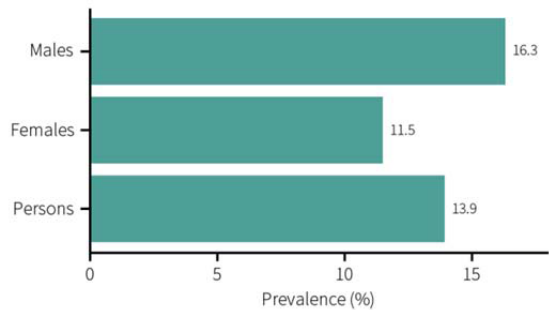


Figure 2: Prevalence of different types of mental disorders in the past 12 months in 4-17 year-olds

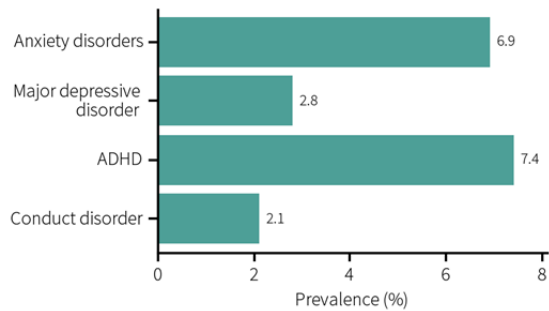
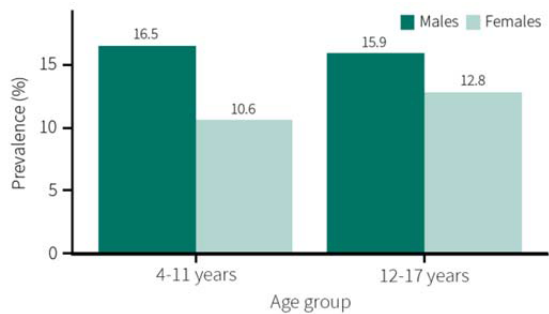


Figure 3: Prevalence of mental disorders in the past 12 months in 4-17 year-olds by sex and age group



IMPACT OF MENTAL DISORDERS

Mental disorders impact on individuals in a wide variety of ways and to varying extents. Assessment of the impact on functioning at school, with family and with friends, and the personal distress symptoms caused was used as the basis for determining the severity of disorders.

- Three fifths (59.8%) of 4-17 year-olds with a mental disorder or 8.3% of all children and adolescents had a mild disorder.
- One quarter (25.4%) of 4-17 year-olds with mental disorders or 3.5% of all children and adolescents had a moderate disorder.
- Just over one in seven (14.7%) 4-17 year-olds with a mental disorder were assessed as having a severe mental disorder. This is equivalent to one in 50 (2.1%) or approximately 82,000 Australian children and adolescents.
- Adolescents were almost three times more likely to experience a severe mental disorder – 23.1% of 12-17 year-olds with a mental disorder had a severe disorder compared with 8.2% of 4-11 year-olds with a mental disorder.
- Major depressive disorder had a greater impact on functioning than the other disorders, with two fifths or 42.8% of cases being severe and another 35.8% assessed as moderate.
- The majority of anxiety disorders, ADHD and conduct disorder cases were mild. Two thirds (65.7%) of 4-17 year-olds with ADHD, 53.8% with anxiety disorders and 58.7% with conduct disorder were assessed as having a mild disorder.
- 3.3% of 12-17 year-olds had a severe mental disorder compared with 1.1% of 4-11 year-olds.

Figure 4: Severity of mental disorders experienced by 4-17 year-olds in the past 12 months

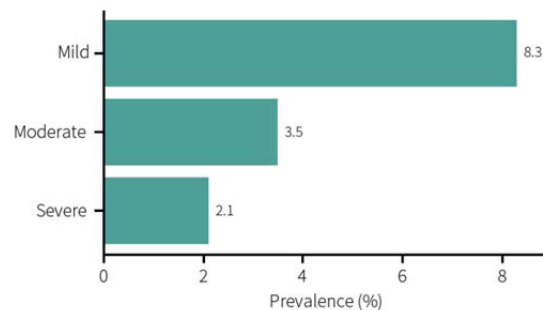


Figure 5: Severity of different types of mental disorders experienced by 4-17 year-olds in the past 12 months

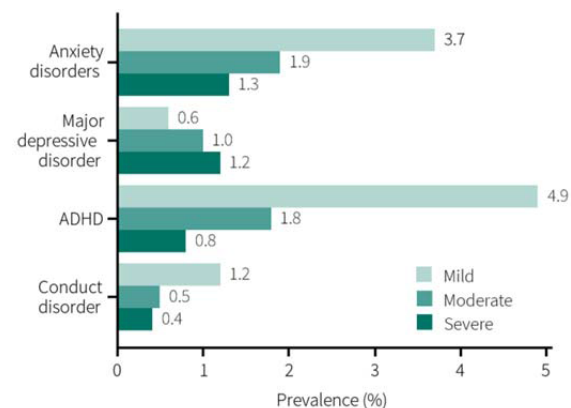
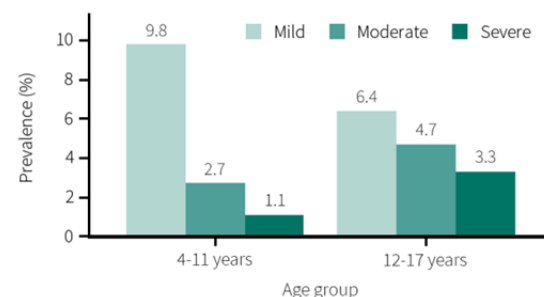


Figure 6: Severity of mental disorders experienced by 4-17 year-olds in the past 12 months by age group



SERVICE USE FOR EMOTIONAL AND BEHAVIOURAL PROBLEMS

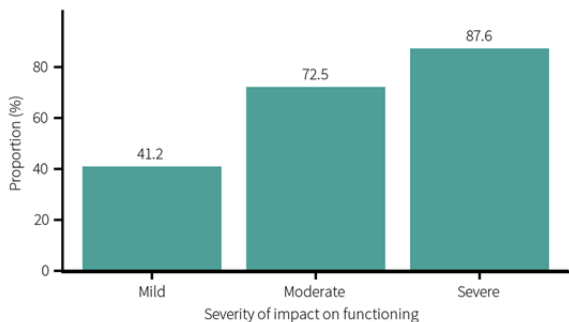
A wide range of services are available to assist young people with emotional and behavioural problems. Parents and carers reported on the health, school, telephone counselling and online services used by young people, as well as any medication taken.

- One in six (17.0%) children and adolescents aged 4-17 years had used services for emotional or behavioural problems in the previous 12 months.
 - One in seven (14.8%) used health services.
 - One in nine (11.5%) used school services.
 - Just over half (53.5%) of 4-17 year-olds using services used both health and school services.
- One in eight (12.8%) children and adolescents with mental disorders had taken a medication for emotional or behavioural problems in the previous two weeks.
- The majority (94.6%) of young people with mental disorders using services in the previous 12 months had used health services.
 - Just over one third (35.0%) of 4-17 year-olds had seen a general practitioner.
 - Almost a quarter (23.9%) had seen a psychologist.
 - One fifth (21.0%) had seen a paediatrician.
 - One fifth (20.7%) had seen a counsellor or a family therapist.

Services for young people with disorders

- Just over half (56.0%) of 4-17 year-olds with mental disorders had used services for emotional and behavioural problems in the previous 12 months.
- Service use was higher among children and adolescents with more severe disorders.
 - Two fifths (41.2%) of those with mild disorders, 72.5% of those with moderate disorders and 87.6% of those with severe disorders had used services.
- One in sixteen (6.2%) 4-17 year-olds with mental disorders were admitted to hospital, or attended an emergency or outpatient department in the previous 12 months.
- Specialist child and adolescent mental health services were used by 3.3% of 4-17 year-olds with mental disorders in the previous 12 months.
- Parents and carers reported that 7.3% of 12-17 year-olds with mental disorders visited a headspace centre in the previous 12 months.
- Schools provided services to 40.2% of the children and adolescents with mental disorders who attended them:
 - 28.4% received individual counselling;
 - 9.2% attended a group counselling or support program;
 - 13.1% used a special class or school;
 - 5.6% had seen a school nurse; and
 - 17.1% received other school services.

Figure 7: Service use in the past 12 months by 4-17 year-olds with mental disorders by severity of the disorder



PERCEIVED NEED FOR SERVICES

Parents and carers were asked about whether their children received the services they needed for emotional and behavioural problems, and whether they had unmet needs or they had no need for services. They were also asked about the barriers to seeking help or receiving more help where their needs were not fully met.

- Just over one quarter (26.8%) of parents and carers reported that their child or adolescent needed help for emotional or behavioural problems in the previous 12 months.
- Of those who had a need for help, four out of ten (42.9%) had their needs fully met and 27.3% partially met.

Service needs of young people with mental disorders

- Nearly four fifths (78.6%) of 4-17 year-olds with mental disorders were reported as needing help in the previous 12 months. Three quarters (73.8%) of these had their needs for help fully or partially met.
- Counselling was identified as being needed more often, with two thirds (68.1%) of 4-17 year-olds needing counselling and two thirds of these (67.7%) having their needs fully or partially met.
- One third (36.0%) of 4-17 year-olds needed life skills training, but for the majority (60.9%) this need was not met.
- Met need increased with severity, with parents and carers reporting that 84.2% of those with severe disorders and 81.8% of those with moderate had their needs for help fully or partially met.
- Parents and carers received a variety of help themselves to assist them with dealing with their children's problems. This included information, counselling, parenting courses, respite care and support groups — 61.0% reported they needed this kind of help and for 78.1% their needs were fully or partially met.

Figure 8: Perceived need for help for emotional and behavioural problems in the past 12 months in 4-17 year-olds with mental disorder

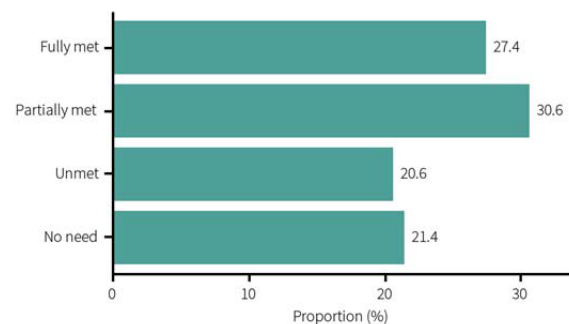


Figure 9: Need for different types of help in the past 12 months in 4-17 year-olds with mental disorder

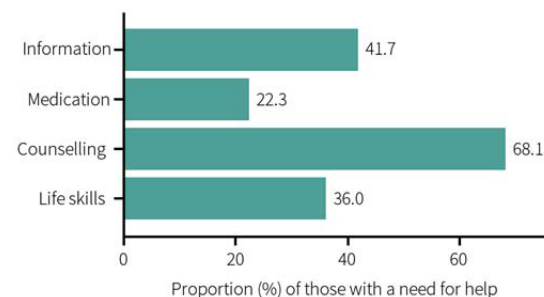
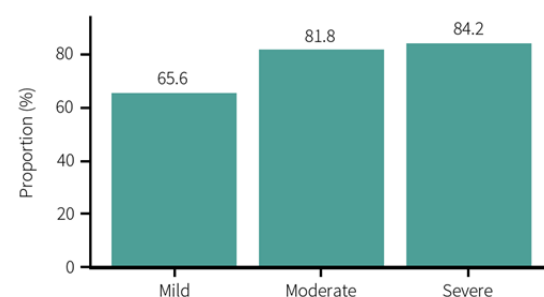


Figure 10: Fully or partially met need for help in the past 12 months in 4-17 year-olds with need for help for mental disorders by severity



SCHOOL SERVICES AND SUPPORTS, AND THE IMPACT OF PROBLEMS ON YOUNG PEOPLE’S SCHOOLING

Schools play a major role in supporting young people with emotional and behavioural problems and are often where symptoms of mental disorders are first identified. Data are for the 95.9% of 4-17 year-olds attending school or another educational institution.

- A school staff member was among those to suggest that some help for emotional or behavioural problems was needed in two fifths (40.5%) of cases.
- One in nine (11.5%) students had used a school service for emotional or behavioural problems in the previous 12 months.
 - 8.0% received individual counselling.
 - 2.7% received group counselling or participated in a support program.
- Just over one fifth (22.6%) of young people who used health services had been referred by their school.
- Teachers and other school staff provided 18.9% of students with informal support for emotional and behavioural problems. This was higher (51.0%) for students assessed as having a mental disorder.
- Of the four types of disorder, major depressive disorder had the greatest impact on school attendance. Students with this disorder averaged 20 days absent from school in the previous 12 months due to its symptoms.
- Major depressive disorder had the greatest impact on functioning at school, with one third (34.3%) of students experiencing severe impact and another 34.1% a moderate impact due to this disorder.
- For adolescents, conduct disorders had almost the same level of impact (22.8% severe and 43.6% moderate), but conversely also had the highest proportion (21.8%) for whom the disorder had no impact.

Figure 11: Proportion of students identified with problems by school staff

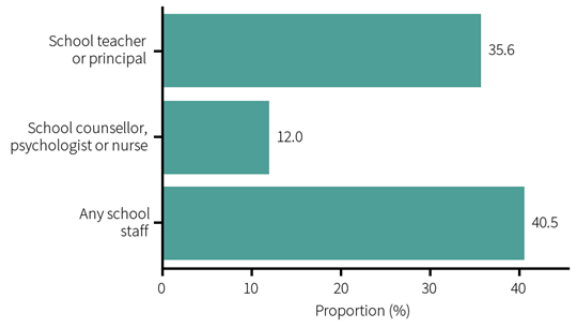


Figure 12: Students using health service provider services in the past 12 months who were referred by their school

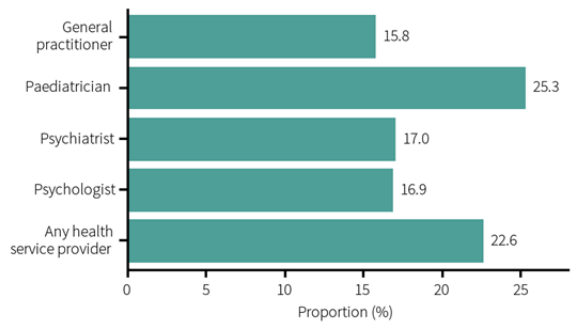
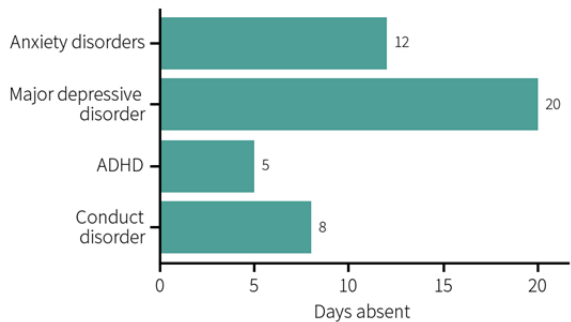


Figure 13: Days absent from school in the past 12 months due to mental disorder symptoms



WHAT ADOLESCENTS TOLD US ABOUT THEIR MENTAL HEALTH

Young people aged 11 years and older were asked, with their parents and carers consent, to complete a questionnaire in private on a tablet computer – 89% did so. This included various measures of their mental health, as well as the same DISC-IV major depressive disorder diagnostic module completed by their parents and carers to assess if they had a major depressive disorder based on DSM-IV criteria.

Major depressive disorder based on adolescent self-report

- One in thirteen (7.7%) adolescents aged 11-17 years met the DSM-IV diagnostic criteria for major depressive disorder in the previous 12 months.
- Major depressive disorder was more common in females and older adolescents, affecting 7.2% of males and 19.6% of females aged 16-17 years.

Differences between youth reports and parent or carer reports of the same mental disorder

- The prevalence of major depressive disorder was far higher when young people provided the information themselves than when their parents and carers did so (7.7% compared with 4.7% of 11-17 year-olds).
- There was low agreement on the prevalence of major depressive disorder when comparing adolescent and parent or carer reported information (1.9%).

Psychological distress

- One fifth (19.9%) of adolescents had very high or high levels of psychological distress.
 - This was almost twice as high for females (25.9% and 14.8% for males).
 - This was four times higher (80.7%) for those with major depressive disorder based on self-report.

Figure 14: Prevalence of major depressive disorder in the past 12 months based on self-reports in 11-17 year-olds

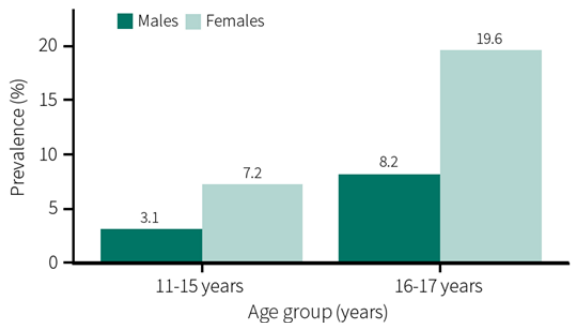


Figure 15: Prevalence of major depressive disorder in the past 12 months in 11-17 year-olds based on self-report and/or parent/carer reports

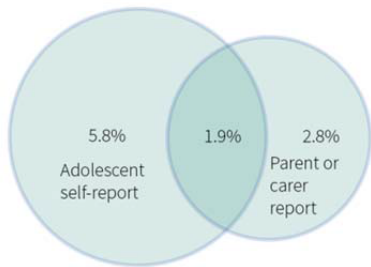
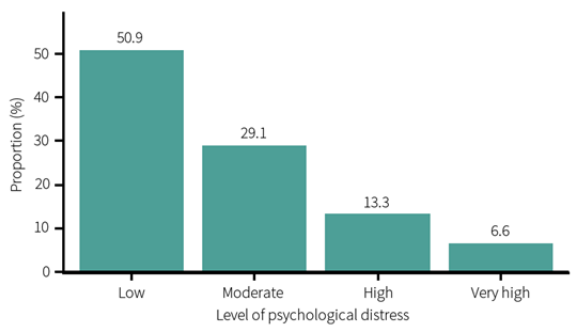


Figure 16: Psychological distress levels in 11-17 year-olds



WHAT ADOLESCENTS TOLD US ABOUT SERVICES THEY USED, OTHER SOURCES OF SUPPORT AND WHAT ELSE THEY DID TO HELP THEMSELVES

Young people aged 13 years and older were asked to provide information on the health, school and telephone counselling services that they used, as well as if they had used the internet to help them with emotional and behavioural problems. They also provided their perspective on whether their needs for help were met, as well as barriers to seeking help.

Services and support

- In addition to receiving health and school services, young people used a variety of other sources of support for their emotional and behavioural problems.
- Of all young people aged 13-17 years 3.6% reported using telephone counselling.
- Just over a fifth (22.2%) of 13-17 year-olds had used internet services.
 - 10.0% used online assessment tools.
 - 4.4% used online self-help.
 - 3.1% participated in a chat room or online support group.
 - 1.7% received online personal support or counselling.
- Three fifths (62.9%) of adolescents reported receiving informal help or support for emotional and behavioural problems, most often from parents and friends. The proportion was much higher at 93.9% for adolescents with major depressive disorder based on self-report.

Behaviours to assist with mental health

- Two thirds (66.4%) of adolescents reported other strategies to help them manage any emotional or behavioural problems that they may have had or to avoid having problems.
- More often they did positive things, such as doing more exercise or taking up a sport (37.9%), doing more activities they enjoyed (45.1%), seeking support from friends (24.4%) and improving their diet (23.2%).

- Just under one in 12 (7.9%) reported smoking cigarettes, or using alcohol or drugs to help. The proportion was much higher at 31.5% for adolescents with major depressive disorder based on self-report.

Perceived need for help

- Four fifths (82.4%) of 13-17 year-olds reported needing some type of help for emotional and behavioural problems in the previous 12 months. Of these, three quarters (76.8%) had their needs fully or partially met.
- The proportions needing help and whose needs were met were far higher for those with more severe disorders, with 90.6% of 13-17 year-olds with major depressive disorder based on self-report indicating they had needed help and 88.0% that these needs were met in the previous 12 months.

Barriers to seeking help or receiving more help

- The most common reasons for not seeking help or receiving more help given by 13-17 year-old adolescents with major depressive disorder based on self-report were related to stigma or poor mental health literacy.
 - 62.9% worried what other people might think or not want to talk to a stranger.
 - 61.7% thought the problem would get better by itself.
 - 57.1% wanted to work out the problem on their own or with help from family or friends.

WHAT ADOLESCENTS TOLD US
ABOUT SELF-HARM

The term self-harm refers to deliberately hurting or injuring yourself without trying to end your life. It is often done secretly.

- Around one in 10 12-17 year-olds (10.9%) reported having ever self-harmed.
 - This is equivalent to 186,000 young people aged 12-17 years who had deliberately injured themselves.
 - About three quarters (73.5%) of these adolescents had harmed themselves in the previous 12 months.
- Self-harm was roughly twice as high in females compared with males and also in older compared with younger adolescents.
- Females aged 16-17 years had the highest rates of self-harm, with 16.8% having harmed themselves in the previous 12 months.
- Self-harm was markedly higher in young people with major depressive disorder. One quarter (25.8%) of males and just over half (54.9%) of females with major depressive disorder (based on self-report) had harmed themselves in the previous 12 months.
- Self-harm can result in serious injuries and 0.8% of young people had been admitted to hospital as a direct result of these injuries.

Figure 17: Self harm in the past 12 months in 12-17 year-olds by sex and age group

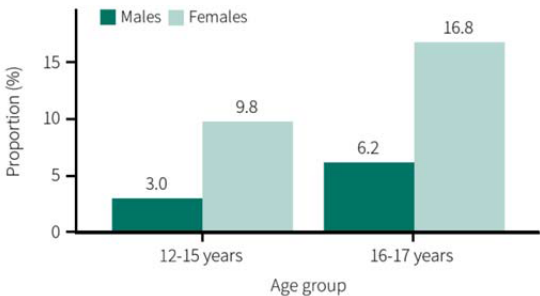
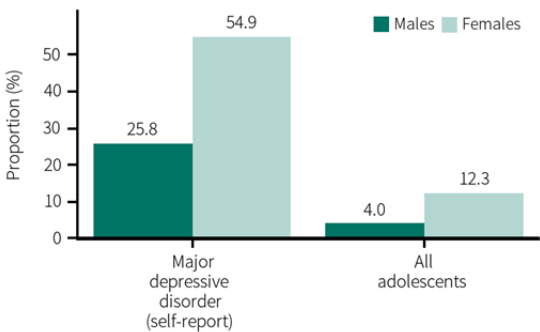


Figure 18: Self-harm in the past 12 months in 12-17 year-olds with major depressive disorder based on self-report and for all adolescents by sex



WHAT ADOLESCENTS TOLD US
ABOUT SUICIDAL BEHAVIOURS

Suicidal behaviours include suicidal ideation (serious thoughts about taking one’s own life), suicide plans and suicide attempts. These differ from self-harm in that the self-injury is intended to end in death.

- About one in thirteen (7.5%) 12-17 year-olds had seriously considered attempting suicide in the previous 12 months. This is equivalent to around 128,000 young people aged 12-17 years.
- One in twenty (5.2%) had made a plan.
- One in forty (2.4%) or around 41,000 12-17 year-olds reported having attempted suicide in the previous 12 months. One quarter or 0.6% received medical treatment as a result of their injuries.
- Suicidal behaviours were more common in females than males and in 16-17 year-olds compared with younger adolescents.
- Around one in seven (15.4%) females aged 16-17 years had seriously considered attempting suicide and one in twenty (4.7%) had attempted suicide in the previous 12 months.
- The rates of all suicidal behaviours were markedly higher in young people with major depressive disorder. These were even higher for young females with major depressive disorder.
 - Approximately half (56.4%) of females aged 12-17 years with major depressive disorder (based on self-report) had seriously considered suicide and just over a fifth (22.1%) had attempted suicide in the previous 12 months.
 - 13.8% of males aged 12-17 years with major depressive disorder (based on self-report) had attempted suicide in the previous 12 months.

Figure 19: Suicidal behaviours in the past 12 months among 12-17 year-olds by sex and age group

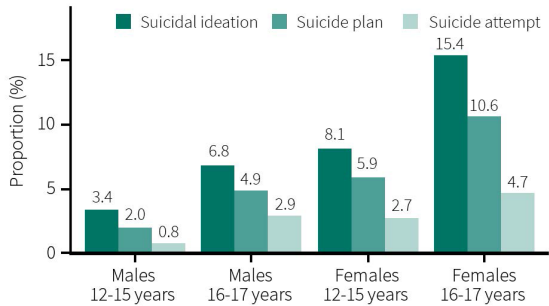
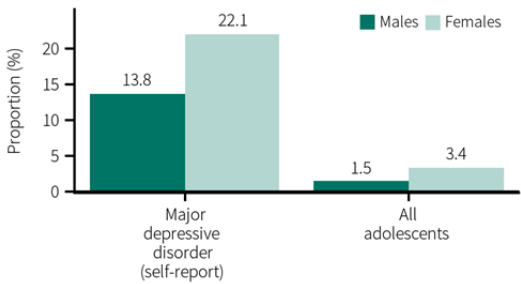


Figure 20: Suicide attempts in the past 12 months in 12-17 year-olds with major depressive disorder based on self-report and for all adolescents by sex



WHAT ADOLESCENTS TOLD US

ABOUT BEHAVIOURS THAT COULD PUT THEM AT RISK

Young people aged 11 years and older provided information on face-to-face and cyber bullying, problem eating behaviours and other behaviours that could put them at risk physically and/or mentally.

Bullying

- One third (34.3%) of 11-17 year-olds had been bullied in the previous 12 months. 11.3% felt a lot or extremely upset when bullied.
- Three fifths (62.8%) of young people with major depressive disorder based on self-report had been bullied in the previous 12 months, and they were bullied more often.
 - Three times as many (28.3% compared with 10.0% of all adolescents) were bullied every few weeks or more often.
 - Two fifths (39.4%) felt a lot or extremely upset when bullied.
- One in eight (12.7%) young people bullied someone else every few months or less and 2.0% did so every few weeks or more often in the previous 12 months. Young people with major depressive disorder were roughly twice as likely (22.5%) to bully someone else.

Problem eating behaviours

- Low weight problem eating behaviours (underweight on the age-adjusted BMI and practising weight controlling behaviours) were reported by 1.1% of 11-17 year-olds
- Binge eating and purging were reported by 1.3% of 11-17 year-olds.

Smoking, alcohol and other substance use

- One in fourteen (7.2%) 13-17 year-olds had smoked in the last 30 days.
- Smoking was higher for young people with major depressive disorder, with one quarter (24.4%) having smoked in the last 30 days.

- Just over one in six (18.1%) young people had drunk alcohol in the last 30 days and 12.5% had drunk more than four drinks in a row in the last 30 days.
- Alcohol consumption was higher among young people with major depressive disorder based on self-report, with 27.6% having drunk more than four drinks in a row in the last 30 days.
- One in twenty (5.0%) young people had used cannabis and 1.6% had used other drugs in the last 30 days.
- Use was far higher for young people with major depressive disorder based on self-report, with 13.1% having used cannabis and 6.1% other drugs in the last 30 days.

Internet use and electronic gaming

- One quarter (24.9%) of 11-17 year-olds spent 3-4 hours a day on weekdays on the internet, while 17.6% spent 5-8 hours and 10.3% spent 9 hours or more. Use was similar on the weekend (25.9%, 23.7% and 12.1%).
- One eighth (12.2%) of 11-17 year-olds spent 3-4 hours a day on weekdays playing electronic games, while 6.9% spent 5-8 hours and 2.5% spent 9 hours or more. Use almost doubled on the weekend (19.7%, 12.3% and 4.7%).
- Internet use and/or electronic gaming were highly problematic for 3.9% of 11-17 year-olds, affecting their ability to eat, sleep, and spend time with family, friends and doing homework.

COMPARISONS BETWEEN THE FIRST AND SECOND SURVEYS

The first national survey of the mental health of children and adolescent was undertaken in 1998. This produced the first evidence of the prevalence of mental disorders in Australian young people and their use of services for these problems. While the second survey has the same focus and was designed to enable comparisons to be made, there are some significant differences in the mental disorders assessed, and the service use timeframe and scope.

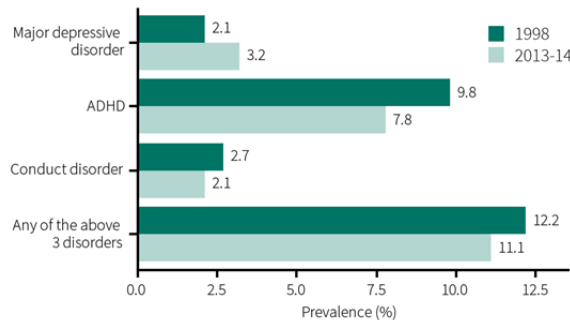
Prevalence of disorders

- The DISC-IV was used in both the first and second surveys to assess whether young people had mental disorders according to the standard DSM-IV diagnostic criteria.
- In 1998 major depressive disorder, dysthymic disorder, attention-deficit/hyperactivity disorder, conduct disorder and eating disorders were assessed.
- In 2013-14 the dysthymic and eating disorders modules were not included, as the prevalences for these were found to be too low for reporting in 1998.
- Four types of anxiety disorder (social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder) were also included in 2013-14. These were found to affect 6.9% of children and adolescents, with the majority only experiencing anxiety disorders. This has a significant impact on comparisons between surveys of the overall prevalence of mental disorders.
- Comparison of prevalence data from 1998 and 2013-14 did not reveal a great deal of change overall, however, there were significant changes in the prevalence of each of those mental disorders covered by both surveys.
 - The prevalence of major depressive disorder increased from 2.1% to 3.2% in 2013-14.
 - The prevalence of ADHD decreased from 9.8% to 7.8%.
 - Conduct disorder decreased slightly from 2.7% to 2.1%.

Service use

- The service use module was redesigned for the second survey, both to ensure its relevance to the current mental health care environment, particularly the development of online information and services, and to better capture the role of schools in providing services, referrals and support.
- The first survey produced evidence of service use in the previous 6 months, and found that only 31.2% of 6-17 year olds with mental disorders used services in 1998. By contrast the second survey found 68.3% of this population used services, but this was measured over a 12-month period.
- While differences in survey content and time periods covered make comparisons difficult, the increase in use of services is higher than is likely to be attributable to changes in methodology alone. On balance, the data suggest that there has been a significant increase in service use by children and adolescents with mental disorders in Australia between 1998 and 2013-14.

Figure 21: 12-month prevalence of selected mental disorders among 6-17 year-olds in 1998 and 2013-14



PART 1

Introduction

The second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter) was designed to provide current information about the mental health and wellbeing of children and adolescents in Australia and the extent to which they use health and education services to obtain help with problems.

The main aims of the survey were to determine:

1. How many children and adolescents have which mental health problems and disorders.
2. The nature of these mental health problems and disorders.
3. The impact of these problems and disorders.
4. How many children and adolescents have used services for mental health problems and disorders.
5. The role of the education sector in providing services for children and adolescents with mental health problems and disorders.

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1 INTRODUCTION

Young Minds Matter: The second Australian Child and Adolescent Survey of Mental Health and Wellbeing is part of the National Survey of Mental Health and Wellbeing initiative. This is an Australian Government Department of Health funded initiative comprising national surveys of adults in the general population in 1997 and 2007, those with psychotic illnesses in 1997-98 and 2010, and the first national child and adolescent survey.

The 1998 Australian Child and Adolescent Survey of Mental Health and Wellbeing was the first national survey anywhere in the world to focus on the mental health of children and adolescents. The survey found that mental health problems were relatively common, with approximately 14% of children and adolescents having mental health problems based on scores obtained from the Child Behaviour Checklist (CBCL). It also found that only one in four children and adolescents with mental health problems had attended professional services in the six months prior to the survey.

Since 1998 there have been substantial changes in the way mental health care is provided in Australia. There have been significant changes in people's understanding of mental health. A range of new programmes and services has been developed in the education and health sectors that provide information, support, and specialist help for young people and their families. Programmes such as *KidsMatter* and *Mind Matters* promote mental health through the school environment. While each jurisdiction has taken its own approach, schools are generally providing higher levels of support, including access to specialist counselling. Through the Australian Government's *Better Access* programme introduced in November 2006, more general practitioners have been trained in supporting the mental health needs of children and adolescents and their families, and children and families now have access to Medicare-subsidised psychological therapy. Also launched in 2006, *headspace* has rapidly expanded and provides a range of support services for young people aged 12-25 years with emotional and behavioural problems and substance use problems. Additionally, several counselling services are now available by telephone, and a range of internet-based services has also been created that provide information and counselling support online.

A second national adult survey of mental health and wellbeing was conducted in 2007. The survey found approximately one in five adults had experienced a mental health problem in the preceding year, and for a substantial proportion of these adults, their problems first started in childhood or adolescence. While access to mental health services has improved considerably, it is recognised that for many people there can still be substantial delays in seeking help, at the time when early interventions may have the greatest impact.

The second Australian Child and Adolescent Survey not only provides data that complements other national surveys, but also presents a contemporary picture of mental disorders and services used by those young people who have mental health problems.

1.1 *Young Minds Matter*

The Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (*Young Minds Matter*) was designed to provide current information about the mental health and wellbeing of

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children and adolescents in Australia and the extent to which they use health and education services to obtain help with problems.

The main aims of the survey were to determine:

1. How many children and adolescents have which mental health problems and disorders.
2. The nature of these mental health problems and disorders.
3. The impact of these problems and disorders.
4. How many children and adolescents have used services for mental health problems and disorders.
5. The role of the education sector in providing services for children and adolescents with mental health problems and disorders.

In order to fulfil these aims a broad range of information was collected from parents and carers, and adolescents themselves. This included diagnostic modules, questions specifically tailored for the Australian health care environment and schools, and sections dealing with current practices, including the use of the internet. Background information about the environment in which young people live and develop, including the functioning of families and mental health of their parents and carers, and their experiences at school and online, was also collected.

Mental disorders were assessed using specific diagnostic modules from the Diagnostic Interview Schedule for Children Version IV (DISC-IV) and a specifically developed Impact on Functioning module. The DISC-IV is a standardised diagnostic instrument developed under the auspices of the United States National Institute of Mental Health, which is used worldwide to assess mental disorders in large samples. Disorder status is determined according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders Version IV* (DSM-IV), which is the diagnostic classification system used clinically world-wide. DISC-IV modules for seven disorders were included in the survey:

- Anxiety disorders: Social phobia, separation anxiety disorder, generalised anxiety disorder and obsessive-compulsive disorder;
- Major depressive disorder;
- Attention-Deficit/Hyperactivity Disorder (ADHD); and
- Conduct disorder.

1.2 Who conducted the survey?

The Australian Government Department of Health funded *Young Minds Matter* and commissioned The University of Western Australia to undertake the survey through the Telethon Kids Institute in partnership with Roy Morgan Research. Data were collected between June 2013 and April 2014 by trained interviewers.

The survey was developed with guidance from a Survey Reference Group, comprising over 20 experts in mental health for children and adolescents (spanning the health, education and community sectors), as well as consumer and community representatives.

1.3 Who was surveyed?

The survey aimed to collect information from 5,500 randomly sampled families who had children and adolescents aged 4-17 years from across the country, with the exception of very remote areas. An additional random sample of 800 families with adolescents aged 16-17 years was also undertaken to enable specific estimates to be produced for this age group. In total 76,606 households were approached and those eligible households with children in the age range were visited up to a maximum of six times to make contact with the household.

Area based sampling was used to select both samples and where there was more than one child in a household, a child was selected at random by a computer.

In total 6,310 parents and carers or 55% of eligible households responded and 2,967 or 89% young people aged 11-17 years in those households for whom their parents or carers had given permission also completed a questionnaire.

Analyses showed the sample to be representative of Australian children and adolescents aged 4-17 years on the basis of the age and sex of the child, family structure, parental education, income and employment, housing tenure and country of birth of both children and adolescents and their parents and carers.

1.4 What were they asked?

The survey was based on a face-to-face interview with the parent or primary carer for each selected child. When the selected child was aged 11 years or older, they were also invited to complete a confidential questionnaire on a tablet computer.

The parent and carer interview comprised the following modules:

- Demographics;
- Diagnostic Interview Schedule for Children (DISC-IV) modules;
- Level of functional impairment;
- Strengths and Difficulties Questionnaire (SDQ);
- Use of services and perceived need for services;
- Education; and
- Family characteristics, including measures of parental mental health and family functioning.

The youth questionnaire comprised the following modules:

- DISC-IV major depressive disorder module;
- Presence of symptoms of psychosis;
- Strengths and Difficulties Questionnaire (SDQ);

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- An enhanced version of the Kessler 10 Psychological Distress Scale (K10+);
- Use of services and perceived need for services;
- Use of internet and electronic games;
- Youth health-risk behaviours, including self-harm, suicidal behaviours, substance use, problem eating behaviours and sexual behaviour;
- Experience of bullying;
- Level of education; and
- Level of self-esteem.

1.5 Strengths and limitations of the survey

The survey provides estimates of the prevalence of mental disorders in children and adolescents in Australia using a methodology that assesses these against the DSM-IV diagnostic criteria used in most clinical settings. For the purposes of the survey seven DISC-IV modules were used, assessing seven mental disorders. The most recent version of the DISC-IV, however, is able to address more than 30 psychiatric diagnoses. This has had a three-fold effect. Firstly, prevalence data are not available for less common mental disorders. Secondly, there is an underestimation of the comorbidity of disorders, as some young people who participated in the survey may have had other mental disorders not covered. Finally, the overall prevalence of mental disorders among children and adolescents is an underestimate. From evidence of other surveys both in Australia and internationally, these seven disorders are the most common disorders. So, while the exact level of this underestimation is unable to be determined, it is considered to be small in relation to the overall prevalence.

International, standardised instruments for the assessment of mental disorders and mental health problems have been used whenever possible. These include the DISC-IV, the Strengths and Difficulties Questionnaire (SDQ) and the Kessler 10. This will facilitate international comparability of the results, and will allow for the data to be analysed together with that of other Australian surveys and data collections.

Additional questions have been added to the survey to improve its applicability to the Australian context, particularly in relation to use of services. These questions have been written specifically for this survey to be relevant to the Australian health and education context.

While it is possible to provide data on primary and secondary school-aged children, the sample was not large enough to provide prevalence data or support further disaggregation of data for single year age groups.

In spite of systematic efforts to improve approaches to households, reduce refusals and provide incentives for participation, the 55% response rate was lower than expected, and lower than the 70% achieved in the 1998 survey. However, there is little evidence of any systematic biases and the results are considered to be statistically representative of Australian children and adolescents aged 4-17 years.

1.6 Presentation of data and scope of the report

This report provides the main summary results from *Young Minds Matter*.

Standard statistical and reporting protocols have been observed throughout the report, and the data processed, analysed and presented as follows:

- Data from both the main sample and oversample of 16 and 17 year-olds have been combined into a single data set and weighted appropriately to represent the population of children and adolescents aged 4-17 years in Australia.
- The data have been collated from the responses by parents and carers, and adolescents aged 11-17 years. When they are from adolescent self-reports this has been noted.
- Where table cells were based on less than five individuals, the data have been suppressed.
- The 95% confidence intervals for all data have been examined and only those differences that are statistically significant (i.e. not likely to be due to chance) with this level of confidence have been highlighted in the text.

The report includes estimates of the number of children and adolescents who have mental disorders and social and emotional problems. The primary findings on the prevalence of mental disorders presented in Chapter 2 and data on the four specific types of disorders covered in Chapters 3 to 6 are based on the reports of the parent or primary carer for each child. Prevalence of major depressive disorder based on the reports of young people themselves is included in Chapter 10.

A particular focus of the survey was on the use of services in the health and education sectors. Service use, by health service providers, in schools, telephone and online services are covered in Chapter 7 and Chapter 13 presents what young people reported about what they used, also including informal supports. Further information on the role of schools is provided in Chapter 9.

The survey included an assessment by each primary carer of whether they felt their child needed help or support for any emotional or behavioural problems, what support or services they received, and whether they felt the support met their children's needs. Where parents or carers identified needs that were not being met, the survey sought to identify the reasons or barriers for not seeking or receiving further services. This information on perceived need is covered in Chapter 8.

Self-harm and suicidality, and the use of alcohol and other drugs, and problem eating behaviours, as reported by young people themselves, are covered in Chapters 11 and 12.

The Appendix provides more detailed information on the methodology and technical issues, as well as further information on access to online tables and the Confidentialised Unit Record File, which is available subject to the necessary approvals through the Australian Data Archive.

A Glossary of terms used in the survey and this report is also appended.

EXHIBIT 662

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PART 2

Prevalence of mental disorders in children and adolescents

A key aim of the survey was to provide current estimates of the prevalence of mental disorders in Australian children and adolescents.

Parents and carers were asked to complete a questionnaire with a trained interviewer consisting of 22 modules. This included a number of diagnostic modules to determine the prevalence of mental disorders in children and adolescents.

The *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) is a validated tool for identifying mental disorders in children and adolescents according to criteria specified in the *Diagnostic and Statistical Manual for Mental Disorders Version IV* (DSM-IV). The DISC-IV was the main tool used to assess mental disorders in children and adolescents. Modules from the DISC-IV administered to parents and carers included:

- Anxiety disorders
 - Social phobia
 - Separation anxiety disorder
 - Generalised anxiety disorder
 - Obsessive-compulsive disorder
- Major depressive disorder
- Attention-deficit/hyperactivity disorder
- Conduct disorder

Responses from parents and carers provided the information necessary for diagnoses of each of these mental disorders according to the DSM-IV diagnostic classification, as well as a measure of the impact of these disorders.

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2 OVERVIEW OF MENTAL DISORDERS (DISC-IV)

Diagnostic modules from the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) were used to assess the seven most common and disabling mental disorders experienced by children and adolescents. These included major depressive disorder, attention-deficit/hyperactivity disorder (ADHD), conduct disorder, and four anxiety disorders. Anxiety is not a single disorder, but a class of disorders, and children and adolescents were assessed for the four anxiety disorders that are most common and cause the greatest distress, namely: social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder. The DISC-IV is a standardised instrument used worldwide and developed under the auspices of the United States National Institute of Mental Health. It was used in the first child and adolescent survey in Australia in 1998 and again in this survey to assess the prevalence of mental disorders and the severity of impact of these on Australian children and adolescents.

2.1 Overall prevalence of mental disorders in children and adolescents

In the 12 months prior to the survey around one in seven (13.9%) children and adolescents aged 4-17 years experienced a mental disorder (Table 2-1). This is equivalent to an estimated 560,000 Australian children and adolescents.

ADHD was the most common mental disorder overall, with 7.4% of children and adolescents assessed as having ADHD in the previous 12 months. Anxiety disorders were the next most common (6.9%), followed by major depressive disorder (2.8%) and conduct disorder (2.1%).

2.1.1 Sex and age differences

The prevalence of mental disorders varied considerably between males and females, with 16.3% of males and 11.5% of females having had a mental disorder in the previous 12 months.

The difference between the sexes was mainly due to the higher prevalence of ADHD in males (10.4% compared with 4.3% for females). Conduct disorder was also more common in males (2.5%) than females (1.6%). However, the rate of depression was slightly higher in females (3.1% compared with 2.5% in males). There was little difference in the prevalence of anxiety disorders.

Table 2-1: 12-month prevalence of mental disorders among 4-17 year-olds by sex

Disorder	Males population estimate	Males prevalence (%)	Females population estimate	Females prevalence (%)	Persons population estimate	Persons prevalence (%)
Anxiety disorders	145,000	7.0	133,000	6.8	278,000	6.9
Major depressive disorder	50,900	2.5	61,300	3.1	112,000	2.8
ADHD	215,000	10.4	83,200	4.3	298,000	7.4
Conduct disorder	52,400	2.5	31,200	1.6	83,600	2.1
Any mental disorder (a)	335,000	16.3	225,000	11.5	560,000	13.9

(a) Totals are lower than the sum of disorders as children and adolescents may have had more than one class of mental disorder in the previous 12 months.

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There were some distinct differences in the prevalence of disorders between children and adolescents (Table 2-2).

ADHD continued to be the most common disorder for males into their teen years (10.9% for 4-11 year-olds and 9.8% for 12-17 year-olds), but the prevalence halved for females (5.4% for 4-11 year-olds to 2.7% for 12-17 year-olds).

The prevalence of major depressive disorder was higher in adolescents compared to those aged 4-11 years for both sexes. Among those aged 4-11 years prevalence was almost the same at 1.2% for females and 1.1% for males. However, among adolescents the prevalence of major depressive disorder was 5.8% for females and 4.3% for males.

Table 2-2: 12-month prevalence of mental disorders among 4-17 year-olds by sex and age group

Disorder	Males 4-11 years (%)	Males 12-17 years (%)	Females 4-11 years (%)	Females 12-17 years (%)	Persons 4-11 years (%)	Persons 12-17 years (%)
Anxiety disorders	7.6	6.3	6.1	7.7	6.9	7.0
Major depressive disorder	1.1	4.3	1.2	5.8	1.1	5.0
ADHD	10.9	9.8	5.4	2.7	8.2	6.3
Conduct disorder	2.5	2.6	1.6	1.6	2.0	2.1
Any mental disorder	16.5	15.9	10.6	12.8	13.6	14.4

2.2 Social and demographic characteristics

Several socio-demographic characteristics were examined for their association with the prevalence of mental disorders. These included family type, household income, level of parent and carer education, parent and carer labour force status, area of residence and family functioning. Table 2-3 to Table 2-8 show the relationships of these characteristics to the prevalence of mental disorders.

Children and adolescents in low-income families, with parents and carers with lower levels of education and with higher levels of unemployment had higher rates of mental disorders in the previous 12 months. There was also a strong relationship with where they lived with higher rates of mental disorders in non-metropolitan areas. This was particularly evident in males. However, while it is possible to identify sub-groups in which the prevalence of mental disorders is relatively high, it is not possible to draw conclusions about the causal relationships between these demographic characteristics and mental illness, or to exclude the possibility that the association may be due to another factor with which both are associated.

2.2.1 Family type

Table 2-3 shows the prevalence of mental disorders for children and adolescents in different types of families. Young people in step, blended and one parent or carer families had higher rates of mental disorders than young people living in original families, that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The prevalence was higher for males than females in both two parent and one parent families.

Table 2-3: 12-month prevalence of mental disorders among 4-17 year-olds by family type and sex

Family type	Males (%)	Females (%)	Persons (%)
Families with two parents or carers	13.9	9.6	11.8
Original family	12.4	8.4	10.4
Step family	21.1	15.6	18.3
Blended family	24.0	16.4	20.2
Other family (a)	29.5	18.4	23.7
Families with one parent or carer	25.3	19.2	22.4

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.

‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

2.2.2 Household income

Table 2-4 shows the association of the prevalence of mental disorders with income. Children and adolescents in families in the lowest income bracket (less than \$52,000 per year or \$1,000 per week) had the highest rate of mental disorders in the previous 12 months, with this being almost double that of young people in the highest income bracket (\$130,000 or more per year or \$2,500 or more per week) (24.4% and 12.3% respectively in males and 16.1% and 8.8% respectively in females).

Table 2-4: 12-month prevalence of mental disorders among 4-17 year-olds by household income and sex

Household income before tax	Males (%)	Females (%)	Persons (%)
\$130,000 or more per year	12.3	8.8	10.5
\$52,000-\$129,999 per year	13.8	10.8	12.3
Less than \$52,000 per year	24.4	16.1	20.5

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

2.2.3 Parent and carer education

Table 2-5 shows the highest level of education of either the young person’s primary or secondary parent or carer where present.

Males from families where the highest level of education of either parent or carer was year 10 or below had the highest rates of mental disorders in the previous 12 months (26.2%). This was over twice as high as females in the same category (12.7%) and males whose primary and/or secondary parent or carer had a bachelor or higher degree (12.5%).

Table 2-5: 12-month prevalence of mental disorders among 4-17 year-olds by parent or carer education and sex

Highest level of education of either primary or secondary parent or carer	Males (%)	Females (%)	Persons (%)
Bachelor degree or higher	12.5	8.8	10.6
Diploma or certificate III/IV	17.0	14.5	15.8
Year 11 or 12	19.4	10.6	15.4
Year 10 or below	26.2	12.7	19.7

2.2.4 Parent and carer labour force status

Children and adolescents with no parents or carers in employment had higher rates of mental disorders than children and adolescents living in households with one or both parents or carers in employment (Table 2-6). The highest rates of mental disorder were in families in which the sole parent or carer was not in employment, where 29.6% of children and adolescents had mental disorders in the previous 12 months. The rate was markedly less when the sole parent or carer was employed (17.0%).

Table 2-6: 12-month prevalence of mental disorders among 4-17 year-olds by parent or carer labour force status and sex

Parent or carer labour force status	Males (%)	Females (%)	Persons (%)
Both parents or carers employed	12.6	9.0	10.8
One parent or carer employed, one parent or carer not in employment	15.5	10.1	12.9
Both parents or carers not in employment	23.4	18.7	21.3
Sole parent or carer employed	16.9	17.1	17.0
Sole parent or carer not in employment	36.0	22.0	29.6

‘Not in employment’ combines unemployed and not in the labour force.

2.2.5 Area of residence

Children and adolescents who lived outside of the greater capital city areas had higher rates of mental disorders compared with those living in other areas (Table 2-7). This was particularly so for males, with almost one in five (19.6%) young males residing outside of the greater capital city areas having had a mental disorder in the previous 12 months.

Table 2-7: 12-month prevalence of mental disorders among 4-17 year-olds by area of residence and sex

Area of residence	Males (%)	Females (%)	Persons (%)
Greater capital cities	14.2	11.0	12.6
Rest of state	19.6	12.4	16.2

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

2.2.6 Family functioning

A shortened version of the general functioning subscale of the McMaster Family Assessment Device was used to assess the level of family functioning. This covers issues such as communication and planning within the family, dealing with conflict, and levels of emotional and practical support. Of all families in the survey 3.7% had a level of family functioning assessed on the McMaster scale as poor, indicating unhealthy family functioning likely to require clinical intervention.

Table 2-8 shows that the prevalence of mental disorders increased with decreasing levels of family functioning. Just over one third (35.3%) of young people in families with poor family functioning had a mental disorder. However, 15.3% in families with good family functioning and 10.9% in those with very good family functioning had a disorder. Similar associations were observed for both sexes.

Table 2-8: 12-month prevalence of mental disorders among 4-17 year-olds by level of family functioning

Level of family functioning	Males (%)	Females (%)	Persons (%)
Very good	12.7	9.1	10.9
Good	16.7	13.8	15.3
Fair	25.3	13.5	19.7
Poor	36.4	33.8	35.3

2.3 Impact of mental disorders

2.3.1 Severity of impact on functioning

One of the key aims of the survey was to determine the severity of the impact of mental disorders on the functioning of young people and, in particular, how this impact was associated with various facets of their lives. The survey measured the severity of impact of mental disorders in four different domains of functioning: At school or work, with friends and social activities, on the family and on the children themselves. This information also allowed estimating the overall severity of impact of mental disorders across all of these domains. Severity of impact was classified to be mild, moderate or severe. To ease interpretation, throughout this publication, the terms “severity of impact on function”, “severity of impact”, and “severity of disorder” or just “severity” will be used interchangeably, or the phrases mild disorder, moderate disorder and severe disorder will be used.

Overall 13.9% of children and adolescents aged 4-17 years had mental disorders with 8.3% having mild severity of impact, 3.5% had moderate severity of impact and 2.1% had severe disorder (Table 2-9).

For children with anxiety disorders, ADHD and conduct disorder the majority of these had a mild impact on functioning, with fewer that were moderate and fewer again severe. However, the converse was true with major depressive disorder, with the largest proportion of children (42.9% of those with major depressive disorder or 1.2% of all 4-17 year-olds) classified as having a severe impact, less as moderate (1.0% of 4-17 year-olds) and less again as mild (0.6% of 4-17 year-olds).

Table 2-9: 12-month prevalence of mental disorders among 4-17 year-olds by type of disorder and severity

Disorder	Mild (%)	Moderate (%)	Severe (%)	Total (%)
Any anxiety disorder	3.7	1.9	1.3	6.9
Major depressive disorder	0.6	1.0	1.2	2.8
ADHD	4.9	1.8	0.8	7.4
Conduct disorder	1.2	0.5	0.4	2.1
Any mental disorder	8.3	3.5	2.1	13.9

Three fifths (59.8%) of children and adolescents with a mental disorder had disorders with a mild impact on functioning, one quarter (25.4%) were moderate, and 14.7% were assessed as severe. There was little difference in the proportions of males and females at each level of impact. There were, however, marked differences between children and adolescents, with almost three times as many adolescents as children with mental disorders with severe impact (23.1% for 12-17 year-olds compared with 8.2% for 4-11 year-olds). In contrast, far more children had disorders with mild impact than adolescents (72.1% of 4-11 year-olds compared with 44.1% of 12-17 year-olds) (Table 2-10).

Table 2-10: Severity of mental disorders among 4-17 year-olds with mental disorders by sex and age group

Sex	Age group	Mild (%)	Moderate (%)	Severe (%)
Males	4-11 years	69.8	20.4	9.9
	12-17 years	44.4	31.9	23.7
	4-17 years	59.2	25.2	15.6
Females	4-11 years	75.9	18.5	5.6
	12-17 years	43.8	33.9	22.4
	4-17 years	60.8	25.8	13.4
Persons	4-11 years	72.1	19.7	8.2
	12-17 years	44.1	32.8	23.1
	4-17 years	59.8	25.4	14.7

When children and adolescents had mental disorders, slightly more of these disorders had a severe impact in the domains of family and school or work than in the domains of friends and self (19.5% and 17.6% compared with 12.4% and 14.4% respectively). Overall 15.0% of children and adolescents with mental disorders had no impact on functioning in the domain of school or work, 26.5% had no impact in the friends domain, 14.4% had no impact in the family domain, and 14.8% had no impact on self (Table 2-11).

Table 2-11: Severity of impact in different life domains among 4-17 year-olds with mental disorders

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	15.0	26.5	14.4	14.8	
Mild	34.5	29.7	35.2	39.8	59.8
Moderate	29.3	31.4	30.8	31.0	25.4
Severe	17.6	12.4	19.5	14.4	14.7
Does not go to school or work	3.6				

2.3.2 Days absent from school

Where parents or carers reported symptoms of mental disorders in their children, they were asked how many days in the previous 12 months the child or adolescent was absent from school due to those symptoms. Because of the way the questions were asked it was not possible to calculate the total number of days absent from school due to any mental disorder if the child or adolescent had more than one disorder. Major depressive disorder was associated with the highest average number of days absent from school (20 days), followed by anxiety disorders (12 days), conduct disorder (8 days) and ADHD (5 days) (Table 2-12).

Table 2-12: Average days absent from school in past 12 months due to symptoms of mental disorders among 4-17 year-olds with mental disorders by type of disorder

Disorder	Average days absent
Any anxiety disorder	12
Major depressive disorder	20
ADHD	5
Conduct disorder	8

2.4 Comorbidity

Children and adolescents may experience more than one mental disorder within the same time period and this is referred to as comorbidity. Of the 13.9% of children and adolescents diagnosed with a mental disorder almost one third (30.0% or 4.2% of all 4-17 year-olds) had two or more disorders at some time in the previous 12 months. For this purpose the class of anxiety disorders have been considered as a single disorder and children could have a maximum of four disorders.

Over half of the children and adolescents with major depressive disorder (1.6% of all 4-17 year-olds) also had an anxiety disorder (Figure 2-1). Two thirds of the children and adolescents with conduct disorder also had another disorder (1.4% out of the 2.1% of all 4-17 year-olds with conduct disorders). One third of the children and adolescents with either anxiety disorders or major depressive disorder also had conduct disorder or ADHD in the previous 12 months (2.6% out of the 8.1% of all 4-17 year-olds with either or both). A small proportion of children and adolescents (0.4%) experienced three

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classes of mental disorder (anxiety disorders or major depressive disorder, ADHD and conduct disorder) in the previous 12 months (Figure 2-2).

Figure 2-1: Comorbidity of anxiety disorders and major depressive disorder among 4-17 year-olds

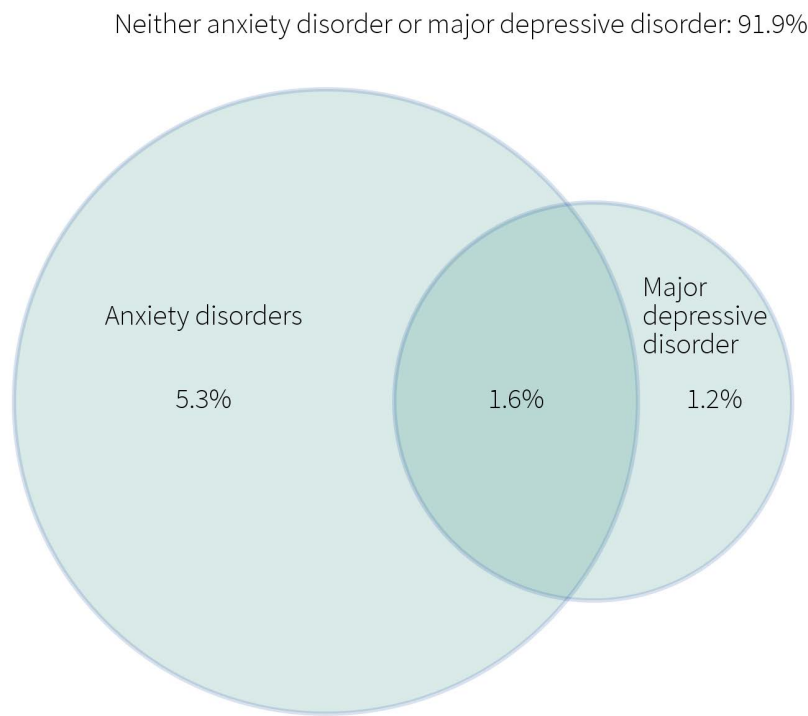
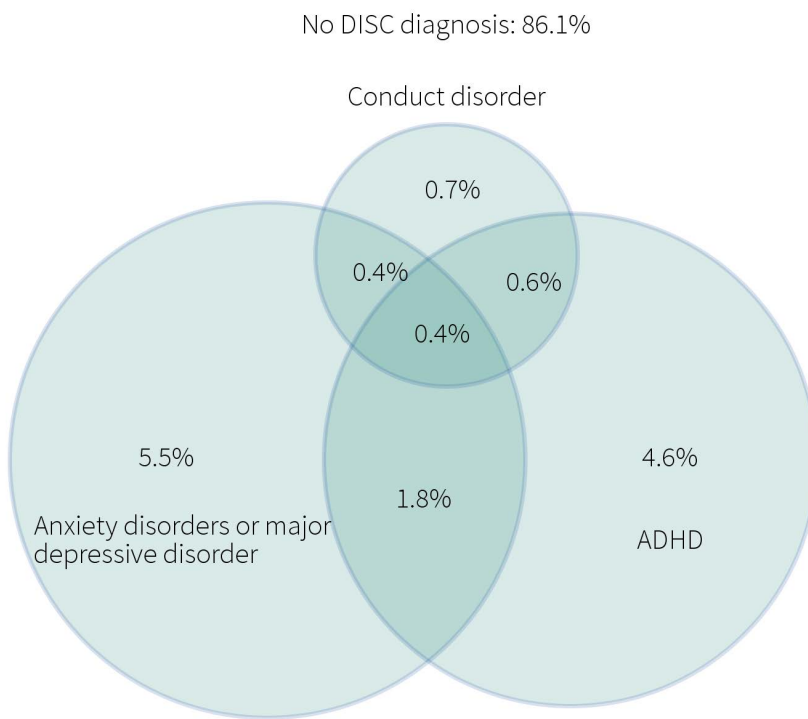


Figure 2-2: Comorbidity of anxiety or major depressive disorders, conduct disorder and ADHD among 4-17 year-olds



2.5 Principal condition

When a child or adolescent was found to have experienced more than one disorder in the previous 12 months, his or her parent or carer was asked which of the disorders caused the most distress to the child. This approach allows each person to be uniquely assigned to a principal condition.

ADHD and anxiety disorders were the most commonly identified principal conditions but their relative importance differed for males and females. ADHD was the most common principal condition for males (7.9%), while anxiety disorders were the most common principal condition for females (5.1%). Males and females had comparable rates of anxiety disorders (5.6% compared with 5.1%), major depressive disorder (1.6% compared with 2.4%) and conduct disorder (1.1% compared with 1.0%). However ADHD was more common identified as the principal condition in males than females (7.9% compared with 3.1%) (Table 2-13).

Table 2-13: Principal condition by sex

Disorder	Males (%)	Females (%)	Persons (%)
Any anxiety disorder	5.6	5.1	5.4
Major depressive disorder	1.6	2.4	2.0
ADHD	7.9	3.1	5.5
Conduct disorder	1.1	1.0	1.1
Any disorder	16.3	11.5	13.9

ADHD and anxiety disorders were both commonly identified as the principal condition for children and adolescents. However, ADHD was the most common principal condition for children aged 4-11 years while parents and carers identified that anxiety disorders were most common in adolescents aged 12-17 years (Table 2-14).

Table 2-14: Principal condition by age group

Disorder	4-11 years (%)	12-17 years (%)	4-17 years (%)
Any anxiety disorder	5.7	5.0	5.4
Major depressive disorder	0.6	3.8	2.0
ADHD	6.3	4.5	5.5
Conduct disorder	1.0	1.1	1.1
Any disorder	13.6	14.4	13.9

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3 MAJOR DEPRESSIVE DISORDER

This chapter presents data on children and adolescents who met diagnostic criteria as specified in DSM-IV for major depressive disorder based on information reported by parents and carers. The prevalence of major depressive disorder based on information reported by young people themselves is presented in Chapter 10.

Major depressive disorder

The key feature of major depressive disorder is the presence of either depressed mood, loss of interest or pleasure or being grouchy, irritable and in a bad mood. The DSM-IV criteria specify that at least five symptoms of depression must be present for a minimum of a two-week period, that these symptoms cause clinically significant distress to the child or adolescent and that they must interfere with the child or adolescent’s normal functioning at school, at home or in social settings. Symptoms of major depressive disorder may include significant weight loss or weight gain, loss of appetite, insomnia or hypersomnia, restlessness, fatigue and loss of energy, feelings of worthlessness and inability to concentrate.

3.1 Prevalence of major depressive disorder in children and adolescents

Overall 2.8% of children and adolescents aged 4-17 years met diagnostic criteria for major depressive disorder (Table 3-1). This corresponds to an estimated 112,000 children and adolescents in Australia with major depressive disorder. The prevalence of major depressive disorder in children aged 4-11 years was 1.1% in males and 1.2% in females. The prevalence of major depressive disorder was higher in the older age group. Some 4.3% of males 12-17 years and 5.8% of females 12-17 years had major depressive disorder.

Table 3-1: 12-month prevalence of major depressive disorder among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	1.1	1.2	1.1
12-17 years	4.3	5.8	5.0
4-17 years	2.5	3.1	2.8

3.2 Social and demographic characteristics

Table 3-2 through Table 3-7 show the 12-month prevalence of major depressive disorder by a range of socio-demographic characteristics, including family type, household income, parent or carer education and labour force status, area of residence and family functioning. Overall prevalence of depression was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

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3.2.1 Family type

The prevalence of major depressive disorder was lowest in original families (1.7%), that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The prevalence of major depressive disorder was higher for young people in step families (4.7%), and in families with just one parent or carer (5.5%) (Table 3-2).

Table 3-2: 12-month prevalence of major depressive disorder among 4-17 year-olds by family type

Family type	Prevalence (%)
Families with two parents or carers	2.1
Original family	1.7
Step family	4.7
Blended family	3.5
Other family (a)	9.4
Families with one parent or carer	5.5

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.

‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

3.2.2 Household income

The prevalence of major depressive disorder was lowest in families with higher household incomes (1.8% in families with a household income of \$130,000 or more per year) and highest (3.8%) in families in the lowest household income bracket (Table 3-3).

Table 3-3: 12-month prevalence of major depressive disorder among 4-17 year-olds by household income

Household income before tax	Prevalence (%)
\$130,000 or more per year	1.8
\$52,000-\$129,999 per year	2.7
Less than \$52,000 per year	3.8

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

3.2.3 Parent and carer education

The differences in the prevalence of major depressive disorder by parent or carer education were small and not statistically significant (Table 3-4).

Table 3-4: 12-month prevalence of major depressive disorder among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Prevalence (%)
Bachelor degree or higher	2.1
Diploma or certificate III/IV	3.0
Year 11 or 12	4.1
Year 10 or below	3.5

3.2.4 Parent and carer labour force status

The prevalence of major depressive disorder was higher in families with a sole parent or carer not in employment (6.9%) compared with families with two parents or carers both in employment (1.8%) (Table 3-5).

Table 3-5: 12-month prevalence of major depressive disorder among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Prevalence (%)
Both parents or carers employed	1.8
One parent or carer employed, one parent or carer not in employment	2.4
Both parents or carers not in employment	4.9
Sole parent or carer employed	4.6
Sole parent or carer not in employment	6.9

‘Not in employment’ combines unemployed and not in the labour force.

3.2.5 Area of residence

There was no difference in the prevalence of major depressive disorder for children and adolescents living in greater capital city areas compared with those living in other areas (Table 3-6).

Table 3-6: 12-month prevalence of major depressive disorder among 4-17 year-olds by area of residence

Area of residence	Prevalence (%)
Greater capital cities	2.8
Rest of state	2.8

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

3.2.6 Family functioning

The prevalence of major depressive disorder was higher in children and adolescents from families with poorer levels of family functioning, varying from 2.1% for those with very good family functioning up to 7.7% for those with poor family functioning.

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Among adolescents aged 12-17 years, the prevalence of major depressive disorder was 4.2% in families with very good functioning and 11.6% in families with poor functioning (Table 3-7).

Table 3-7: 12-month prevalence of major depressive disorder among 4-17 year-olds by level of family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	0.8	4.2	2.1
Good	1.5	4.8	3.0
Fair	1.5	7.0	4.1
Poor	3.8	11.6	7.7

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

3.3 Impact of major depressive disorder

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity that symptoms of major depressive disorders had across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of major depressive disorder symptoms.

3.3.1 Severity of impact on functioning

The severity of major depressive disorder in four different domains (school or work, friends and social activities, family and self) and overall is reported in Table 3-8. Two fifths (40.3%) of 4-17 year-olds experienced a severe level of impact on self (that is, where the young person experienced a severe level of distress due to their symptoms). A third (34.3%) of children and adolescents experienced a severe level of impact in the school or work domain. Overall two fifths (42.8%) of 4-17 year-olds with major depressive disorder experienced a severe level of impact. This was the highest proportion of severe cases among those with a disorder of any of the disorders measured in the survey.

Compared with other disorders, a higher proportion of children and adolescents with major depressive disorder had severe impact in the self, friends and school/work domains (40.3%, 23.4% and 34.3% respectively). A large proportion of young people with social phobia also had severe impact in the friends' domain (23.4%) while a large proportion with obsessive-compulsive disorder had severe impact in the school/work domain (33.0%).

Table 3-8: Severity of impact in different life domains among 4-17 year-olds with major depressive disorder

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	9.6	14.4	8.4	np	
Mild	17.3	19.1	30.6	np	21.4
Moderate	34.1	43.1	33.5	37.5	35.8
Severe	34.3	23.4	27.4	40.3	42.8
Does not go to school or work	4.8				

np Not available for publication because of small cell size, but included in totals where applicable.

3.3.2 Days absent from school

Approximately three quarters (74%) of children and adolescents with major depressive disorder attending school had been absent from school for one or more days in the previous 12 months due to their depressive symptoms.

Young people with major depressive disorder averaged 20 days absent from school in the previous 12 months due to their depressive symptoms. The average was higher for adolescents, with those aged 4-11 years averaging 14 days absent compared with an average of 23 days absent for young people aged 12-17 years (Table 3-9). Compared to other disorders, children and adolescents with major depressive disorder missed on average the most days of school due to their symptoms.

Table 3-9: Average days absent from school in past 12 months due to depressive symptoms among 4-17 year-olds with major depressive disorder by age group

Age group	Average days absent
4-11 years	14
12-17 years	23
4-17 years	20

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4 ANXIETY DISORDERS

This chapter presents data on children and adolescents who met diagnostic criteria identified in DSM-IV for social phobia, separation anxiety disorder, generalised anxiety disorder or obsessive-compulsive disorder.

Anxiety disorders refers to a group of conditions rather than a single disorder. The common characteristic of the conditions that make up this category is that individuals affected experience persistent, excessive worry or fears that typically interferes with their ability to carry out their daily tasks or take pleasure in day-to-day life. It is common for young people to be fearful and anxious, but some may be more anxious than other children of their age and developmental level, and this may stop them participating in activities at school or socially, or interfere with their ability to do what other children and adolescents of their age do.

Social phobia

This disorder is characterised by a marked and persistent fear or avoidance of social or performance situations in which embarrassment may occur. To meet DSM-IV criteria, the fear or avoidance must interfere significantly with the child or adolescent's normal routine, academic functioning, or social activities or relationships, or the person must experience marked distress about the phobia.

Separation anxiety disorder

This disorder is characterised by excessive anxiety concerning separation from the home or from those to whom the child is attached. To meet DSM-IV criteria, the anxiety must be beyond that which is expected for the child or adolescent's developmental level, and cause significant distress in social, academic or other important areas of functioning. While separation anxiety disorder may be more common in younger children it can cause significant impairment in older children.

Generalised anxiety disorder

This disorder is characterised by excessive anxiety, worry or apprehension about a number of different events or activities, occurring more days than not for a period of at least six months. DSM-IV criteria specify that for children the anxiety must be associated with at least one of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension or sleep disturbance. The constant worry causes distress to the individual. The child or adolescent has difficulty controlling the worry, and experiences impairment in social, academic or other important areas of functioning.

Obsessive-compulsive disorder

Key features of this disorder are recurrent obsessions and/or compulsions that are severe enough to be time consuming and cause marked distress or significant impairment. Obsessions are persistent ideas, thoughts, impulses or images that are intrusive and difficult to control and that cause anxiety or distress. Common obsessions include worrying about things being dirty or having germs, or that the person might do something bad in public. Compulsions are repetitive behaviours, such as washing hands or changing clothes over and over, repetitively checking things, or counting or ordering things over and over. To meet DSM-IV criteria the obsessions or compulsions must cause marked distress, be time consuming or significantly interfere with the child or adolescent's normal routine, academic functioning, usual social activities or relationships.

The survey focussed on the four anxiety disorders that are most common and cause greatest distress in children and adolescents. These were social phobia, separation anxiety disorder, generalised anxiety disorder and obsessive-compulsive disorder.

4.1 Prevalence of anxiety disorders in children and adolescents

Half of all children and adolescents aged 4-17 years with mental disorders had an anxiety disorder. This is equivalent to 6.9% of all children and adolescents or an estimated 278,000 children and adolescents. There was little difference between males and females (7.0% and 6.8%).

The prevalence of anxiety disorders was very similar in children and adolescents, with 6.9% of children aged 4-11 years and 7.0% of young people aged 12-17 years having one or more anxiety disorders (Table 4-1). However, there were differences between children and adolescents in the prevalence of individual anxiety disorders. Separation anxiety disorder was the most common anxiety disorder in children (4.9% of those 4-11 years). Among adolescents both social phobia and separation anxiety disorder were equally common (3.4%) and generalised anxiety disorder was almost as common (2.9%).

Among children aged 4-11 years, the prevalence of anxiety disorders was slightly but not significantly higher in males than females (7.6% compared with 6.1%) due mainly to the higher prevalence of obsessive-compulsive disorder in males in this age group. Among young people aged 12-17 years, the prevalence of anxiety disorders was slightly but not significantly higher in females than males (7.7% compared with 6.3%) due mainly to the higher prevalence of generalised anxiety disorder in females in this age group.

Table 4-1: 12-month prevalence of anxiety disorders among 4-17 year-olds by sex and age group

Sex	Age group	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%) (a)
Males	4-11 years	1.8	4.9	1.8	1.3	7.6
	12-17 years	3.3	3.8	2.3	0.9	6.3
	4-17 years	2.4	4.4	2.0	1.1	7.0
Females	4-11 years	1.3	4.8	1.5	0.3	6.1
	12-17 years	3.4	3.1	3.4	0.7	7.7
	4-17 years	2.2	4.1	2.3	0.5	6.8
Persons	4-11 years	1.6	4.9	1.7	0.8	6.9
	12-17 years	3.4	3.4	2.9	0.8	7.0
	4-17 years	2.3	4.3	2.2	0.8	6.9

(a) ‘Any anxiety disorder’ is not the sum of individual anxiety disorders as some children and adolescents had more than one type of disorder.

4.2 Social and demographic characteristics

The relationships between parental, family and household characteristics and anxiety disorders are shown in Table 4-2 through to Table 4-7. Overall, the prevalence of anxiety disorders was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

4.2.1 Family type

For three of the four anxiety disorders the prevalence was higher in families with one parent or carer than families with two parents or carers. Except for obsessive-compulsive disorder, prevalence was lower in original families, that is where at least one child lives with both their natural, adoptive or foster parents and there were no step children, compared with step or blended families. Of children or adolescents living in families with one parent or carer, 9.0% had separation anxiety disorder compared with 2.7% in original families, 5.7% in step families and 4.8% in blended families (Table 4-2).

Table 4-2: 12-month prevalence of anxiety disorders among 4-17 year-olds by family type

Family type	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Families with two parents or carers	1.8	3.0	1.8	0.6	5.4
Original family	1.6	2.7	1.4	0.6	4.7
Step family	2.8	5.7	2.9	np	9.3
Blended family	3.3	4.8	4.1	np	9.0
Other family (a)	5.5	6.8	5.3	np	15.0
Families with one parent or carer	4.2	9.0	3.8	1.6	12.9

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.

‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

np Not available for publication because of small cell size, but included in totals where applicable.

4.2.2 Household income

The prevalence of anxiety disorders was highest in families with the lowest incomes, with the rates of each of the anxiety disorders being almost double in households with incomes below \$52,000 per year (\$1,000 per week) than in families with higher household incomes (Table 4-3).

Table 4-3: 12-month prevalence of anxiety disorders among 4-17 year-olds by household income

Household income before tax	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
\$130,000 or more per year	1.8	2.3	1.8	0.3	5.0
\$52,000-\$129,999 per year	1.9	3.8	1.7	0.8	5.8
Less than \$52,000 per year	3.6	6.8	3.2	1.4	10.6

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

4.2.3 Parent and carer education

There was no association between parent and carer education and obsessive-compulsive disorder. However, for each of the other anxiety disorders the lowest prevalence was in families where at least one parent or carer had a bachelor degree or higher. The highest prevalence occurred in families where the highest level of education achieved by either parent or carer was Year 10 or below (Table 4-4).

Table 4-4: 12-month prevalence of anxiety disorders among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Bachelor degree or higher	1.8	3.4	1.5	0.6	5.3
Diploma or certificate III/IV	2.7	4.9	2.6	1.0	8.1
Year 11 or 12	2.4	4.1	2.5	1.1	7.0
Year 10 or below	3.5	6.0	3.1	1.0	9.6

4.2.4 Parent and carer labour force status

In families with two parents or carers, the prevalence of all four anxiety disorders was lower where both parents or carers were currently in employment (Table 4-5). Among children and adolescents living in households with a sole parent or carer, separation anxiety disorder was more common where the parent or carer was not in employment (13.6% compared with 5.8%).

Table 4-5: 12-month prevalence of anxiety disorders among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Both parents or carers employed	1.5	2.4	1.6	0.2	4.6
One parent or carer employed, one parent or carer not in employment	2.1	4.5	1.8	1.1	6.5
Both parents or carers not in employment	4.3	3.5	5.4	2.6	10.6
Sole parent or carer employed	4.4	5.8	3.4	0.8	9.8
Sole parent or carer not in employment	4.4	13.6	3.7	3.0	17.2

‘Not in employment’ combines unemployed and not in the labour force.

4.2.5 Area of residence

All four anxiety disorders were more common in children living outside greater capital city areas (Table 4-6).

Table 4-6: 12-month prevalence of anxiety disorders among 4-17 year-olds by area of residence

Area of residence	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Greater capital cities	2.1	3.9	2.1	0.7	6.3
Rest of state	2.7	4.8	2.3	1.1	7.9

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

4.2.6 Family functioning

Table 4-7 shows the relationship between family functioning and the prevalence of anxiety disorders in children and adolescents. There was a strong relationship between level of family functioning and the prevalence of separation anxiety disorder, with 12.9% of children aged 4-11 years living in families with poor family functioning having separation anxiety disorder as compared with 3.8% of children living in families with very good functioning. Similarly 10.4% of 12-17 year-olds in families with poor family functioning had separation anxiety disorder, compared with 3.0% of 12-17 year-olds in families with very good family functioning.

Table 4-7: 12-month prevalence of anxiety disorders among 4-17 year-olds by family functioning and age group

Anxiety disorder	Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Social phobia	Very good	1.1	3.7	2.1
	Good	2.4	2.2	2.3
	Fair	2.5	3.3	2.9
	Poor	np	5.9	3.7
Separation anxiety	Very good	3.8	3.0	3.5
	Good	7.0	3.3	5.3
	Fair	4.5	3.1	3.9
	Poor	12.9	10.4	11.7
Generalised anxiety	Very good	1.2	2.5	1.7
	Good	1.8	2.1	2.0
	Fair	3.3	4.2	3.7
	Poor	3.4	8.1	5.7
Obsessive-compulsive	Very good	0.8	0.6	0.7
	Good	0.6	0.9	0.7
	Fair	np	1.5	1.0
	Poor	3.5	np	2.3
Any anxiety disorder	Very good	5.4	6.2	5.7
	Good	9.3	6.1	7.8
	Fair	7.9	8.3	8.1
	Poor	15.4	18.1	16.8

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).
np Not available for publication because of small cell size, but included in totals where applicable.

4.3 Impact of anxiety disorders

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity that symptoms of anxiety disorders had across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of anxiety disorder symptoms.

4.3.1 Severity of impact on functioning

The severity of anxiety disorders in four different domains (school or work, friends and social activities, family and self) and overall is reported in Table 4-8. Overall 18.7% of children and adolescents with anxiety disorders had a severe disorder, while 27.5% had a moderate disorder.

The type and severity of impact varied considerably between the four anxiety disorders. There was a lower proportion of cases with severe impact in each domain for separation anxiety compared with the other anxiety disorders. Obsessive-compulsive disorder was the disorder with the largest proportion of cases experiencing severe impact across the functioning domains with the exception of friends.

In contrast to other disorders, a higher proportion of children and adolescents with social phobia had severe impact in the friends domain (23.4%) while a high proportion with generalised anxiety had severe impact in the family domain (30.9). A high proportion of children and adolescents with obsessive-compulsive disorder also had severe impact in the school/work domain and family domains (33.0% and 37.4% respectively).

Table 4-8: Severity of impact in different life domains among 4-17 year-olds with anxiety disorders

Anxiety disorder	Severity	School/ work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
Social phobia	None	8.8	17.7	19.0	7.5	
	Mild	28.3	21.7	21.3	25.5	39.4
	Moderate	28.6	37.2	30.5	39.6	28.8
	Severe	29.4	23.4	29.1	27.4	31.8
	Does not go to school or work	4.9				
Separation anxiety	None	21.2	24.3	15.2	10.0	
	Mild	30.8	31.0	42.0	33.5	54.3
	Moderate	22.3	32.0	22.8	37.0	26.8
	Severe	20.0	12.7	20.0	19.6	18.9
	Does not go to school or work	5.8				
Generalised anxiety	None	14.3	16.7	10.9	3.8	
	Mild	23.4	18.7	25.4	28.1	38.1
	Moderate	28.5	43.4	32.8	38.2	30.7
	Severe	29.4	21.2	30.9	30.0	31.1
	Does not go to school or work	4.4				
Obsessive-compulsive	None	15.2	12.2	8.2	7.9	
	Mild	24.4	13.8	24.4	34.1	32.5
	Moderate	21.1	44.2	30.0	36.2	35.7
	Severe	33.0	29.7	37.4	21.8	31.8
	Does not go to school or work	6.3				
Any anxiety disorder	None	20.0	23.5	17.4	9.9	
	Mild	31.7	28.2	36.2	35.0	53.8
	Moderate	23.9	34.6	27.2	36.7	27.5
	Severe	19.7	13.7	19.2	18.4	18.7
	Does not go to school or work	4.7				

4.3.2 Days absent from school

Most children and adolescents in the survey were attending school (94%). Over half of 4-11 year-olds (58%) and almost three quarters of 12-17 year-olds (73%) attending school who had an anxiety disorder were absent from school for at least one day in the previous 12 months due to their anxiety symptoms. The average number of days absent from school due to anxiety symptoms was more than double in 12-17 year olds compared with 4-11 year-olds (20 days compared with 6 days) (Table 4-9).

Generalised anxiety disorder was associated with the highest number of days off school due to anxiety symptoms for children aged 4-11 years, while separation anxiety disorder was associated with the highest number of days off school due to anxiety symptoms for those aged 12-17 years.

Table 4-9: Average days absent from school in the past 12 months due to anxiety symptoms among 4-17 year-olds with anxiety disorders by age group

Anxiety disorder	4-11 years (days absent)	12-17 years (days absent)	4-17 years (days absent)
Social phobia	8	20	15
Separation anxiety	6	30	14
Generalised anxiety	10	22	17
Obsessive-compulsive	7	22	14
Any anxiety disorder	6	20	12

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5 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

This chapter presents data on children and adolescents who met diagnostic criteria identified in DSM-IV for Attention-deficit/hyperactivity disorder (ADHD).

Attention-deficit/hyperactivity disorder

ADHD is a persistent pattern of inattention and/ or hyperactivity-impulsivity more frequent and severe than in other individuals at a similar developmental stage. Children and adolescents may find it difficult to pay attention and see tasks or activities through to the end or 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”.

There are three subtypes of ADHD based on the most common symptoms. Those with mostly inattentive symptoms are diagnosed with ADHD, predominantly inattentive type and individuals with primarily hyperactivity-impulsivity symptoms are diagnosed with ADHD, predominantly hyperactive-impulsive type. Those children and adolescence with symptoms of both inattentiveness and hyperactivity are diagnosed with ADHD, combined type.

The DSM-IV criteria require at least six symptoms of either inattention or hyperactivity-impulsivity to have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level. Symptoms must be present in at least two settings (e.g. at school and at home), and some symptoms causing impairment must have been present before the age of 7 years.

5.1 Prevalence of ADHD in children and adolescents

In the 12 months prior to the survey 7.4% of children and adolescents had ADHD, equivalent to an estimated 298,000 children and adolescents across Australia (Table 5-1).

Of the three sub-types of ADHD, inattentive type was the most common, with 3.4% of children and adolescents having inattentive type, 1.2% hyperactive type and 2.8% combined type. The tables in this chapter report data which includes all three subtypes of ADHD.

The prevalence of ADHD was higher in males than females, with more than twice as many males as females having had ADHD in the previous 12 months (10.4% compared with 4.3%). The prevalence of ADHD was lower in adolescent females compared with females aged 4-11 years (2.7% compared with 5.4%). There was little difference in the prevalence between males from either age group; 10.9% of males aged 4-11 years and 9.8% of males aged 12-17 years had ADHD (Table 5-1).

Table 5-1: 12-month prevalence of ADHD among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	10.9	5.4	8.2
12-17 years	9.8	2.7	6.3
4-17 years	10.4	4.3	7.4

5.2 Social and demographic characteristics

Table 5-2 through to Table 5-6 report the prevalence of ADHD by a range of socio-demographic characteristics. These include family type, household income, carer education and labour force status, area of residence and family functioning. Overall prevalence of ADHD was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

5.2.1 Family type

The lowest prevalence of ADHD was in children and adolescents living in original families (5.7%), that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The prevalence of ADHD was twice as high in children and adolescents from lone parent or carer families (11.1%) and slightly higher again (13.4%) in those from blended families (Table 5-2).

Table 5-2: 12-month prevalence of ADHD among 4-17 year-olds by family type

Family type	Prevalence (%)
Families with two parents or carers	6.5
Original family	5.7
Step family	7.9
Blended family	13.4
Other family (a)	12.5
Families with one parent or carer	11.1

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.

‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

5.2.2 Household income

The prevalence of ADHD was highest in children and adolescents in households in the lowest income bracket (less than \$52,000 per year or \$1,000 per week), with just over one in ten (11.7%) young people who lived in these households having had ADHD in the previous 12 months (Table 5-3). This was significantly higher than the prevalence of children and adolescents in households in the middle and highest income brackets (6.6% and 5.2% respectively).

Table 5-3: 12-month prevalence of ADHD among 4-17 year-olds by household income

Household income before tax	Prevalence (%)
\$130,000 or more per year	5.2
\$52,000-\$129,999 per year	6.6
Less than \$52,000 per year	11.7

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

5.2.3 Parent and carer education

Children and adolescents from families in which the highest level of education of a parent or carer was a bachelor degree or higher had the lowest prevalence of ADHD. In contrast, children and adolescents from families where the highest level of education of either parent or carer was Year 10 or below had the highest prevalence of ADHD (5.4% compared with 11.7%) (Table 5-4).

Table 5-4: 12-month prevalence of ADHD among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Prevalence (%)
Bachelor degree or higher	5.4
Diploma or certificate III/IV	8.6
Year 11 or 12	8.0
Year 10 or below	11.7

5.2.4 Parent and carer labour force status

The prevalence of ADHD was lowest (5.8%) among children and adolescents in households in which both parents or carers were employed and highest where no parent or carer in the household was employed (Table 5-5). The prevalence of ADHD in children and adolescents with both parents or carers not in employment was twice as high (15.6%) as children or adolescents in families where one parent or carer was employed (7.0%). For children and adolescents with a sole parent or carer, prevalence rates for ADHD were 15.3% where the sole carer was not in employment, double the rate where the parent or carer was employed (7.7%).

Table 5-5: 12-month prevalence of ADHD among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Prevalence (%)
Both parents or carers employed	5.8
One parent or carer employed, one parent or carer not in employment	7.0
Both parents or carers not in employment	15.6
Sole parent or carer employed	7.7
Sole parent or carer not in employment	15.3

‘Not in employment’ combines unemployed and not in the labour force.

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5.2.5 Area of residence

While children and adolescents living in greater capital city areas had a slightly lower prevalence of ADHD than those living in other areas, the difference was not significant (Table 5-6).

Table 5-6: 12-month prevalence of ADHD among 4-17 year-olds by area of residence

Area of residence	Prevalence (%)
Greater capital cities	6.7
Rest of state	8.6

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

5.2.6 Family functioning

There was a strong relationship between level of family functioning and prevalence of ADHD. Just under one fifth (18.1%) of children and adolescents living in families with poor family functioning had ADHD compared with one in twenty (5.6%) living in families with very good family functioning. This pattern was most obvious in children 4-11 years but was also evident in adolescents aged 12-17 years (Table 5-7).

Table 5-7: 12-month prevalence of ADHD among 4-17 year-olds by family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	6.1	4.9	5.6
Good	9.3	6.1	7.8
Fair	14.6	9.7	12.3
Poor	20.9	15.3	18.1

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

5.3 Impact of ADHD

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity of symptoms of ADHD across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of ADHD disorder symptoms.

5.3.1 Severity of impact on functioning

The severity of impact of ADHD on children and adolescents in four different domains (school or work, friends and social actives, family and impact on self) and overall is reported in Table 5-8. Overall one in ten (10.5%) children and adolescents with ADHD had severe impact on functioning in at least one of these domains. Severe impact on functioning was reported most commonly in the domain of family (17.3%), and then school or work (12.8%). Only 3.7% of children and adolescents with ADHD had a severe level of impact on functioning in the self domain (that is, where the young person experienced a high level of distress due to their symptoms). Two fifths (40.9%) of children and adolescents with ADHD had no impact in the friends domain, while only 13.3% of children with ADHD had no impact in the school or work domain.

In contrast to other disorders, a higher proportion of children and adolescents with ADHD had mild impact on functioning overall as a result of their symptoms (65.7%).

Table 5-8: Severity of impact in different life domains among 4-17 year-olds with ADHD

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	13.3	40.9	18.1	29.3	
Mild	40.0	24.9	35.8	45.7	65.7
Moderate	31.1	23.6	28.8	21.3	23.8
Severe	12.8	10.6	17.3	3.7	10.5
Does not go to school or work	2.8				

5.3.2 Days absent from school

Table 5-9 reports the average number of days off school in the previous 12 months of those children who met diagnostic criteria for ADHD. Just under a third of 4-11 year-olds and a half of 12-17 year-olds (29% and 46% respectively) with ADHD had missed at least one day of school in the previous 12 months due to their ADHD symptoms.

The average number of days off school due to ADHD was higher for adolescents. On average, children aged 4-11 years had 4 days off, while 12-17 year-olds had 9 days off (Table 5-9). Compared to children and adolescents with other disorders those with ADHD missed on average the least number of days of school due to their ADHD symptoms.

Table 5-9: Average days off school in the past 12 months due to ADHD symptoms among 4-17 year-olds with ADHD by age group

Age group	Average days absent
4-11 years	4
12-17 years	9
4-17 years	5

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6 CONDUCT DISORDER AND OPPOSITIONAL PROBLEM BEHAVIOURS

This chapter presents data on children and adolescents that met diagnostic criteria identified in DSM-IV for conduct disorder. It also presents information on oppositional problem behaviours.

Conduct disorder

Conduct disorder is defined as repetitive and persistent behaviour to a degree that violates the basic rights of others, major societal norms or rules in the following areas: aggression towards people or animals, destruction of property, deceitfulness or theft and serious violation of rules. Young people with conduct disorder exhibit a range of behaviours often including bullying, frequent physical fights, deliberately destroying other’s property, breaking into properties or cars, staying out late at night without permission, running away from home or frequent truancy from school. DSM-IV criteria require at least three of these behaviours to have been present in the past 12 months, and for the disturbance in behaviour to cause clinically significant impairment in social, academic or occupational functioning.

6.1 Prevalence of conduct disorder in children and adolescents

Around 2% of all children and adolescents had conduct disorder. This is equivalent to around 84,000 children and adolescents across Australia. The prevalence was higher in males than females (2.5% compared with 1.6%). The prevalence did not vary across age groups for either sex (Table 6-1).

Table 6-1: 12-month prevalence of conduct disorder among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	2.5	1.6	2.0
12-17 years	2.6	1.6	2.1
4-17 years	2.5	1.6	2.1

6.2 Social and demographic characteristics

The 12-month prevalence of conduct disorder by a range of socio-demographic characteristics is reported in Table 6-2 to Table 6-7. These include family type, household income, carer education and labour force status, area of residence and family functioning. Overall prevalence of conduct disorder was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

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6.2.1 Family type

The prevalence of conduct disorders was lowest (1.0%) in original families, that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The highest prevalences were in families with one parent or carer and step families, in which 4.8% and 4.4% of children and adolescents had conduct disorder respectively (Table 6-2).

Table 6-2: 12-month prevalence of conduct disorder among 4-17 year-olds by family type

Family type	Prevalence (%)
Families with two parents or carers	1.4
Original family	1.0
Step family	4.4
Blended family	3.4
Other family	np
Families with one parent or carer	4.8

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.

‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.

np Not available for publication because of small cell size, but included in totals where applicable.

6.2.2 Household income

The prevalence of conduct disorder was associated with household income (Table 6-3). Children and adolescents from families in the highest income bracket, with incomes of \$130,000 or more per year, had the lowest prevalence of conduct disorder (0.8%). Over four times as many children and adolescents from families in the lowest income bracket (less than \$52,000 per year) had conduct disorder compared with families in the highest income bracket (4.3% compared with 0.8%).

Table 6-3: 12-month prevalence of conduct disorder among 4-17 year-olds by household income

Household income before tax	Prevalence (%)
\$130,000 or more per year	0.8
\$52,000-\$129,999 per year	1.7
Less than \$52,000 per year	4.3

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

6.2.3 Parent and carer education

The prevalence of conduct disorder was lowest in families in which at least one parent or carer had a bachelor degree or higher (1.2%) and highest in families in which the highest level of education achieved by either parent or carer was year 10 or below (4.6%) (Table 6-4).

Table 6-4: 12-month prevalence of conduct disorder among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Prevalence (%)
Bachelor degree or higher	1.2
Diploma or certificate III/IV	2.4
Year 11 or 12	2.6
Year 10 or below	4.6

6.2.4 Parent and carer labour force status

Children and adolescents from families with both parents or carers in employment had the lowest prevalence of conduct disorder at 1.0% (Table 6-5). In contrast, the prevalence of conduct disorder was 4.6% in children and adolescents in households where both parents or carers were not in employment. In households with a sole parent or carer, where the parent or carer was in employment, the prevalence was lower at 2.8%, however, it was almost three times (7.9%) higher for children and adolescents in families in which the sole parent or carer was not in employment.

Table 6-5: 12-month prevalence of conduct disorder among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Prevalence (%)
Both parents or carers employed	1.0
One parent or carer employed, one parent or carer not in employment	1.7
Both parents or carers not in employment	4.6
Sole parent or carer employed	2.8
Sole parent or carer not in employment	7.9

‘Not in employment’ combines unemployed and not in the labour force.

6.2.5 Area of residence

The prevalence of conduct disorder was twice as high in children and adolescents living outside greater capital city areas compared with those living within these areas (3.2% compared to 1.4%) (Table 6-6).

Table 6-6: 12-month prevalence of conduct disorder among 4-17 year-olds by area of residence

Area of residence	Prevalence (%)
Greater capital cities	1.4
Rest of state	3.2

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

6.2.6 Family functioning

The prevalence of conduct disorder was highest in families who had poor family functioning and lowest in families with very good family functioning. Only 1.4% of 4-11 year-olds and 1.0% of 12-17 year-olds in families with very good family functioning had conduct disorder. In contrast, 6.9% of 4-11 year-olds and 7.5% of 12-17 year-olds had conduct disorder in families with poor family functioning (Table 6-7).

Table 6-7: 12-month prevalence of conduct disorder among 4-17 year-olds by level of family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	1.4	1.0	1.2
Good	2.1	2.4	2.3
Fair	4.0	4.6	4.3
Poor	6.9	7.5	7.2

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

6.3 Impact of conduct disorder

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity that symptoms of conduct disorder had across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of conduct disorder symptoms.

6.3.1 Severity of impact on functioning

The severity of conduct disorder on children and adolescent’s functioning was assessed in four different domains (school or work, friends and social activities, family and self) and overall. Overall 18.9% of children and adolescents with conduct disorder had severe disorder. The family domain was most severely affected by conduct disorder, with nearly one third (29.5%) of children or adolescents with conduct disorder having severe impact in the family domain (Table 6-8). Only 4.3% of children or adolescents with conduct disorder had no impact in the family domain. The self domain (that is, where the young person experienced distress due to their symptoms) showed the smallest proportion of children or adolescents with severe impact (3.6%).

In comparison to other disorders, a higher proportion of children and adolescents with conduct disorder had severe impact in the family domain (29.5%). A large proportion of families with young people who had generalised anxiety and obsessive-compulsive disorder also had severe impact in the family domain (30.9% and 37.4% respectively).

Table 6-8: Severity of impact in different life domains among 4-17 year-olds with conduct disorder

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	35.6	32.5	4.3	28.3	
Mild	18.1	26.2	30.7	43.6	58.7
Moderate	25.2	31.4	35.5	24.6	22.4
Severe	15.8	10.0	29.5	3.6	18.9
Does not go to school or work	5.4				

6.3.2 Days absent from school

One quarter of 4-11 year-olds (26%) and just over a half (54%) of 12-17 year-olds with conduct disorder attending school had missed at least one day of school in the previous 12 months due to symptoms of their conduct disorder.

The average number of days missed of school was higher in 12-17 year-olds than 4-11 year-olds (Table 6-9). Children aged 4-11 years missed an average of two days in the previous 12 months, while 12-17 year-olds missed an average of 17 days.

Table 6-9: Average days off school in the past 12 months due to conduct disorder symptoms among 4-17 year-olds with conduct disorder by age group

Age group	Average days absent
4-11 years	2
12-17 years	17
4-17 years	8

6.4 Oppositional problem behaviours

The DSM-IV includes a mental disorder category called *oppositional defiant disorder* and the DISC-IV module for oppositional defiant disorder was included in *Young Minds Matter*. However, unlike other disorders included in this publication, the diagnosis for oppositional defiant disorder includes an element of clinical judgement that could not be implemented within the DISC-IV questions. In particular, for each symptom assessed in oppositional defiant disorder the DSM-IV specifies that the symptom criterion is met only if the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level. A mental health trained clinician is required to make this judgement. The data collection for *Young Minds Matter* was undertaken by lay professional interviewers who were not specifically trained in psychology or psychiatry and expert clinical review of each child or adolescent in the survey was not undertaken. As such it was not possible to implement all of the diagnostic criteria for oppositional defiant disorder.

Despite these limitations, information collected in the survey on the prevalence of oppositional problem behaviours in children and adolescents is useful for a broad range of purposes. The information from parents and carers on oppositional problem behaviours in their children that was

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obtained from the DISC-IV module is presented in this section. These are referred to as oppositional problem behaviours to distinguish them from the diagnostic condition of oppositional defiant disorder.

Oppositional problem behaviours

Oppositional problem behaviours are negativistic, hostile and defiant behaviours lasting at least six months characterised by behaviour such as often losing temper, arguing with adults, actively defying adults’ requests and rules, being angry, resentful, spiteful or vindictive.

If a child or adolescent met diagnostic criteria for conduct disorder, the oppositional problem behaviours module was not administered for that child or adolescent.

6.4.1 Prevalence of oppositional problem behaviours in children and adolescents

Around 5.1% of all children and adolescents had oppositional problem behaviours. This is equivalent to around 204,000 children and adolescents across Australia. The prevalence was higher in males than females (5.6% compared with 4.5%). The prevalence did not vary across age groups for either sex (Table 6-10).

Table 6-10: 12-month prevalence of oppositional problem behaviours among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	5.6	4.4	5.0
12-17 years	5.6	4.6	5.1
4-17 years	5.6	4.5	5.1

6.4.2 Co-occurrence of oppositional problem behaviours and mental disorders

As conduct disorder is regarded as a more severe form of oppositional problem behaviours, an exclusion rule was applied so that no child or adolescent could be given the diagnosis of conduct disorder and oppositional problem behaviours. To reduce respondent burden in the survey, parents and carers of children or adolescents who met diagnostic criteria for conduct disorder were not asked questions about oppositional problem behaviours.

There was a substantial overlap between oppositional problem behaviours and the group of mental disorders included in the survey. Over half of children and adolescents with oppositional problem behaviours also met diagnostic criteria for a mental disorder (3.0% of all children and adolescents had oppositional problem behaviours and met diagnostic criteria for a mental disorder, and 2.1% had oppositional problem behaviours and did not meet diagnostic criteria for any mental disorders). Some 1.0% of children and adolescents had oppositional problem behaviours and ADHD, 1.1% had oppositional problem behaviours and anxiety or depression, and 0.9% of children and adolescents had oppositional problem behaviours and both ADHD and anxiety or depression (Table 6-11).

Table 6-11: Co-occurrence of oppositional problem behaviours and mental disorders among 4-17 year-olds

Problem or disorder	Prevalence (%)
Oppositional problem behaviours only	2.1
Oppositional problem behaviours and one or more DISC-IV disorder	3.0
Oppositional problem behaviours and ADHD	1.0
Oppositional problem behaviours and anxiety or depression	1.1
Oppositional problem behaviours and ADHD and anxiety or depression	0.9

6.4.3 Family functioning

The prevalence of oppositional problem behaviours was highest in families who had poor family functioning and lowest in those with very good family functioning. Only 3.5% of 4-11 year-olds and 4.0% of 12-17 year-olds in families with very good family functioning had oppositional problem behaviours. In contrast, 18.0% of 4-11 year-olds and 15.5% of 12-17 year-olds had oppositional problem behaviours in families with poor family functioning (Table 6-12).

Table 6-12: 12-month prevalence of oppositional problem behaviours among 4-17 year-olds by family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	3.5	4.0	3.7
Good	6.2	4.6	5.4
Fair	7.6	7.7	7.6
Poor	18.0	15.5	16.8

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

6.4.4 Severity of impact on functioning

The severity of oppositional problem behaviours on children and adolescent’s functioning was assessed in four different domains (school or work, friends and social activities, family and self) and overall. The overall impact on functioning was assessed as mild for more than two thirds (68.6%) of the children and adolescents with oppositional problem behaviours. One fifth (20.3%) of children and adolescents experienced moderate impact and just over one in ten (11.1%) experienced severe impact on functioning.

Family was the domain in which the most children and adolescents with oppositional problem behaviours had moderate or severe impact (35.1% moderate, 16.6% severe) (Table 6-13).

Table 6-13: Severity of impact in different life domains among 4-17 year-olds with oppositional problem behaviours

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	43.3	46.5	11.0	30.2	
Mild	26.0	24.5	37.3	42.8	68.6
Moderate	18.3	23.3	35.1	20.7	20.3
Severe	9.7	5.7	16.6	6.3	11.1
Does not go to school or work	2.8				

6.4.5 Days absent from school

Some 40% of 4-11 year-olds and 13% of 12-17 year-olds with oppositional problem behaviours attending school had missed at least one day of school in the last 12 months due to their oppositional problem behaviours.

The average number of days missed of school was significantly higher in adolescents than 4-11 year-olds (Table 6-14). Children 4-11 years missed an average of four days in the past 12 months, while 12-17 year-olds missed an average of nine days.

Table 6-14: Average days off school in the past 12 months due to oppositional problem behaviours among 4-17 year-olds by age group

Age group	Average days absent
4-11 years	4
12-17 years	9
4-17 years	6

PART 3

Service use

Services used and those felt to be needed by children and adolescents for emotional or behavioural problems and their families, and barriers to seeking and receiving help

A key aim of the survey was to determine the services used by children and adolescents to assist them with their emotional or behavioural problems. Questions were specifically tailored to the current Australian health care environment.

Health services across the full range of settings and by different providers are identified and information on services provided by schools is also provided in recognition of the important role that the education sector plays in providing support for children and adolescents with problems.

Service use by young people with mental disorders is examined in detail, and those who did and did not use services further explored.

The survey also measured perceived need for care. Specifically this identified whether parents and carers felt that their children needed any help with emotional or behavioural problems and, if so, whether their needs have been fully or partially met by the services they received. Where needs were not fully met information was collected on the barriers to seeking help or receiving more of the help they felt their children needed.

Parents and carers were asked about the services they had received and their need for help for themselves and other family members to deal with the emotional and behavioural problems affecting their children.

EXHIBIT 662

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7 SERVICE USE

This chapter presents data provided by parents and carers on the services used by their children and adolescents for emotional or behavioural problems. This reflects service use for a range of emotional and behavioural problems and for specific mental disorders.

Children and adolescents use a wide variety of services to support and assist them with emotional or behavioural problems. These include health services, school services, telephone counselling and online services. A summary measure of 'service use' was created that includes all of these services, but online services were limited to those providing structured or personalised assistance. While valuable in their own right, online services where information is accessed on the internet but no other service is provided were excluded from this composite measure.

The data presented in this chapter on telephone and online services do not provide a particularly accurate picture of the use of telephone and online services. Parents and carers often reported that they did not know services of these types that their child or adolescent had used. These data have, however, been included with those on health and school services, as together they provide the most complete picture of services used by children and adolescents.

Young people aged 13 years and over were asked directly about the services they used. Their responses are reported in Chapter 13 which provides a more accurate picture of young people's use of telephone and online services, not only for counselling and support, but also as an important source of information on their emotional and behavioural problems. Young people also reported on the informal support for their emotional and behavioural problems that they received from family, friends and other significant people in their lives. This is also reported in Chapter 13.

7.1 Service use by all children and adolescents

'Services' comprise the following:

- i. health services — any service provided by a qualified health professional regardless of where that service was provided including in the community, hospital inpatient, outpatient and emergency, and private rooms;
- ii. school services — any service provided by the school or other educational institution that a young person was attending;
- iii. telephone counselling services; and
- iv. online services that provided personalised assessment, support, counselling or structured self-help programs.

One sixth (17.0%) of all children and adolescents aged 4-17 years had used services for emotional or behavioural problems in the previous 12 months (Table 7-1). One in seven (14.8%) of all 4-17 year-olds had used services in the health sector, and one in nine (11.5%) had used services provided by schools in the previous 12 months for emotional or behavioural problems. According to parents and carers, very few had used a telephone counselling service (0.5%) or online personal support or counselling (0.1%) for emotional or behavioural problems.

Table 7-1: Service use for emotional or behavioural problems in past 12 months among all 4-17 year-olds by type of service

Type of services	Proportion (%)
Health services	14.8
School services	11.5
Telephone counselling service	0.5
Online personal support or counselling	0.1
Any service (a)	17.0

The proportion using school services is based on those who were at school at the time of the survey.
(a) Any service is not equal to the sum of individual services because adolescents may have used more than one type of service.

Just over half (53.5%) of 4-17 year-olds who had used services for emotional or behavioural problems in the previous 12 months had used both health and school services. About one third (34.5%) had only used health services and just under one in eight (12.0%) had only used school services.

The proportion of males and females using services for emotional and behavioural problems was similar, but the proportion was higher among adolescents than children (21.4% for 12-17 year-olds compared with 13.7% for 4-11 year-olds) (Table 7-2).

Table 7-2: Service use for emotional or behavioural problems in past 12 months among all 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	15.3	12.0	13.7
12-17 years	20.5	22.4	21.4
4-17 years	17.5	16.4	17.0

7.2 Service use by children and adolescents with mental disorders

Just over half (56.0%) of children and adolescents with mental disorders had used services for emotional or behavioural problems in the previous 12 months (Table 7-3).

7.2.1 Sex and age group

Service use was similar for males and females with mental disorders. However, there was a difference between age groups, with two thirds (65.1%) of adolescents aged 12-17 years with mental disorders having used services compared with half (48.9%) of children aged 4-11 years (Table 7-3).

Table 7-3: Service use in past 12 months among 4-17 year-olds with mental disorders by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	49.8	47.5	48.9
12-17 years	63.5	67.2	65.1
4-17 years	55.5	56.7	56.0

7.2.2 Family type

As discussed in Chapter 2, the prevalence of mental disorders among 4-17 year-olds in families with one parent or carer was twice that in families with two parents or carers. However, service use for emotional and behavioural problems in the previous 12 months was also higher among children or adolescents with mental disorders in families with one parent or carer (65.6%) compared with families with two parents or carers (51.3%) (Table 7-4). Children and adolescents with mental disorders living in blended families were more likely to use services (63.3%) than those living in original (49.4%) or step families (44.2%).

Table 7-4: Service use in past 12 months among 4-17 year-olds with mental disorders by family type

Family type	Proportion (%)
Families with two parents or carers	51.3
Original family	49.4
Step family	44.2
Blended family	63.3
Other family (a)	66.3
Families with one parent or carer	65.6

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.
‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.
(a) Data to be treated with caution due to low respondent numbers in this category.

7.2.3 Household income

As reported in Chapter 2, the prevalence of mental disorders among children and adolescents living in the lowest income bracket (less than \$52,000 per year) was almost double that of those in the highest income bracket (\$130,000 or more per year).

Among children and adolescents with mental disorders, service use in the previous 12 months for emotional or behavioural problems was higher in the lowest income bracket than the highest income bracket (61.9% compared with 50.6% respectively) (Table 7-5).

Table 7-5: Service use in past 12 months among 4-17 year-olds with mental disorders by household income

Household income before tax	Proportion (%)
\$130,000 or more per year	50.6
\$52,000-\$129,999 per year	53.0
Less than \$52,000 per year	61.9

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

7.2.4 Parent and carer education

Rates of mental disorders among 4-17 year-olds were highest when they lived in a family in which the highest level of education for either the parent or carer was Year 10 or below as reported in Chapter 2. Service use for emotional and behavioural problems in the previous 12 months was also highest in these families (62.2%). However, differences in service use by education level of parents and carers should be treated with caution as they are not statistically significant (Table 7-6).

Table 7-6: Service use in past 12 months among 4-17 year-olds with mental disorders by parent or carer education

Highest level of education of either primary or secondary parent or carer	Proportion (%)
Bachelor degree or higher	55.5
Diploma or certificate III/IV	56.3
Year 11 or 12	51.4
Year 10 or below	62.2

7.2.5 Parent and carer labour force status

As presented in Chapter 2, children and adolescents living in households with no parents or carers in employment had higher rates of mental disorders than those living in households with one or both parents or carers in employment. Table 7-7 shows rates of service use for emotional or behavioural problems by the labour force status of the young person’s parents or carers.

About two thirds of children and adolescents with mental disorders in families without an employed parent or carer (65.0% with both parents or carers not employed and 64.0% in families with a sole parent or carer not employed) or in a family where the sole parent or carer was employed (65.4%) had used services for emotional or behavioural problems in the previous 12 months.

Service use was lower among children and adolescents with mental disorders living in families where both parents and carers were employed (50.8%), or where one parent or carer was employed (51.5%). Differences in service use within two parent or carer families by employment status should be treated with caution as they are not statistically significant.

Table 7-7: Service use in past 12 months among 4-17 year-olds with mental disorders by parent or carer labour force status

Parent or carer labour force status	Proportion (%)
Both parents or carers employed	50.8
One parent or carer employed, one parent or carer not in employment	51.5
Both parents or carers not in employment	65.0
Sole parent or carer employed	65.4
Sole parent or carer not in employment	64.0

‘Not in employment’ combines unemployed and not in the labour force.

7.2.6 Area of residence

Rates of mental disorders were higher among those living outside of greater capital cities but service use for emotional and behavioural problems among 4-17 year-olds with mental disorders was similar in greater capital cities and other areas (Table 7-8).

Table 7-8: Service use in past 12 months among 4-17 year-olds with mental disorders by area of residence

Area of residence	Proportion (%)
Greater capital cities	56.7
Rest of state	55.1

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

7.2.7 Type of mental disorder

Service use was highest among children and adolescents with a major depressive disorder, with four fifths (79.6%) of these children and adolescents having used services in the previous 12 months. Just over two thirds (68.8%) of those with a conduct disorder, 61.4% of those with anxiety disorders and half (52.7%) of children and adolescents with ADHD had used services. Service use was consistently higher among adolescents than children for each type of disorder (Table 7-9).

Table 7-9: Service use in past 12 months among 4-17 year-olds with mental disorders by disorder type and age group

Disorder	4-11 years (%)	12-17 years (%)	4-17 years (%)
Anxiety disorders	53.6	71.7	61.4
Major depressive disorder	73.2	81.6	79.6
ADHD	48.9	59.3	52.7
Conduct disorder	66.4	72.0	68.8
Any mental disorder	48.9	65.1	56.0

7.2.8 Severity of disorders

Service use varied markedly with the level of severity of the disorders, ranging from two fifths (41.2%) of those with mild disorders to 72.5% of those with moderate disorders, and up to 87.6% of those with severe disorders having used services in the previous 12 months (Table 7-10).

Table 7-10: Service use in past 12 months among 4-17 year-olds with mental disorders by severity of impact and age group

Severity	4-11 years (%)	12-17 years (%)	4-17 years (%)
Mild	39.9	43.9	41.2
Moderate	67.5	76.3	72.5
Severe	83.3	89.6	87.6
Any mental disorder	48.9	65.1	56.0

7.3 Health service use by children and adolescents with mental disorders

This section reports on the use of services provided by health professionals in the community, hospital inpatient, outpatient or emergency departments, private rooms and at headspace centres.

7.3.1 Type and severity of disorders

Just over half (53.0%) of 4-17 year-olds with mental disorders had used a health service for emotional or behavioural problems in the previous 12 months, with the highest level of health service use among those with a major depressive disorder (77.0%) (Table 7-11).

Most children and adolescents (86.6%) with severe disorders had used health services in the previous 12 months. Whereas two thirds (68.5%) of those with moderate disorders and 38.1% of those with mild disorders had done so.

The proportion of young people using health services in the previous 12 months was, no matter what the type of disorder, consistently high when the disorder was severe, ranging from 90.1% of those with severe conduct disorders down to 86.4% of those with severe major depressive disorder. Service use by those with moderate disorders was also relatively high, ranging between 72.0% and 80.2% in the previous 12 months. There was, however, more variation for mild disorders, with health service use in the previous 12 months being lowest for mild ADHD (37.0%) and mild anxiety disorders (40.2%), but up to 57.1% for those with mild major depressive disorder.

Table 7-11: Health service use in past 12 months among 4-17 year-olds with mental disorders by disorder type and severity of impact

Disorder	Mild (%)	Moderate (%)	Severe (%)	Total (%)
Anxiety disorders	40.2	75.6	87.5	58.8
Major depressive disorder	57.1	77.8	86.4	77.0
ADHD	37.0	72.0	88.1	50.7
Conduct disorder	49.0	80.2	90.1	63.8
Any mental disorder	38.1	68.5	86.6	53.0

Where the child or adolescent had more than one disorder, service use has been counted under each disorder. The severity of any mental disorder is based on the most severe disorder if the child or adolescent has more than one disorder.

7.3.2 Health service providers

Just over half (52.6%) of children and adolescents with mental disorders had seen a health service provider in the previous 12 months for emotional or behavioural problems (Table 7-12).

Just over one third (35.0%) of children and adolescents with mental disorders had seen a general practitioner for their emotional and behavioural problems. However, only 4.3% had seen only a general practitioner and no other health service provider for their emotional and behavioural problems. Almost one quarter (23.9%) had seen a psychologist and 7.1% had seen a psychiatrist.

General practitioners are the most common source of referrals to other health professionals. More particularly, they are responsible for the development of mental health care plans that allow access to Medicare-funded specialised mental health care, notably psychological services. This is reflected in

the survey data, which shows that one fifth (20.6%) of young people had seen a general practitioner and either a psychologist or psychiatrist in the previous 12 months for their emotional and behavioural problems. In addition, 15.4% had seen a general practitioner and paediatrician.

There were some differences between the types of health service providers seen by children and adolescents. A higher proportion of adolescents had seen a psychologist compared with 4-11 year-olds (29.1% compared with 19.8%) and twice as many adolescents had seen a counsellor or family therapist (29.0% compared with 14.1%). They were also more likely to have seen a general practitioner, a psychiatrist or a social worker. While children were more likely to have seen an occupational therapist (10.9% for 4-11 year-olds compared with 4.2% for 12-17 year-olds) (Table 7-12).

Similar proportions of children and adolescents with mental disorders had seen a paediatrician in the previous 12 months (22.5% and 19.2% respectively). However, the proportion seeing a paediatrician for emotional or behavioural problems out of those who had seen any health service provider was higher among children (48.6% for 4-11 year-olds compared with 31.6% of 12-17 year-olds).

Table 7-12: Service use in past 12 months among 4-17 year-olds with mental disorders by health service provider and age group

Health service provider	4-11 years (%)	12-17 years (%)	4-17 years (%)
General practitioner	29.8	41.6	35.0
Paediatrician	22.5	19.2	21.0
Psychiatrist	4.9	10.0	7.1
Psychologist	19.8	29.1	23.9
Nurse	0.9	4.5	2.5
Social worker	6.2	13.4	9.3
Occupational therapist	10.9	4.2	7.9
Counsellor or family therapist	14.1	29.0	20.7
Other or unsure about profession	8.2	8.1	8.2
Any health service provider (a)	46.3	60.7	52.6

(a) The total proportion that had seen any health service provider (52.6%) is slightly lower than the proportion reported in Table 7-11 as it does not include overnight stays in hospital or visits to headspace where the type of health service provider is unknown.

7.3.3 Visits to health service providers

General practitioners and paediatricians were the health service providers most likely to have been seen only once by children and adolescents with mental disorders for emotional and behavioural problems, with 41.7% having seen a general practitioner only once and 31.7% a paediatrician only once in the previous 12 months (Table 7-13).

Occupational therapists, counsellors or family therapists and psychologists were seen the most number of times, with 31.2%, 29.5% and 24.4% respectively of young people with mental disorders having seen these health service providers ten times or more in the previous 12 months. In addition

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almost one fifth of young people with mental disorders saw psychiatrists (19.1%) and social workers (19.9%) on ten or more occasions.

Table 7-13: Visits to health service providers in past 12 months among 4-17 year-olds with mental disorders by type of provider

Health service provider	Once (%)	Two to four times (%)	Five to nine times (%)	Ten or more times (%)
General practitioner	41.7	39.6	13.7	5.0
Paediatrician	31.7	55.6	8.8	3.9
Psychiatrist	21.3	39.8	19.8	19.1
Psychologist	17.2	32.5	25.9	24.4
Social worker	16.8	45.4	18.0	19.9
Occupational therapist	23.8	24.3	20.7	31.2
Counsellor or family therapist	17.3	35.7	17.6	29.5

7.3.4 Hospital, drug and alcohol and specialist mental health services

One in sixteen (6.2%) children and adolescents with mental disorders had attended a hospital emergency or outpatient department or been admitted to hospital due to their emotional or behavioural problems in the previous 12 months (Table 7-14).

Specialist child and adolescent mental health services were seen by 3.3% of children and adolescents (5.7% of 12-17 year-olds) with mental disorders for emotional or behavioural problems in the previous 12 months. This was restricted to those seen by a paediatrician, psychiatrist, psychologist or nurse in these specialist services.

Table 7-14: Hospital and specialist mental health service use in past 12 months by age group and type of service

Type of service	4-11 years (%)	12-17 years (%)	4-17 years (%)
Hospital emergency, outpatient or inpatient service	4.7	8.1	6.2
Specialist mental health service	1.5	5.7	3.3

Some adolescents with mental disorders had spoken to a counsellor or attended a program at a drug or alcohol treatment unit or clinic, with 2.7% of 13-17 year-olds having done so in the previous 12 months.

7.3.5 headspace

Since 2006, the Australian Government has funded headspace — Australia’s National Youth Mental Health Foundation, a national service for young people aged 12-25 years.

Half (50.7%) of all parents and carers of 12-17 year-olds had heard about headspace and two thirds (64.6%) of those with an adolescent who had a mental disorder had heard about headspace.

Parents and carers reported that 7.3% of young people with mental disorders had visited a headspace centre in the previous 12 months. Another 3.4% of parents and carers whose 12-17 year-olds had a mental disorder didn't know if their adolescent had visited a headspace centre.

Data from adolescent reports of the use of headspace services are presented in Chapter 13.

7.3.6 Medication

One in eight (12.8%) children and adolescents with mental disorders had taken a medication for emotional or behavioural problem in the previous two weeks. The proportion of adolescents taking medications for emotional or behavioural problems in the previous two weeks was higher than for children (16.7% for 12-17 year-olds compared with 9.8% for 4-11 year-olds) (Table 7-15).

Medication use was marginally higher among those with conduct disorder and major depressive disorder (19.5% and 18.2% respectively for 4-17 year-olds). It was also higher among adolescents than children for any type of mental disorder. The greatest difference between the two age groups was for those with ADHD, with 21.5% of 12-17 year-olds taking medication for emotional and behavioural problems in the previous 12 months compared with 14.3% of 4-11 year-olds.

Table 7-15: Medication use for emotional or behavioural problems in past 12 months among 4-17 year-olds with mental disorders by disorder type and age group

Disorder	4-11 years (%)	12-17 years (%)	4-17 years (%)
Anxiety disorders	10.4	16.8	13.1
Major depressive disorder	17.4	18.4	18.2
ADHD	14.3	21.5	16.9
Conduct disorder	17.4	22.3	19.5
Any mental disorder	9.8	16.7	12.8

Where the child or adolescent had more than one disorder, medication use has been counted under each disorder, because the exact reason for the prescribed medication is unknown.

7.4 School service use by children and adolescents with mental disorders

Two fifths (40.2%) of children and adolescents with mental disorders had used or attended services provided by their school for emotional or behavioural problems in the previous 12 months. Almost three in ten (28.4%) young people with mental disorders had used individual counselling services and almost one in ten (9.2%) had participated in group counselling or a support program (Table 7-16).

Adolescents with mental disorders were more likely to have used or attended a service at school than children (48.7% for 12-17 year-olds compared with 33.5% for 4-11 year-olds). In particular, adolescents were twice as likely to have used individual counselling services at school (38.8% for 12-17 year-olds compared with 20.3% for 4-11 year-olds) and participated in group counselling or a support program (12.6% for 12-17 year-olds compared with 6.5% for 4-11 year-olds).

Table 7-16: School service use in past 12 months among 4-17 year-olds with mental disorders by age group and type of service

Type of service	4-11 years (%)	12-17 years (%)	4-17 years (%)
Individual counselling	20.3	38.8	28.4
Group counselling or support program	6.5	12.6	9.2
Special class or school	13.1	13.2	13.1
School nurse	3.5	8.3	5.6
Other school services	13.9	21.1	17.1
Any service at school	33.5	48.7	40.2

The majority (85.1%) of children and adolescents with mental disorders who had used individual counselling services at school in the previous 12 months had been more than once, and nearly a third (31.4%) had been ten times or more (Table 7-17).

Table 7-17: School individual counselling services in past 12 months among 4-17 year-olds with mental disorders

Number of counselling sessions	Proportion (%)
Once	14.9
Two to four times	38.0
Five to nine times	15.7
Ten or more times	31.4

7.4.1 Type and severity of mental disorders

The highest level of school service use was by those with a major depressive disorder, with three fifths (61.9%) of 4-17 year-olds having used these services. This was followed by those with conduct disorder (53.8%), anxiety disorders (44.1%) and then ADHD (37.0%) (Table 7-18).

Just over seven out of ten young people (72.6%) with severe disorders had used school services in the previous 12 months. This was one and a half times higher than for those with moderate disorders (52.5%) and about two and a half times higher than for those with mild disorders (27.2%).

Nine out of ten (90.1%) children and adolescents with a severe conduct disorder had used school services in the previous 12 months. Comparisons in the use of school services among those with severe disorders by disorder type should be treated with caution as the differences are not statistically significant.

Table 7-18: School service use in past 12 months among 4-17 year-olds with mental disorders by disorder type and severity of impact

Disorder	Mild (%)	Moderate (%)	Severe (%)	Total (%)
Anxiety disorder	26.1	58.4	75.4	44.1
Major depressive disorder	40.2	63.0	72.1	61.9
ADHD	24.9	56.5	70.6	37.0
Conduct disorder	35.6	70.2	90.1	53.8
Any mental disorder	27.2	52.5	72.6	40.2

Where the child or adolescent had more than one disorder, service use has been counted under each disorder. The severity of any mental disorder is based on the most severe disorder if the child or adolescent has more than one disorder.

7.5 Telephone counselling and online service use by children and adolescents with mental disorders

An ever increasing range of telephone and online information, assessment tools, support and counselling services are available to young people to assist them with their emotional and behavioural problems. Given that these services can be accessed directly by young people, and without parental or carer permission, it is more difficult for parents or carers to know whether their children have used these services. Very few children under the age of 12 years had used telephone or online services and so results are reported for 12-17 year-olds only.

Just 3.6% of 12-17 year-olds with mental disorders had used a telephone counselling service in the previous 12 months. The parents and carers of another 12.8% of 12-17 year-olds said that they didn't know whether their adolescent had used these services or not.

Parents and carers reported that 10.9% of 12-17 year-olds with mental disorders had used online services, including services provided by headspace, Reachout and Youth beyondblue, to get help or information about emotional or behavioural problems in the previous 12 months. Another 17.0% didn't know whether their adolescent had used these online services.

7.6 Use of services by parents and carers

Apart from young people directly receiving services for their emotional or behavioural problems, parents and carers (and other family members) may use a variety of services to help them manage their child's or adolescent's problems. This section describes use of health service providers and online services by parents and carers for this purpose.

7.6.1 Service use

Other than when they had taken the child to see someone, almost one third of parents and carers (29.5%) of children and adolescents with mental disorders reported that they or other family members had used services in the past 12 months to help manage their child's or adolescent's problems. One fifth or 6.1% of these reported that they had used these services, but that their child or adolescent had not used any services for emotional and behavioural problems in the previous 12 months.

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7.6.2 Health service use

Overall 27.3% of parents and carers of children and adolescents with mental disorders had used a health service in the past 12 months to help them with their child’s or adolescent’s problems. Parents and carers most commonly used the services of general practitioners (17.7%), psychologists (12.4%) and counsellors or family therapists (11.0%) to help them with their child’s or adolescent’s problems (Table 7-19).

Table 7-19: Service use in past 12 months by parents or carers of 4-17 year-olds with mental disorders for help with managing child’s problems

Health service provider	Proportion (%)
General practitioner	17.7
Paediatrician	6.9
Psychiatrist	4.8
Psychologist	12.4
Nurse	1.8
Social worker	6.7
Occupational therapist	3.1
Counsellor or family therapist	11.0
Other or unsure about profession	5.3
Any health service provider	27.3

Parents and carers may also have spoken to a general practitioner about their child’s or adolescent’s problems in the course of a consultation primarily for some other purpose. Two fifths of parents and carers (42.6%) had spoken to a general practitioner about their child’s problems in the previous 12 months. Of those that had spoken to a general practitioner, nearly three quarters (73.3%) had done this on more than one occasion, and one fifth (20.3%) had done so five or more times.

7.6.2 Online service use

Almost two fifths (37.6%) of parents and carers of children and adolescents with mental disorders had used an online service in the previous 12 months for help or information about their child’s or adolescent’s problems (Table 7-20).

Most of these parents and carers had used online services for information about mental health issues or services in the community and about half had used another type of online service such as an assessment tool, personal support or counselling (32.6% and 18.4% respectively).

Table 7-20: Online service use in past 12 months by parents or carers of 4-17 year-olds with mental disorders by type of service

Type of online service	Proportion (%)
Information about mental health issues and services in the community	32.6
Assessment tool, self-help, chat room or support group, personal support or counselling	18.4
Any online service	37.6

7.7 Understanding who does and does not use services

The majority of young people using services were assessed as having one or more of the four types of mental disorders (anxiety disorder, major depressive disorder, ADHD and conduct disorder), however, many did not. Information was collected in the survey on a number of factors that provide further insight into who else was using services for emotional and behavioural problems and what might have contributed to their service use. The other indicators of mental health problems or distress were as follows:

- A clinically sub-threshold level of mental disorder, in which symptoms are present but not at a level of severity and/or for a sufficient time for diagnosis of the disorder, as indicated on one or more of the DISC-IV diagnostic modules completed by parents and carers and/or the major depressive disorder module completed by 11-17 year-olds;
- A score in the ‘abnormal’ range on the Strengths and Difficulties Questionnaire (SDQ), indicating a substantial risk of clinically significant problems;
- A ‘very high’ level of psychological distress as indicated by the Kessler 10 Psychological Distress Scale; and
- Suicide attempt or attempts ever in their lifetime as reported by 12-17 year-olds.

7.7.1 Any service

Half (50.4%) of children and adolescents who had used services for emotional or behavioural problems in the previous 12 months were assessed on the basis of information provided by their parents and carers, or themselves in the case of adolescents, as having a mental disorder according to DSM-IV diagnostic criteria (Table 7-21).

Another 40.0% of those using services had symptoms of a mental disorder but at a clinically sub-threshold level based on the DISC-IV responses, an abnormal SDQ score, a Kessler 10 score indicating distress at a very high level and/or had ever attempted suicide. A little under one in ten (9.7%) children and adolescents who had used a service did not appear to have significant mental health problems based on any of these indicators.

Table 7-21: Service use in past 12 months among 4-17 year-olds by indicators of significant problems

Factor indicating significant problems	Proportion (%)	Population estimate
Mental disorder based on DISC-IV	50.4	343,000
Sub-threshold level on DISC-IV or other indicators of significant mental ill-health (a)	40.0	272,000
None of the above	9.7	66,000
Total	100.0	681,000

(a) Other indicators are SDQ in ‘abnormal’ range, Kessler 10 in ‘very high’ distress range and/or suicide attempt.

7.7.2 Health services

Just over half (54.3%) of 4-17 year-olds who had used health services for emotional or behavioural problems in the previous 12 months had mental disorders based upon DISC-IV. Another 37.1% had a sub-threshold level of mental disorder or other indicators of significant mental ill-health. The

remaining 8.6% of those using health services for emotional or behavioural problems did not appear to have significant mental health problems based on these indicators (Table 7-22).

Table 7-22: Health service use in past 12 months among 4-17 year-olds by indicators of significant problems

Factor indicating significant problems	Proportion (%)	Population estimate
Mental disorder based on DISC-IV diagnosis	54.3	323,000
Sub-threshold level on DISC-IV or other indicators of significant mental ill-health (a)	37.1	221,000
None of above	8.6	51,000
Total	100.0	595,000

(a) Other indicators are SDQ in ‘abnormal’ range, Kessler 10 in ‘very high’ distress range and/or suicide attempt.

7.8 Young people with mental disorders who did not use services

Overall, 44.0% or an estimated 246,000 children and adolescents who were assessed as having a mental disorder had not used services in the previous 12 months. This is the equivalent of 5.9% of all 4-17 year-olds.

Four fifths (79.9%) of children and adolescents aged 4-17 years with a mental disorder who did not use services had mild disorders, however, 15.9% had moderate disorders and 4.2% had severe disorders. Four fifths (81.9%) of 4-17 year-olds with a mental disorder who did not use services had one type of mental disorder, 15.4% had two disorders and 2.7% had three disorders.

Children with mental disorders were less likely to have used services than adolescents. Two thirds (65.2%) of those with mental disorders who had not used services were aged 4-11 years and one third (34.8%) were aged 12-17 years.

Of those 4-17 year-olds who had a mental disorder in the past 12 months and who did not use services in that period, almost three in ten (28.5%) had used a service for emotional or behavioural problems at some point prior to the 12-month period covered by the survey. However, the remaining 71.5% had never used any service for emotional or behavioural problems. This corresponds to 30.2% of all 4-17 year-olds with a mental disorder.

Chapter 8 reports on parents and carers perception of their children’s and adolescents’ needs for services and provides important insights as to why many of these young people did not use services.

8 PERCEIVED NEED AND BARRIERS TO RECEIVING MENTAL HEALTH CARE

There are several factors that determine whether young people receive services for their emotional and behavioural problems. Firstly, the young person or their parents and carers or another significant person in their lives must recognise that there is a problem and that the problem requires assistance. Secondly, they or people close to them need to know that there are effective services to deal with these problems and these must be accessible. Lastly, parents and carers, and young people themselves particularly when they are older, must feel able to receive care and be willing to use services.

This chapter reports on the need for services and barriers to care for young people as perceived by their parents and carers.

8.1 Perceived need for mental health care

Parents and carers were asked about the help their child or adolescent needed with their emotional or behavioural problems and whether their needs for these had been met. The help was categorised into four types:

- Information about emotional or behavioural problems, treatment and available services;
- Prescribed medication for emotional or behavioural problems;
- Counselling or a talking therapy about problems or difficulties (either one-on-one, as a family or in a group); and
- Courses or other counselling for life skills, self-esteem or motivation.

8.1.1 Perceived need for help for all children and adolescents

Just over a quarter (26.8%) of all parents and carers reported that in the previous 12 months their child or adolescent had some need for help for emotional or behavioural problems. Seven out of ten parents and carers (70.2%) who indicated a need for help reported their child's or adolescent's needs were met either fully (42.9%) or partially (27.3%). The remainder (29.8%) indicated their needs were not met at all (Table 8-1).

The most common type of help parents and carers felt their children needed was counselling or a talking therapy, with one fifth of all parents (21.6%) reporting a need for such services in the previous 12 months. Of the 4-17 year-olds whose parents indicated a need for counselling or talking therapy, two thirds (66.8%) reported that their needs were met either fully (42.7%) or partially (24.1%).

One in ten parents and carers of 4-17 year-olds (10.3%) indicated a need for courses or other counselling for life skills, self-esteem or motivation in the previous 12 months, of which less than half (43.1%) indicated the need was met either fully (29.0%) or partially (14.1%). Similarly, about one in ten (12.1%) parents and carers identified a need for information, of which 62.4% reported that the need was met either fully (44.3%) or partially (18.1%). Relatively few (4.2%) parents and carers identified a need for medication.

Table 8-1: Perceived need for help in past 12 months for 4-17 year-olds

Level of perceived need	Information (%)	Medication (%)	Counselling (%)	Life skills (%)	Any type of help (%) (b)
No need	87.9	95.8	78.4	89.7	73.2
Any need—	12.1	4.2	21.6	10.3	26.8
Needs fully met (a)	44.3	54.4	42.7	29.0	42.9
Needs partially met (a)	18.1	18.7	24.1	14.1	27.3
Needs unmet (a)	37.7	27.0	33.2	56.9	29.8

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.
(b) Where need for more than one type of help was identified, level of perceived need for any type of help has been derived from the level of perceived need for each type of help needed (see glossary for details).

8.1.2 Perceived need for help for young people with mental disorders

Almost four fifths (78.6%) of parents and carers of children and adolescents with mental disorders identified that their children had a need for some type of help with their emotional and behavioural problems in the previous 12 months. Almost three quarters (73.8%) of these parents and carers reported that their children’s need for help in the previous 12 months had been either fully (34.9%) or partially met (38.9%). However, one quarter (26.2%) reported that they had unmet need (Table 8-2).

Almost double the proportion of parents and carers of 4-11 year-olds with mental disorders than of 12-17 year-olds with mental disorders felt that their children had no need for help (26.8% compared to 14.6%).

Table 8-2: Perceived need for any type of help in past 12 months for 4-17 year-olds with mental disorders by age group

Level of perceived need	4-11 years (%)	12-17 years (%)	4-17 years (%)
No need	26.8	14.6	21.4
Any need—	73.2	85.4	78.6
Needs fully met (a)	35.2	34.6	34.9
Needs partially met (a)	33.7	44.7	38.9
Needs unmet (a)	31.2	20.7	26.2

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.

Counselling was the type of help most often reported as needed. Two thirds (68.1%) of parents and carers of children and adolescents with mental disorders reported that their child or adolescent needed counselling. Of these, just over two thirds (67.7%) indicated that their needs were met either fully (36.8%) or partially (30.9%) (Table 8-3).

Two fifths of parents and carers (41.7%) of children and adolescents with mental disorders reported a need for information, and this need was met fully (39.4%) or partially (25.0%) in about two thirds of cases. Just over one fifth (22.3%) of parents and carers reported a need for medication for their child or adolescent in the previous 12 months and this need was met in 76.5% of cases, either fully (54.5%) or partially (22.0%).

One third (36.0%) of parents and carers of children and adolescents with mental disorders reported that the young person needed life skills training. A relatively low proportion (39.1%) reported that this need was met either fully (20.6%) or partially (18.5%). The majority (60.9%) of parents reporting a need for life skills training indicated the need was not met.

Table 8-3: Perceived need for help in past 12 months for 4-17 year-olds with mental disorders by type of help

Level of perceived need	Information (%)	Medication (%)	Counselling (%)	Life skills (%)	Any type of help (%) (b)
No need	58.3	77.7	31.9	64.0	21.4
Any need—	41.7	22.3	68.1	36.0	78.6
Needs fully met (a)	39.4	54.5	36.8	20.6	34.9
Needs partially met (a)	25.0	22.0	30.9	18.5	38.9
Needs unmet (a)	35.5	23.5	32.3	60.9	26.2

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.

(b) Where need for more than one type of help was identified, level of perceived need for any type of help has been derived from the level of perceived need for each type of help needed (see glossary for details).

The extent to which parents perceived a need for help varied with the severity of the young person's disorder (Table 8-4). Two thirds (68.3%) of parents and carers of 4-17 year-olds with mild mental disorders felt that their child or adolescent needed help, and in 65.6% of cases these needs were met either fully (40.2%) or partially (25.4%). By contrast, all or nearly all parents of children or adolescents with a moderate or severe mental disorder (91.8% and 100.0% respectively) reported that they needed some form of help. A higher proportion of parents of children and adolescents with moderate and severe disorders (81.8% and 84.2% respectively) reported that their needs were met fully or partially than did those parents of 4-17 year-olds with mild mental disorders (65.6%).

Parents and carers of three quarters (73.6%) of those with severe disorders, one half (51.6%) of those with moderate disorders and less than one third (29.6%) of those with mild disorders identified a need for information. The need for information was unmet in about one third of cases (34.6% in those with severe disorders, 31.5% for moderate disorders, and 39.1% for mild disorders).

Parents and carers reported that half (52.4%) of children and adolescents with severe disorders, one third (36.7%) of those with moderate disorders and less than one in ten (8.7%) of those with mild disorders had a need for prescribed medication. This need was unmet for around one quarter of those with severe disorders (23.3%) and moderate disorders (28.4%).

Counselling or talking therapies were the type of help most often reported by parents and carers as being needed, with 87.0% of those with severe disorders, 85.8% of those with moderate disorders and 55.9% of those with mild disorders identifying a need for this type of help. According to parents and carers, four fifths (84.9%) of children and adolescents with severe disorders needing counselling had their needs met either fully (30.9%) or partially (54.0%) with the remainder (15.1%) reporting their needs were unmet. Unlike other types of help, unmet need for counselling was strongly associated with severity, increasing for those with moderate disorders and again for those with mild disorders (28.7% and 41.3% respectively).

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Two thirds (66.0%) of parents and carers of children and adolescents with severe disorders identified a need for courses or other counselling for life skills, self-esteem or motivation as did 38.3% of those with moderate disorders and 27.6% of those with mild disorders. Need for courses or other counselling for life skills, self-esteem or motivation was unmet in three fifths of cases with 58.5% of those with severe disorders, 64.9% of those with moderate disorders and 60.0% of those with mild disorders having unmet need.

Table 8-4: Perceived need for help in past 12 months for 4-17 year-olds with mental disorders by severity of disorder and type of help

Severity	Level of perceived need	Information (%)	Medication (%)	Counselling (%)	Life skills (%)	Any type of help (%) (b)
Mild	No need	70.4	91.3	44.1	72.4	31.7
	Any need—	29.6	8.7	55.9	27.6	68.3
	Needs fully met (a)	41.8	71.2	39.7	23.3	40.2
	Needs partially met (a)	19.1	np	19.0	16.6	25.4
	Needs unmet (a)	39.1	np	41.3	60.0	34.4
Moderate	No need	48.4	63.3	14.2	61.7	8.2
	Any need—	51.6	36.7	85.8	38.3	91.8
	Needs fully met (a)	44.8	51.3	35.9	17.2	31.3
	Needs partially met (a)	23.7	20.4	35.4	17.9	50.5
	Needs unmet (a)	31.5	28.4	28.7	64.9	18.2
Severe	No need	26.4	47.6	13.0	34.0	0.0
	Any need—	73.6	52.4	87.0	66.0	100.0
	Needs fully met (a)	29.2	47.1	30.9	19.3	25.6
	Needs partially met (a)	36.2	29.6	54.0	22.2	58.6
	Needs unmet (a)	34.6	23.3	15.1	58.5	15.8

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.

(b) Where need for more than one type of help was identified, level of perceived need for any type of help has been derived from the level of perceived need for each type of help needed (see glossary for details).

np Not available for publication because of small cell size, but included in totals where applicable.

8.1.3 Differences in perceived need between those using and not using services

As reported in Chapter 7, just over half (56.0%) of children and adolescents with mental disorders had used services for emotional and behavioural problems in the previous 12 months. Conversely, 44.0% had not used any services.

Virtually all (97.1%) parents and carers of children and adolescents with mental disorders who had used services in the previous 12 months reported that their child or adolescent had a need for some type of help (Table 8-5). Of these, only a small proportion (6.2%) reported that these needs were unmet. In terms of the particular types of help needed by those who had used services in the previous 12 months, the greatest area of need reported by parents was for counselling (87.0%).

By contrast, just over half (54.9%) of parents and carers of children and adolescents with mental disorders who had not used services in the previous 12 months reported that their child or adolescent had a need for some type of help (Table 8-5). Almost three quarters (71.1%) of those with needs reported that their child’s or adolescent’s needs were not met. In terms of the particular types of help needed by those who had not used services in the previous 12 months, the greatest area of need reported by parents and carers was for counselling (44.1%).

Table 8-5: Perceived need for help in past 12 months for 4-17 year-olds with mental disorders by service use and type of help

Service use	Level of perceived need	Information (%)	Medication (%)	Counselling (%)	Life skills (%)	Any type of help (%) (b)
Used services	No need	43.7	63.7	13.0	53.9	2.9
	Any need—	56.3	36.3	87.0	46.1	97.1
	Needs fully met (a)	46.4	59.7	47.2	24.9	44.5
	Needs partially met (a)	29.7	24.1	39.2	21.2	49.3
	Needs unmet (a)	23.9	16.2	13.6	53.8	6.2
No service use	No need	76.9	95.6	55.9	76.9	45.1
	Any need—	23.1	4.4	44.1	23.1	54.9
	Needs fully met (a)	17.8	0.0	10.6	9.5	13.2
	Needs partially met (a)	10.7	0.0	10.0	11.5	15.7
	Needs unmet (a)	71.6	100.0	79.4	79.1	71.1

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.
(b) Where need for more than one type of help was identified, level of perceived need for any type of help has been derived from the level of perceived need for each type of help needed (see glossary for details).

8.2 Barriers to seeking and receiving help

Table 8-6 shows all the reasons given by parents and carers of children and adolescents with mental disorders for not seeking help or receiving more help when needs were not fully met. The most commonly identified reasons were not being sure where to get help (39.6%), not being able to afford help (37.0%) and preferring to handle the problem by themselves or with help from family or friends (31.1%). Being concerned with what other people might think was identified as a barrier by only 5.3% of parents and carers.

Table 8-6: Barriers to seeking help or receiving more help in past 12 months for 4-17 year-olds with mental disorders by age group

Barrier	4-11 years (%)	12-17 years (%)	4-17 years (%)
Preferred to handle by self or with family/friends	36.5	24.5	31.1
Concerned about what people might think	5.2	5.4	5.3
Not sure if child or adolescent needed help	33.5	19.8	27.3
Not sure where to get help	39.9	39.3	39.6
Thought problem would get better by itself	30.1	21.9	26.4
Problem getting to a service that could help	31.8	25.3	28.9
Couldn't afford it	40.5	32.9	37.0
Couldn't get an appointment	29.5	28.8	29.2
Child or adolescent refused help, didn't turn up for appointment or didn't think they had a problem	6.2	48.4	25.4

Some reasons for not seeking help or receiving more help were more common among children than adolescents with mental disorders (Table 8-6). These included parents and carers preferring to handle the problem by themselves or with the help of family or friends (36.5% for 4-11 year-olds compared with 24.5% for 12-17 year-olds), and not being sure if help was needed (33.5% for 4-11 year-olds compared with 19.8% for 12-17 year-olds). In comparison, the most commonly identified reasons for not seeking help or receiving more help for 12-17 year-olds were related to the adolescent themselves, including the young person refusing help, not turning up for an appointment or thinking that they did not have a problem (48.4% compared with 6.2% of 4-11 year-olds).

If parents and carers reported more than one reason, they were also asked about the main reason for not seeking help or receiving more help. About one third (30.9%) of parents and carers identified issues to do with the accessibility of services, specifically problems in getting to a service, not being able to afford it, or not being able to get an appointment. For about another third of parents and carers (36.4%), the most common main reasons for not seeking help or not receiving more help were being unsure if their child or adolescent needed help, where to get help, or thinking the problem would get better by itself, issues that could be broadly considered as mental health literacy (Table 8-7).

Just under one fifth (17.3%) reported that the main reason was related to the child or adolescent not wanting to seek help, and 15.4% of parents and carers reported that the main reason was related to them wanting to manage the problems themselves.

The main barriers to seeking help or receiving more help differed between the age groups. The reasons most commonly identified as the main barriers for 4-11 year-olds were issues primarily related to mental health literacy (43.6%) or accessibility (36.2%). In contrast, the main barrier to adolescents seeking help or receiving more help was identified by about one third (34.8%) of parents as the young person refusing help, not turning up for appointments or because they did not think they had a problem.

Table 8-7: Main barrier to seeking help or receiving more help in past 12 months for 4-17 year-olds with mental disorders by age group

Main barrier	4-11 years (%)	12-17 years (%)	4-17 years (%)
Self-management/stigma	18.3	12.1	15.4
Mental health literacy	43.6	28.2	36.4
Accessibility	36.2	24.9	30.9
Child-related	np	34.8	17.3

np Not available for publication because of small cell size, but included in totals where applicable.

8.3 Perceived need for help for parents and carers of children and adolescents with mental disorders

Parents and carers of children and adolescents with emotional and behavioural problems were also asked about whether they themselves or another family member had received any help to deal with their children’s problems, whether their own needs had been met and, if not, what types of help they felt that they needed. Two fifths (39.0%) of parents and carers reported that they had no need for any type of help (Table 8-8).

Of those who reported a need for any type of help (61.0%), four fifths (78.1%) indicated their needs were met either fully (37.3%) or in part (40.8%) (Table 8-9). Conversely, around one fifth (21.9%) reported unmet need.

The type of help for which there was greatest need was counselling, not only on how to manage the child’s problems, but also to help family relationships and to deal with parents’ and carers’ own problems, worries or stresses as a result of their child’s problems. Counselling was identified by 86.5% of parents and carer’s who indicated some need for help. While this need was either fully or partially met for nearly two thirds of parents and carers (64.4%), 45.6% of parents and carers reported their needs for counselling on how to manage their children’s problems were not being met at all, 44.8% had unmet need for counselling to help family relationships, and 38.7% had unmet need for counselling for their own problems, worries or stresses as a result of their child’s problems.

In terms of information about their child’s problems, treatments and services, 41.0% had any need of which one third (32.6%) had unmet need. About one fifth (18.4%) of parents and carers reported some need for a parenting skills course of which over half (52.4%) did not have these needs met.

Table 8-8: Perceived need for help in past 12 months for parents and carers to deal with problems of 4-17 year-olds with mental disorders

Type of help	Any need (%)
Information about child's problems, treatments and services	41.0
Counselling on how to manage child's problems	44.4
Counselling to help family relationships	30.0
Counselling for own problems, worries or stresses	36.1
Parenting skills course	18.4
Respite care	11.3
Support group	13.6
Help to meet people for support or company	10.3
Any type of help	61.0

Table 8-9: Level of perceived need for help in past 12 months among parents and carers reporting any need for help to deal with problems of 4-17 year-olds with mental disorders

Type of help	Fully met need (%)	Partially met need (%)	Unmet need (%)
Information about child's problems, treatments and services	40.6	26.8	32.6
Counselling on how to manage child's problems	30.3	24.2	45.6
Counselling to help family relationships	27.9	27.3	44.8
Counselling for own problems, worries or stresses	37.2	24.1	38.7
Parenting skills course	35.0	12.6	52.4
Respite care	18.2	18.2	63.6
Support group	25.3	16.7	58.0
Help to meet people for support or company	15.9	11.8	72.3
Any type of help	37.3	40.8	21.9

9 THE ROLE OF SCHOOLS AND IMPACT ON EDUCATION

Schools and other educational institutions play a significant role in providing services to young people with mental disorders and are sometimes where emotional and behavioural problems are first identified.

This chapter provides an overview of the role played by teachers and other school staff in providing support and other services, and referring young people with emotional and behavioural problems to health service providers. The relationship between mental disorders and school attendance, functioning at school and academic performance is also reported.

Data are presented for the 95.9% of young people participating in the survey who were either attending school or another educational institution or had attended in the past 12 months and are based on parent and carer reports. This includes children who were attending part-time or full-time schooling prior to Year 1.

9.1 Identification of young people with emotional or behavioural problems by school staff

Where parents had acknowledged that their child or adolescent had ever experienced emotional or behavioural problems that were significant enough to need help, they were asked who it was that thought that their child needed help including school staff.

Two fifths (40.5%) of parents and carers reported that a school staff member was among those to suggest that their child may need help for emotional or behavioural problems. Just over a third (35.6%) of parents and carers reported that a school teacher or principal was among those to suggest that their child needed some help for emotional or behavioural problems and 12.0% said that either the school counsellor, psychologist or nurse were among those to identify emotional or behavioural problems in their child or adolescent (Table 9-1).

Table 9-1: Proportion of parents or carers who reported that their child’s emotional or behavioural problems were identified by school staff

Staff member identifying problem	Students who have ever had emotional or behavioural problems (%)
School teacher or principal	35.6
School counsellor, psychologist or nurse	12.0
Any school staff	40.5

9.2 School contact with families

One eighth (12.8%) of parents and carers had been contacted in the previous 12 months by the school about a range of emotional or behavioural issues, including bullying (both as perpetrator or victim), aggressive behaviour and conduct issues (Table 9-2).

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It was more common that schools contacted families about emotional or behavioural issues when the student was male (16.2%) rather than female (9.3%). It was also more common that families were contacted by the school about emotional or behavioural issues when students were older (15.4% of 12-17 year-olds compared with 10.8% of 4-11 year-olds).

Contact by the school in respect of emotional or behavioural issues was over four times more common for those students who were identified in the survey as having mental disorders (39.7% compared to 8.3% of students without a disorder). The proportion contacted was higher for older students (45.3%) with a mental disorder than younger students with mental disorders (35.4%). The proportion was also higher for males with mental disorders (43.4%), than for females with mental disorders (34.3%) especially in the 4-11 year-olds age group (40.2% of males compared with 27.6% of females).

Table 9-2: School contact in past 12 months by sex, age group and mental disorder status

Sex	Age group	Mental disorder (%)	No disorder (%)	All students (%)
Males	4-11 years	40.2	9.4	14.6
	12-17 years	47.8	12.5	18.1
	4-17 years	43.4	10.8	16.2
Females	4-11 years	27.6	4.2	6.8
	12-17 years	41.9	8.3	12.5
	4-17 years	34.3	6.0	9.3
Persons	4-11 years	35.4	6.7	10.8
	12-17 years	45.3	10.4	15.4
	4-17 years	39.7	8.3	12.8

9.3 Services used at school

Just over one in ten (11.5%) students had used a school service for emotional or behavioural problems in the previous 12 months, with a higher proportion of older students (14.2% of 12-17 year-olds) than younger students (9.4% of 4-11 year-olds) using services (Table 9-3).

Individual counselling was the most commonly used type of school service in the previous 12 months (8.0% of students). Twice as many older students (11.0%) as younger students (5.6%) used individual counselling services at school.

Table 9-3: School service use for emotional or behavioural problems in past 12 months among 4-17 year-olds by type of service and age group

Type of school service	4-11 years (%)	12-17 years (%)	4-17 years (%)
Individual counselling	5.6	11.0	8.0
Group counselling or support program	2.2	3.2	2.7
Special class or school	2.7	2.8	2.7
School nurse	0.8	2.0	1.4
Other school services	3.3	5.2	4.1
Any service at school	9.4	14.2	11.5

9.3.1 Referral from school to health service providers

When parents and carers reported that the child or adolescent had used the services of particular health service providers in the previous 12 months for emotional or behavioural problems, they were asked if the recommendation or advice to see the provider came from the school.

Of those children or adolescents who had seen a paediatrician, one quarter (25.3%) had been recommended or advised to see the paediatrician by their school. About one in six children and adolescents who used the services of a general practitioner, psychiatrist or psychologist in the previous 12 months (15.8%, 17.0% and 16.9% respectively) had seen the health service provider following recommendation or advice from the school (Table 9-4).

Table 9-4: Proportion of students using health services in past 12 months who were referred by their school by provider type

Health service provider	All students (%)
General practitioner	15.8
Paediatrician	25.3
Psychiatrist	17.0
Psychologist	16.9
Any health service provider	22.6

9.4 Informal support from teachers and other school staff

One in five students (18.9%) had received informal support for emotional or behavioural problems from a school staff member in the previous 12 months. Of those that had received informal support from school staff nearly three fifths (57.2%) had not used formal school services in the previous 12 months as reported in the previous section. One in six students (15.7%) had received informal support from their teachers and one eighth (12.2%) had received informal support for emotional or behavioural problems from other school staff (Table 9-5).

Informal support was around four times higher for young people with a mental disorder, with around half of students with a mental disorder (51.0%) receiving informal support from their teacher and/or other school staff in the previous 12 months compared with 13.6% of those without a mental disorder.

Table 9-5: Proportion of students receiving school-based informal support in past 12 months by mental disorder status

Staff member providing support	Mental disorder (%)	No disorder (%)	All students (%)
His or her teacher	43.2	11.4	15.7
Other school staff	38.6	7.9	12.2
Any school staff	51.0	13.6	18.9

9.5 Relationship between mental disorders and schooling

This section reports on the relationship between mental disorders and school-related outcomes, including days absent from school, impact on functioning at school due to symptoms of mental disorder, school performance in different learning areas and enjoyment of school.

9.5.1 Days absent from school

The average days absent from school due to symptoms of the mental disorder were greatest for those with major depressive disorder and anxiety disorders (on average 20 and 12 days in the previous 12 months respectively). The days absent were far higher among older students for all disorders, with 12-17 year-olds with major depressive disorder being absent 23 days and those with anxiety disorders absent 20 days on average in the previous 12 months. Although adolescents with conduct disorder did not have as many days absent from school, the difference between the two age groups was greatest, with 12-17 year-olds absent 17 days and 4-11 year olds absent just 2 days on average in the previous 12 months due to the symptoms of their disorder (Table 9-6).

Table 9-6: Average days absent in past 12 months due to symptoms of mental disorder by age group and disorder type

Age group	Anxiety disorders (days)	Major depressive disorder (days)	ADHD (days)	Conduct disorder (days)
4-11 years	6	14	4	2
12-17 years	20	23	9	17
4-17 years	12	20	5	8

9.5.2 Impact on functioning at school

The level of impact on functioning at school varied with the type of mental disorder. The greatest impact was due to symptoms of major depressive disorder, with this having had a severe impact on school function for one third (34.3%) of students with this disorder. The symptoms of ADHD had the least impact for most students, with this having mild impact on schooling for 40.0% of students. One third (35.6%) of those with conduct disorder and 20.0% with anxiety disorders experienced no impact on schooling according to parents and carers (Table 9-7).

The level of impact on schooling differed between the age groups for all types of mental disorders. In particular, severe impact on functioning at school due to symptoms of anxiety or ADHD was more common among 12-17 year-old students than 4-11 year-old students (29.1% compared with 12.6% for anxiety disorders and 20.4% compared with 8.5% for ADHD). The greatest difference was for conduct disorders, with the impact being severe for 22.8% of 12-17 year olds and moderate for another 43.6% compared with 10.3% with severe impact and 11.0% with moderate impact for 4-11 year-olds.

Table 9-7: Impact on functioning at school in past 12 months among 4-17 year-olds with mental disorders by age group and mental disorder type

Age group	Level of impact on functioning	Anxiety disorders (%)	Major depressive disorder (%)	ADHD (%)	Conduct disorder (%)
4-11 years	None	27.1	np	16.9	46.2
	Mild	36.9	15.7	42.2	26.7
	Moderate	19.5	27.3	29.9	11.0
	Severe	12.6	45.4	8.5	10.3
	Does not go to school	4.0	np	2.6	np
12-17 years	None	10.7	8.9	7.0	21.8
	Mild	24.7	17.8	36.2	6.9
	Moderate	29.9	36.1	33.2	43.6
	Severe	29.1	30.8	20.4	22.8
	Does not go to school	5.7	6.3	3.3	np
4-17 years	None	20.0	9.6	13.3	35.6
	Mild	31.7	17.3	40.0	18.1
	Moderate	23.9	34.1	31.1	25.2
	Severe	19.7	34.3	12.8	15.8
	Does not go to school	4.7	4.8	2.8	5.4

np Not available for publication because of small cell size, but included in totals where applicable.

9.5.3 School performance by mental disorder status

Table 9-8 shows parent and carer ratings of students’ performance across five different learning areas for those with and without a mental disorder. Given the different ages at which learning areas are introduced, performance in Maths, English, Art and Sports is reported for children aged six and older, and performance in Science is reported for children aged 11 and over.

School performance in all subjects was markedly poorer for those with a mental disorder. In particular there was a greater difference in the core learning areas. In Maths 37.0% of students with mental disorders were rated below average compared with 10.5% of those with no disorder. In English 39.4% of students with mental disorders were rated below average compared with 10.8% of those with no disorder. In Science 33.7% of students with mental disorders were rated below average compared with 8.8% of those with no disorder. The same was true for Art and Sports learning areas, but the differences were somewhat less.

Table 9-8: School performance in past 12 months by mental disorder status and school subject

Mental disorder status	Subject	Far above average (%)	Somewhat above average (%)	Average (%)	Somewhat below average (%)	Far below average (%)
Any disorder	Maths	9.1	18.3	35.6	24.5	12.5
	English, reading or writing	12.2	19.1	29.2	25.0	14.4
	Science	5.7	15.7	45.0	21.9	11.8
	Art or drawing	11.2	26.2	44.3	12.7	5.6
	Sports or physical education	14.3	23.5	38.8	16.0	7.3
No disorder	Maths	17.1	33.5	38.8	9.0	1.5
	English, reading or writing	20.2	33.8	35.2	9.3	1.5
	Science	13.2	32.5	45.6	7.7	1.1
	Art or drawing	15.2	34.6	43.9	5.3	1.0
	Sports or physical education	21.5	30.7	38.9	7.7	1.2

Note: Performance in Maths, English, Art and Sports is reported for children aged six and older, while performance in Science is reported for children aged 11 and over.

The survey also gathered data from parents and carers concerning how much their children liked school. A higher proportion of children and adolescents with a mental disorder than those without a mental disorder somewhat disliked or very much disliked school (21.6% compared with 5.1%) (Table 9-9).

Table 9-9: Rating of how much students liked school in past 12 months by mental disorder status

Level of liking	Mental disorder (%)	No disorder (%)	All students (%)
Very much likes school	31.3	59.3	55.3
Somewhat likes school	37.4	29.5	30.6
Neither likes nor dislikes school	9.7	6.1	6.6
Somewhat dislikes school	12.1	3.9	5.1
Very much dislikes school	9.5	1.2	2.4

PART 4

What adolescents told us

Mental health problems, self-harm, suicidal behaviours and risk behaviours based on adolescents' self-reported information

Adolescents aged 11-17 years were asked to complete a self-report questionnaire on a tablet computer in the privacy of their own bedrooms.

The questionnaire had 12 modules, took 37 minutes on average to complete, and was completed by 89% of the selected young people.

The questionnaire included the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) major depressive disorder module, as well as questions on services used for emotional or behavioural problems.

Additional modules were included about young people's experiences at school, family relationships, self-esteem, protective factors and a range of risk behaviours as well as any self-harm and suicidality. Age cut-offs were implemented for certain questions that were considered inappropriate to ask younger adolescents.

All young people also completed the Kessler 10 Psychological Distress Scale, a measure of psychological distress and the Strengths and Difficulties Questionnaire, a brief behavioural screening questionnaire.

Comparison of responses with those from parents and carers highlights the importance of collecting information from young people themselves.

10 MENTAL DISORDERS, SELF-REPORTED PROBLEMS AND DISTRESS

The survey collected information about major depressive disorder in children and adolescents aged 4-17 years from parents and carers (see Chapter 3) and also from young people themselves aged 11-17 years. The tool used for assessing major depressive disorder was the major depressive disorder module from the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV). This was included in the adolescent self-report questionnaire for 11-17 year-olds, and the parent report version was given to parents and carers. The information provided was used to determine whether a young person met the diagnostic criteria for the disorder as described in the *Diagnostic and Statistical Manual of Mental Disorders Version IV* (DSM-IV).

This chapter presents the prevalence of major depressive disorder determined on the basis of adolescents’ responses to the DISC-IV module. Differences in the prevalence from the perspectives of young people and parents and carers are also examined.

Further insight into young people’s mental health is provided by the Kessler 10 Psychological Distress Scale (K10) and the Strengths and Difficulties Questionnaire (SDQ), which were also completed as part of the adolescent self-report questionnaire.

10.1 Prevalence of major depressive disorder

Based on information from young people themselves, 7.7% of adolescents aged 11-17 years met the diagnostic criteria for major depressive disorder. This is equivalent to an estimated 152,000 adolescents with major depressive disorder.

The prevalence of major depressive disorder was higher in females than males (11.0% compared with 4.5%), and higher in older adolescents (16-17 years) than younger adolescents (11-15 years). Some 8.2% of males aged 16-17 years met diagnostic criteria for major depressive disorder, compared with 3.1% of males aged 11-15 years. In females, 19.6% of 16-17 year-olds had major depressive disorder compared with 7.2% of 11-15 year-olds (Table 10-1).

Table 10-1: Prevalence of major depressive disorder among 11-17 year-olds based on adolescent report by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
11-15 years	3.1	7.2	5.0
16-17 years	8.2	19.6	14.0
11-17 years	4.5	11.0	7.7

10.2 Severity of impact on functioning of major depressive disorder

The severity of major depressive disorder in four different domains (school or work, friends and social activities, family and self) and overall was assessed from young people directly using the same set of

questions that was administered to their parents and carers. Based on information from young people themselves, one in three young people with major depressive disorder (34.2%) had severe impact on functioning. Similar proportions of young people with major depressive disorder experienced a severe level of impact in each of the four domains considered (Table 10-2).

Table 10-2: Severity of impact in different life domains among 11-17 year-olds with major depressive disorder based on adolescent report

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	5.7	2.7	4.2	3.0	
Mild	28.5	31.8	25.8	28.3	38.8
Moderate	35.7	36.3	40.6	41.0	27.0
Severe	25.5	29.3	29.5	27.7	34.2
Does not go to school or work	4.5				

10.3 Comparison of prevalence of major depressive disorder based on adolescent report with parent and carer report

The prevalence of major depressive disorder based on information provided by adolescents and that based on information provided by parents and carers are presented in Table 10-3. Overall, the prevalence of major depressive disorder was higher based on adolescent reported information (7.7% of 11-17 year-olds) compared with parent or carer reported information (4.7% of 11-17 year-olds). However, the prevalence is considerably higher when considered together (i.e. when either source is used as the basis for classification), with one in ten young people (10.5% of adolescents aged 11-17 years) meeting the diagnostic criteria for major depressive disorder based on information provided by either or both the young person and his or her parent or carer.

The prevalence of major depressive disorder was higher in females than in males and the difference was greater when the prevalence was based on adolescent report (11.0% for females and 4.5% for males compared with 5.7% for females and 3.7% for males when based on parent and carer report).

Table 10-3: Prevalence of major depressive disorder among 11-17 year-olds by sex, age group and informant

Sex	Age group	Adolescent report (%)	Parent/carer report (%)	Adolescent report and/or parent/carer report (%)
Males	11-15 years	3.1	3.1	5.4
	16-17 years	8.2	5.4	11.4
	11-17 years	4.5	3.7	7.1
Females	11-15 years	7.2	3.6	9.5
	16-17 years	19.6	10.6	24.3
	11-17 years	11.0	5.7	14.0
Persons	11-15 years	5.0	3.3	7.3
	16-17 years	14.0	8.1	18.0
	11-17 years	7.7	4.7	10.5

Young people rated how much their parents or carers knew about how they were feeling. Among adolescents who did not have major depressive disorder based on either their own or their parent’s and carer’s reports, 7.4% said their parents or carers know ‘not at all’ how they are feeling, compared with 14.9% of young people where both the adolescent report and parent or carer report indicate the young person had major depressive disorder, and 29.5% where only the adolescent report indicated the young person has major depressive disorder. Among adolescents without major depressive disorder 40.2% said their parents or carers knew a lot about how they were feeling compared with 14.3% of adolescents with major depressive disorder identified based on the adolescent report only.

Two thirds of young people with major depressive disorder based on information in their self-report said that their parents or carers only knew ‘a little’ or ‘not at all’ about their feelings (37.6% and 29.5% respectively). Where parents and carers had also provided information on which to base a diagnosis of major depressive disorder, just over half of young people reported that their parents or carers had poor knowledge about how they were feeling (40.3% ‘a little’ and 14.9% ‘not at all’). In contrast three quarters (75.7%) of young people without major depressive disorder reported that their parents or carers knew ‘a lot’ or ‘some’ about how they were feeling (Table 10-4).

Table 10-4: Young people’s perceptions of how much parents or carers know about how they are feeling for those with and without major depressive disorder

Level of parental/carers knowledge	Major depressive disorder based on adolescent report only (%)	Major depressive disorder based on both adolescent and parent/carers reports (%)	No major depressive disorder (%)
A lot	14.3	18.1	40.2
Some	18.6	26.6	35.5
A little	37.6	40.3	16.8
Not at all	29.5	14.9	7.4

10.4 Psychological distress

The Kessler 10 Psychological Distress Scale (K10) is a measure of psychological distress that has been shown to be highly correlated with the presence of depressive or anxiety disorders. Scores are classified into four levels of psychological distress — low, moderate, high and very high distress.

One fifth of adolescents aged 11-17 years had very high or high levels of psychological distress (6.6% and 13.3% respectively). The proportion was higher for females than males (9.5% and 16.4% compared with 4.0% and 10.4%). A higher proportion of older adolescents had very high and high levels of psychological distress (11.0% and 16.2% of 16-17 year-olds compared with 4.8% and 12.2% of 11-15 year-olds) (Table 10-5).

Table 10-5: Kessler 10 level of psychological distress among 11-17 year-olds by sex and age group

Sex	Age group	Low (%)	Moderate (%)	High (%)	Very high (%)
Males	11-15 years	57.6	29.2	9.9	3.3
	16-17 years	53.0	29.4	11.8	5.8
	11-17 years	56.3	29.3	10.4	4.0
Females	11-15 years	49.8	28.9	14.7	6.6
	16-17 years	34.8	29.0	20.3	15.9
	11-17 years	45.1	29.0	16.4	9.5
Persons	11-15 years	53.9	29.1	12.2	4.8
	16-17 years	43.6	29.2	16.2	11.0
	11-17 years	50.9	29.1	13.3	6.6

Four fifths of young people who were identified as having major depressive disorder from information that they provided alone also had very high and high levels of psychological distress (45.2% and 35.5% respectively). The proportion was slightly higher for young people with major depressive disorder identified from both parent or carer and adolescent reported information, with just over half (55.2%) being very highly distressed and another 36.0% highly distressed. The level of distress was not as strongly associated with major depressive disorder status based on parent or

carer report only, with just over one third of young people (36.0%) who were identified as having the disorder based on information from their parents and carers only reporting that they had low levels of distress (Table 10-6).

Table 10-6: Kessler 10 level of psychological distress among 11-17 year-olds by major depressive disorder status

Level of psychological distress	Adolescent report only (%)	Parent/carers report only (%)	Both parent/ carer report and adolescent report (%)	No major depressive disorder (%)
Low	5.4	36.0	np	55.4
Moderate	13.9	28.1	np	30.6
High	35.5	24.1	36.0	11.1
Very high	45.2	11.9	55.2	3.0

np Not available for publication because of small cell size, but included in totals where applicable.

10.5 Strengths and difficulties questionnaire

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire comprising five subscales of five items each. Items in four of these subscales, that is emotional problems, conduct problems, hyperactivity and peer problems, are combined to generate a total difficulties score. Scores in the ‘abnormal’ range indicate substantial risk of clinically significant problems. The SDQ was designed so that approximately 10% of children and adolescents will fall into the ‘abnormal’ range on the total difficulties score.

One tenth (10.2%) of young people aged 11-17 years scored in the abnormal range on the SDQ total difficulties scale. The proportion was higher in females than males (12.1% compared with 8.3%), and higher in older adolescents than younger adolescents (12.4% in 16-17 year-olds compared with 9.2% in 11-15 year-olds) (Table 10-7).

Table 10-7: SDQ total difficulties score among 11-17 year-olds by sex and age group

Sex	Age group	Normal (%)	Borderline (%)	Abnormal (%)
Males	11-15 years	77.7	13.6	8.7
	16-17 years	80.5	12.2	7.3
	11-17 years	78.5	13.2	8.3
Females	11-15 years	76.0	14.2	9.8
	16-17 years	69.6	13.1	17.3
	11-17 years	74.0	13.9	12.1
Persons	11-15 years	76.9	13.9	9.2
	16-17 years	74.9	12.6	12.4
	11-17 years	76.3	13.5	10.2

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The proportion of young people with abnormal scores was highest on the hyperactivity scale followed by the emotional problems scale (13.8% and 10.9% respectively). Emotional problems were more prevalent in females than males (16.3% compared with 5.8%), while conduct problems were more common in males than females (10.0% compared with 7.5%). Emotional problems were more common in older adolescents compared with younger adolescents (16.0% in 16-17 year-olds compared with 8.8% in 11-15 year-olds) (Table 10-8).

Table 10-8: SDQ subscale scores in the abnormal range among 11-17 year-olds by sex and age group

Sex	Age group	Emotional problems (%)	Conduct problems (%)	Hyperactivity (%)	Peer problems (%)
Males	11-15 years	5.4	10.9	14.5	3.7
	16-17 years	7.0	7.8	15.4	3.9
	11-17 years	5.8	10.0	14.7	3.8
Females	11-15 years	12.6	7.5	11.4	5.0
	16-17 years	24.5	7.4	16.2	7.8
	11-17 years	16.3	7.5	12.9	5.9
Persons	11-15 years	8.8	9.3	13.0	4.3
	16-17 years	16.0	7.6	15.8	5.9
	11-17 years	10.9	8.8	13.8	4.8

The SDQ also includes an impact scale that measures interference in life due to emotional and behavioural problems in the domains of home life, friendships, classroom learning and leisure activities. Overall 19.2% of young people aged 11-17 years were in the abnormal range on the SDQ impact scale. More females than males were in the abnormal range on the SDQ impact scale (22.3% compared with 16.3%) and more older adolescents were in the abnormal range than younger adolescents (24.4% in 16-17 year-olds compared with 17.1% in 11-15 year-olds).

Table 10-9: Proportion of 11-17 year-olds with each level of SDQ impact scale by sex and age group

Sex	Age group	Normal (%)	Borderline (%)	Abnormal (%)
Males	11-15 years	75.2	9.1	15.7
	16-17 years	72.9	9.2	17.9
	11-17 years	74.6	9.1	16.3
Females	11-15 years	70.5	10.9	18.6
	16-17 years	60.8	8.8	30.5
	11-17 years	67.5	10.2	22.3
Persons	11-15 years	73.0	10.0	17.1
	16-17 years	66.7	9.0	24.4
	11-17 years	71.1	9.7	19.2

11 ADOLESCENT REPORTED SELF-HARM AND SUICIDAL BEHAVIOURS

Self-harm refers to deliberately hurting or injuring yourself without trying to end your life. *Suicidal behaviours* refer to suicidal ideation (serious thoughts about taking one's own life), making suicide plans and suicide attempts where the self-injury is intended to end in death.

This chapter describes results obtained from the adolescent self-report questionnaire about the prevalence of self-harm and suicidal behaviours and the association between these behaviours and mental disorders. These questions were only asked of young people aged 12 years and over.

11.1 Self-harm

Around one in ten adolescents (10.9%) reported having ever self-harmed. This is equivalent to 186,000 young people aged 12-17 years who had deliberately injured themselves. About three quarters of these adolescents (amounting to 8.0% of the full population or an estimated 137,000 young people) harmed themselves in the previous 12 months (Table 11-1). In addition, 7.5% of 12-17 year-olds answered "prefer not to say" to the first question on self-harm and were not asked subsequent questions. As such the proportion of young people who have ever self-harmed may be higher than indicated in these estimates.

Self-harm was more common among females than among males and more common in older adolescents, with 16.8% of females aged 16-17 years having self-harmed in the previous 12 months and 22.8% having ever self-harmed. The prevalence among 12-15 year-old females was lower, but still higher than for males, with 9.8% of females aged 12-15 years having self-harmed in the previous 12 months and 11.1% having ever self-harmed. In comparison 9.1% of males aged 16-17 years and 5.7% of males aged 12-15 years had ever self-harmed with 6.2% of 16-17 year-old males and 3.0% of 12-15 year-old males having self-harmed in the previous 12 months.

Over half of females who had ever self-harmed had self-harmed four or more times (amounting to 6.0% of females aged 12-15 years and 14.9% of females aged 16-17 years). The proportion of males who had self-harmed four or more times were much lower (1.9% of males aged 12-15 years and 4.5% of males aged 16-17 years). One in ten of the young people aged 12-17 years who had self-harmed in the previous 12 months or 0.8% overall had received medical treatment as a direct result of injuries incurred by an act of deliberate self-harm.

Of those adolescents that had self-harmed in the previous 12 months, 61.6% had self-harmed more than four times at any time in the past.

Rates of self-harm by selected socio-demographic characteristics (family type, household income, carer education, carer labour force status and area of residence) are shown in supplementary tables S-52 through S-56. In young people who did not have major depressive disorder based on adolescent self-report, self-harm rates were higher in young people from step families compared with original families. Of young people without major depressive disorder, 14.7% had ever self-harmed and 7.8% had self-harmed 4 or more times from step families compared with 6.4% and 2.5% respectively from

original families. There were no significant differences in self-harm rates by other socio-demographic characteristics.

Table 11-1: Self-harm among 12-17 year-olds by sex and age group

Sex	Age group	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)	Received medical treatment for self-harm in previous 12 months (%)
Males	12-15 years	5.7	1.9	3.0	np
	16-17 years	9.1	4.5	6.2	np
	12-17 years	6.8	2.8	4.0	np
Females	12-15 years	11.1	6.0	9.8	1.1
	16-17 years	22.8	14.9	16.8	1.8
	12-17 years	15.3	9.2	12.3	1.3
Persons	12-15 years	8.2	3.8	6.2	0.7
	16-17 years	16.1	9.8	11.6	1.1
	12-17 years	10.9	5.9	8.0	0.8

np Not available for publication because of small cell size, but included in totals where applicable.

11.1.1 Self-harm and mental disorder

The highest rate of self-harm was in adolescents with major depressive disorder. This was particularly so for females with major depressive disorder, approximately half of whom had self-harmed (54.9% and 49.2% of those with major depressive disorder based on adolescent and parent reports respectively). While young people with other mental disorders had rates of self-harm more than twice as high as those with no disorder, the rates for these young people were markedly lower than for young people with major depressive disorder (32.5% for all 12-17 year-olds with major depressive disorder, 10.6% for those with other disorders and 4.2% for those with no disorder based on parent reports) (Table 11-2).

Receiving medical treatment as the direct result of injuries incurred in an act of deliberate self-harm was also markedly higher for young people with major depressive disorder compared to those with no disorder (6.6% when based on self-report or 9.9% when based on parent report compared with 0.8% for all persons).

One in twelve (8.5%) females who had major depressive disorder based on their self-reports received medical treatment in the previous 12 months. However, the rate for females with major depressive disorder was double this (16.9%) when their disorder status was based on parent or carer reports.

Table 11-2: Self-harm and self-harm requiring medical treatment among 12-17 year-olds by sex and mental health status

Sex	Mental health status	Self-harm in previous 12 months (%)	Received medical treatment for self-harm in previous 12 months (%)
Males	Major depressive disorder based on adolescent report	25.8	np
	Major depressive disorder based on parent or carer report	9.1	np
	Other disorder based on parent or carer report	6.2	np
	No disorder	2.7	np
	All males	4.0	np
Females	Major depressive disorder based on adolescent report	54.9	8.5
	Major depressive disorder based on parent or carer report	49.2	16.9
	Other disorder based on parent or carer report	17.8	np
	No disorder	5.9	np
	All females	12.3	1.3
Persons	Major depressive disorder based on adolescent report	46.6	6.6
	Major depressive disorder based on parent or carer report	32.5	9.9
	Other disorder based on parent or carer report	10.6	np
	No disorder	4.2	np
	All persons	8.0	0.8

np Not available for publication because of small cell size, but included in totals where applicable.

11.1.2 Self-harm and service use

More than half (57.6%) of adolescents who had self harmed more than four times at any time in the past had used services for emotional or behavioural problems in the previous 12 months (Table 11-3). Most commonly these adolescents had used a health service (53.5%) or school service (48.8%) while fewer had used telephone counselling (15.4%) or online personal support or counselling services such as those provided by headspace, Reachout, and Youth beyondblue (7.4%).

Rates of service use among 13-17 year-olds who had self-harmed in the previous 12 months were similar to rates of service use among those who had ever self-harmed more than four times. Service use among those who had self-harmed in the previous 12 months was higher among females than males (60.9% compared with 40.1%).

It is not possible to say from the survey whether the services were used before or after the time that the person had harmed themselves.

Table 11-3: Service use in past 12 months among 13-17 year-olds who had self-harmed by type of service

Type of service	Self-harm in the previous 12 months (%)	Self-harm more than 4 times (%)
Health service	49.1	53.5
School service	45.0	48.8
Telephone counselling	15.7	15.4
Online personal support or counselling	7.7	7.4
Any service (a)	55.6	57.6

The proportion using school services is based on those who were attending school at the time of the survey.
(a) Any service is not equal to the sum of individual services because adolescents may have used more than one type of service.

11.2 Suicidal behaviours

Around 128,000 or 7.5% of young people aged 12-17 years had seriously considered attempting suicide in the previous 12 months. The proportion was over twice as high for females as for males (10.7% and 4.5% respectively). In addition, 4.7% of males and 6.6% of females answered “prefer not to say” to the question on suicidal ideation and were not asked subsequent questions about suicide plans or suicide attempts. As such, the results presented here may underestimate the full extent of suicidal behaviours in Australian young people.

Overall one third of young people who had seriously considered attempting suicide in the previous 12 months, or 2.4% of all 12-17 year-olds, reported having attempted suicide in the previous 12 months. This is equivalent to 41,000 young people. One quarter or 0.6% of all 12-17 year-olds received medical treatment as a direct result of their injuries (Table 11-4).

Suicide attempts were more common among females than among males and for 16-17 year-olds compared with younger adolescents (4.7% for females and 2.9% for males aged 16-17 years compared with 2.7% for females and 0.8% for males aged 12-15 years in the previous 12 months).

Rates of suicidal behaviours by selected socio-demographic characteristics (family type, household income, carer education, carer labour force status and area of residence) are shown in supplementary tables S-58 through S-62. There were no significant differences in rates of suicidal behaviours by socio-demographic characteristics.

Table 11-4: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds by sex and age group

Sex	Age group	Suicidal ideation in previous 12 months (%)	Suicide plan in previous 12 months (%)	Suicide attempt ever (%)	Suicide attempt in previous 12 months (%)	Medical treatment for suicide attempt in previous 12 months (%)
Males	12-15 years	3.4	2.0	0.9	0.8	np
	16-17 years	6.8	4.9	3.9	2.9	np
	12-17 years	4.5	2.9	1.9	1.5	np
Females	12-15 years	8.1	5.9	3.3	2.7	np
	16-17 years	15.4	10.6	6.7	4.7	1.6
	12-17 years	10.7	7.6	4.5	3.4	1.1
Persons	12-15 years	5.6	3.8	2.0	1.7	np
	16-17 years	11.2	7.8	5.3	3.8	1.0
	12-17 years	7.5	5.2	3.2	2.4	0.6

np Not available for publication because of small cell size, but included in totals where applicable.

11.2.1 Suicidal behaviours and mental disorder

Suicidal behaviours were strongly associated with mental disorder, in particular major depressive disorder. Rates of suicidal ideation, suicide plans and suicide attempts were much lower in young people whose parents or carers had identified any other mental illness apart from major depressive disorder than in those young people where major depressive disorder was identified. In addition these rates were higher when the major depressive disorder was based on information provided by the young person themselves than when based on information provided by the parent or carer.

Among young males identified with major depressive disorder based on adolescent self-report information, nearly one third (29.2%) had seriously considered suicide and 13.8% had attempted suicide in the previous 12 months, compared with 3.1% and 0.4% of young males without a mental disorder based on either the parent or adolescent report. Similarly for females, over half (56.4%) of those who were identified with major depressive disorder based on adolescent self-report information had seriously considered suicide, and over one fifth (22.1%) had attempted suicide while 3.5% of females with no identified mental disorder had seriously considered suicide and the number of females with no identified mental disorder who had attempted suicide was too small to allow an estimate to be produced (Table 11-5).

The highest rates of suicidal behaviours were in young people with major depressive disorder. This was particularly so for adolescent females. Approximately half of females with major depressive disorder based on self-report (56.4% or 47.7% based on parent or carer report) had seriously considered attempting suicide in the previous 12 months compared with just under one third (29.2%) of males with major depressive disorder based on self-report (or 17.0% based on parent or carer report). These rates were four to five times higher than for young people with other disorders based

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on their parents’ or carers’ reports and around ten times the rates for young people with no disorder (Table 11-5).

Suicide plans followed a similar pattern, with 45.3% of young females and 26.0% of young males with major depressive disorder based on self-report having made a suicide plan in the previous 12 months compared with 15.1% of females and 3.5% of males with another disorder and 1.9% of females and 1.6% of males with no disorder.

Just over one in eight young males with major depressive disorder (13.8% when based on their self-report or 12.2% based on parent report) attempted suicide in the previous 12 months. One quarter of these (3.4% of males with major depressive disorder based on self-report) received medical treatment as a direct result of their injuries. The rate of suicide attempts was much higher for females with major depressive disorder. Just over one in five (22.1% when major depressive disorder based on self-report or 22.7% based on parent report) attempted suicide in the previous 12 months and around one third of these (6.8% of females with major depressive disorder based on self-report) had received medical treatment as a direct result of their injuries. By comparison just 0.4% of young people with no disorder had attempted suicide in the previous year.

Table 11-5: Suicidal ideation, suicide plans and suicide attempts in the past 12 months among 12-17 year-olds by sex and mental health status

Sex	Mental health status	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Males	Major depressive disorder based on adolescent report	29.2	26.0	13.8
	Major depressive disorder based on parent or carer report	17.0	13.5	12.2
	Other disorder based on parent or carer report	5.2	3.5	4.4
	No disorder	3.1	1.6	0.4
	All males	4.5	2.9	1.5
Females	Major depressive disorder based on adolescent report	56.4	45.3	22.1
	Major depressive disorder based on parent or carer report	47.7	36.0	22.7
	Other disorder based on parent or carer report	17.5	15.1	7.5
	No disorder	3.5	1.9	np
	All females	10.7	7.6	3.4
Persons	Major depressive disorder based on adolescent report	48.6	39.8	19.7
	Major depressive disorder based on parent or carer report	34.9	26.7	18.4
	Other disorder based on parent or carer report	9.8	7.9	5.5
	No disorder	3.3	1.8	0.4
	All persons	7.5	5.2	2.4

np Not available for publication because of small cell size, but included in totals where applicable.

The DSM-IV criteria for major depressive disorder require a minimum of five symptoms of depression to be present in the same period. One of the symptoms is “recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for

committing suicide”. As such, suicidal behaviours contribute towards establishing the diagnosis of major depressive disorder.

11.2.2 Suicidal behaviours and service use

Seven in ten (70.9%) 13-17 year-olds who reported a suicide attempt in the previous 12 months had used services for emotional or behavioural problems in the previous 12 months (Table 11-6). Most of these had used health services (69.8%). Over half of 13-17 year-olds who reported a suicide attempt in the previous 12 months had used school services (57.9%), one fifth had used a telephone counselling service (21.9%) and one tenth (10.9%) had used an online personal support or counselling service such as those provided by headspace, Reachout, and Youth beyondblue. The proportion that had used services was higher for females than males (77.9% and 50.6% respectively).

Around six in ten adolescents who had seriously considered attempting suicide or had made a suicide plan in the previous 12 months had used services in the previous 12 months (56.6% and 59.2% respectively).

It is not possible to say from the survey whether the services were used before or after the time of the young person seriously considering suicide, making a plan or making a suicide attempt.

Table 11-6: Service use in past 12 months among 13-17 year-olds reporting suicidal ideation, a suicide plan, or suicide attempt in past 12 months by type of service

Type of service	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Health service	53.2	57.2	69.8
School service	44.7	50.0	57.9
Telephone counselling	17.3	18.7	21.9
Online personal support or counselling	8.8	8.0	10.9
Any service (a)	56.6	59.2	70.9

The proportion using school services is based on those who were attending school at the time of the survey.
(a) Any service is not equal to the sum of individual services because adolescents may have used more than one type of service.

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12 SELF-REPORTED PROBLEMS, BEHAVIOURS AND RISK FACTORS IN YOUNG PEOPLE

This chapter describes what young people reported about their mental health problems and behaviours that are generally considered to put them at risk. While all young people aged 11 years or older were asked to complete a self-report questionnaire, questions about smoking, alcohol and other drugs and about sexual behaviours were only asked of young people aged 13 years and older.

12.1 Smoking

Overall one tenth (9.9%) of young people aged 13-17 years had smoked at least once a week at some point in their lives and 7.2% had smoked in the last 30 days. Rates of smoking were higher in young people with major depressive disorder and in young people with other mental disorders compared with young people with no mental disorder. Some 29.9% of young people with major depressive disorder identified from adolescent report had ever smoked and 24.4% had smoked in the last 30 days. These rates compared with 29.6% ever smoked and 24.1% smoked in the past 30 days among young people with other mental disorders based on parent or carer report. The corresponding rates were 5.9% ever smoked and 4.1% smoked in the last 30 days among young people with no mental disorder (Table 12-1).

Table 12-1: Smoking among 13-17 year-olds by sex and mental health status

Sex	Mental health status	Ever smoked at least once a week (%)	Smoked in last 30 days (%)
Males	Major depressive disorder based on adolescent report	22.5	18.0
	Major depressive disorder based on parent or carer report	20.6	20.6
	Other disorder based on parent or carer report	21.9	12.9
	No disorder	6.0	4.3
	All males	8.6	6.2
Females	Major depressive disorder based on adolescent report	32.7	26.7
	Major depressive disorder based on parent or carer report	34.7	26.1
	Other disorder based on parent or carer report	28.1	22.2
	No disorder	5.8	3.8
	All females	11.2	8.2
Persons	Major depressive disorder based on adolescent report	29.9	24.4
	Major depressive disorder based on parent or carer report	29.6	24.1
	Other disorder based on parent or carer report	24.4	16.6
	No disorder	5.9	4.1
	All persons	9.9	7.2

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12.2 Alcohol

Almost two in five (37.9%) young people 13-17 years had ever drunk alcohol, 18.1% had drunk alcohol in the past 30 days and 12.5% had drunk more than 4 drinks in a row in the last 30 days. Rates were essentially the same in males and females (Table 12-2).

Young people with major depressive disorder had higher rates of drinking alcohol. Some two thirds (65.3%) of young people with major depressive disorder based on adolescent report had ever drunk alcohol compared with one third (33.8%) of young people with no mental disorder. Some 34.3% of young people with major depressive disorder based on adolescent report had drunk alcohol in the last 30 days compared with half as many (15.4%) young people with no mental disorder, and approximately one quarter (27.6%) of young people with major depressive disorder based on adolescent report had drunk more than 4 drinks in a row in the last 30 days compared with one in ten (10.1%) young people with no mental disorder. Higher rates of alcohol consumption were seen in young people with other mental disorders than in young people with no disorder, but these rates were less than in young people with major depressive disorder (Table 12-2).

Table 12-2: Alcohol consumption among 13-17 year-olds by sex and mental health status

Sex	Mental health status	Ever drunk alcohol (%)	Drunk alcohol in last 30 days (%)	More than 4 drinks in a row in last 30 days (%)
Males	Major depressive disorder based on adolescent report	65.2	25.0	19.3
	Major depressive disorder based on parent or carer report	51.0	19.2	18.3
	Other disorder based on parent or carer report	41.9	24.8	18.5
	No disorder	35.0	16.6	11.3
	All males	37.1	17.9	12.6
Females	Major depressive disorder based on adolescent report	65.3	37.8	30.7
	Major depressive disorder based on parent or carer report	66.3	36.3	27.2
	Other disorder based on parent or carer report	47.5	21.3	12.9
	No disorder	32.4	13.9	8.9
	All females	38.7	18.3	12.5
Persons	Major depressive disorder based on adolescent report	65.3	34.3	27.6
	Major depressive disorder based on parent or carer report	60.8	30.2	24.0
	Other disorder based on parent or carer report	44.1	23.4	16.2
	No disorder	33.8	15.4	10.1
	All persons	37.9	18.1	12.5

12.3 Cannabis and other drugs

Overall one in ten (11.6%) young people aged 13-17 years had ever used cannabis, and one in twenty (5.0%) had used cannabis in the last 30 days. Some 4.5% of young people had ever used other drugs and 1.6% had used other drugs in the last 30 days (e.g. prescription drugs for non-medical purposes, ecstasy, amphetamines, cocaine). Rates of drug use were broadly similar between males and females. Higher rates of drug use were seen in young people with major depressive disorder. Among young people with major depressive disorder identified from adolescent report 28.8% had ever used cannabis, and 13.1% had used cannabis in the last 30 days, while 16.1% had used other drugs, and 6.1% had used other drugs in the last 30 days. Among young people with other mental disorders identified from parent or carer report, rates of drug use were higher compared with young people with no mental disorder, but not as high as for young people with major depressive disorder. Among young people with other mental disorders 18.9% had ever used cannabis, 8.6% had used cannabis in the last 30 days, 9.8% had used other drugs and 3.7% had used other drugs in the last 30 days (Table 12-3).

Table 12-3: Use of cannabis and other drugs among 13-17 year-olds by sex and mental health status

Sex	Mental health status	Ever used cannabis (%)	Used cannabis in last 30 days (%)	Ever used other drugs (%)	Used other drugs in last 30 days (%)
Males	Major depressive disorder based on adolescent report	28.9	12.7	12.3	np
	Major depressive disorder based on parent or carer report	23.5	14.6	6.9	np
	Other disorder based on parent or carer report	17.8	10.4	7.9	np
	No disorder	10.3	4.1	2.9	0.7
	All males	12.1	5.5	3.9	1.1
Females	Major depressive disorder based on adolescent report	28.8	13.3	17.6	6.9
	Major depressive disorder based on parent or carer report	31.6	13.1	15.9	7.6
	Other disorder based on parent or carer report	20.6	np	12.6	np
	No disorder	6.8	2.8	2.5	1.1
	All females	11.1	4.4	5.2	2.1
Persons	Major depressive disorder based on adolescent report	28.8	13.1	16.1	6.1
	Major depressive disorder based on parent or carer report	28.7	13.6	12.7	6.4
	Other disorder based on parent or carer report	18.9	8.6	9.8	3.7
	No disorder	8.7	3.5	2.7	0.9
	All persons	11.6	5.0	4.5	1.6

np Not available for publication because of small cell size, but included in totals where applicable.

12.4 Problem eating behaviours

Based upon self-report of their heights and weights, 6.1% of 11-17 year-olds had a BMI that placed them in the underweight range, 19.4% were in the overweight range and 6.7% were in the obese range using established age-specific BMI cut-offs¹ (Table 12-4).

Table 12-4: Body mass index of 11-17 year-olds by sex

BMI category	Males (%)	Females (%)	Persons (%)
Underweight	5.8	6.4	6.1
Normal	66.3	69.6	67.9
Overweight	21.5	17.1	19.4
Obese	6.5	6.9	6.7

Among young people with major depressive disorder based on self-report, 10.5% had a BMI in the obese range, compared with 5.9% of those with no mental disorder. The difference was largest for males with 16.7% of males with major depressive disorder based on self-report in the obese range compared with 5.8% of males with no disorder. A higher proportion of males with major depressive disorder were in the underweight range (10.6% compared with 5.3%) while a lower proportion of females with major depressive disorder were in the underweight range (4.2% compared with 6.7%) (Table 12-5).

Table 12-5: Body mass index of 11-17 year-olds by sex and mental health status

Mental health status	BMI category	Males (%)	Females (%)	Persons (%)
Major depressive disorder based on adolescent report	Underweight	10.6	4.2	6.2
	Normal	46.9	65.0	59.4
	Overweight	25.8	23.0	23.9
	Obese	16.7	7.7	10.5
Major depressive disorder based on parent or carer report	Underweight	5.7	2.0	3.5
	Normal	54.5	49.5	51.6
	Overweight	28.2	37.8	33.8
	Obese	11.7	10.7	11.1
Other disorder based on parent or carer report	Underweight	7.9	7.4	7.7
	Normal	61.7	59.8	61.0
	Overweight	23.9	17.6	21.7
	Obese	6.5	15.1	9.6
No disorder	Underweight	5.3	6.7	6.0
	Normal	68.4	72.0	70.1
	Overweight	20.5	15.4	18.1
	Obese	5.8	5.9	5.9

¹ Cole TJ, Flegal KM, Nicholls D, Jackson AA (2007). Body mass index cut offs to define thinness in children and adolescents: international survey. *British Medical Journal*. 335(7612): 194. doi: 10.1136/bmj.39238.399444.55

Low weight problem eating behaviour (where the young person was assessed as underweight on the age-adjusted BMI scale and was practising weight controlling behaviours such as dieting, fasting, vomiting or using laxatives or regularly exercising when they were supposed to be doing other things) was identified in 1.1% of 11-17 year-olds. Differences between males and females and between younger and older adolescents were not statistically significant (Table 12-6).

Binge eating and purging problem eating behaviour (where a young person of normal weight BMI or higher was both binge eating and either vomiting or taking laxatives to control weight) was identified in 1.3% of 11-17 year-olds. Differences between males and females and between younger and older adolescents were not statistically significant (Table 12-6). Prevalence of the individual behaviours used to define low weight problem eating behaviour and binge eating and purging problem eating behaviour is shown in Supplementary Table S-68.

Taken together, 1.6% of males and 3.2% of females had either low weight or binge either and purging problem eating behaviours. Among 11-15 year-olds proportions were similar for males and females. However among 16-17 year-olds a higher proportion of females (4.9%) had either low weight or binge either and purging problem eating behaviours than males (0.7%).

Not all young people identified with problem eating behaviours in these questions would be expected to receive a formal diagnosis of an eating disorder under DSM-IV.

Table 12-6: Problem eating behaviours among 11-17 year-olds by sex and age group

Age group	Eating behaviour	Males (%)	Females (%)	Persons (%)
11-15 years	Low weight problem eating behaviour	0.9	1.3	1.1
	Binge eating and purging problem eating behaviour	1.1	1.1	1.1
	Either low weight or binge eating and purging problem eating behaviours	2.0	2.4	2.2
16-17 years	Low weight problem eating behaviour	np	2.0	1.1
	Binge eating and purging problem eating behaviour	np	3.0	1.8
	Either low weight or binge eating and purging problem eating behaviours	0.7	4.9	2.9
11-17 years	Low weight problem eating behaviour	0.7	1.5	1.1
	Binge eating and purging problem eating behaviour	0.9	1.7	1.3
	Either low weight or binge eating and purging problem eating behaviours	1.6	3.2	2.4

np Not available for publication because of small cell size, but included in totals where applicable.

12.5 Sexual behaviours

Young people aged 13-17 years were asked several questions about their sexual activity. These questions were sourced from the *Youth Risk Behavior Surveillance System* questionnaire developed by the Centers for Disease Control and Prevention (CDC) in the United States. Overall, 14.9% of young people aged 13-17 years had ever had sexual intercourse and 4.2% reported having had sexual intercourse with 4 or more persons (Table 12-7).

The proportion of young people who had ever had sexual intercourse was higher in adolescents who had mental disorders and highest in young people with major depressive disorder. Among young people with major depressive disorder based on adolescent report, 38.0% had ever had sexual intercourse, compared with 11.5% among young people with no mental disorder. Some 13.4% of young people with major depressive disorder based on adolescent report had had sexual intercourse with four or more persons during their life compared with 2.8% of young people with no mental disorder.

Table 12-7: Sexual behaviours among 13-17 year-olds by mental health status

Mental health status	Ever had sexual intercourse (%)	Had sexual intercourse with 4 or more persons (%)
Major depressive disorder based on adolescent report	38.0	13.4
Major depressive disorder based on parent or carer report	41.4	13.6
Other disorder based on parent or carer report	20.6	7.5
No disorder	11.5	2.8
All persons	14.9	4.2

Two thirds of sexually active young people used a condom during last sexual intercourse (66.0%) and two fifths (39.7%) used birth control pills. Around one in ten young people did not use any method to prevent pregnancy or sexually transmitted infections during last sexual intercourse (11.5%). This was higher for young people with mental disorders other than major depressive disorder (19.1% compared with 9.6% among young people with no mental disorder).

Young people with major depressive disorder were more likely to have drunk alcohol or used drugs before last sexual intercourse (27.8% based on adolescent report compared with 20.6% of young people with no mental disorder). Almost 40% of young people with mental disorders other than major depressive disorder drank alcohol or used drugs before last sexual intercourse (Table 12-8).

Table 12-8: Use of protection during last sexual intercourse or consumption of alcohol or drugs prior to last sexual intercourse among 13-17 year-olds who had ever had sexual intercourse

Mental health status	Used a condom (%)	Used birth control pills (%)	Did not use any method to prevent pregnancy or sexually transmitted infections (%)	Drank alcohol or used drugs (%)
Major depressive disorder based on adolescent report	48.7	45.0	17.0	27.8
Major depressive disorder based on parent or carer report	63.9	43.9	7.7	26.2
Other disorder based on parent or carer report	56.6	24.1	19.1	39.4
No disorder	72.6	40.0	9.6	20.6
All persons	66.0	39.7	11.5	23.9

12.6 Bullying

Bullying covered both face-to-face teasing, threatening, spreading rumours and physically hurting another person, and cyber bullying when mobile phones and/or the internet were used to send emails or messages, post comments or pictures, or pretend to be someone online with the aim of hurting or threatening another person.

One quarter (24.3%) of young people aged 11-17 years had been bullied every few months or less often in the previous year and another 10.0% had been bullied every few weeks or more often (Table 12-9).

Slightly more younger adolescents experienced bullying, with 11.2% of 11-15 year-olds and 7.1% of 16-17 year-olds being bullied every few weeks or more often.

Three fifths of young people with major depressive disorder (62.8% based on self-report) had been bullied in the previous year. This was twice the proportion among those with no disorder (30.2%). The difference in proportions was greatest for those who were bullied more often, with 28.3% of 11-17 year-olds with major depressive disorder based on self-report having been bullied every few weeks or more often in the previous 12 months. This proportion was over three times higher the proportion of young people with no mental disorder (7.6%) (Table 12-9).

118 The Mental Health of Children and Adolescents**Table 12-9: Frequency of being bullied in past 12 months among 11-17 year-olds by mental health status and age group**

Mental health status	Frequency of bullying	11-15 years (%)	16-17 years (%)	11-17 years (%)
Major depressive disorder based on adolescent report	Every few months or less often	35.4	33.8	34.5
	Every few weeks, or more often	35.2	22.3	28.3
Major depressive disorder based on parent or carer report	Every few months or less often	31.6	22.9	29.7
	Every few weeks, or more often	19.9	12.4	18.2
Other disorder based on parent or carer report	Every few months or less often	24.9	19.5	23.4
	Every few weeks, or more often	9.4	5.5	8.3
No disorder	Every few months or less often	24.4	17.9	22.6
	Every few weeks, or more often	8.9	4.1	7.6
All persons	Every few months or less often	25.7	20.9	24.3
	Every few weeks, or more often	11.2	7.1	10.0

Overall 11.3% of young people felt either ‘a lot’ or ‘extremely’ upset as a result of bullying in the previous 12 months. The proportion who felt this way was far higher for young people with major depressive disorder, with 39.4% of those with major depressive disorder based on adolescent report feeling either ‘a lot’ or ‘extremely’ upset as a result of bullying (Table 12-10). It is not possible to establish if the depression was caused by or contributed to the bullying.

Table 12-10: Level of distress caused by bullying in past 12 months among 11-17 year-olds by mental health status and age group

Mental health status	Distress level	11-15 years (%)	16-17 years (%)	11-17 years (%)
Major depressive disorder based on adolescent report	Not bullied	29.4	43.8	37.1
	None, a little bit or somewhat	21.7	25.0	23.5
	A lot/extremely	48.9	31.2	39.4
Major depressive disorder based on parent or carer report	Not bullied	48.5	64.7	52.0
	None, a little bit or somewhat	34.6	21.6	31.7
	A lot/extremely	16.9	13.6	16.2
Other disorder based on parent or carer report	Not bullied	65.6	75.0	68.3
	None, a little bit or somewhat	23.9	16.7	21.8
	A lot/extremely	10.5	8.2	9.9
No disorder	Not bullied	66.7	78.0	69.8
	None, a little bit or somewhat	23.8	15.8	21.6
	A lot/extremely	9.5	6.2	8.6
All persons	Not bullied	63.2	72.0	65.7
	None, a little bit or somewhat	24.9	18.2	22.9
	A lot/extremely	12.0	9.8	11.3

One in eight (12.7%) young people bullied someone else every few months or less often and 2.0% did so at least every few weeks or more often. Young people with major depressive disorder were more likely to have bullied someone else than those with other disorders or no disorders (22.5% based on self-report compared with 13.8% with other disorders and 13.1% with no disorder) (Table 12-11).

Table 12-11: Perpetrator of bullying in the past 12 months among 11-17 year-olds by age group and mental health status

Mental health status	Frequency of bullying	11-15 years (%)	16-17 years (%)	11-17 years (%)
Major depressive disorder based on adolescent report	Every few months or less often	19.8	16.4	18.0
	Every few weeks, or more often	7.6	np	4.5
Major depressive disorder based on parent or carer report	Every few months or less often	18.1	14.3	17.3
	Every few weeks, or more often	3.9	np	3.8
Other disorder based on parent or carer report	Every few months or less often	12.1	11.9	12.0
	Every few weeks, or more often	2.0	1.1	1.8
No disorder	Every few months or less often	11.6	11.5	11.5
	Every few weeks, or more often	1.9	1.0	1.6
All persons	Every few months or less often	12.8	12.5	12.7
	Every few weeks, or more often	2.3	1.4	2.0

np Not available for publication because of small cell size, but included in totals where applicable.

There was a strong relationship between being bullied and bullying another person. Just over one quarter (28.7%) of young people who were bullied in the previous 12 months had bullied another person. Whereas only 7.5% of young people who had not been bullied did so.

12.7 Internet use and electronic games

Most young people spend several hours per day on the internet or playing electronic games, but a small proportion of young people spent much larger proportions of time on the internet or gaming. On average, males spent more time playing electronic games than females, even though males and females spend similar amounts of time using the internet. Some 5.3% of males didn’t use electronic games compared with 24.8% of females. Some 4.1% of males used electronic games for an average of 9 hours or more on an average weekday, and 7.8% used electronic games for an average of 9 hours or more on weekends, compared with 0.9% and 1.4% of females (Table 12-12).

Only a small proportion of young people did not use the internet (1.1%). Among 11-15 year-olds, only 3.7% of males did not play electronic games while almost one fifth of females (19%) did not do so. The proportions rose to 9.4% of 16-17 year-old males and 37.6% of 16-17 year-old females (see Supplementary Table S-70).

Table 12-12: Time spent using the internet or playing electronic games among 11-17 year-olds by sex

Sex	Average time spent per day	Internet use on weekdays (%)	Internet use on weekends (%)	Electronic games on weekdays (%)	Electronic games on weekends (%)
Males	Doesn't use	1.1	1.1	5.3	5.3
	1-2 hours	47.5	37.9	64.0	41.5
	3-4 hours	24.4	25.6	15.9	26.4
	5-8 hours	16.1	23.2	10.7	19.1
	9 hours or more	11.1	12.2	4.1	7.8
Females	Doesn't use	1.1	1.1	24.8	24.8
	1-2 hours	44.8	36.5	63.0	55.9
	3-4 hours	25.5	26.2	8.4	12.7
	5-8 hours	19.2	24.2	2.9	5.2
	9 hours or more	9.4	12.0	0.9	1.4
Persons	Doesn't use	1.1	1.1	14.7	14.7
	1-2 hours	46.2	37.2	63.6	48.5
	3-4 hours	24.9	25.9	12.2	19.7
	5-8 hours	17.6	23.7	6.9	12.3
	9 hours or more	10.3	12.1	2.5	4.7

Young people were asked several questions that may be indicators of potential addictive behaviours such as going without eating or sleeping because of the internet or electronic games. The prevalence of these individual behaviours is shown in Supplementary Table S-71. Significant proportions of young people reported one or more of these indicators. For this report, problem internet or electronic gaming behaviours have been defined as reporting four or five of these individual indicators. About 3.5% of males aged 11-15 years, 3.0% of females 11-15 years, 4.4% of males 16-17 years and 6.5% of females 16-17 years reported this level of problem behaviours.

Problem internet or gaming behaviour is more common in young people with mental disorders, particularly young people with major depressive disorder. Some 13.0% of young people with major depressive disorder identified through the adolescent self-report questionnaire reported four of five of these problem behaviours compared with 3.1% of young people with no identified mental disorder (Table 12-13).

Table 12-13: Problem internet or electronic gaming behaviours among 11-17 year-olds by sex and mental health status

Mental health status	Males (%)	Females (%)	Persons (%)
Major depressive disorder based on adolescent report	11.5	13.7	13.0
Major depressive disorder based on parent or carer report	11.5	7.8	9.3
Other disorder based on parent or carer report	4.1	7.9	5.5
No disorder	3.3	2.9	3.1

13 WHAT ADOLESCENTS TOLD US ABOUT SERVICE USE AND SEEKING HELP

This chapter reports on services and other help, both formal and informal, that young people used for emotional or behavioural problems as reported by 13-17 year-olds themselves.

Information about use of services, informal supports, and self-help strategies is presented for all 13-17 year-old adolescents and then by mental health status, that is, adolescents who:

- i. met diagnostic criteria identified in DSM-IV for major depressive disorder based on their own responses;
- ii. met diagnostic criteria for any mental disorder identified in DSM-IV based on parent and carer report (including major depressive disorder); and
- iii. had no mental disorder on the basis of their own self-report, or parent or carer report.

This chapter also reports on adolescents' perceived need for mental health care and the barriers that they identified to seeking help or getting more help for their emotional or behavioural problems when they had a mental disorder on the basis of their own report, or from parent and carer reports.

13.1 Service use by all adolescents

For the purpose of reporting service use in this section, a summary measure of 'service use' was created that included all health, school and telephone counselling services, but only those online services that provide structured or personalised assistance. While valuable in their own right, online services where information is accessed on the internet but no other service is provided were excluded from this composite measure.

'Services' comprised the following:

- i. health services — any service provided by a qualified health professional regardless of where that service was provided including in the community, hospital inpatient, outpatient and emergency, and private rooms;
- ii. school services — any service provided by the school or other educational institution that a young person was attending;
- iii. telephone counselling services; and
- iv. online services that provided personalised assessment, support, counselling or structured self-help programs.

Overall, 18.0% of 13-17 year-olds reported using services for emotional and behavioural problems in the previous 12 months (Table 13-1). This figure of 18.0% is slightly less than the 21.4% of all 12-17 year-olds reported to have used services by their parents and carers as discussed in Chapter 7. The proportion of females who reported using services was almost twice that of males (23.6% compared with 12.7%).

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Table 13-1: Service use for emotional or behavioural problems in past 12 months among 13-17 year-olds by sex and type of service

Type of service	Males (%)	Females (%)	Persons (%)
Health service	9.6	18.9	14.1
School service	8.8	16.2	12.4
Telephone counselling	2.4	4.8	3.6
Online personal support or counselling	1.5	2.7	2.1
Any service (a)	12.7	23.6	18.0

The proportion using school services is based on those who were at school at the time of the survey.

(a) Any service is not equal to the sum of individual services because adolescents may have used more than one type of service.

13.2 headspace

headspace is the Australian Government funded National Youth Mental Health Foundation providing support to young people aged 12-25 years who are experiencing mild to moderate mental health concerns and/or substance use issues.

13.2.1 All adolescents

Just over one third (37.2%) of all 13-17 year-olds had heard about headspace.

Among all adolescents, 3.4% had either been in contact with a health professional by telephone or online (1.6%) or had visited a headspace centre (2.8%) (Table 13-2). A larger proportion of 13-17 year-olds had accessed information via the headspace or eheadspace websites (5.7%). More females than males had accessed headspace services (10.2% versus 4.8%) largely due to higher proportions accessing information on the websites.

Table 13-2: headspace services used for emotional or behavioural problems in past 12 months among 13-17 year-olds by sex and type of service

Type of service	Males (%)	Females (%)	Persons (%)
Accessed information through headspace or eheadspace websites	3.1	8.4	5.7
Spoken to a mental health professional over the telephone or received online support	1.1	2.2	1.6
Visited a headspace centre	2.4	3.3	2.8
Any headspace service (a)	4.8	10.2	7.4

(a) Any headspace service is not equal to the sum of individual headspace services because adolescents may have used more than one type of service.

13.2.2 Adolescents with mental disorders

Half (54.4%) of those with major depressive disorder based on adolescent report and two fifths (43.6%) of those with mental disorders based on parent and carer report had heard about headspace.

One fifth (20.2%) of 13-17 year-olds with major depressive disorder reported using a service provided by headspace, with the majority of these accessing information on the headspace website or through eheadspace (14.8%). One twelfth (8.5%) spoke to a mental health professional on the telephone or received online support, and 11.0% visited a headspace centre (Table 13-3).

Table 13-3: headspace services used for emotional or behavioural problems in past 12 months among 13-17 year-olds by mental health status and type of service

Type of service	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)	No disorder (%)
Accessed information through headspace or eheadspace websites	14.8	7.8	4.8
Spoken to a mental health professional over the telephone or received online support	8.5	4.3	0.7
Visited a headspace centre	11.0	8.2	1.6
Any headspace service (a)	20.2	13.0	5.8

(a) Any headspace service is not equal to the sum of individual headspace services because adolescents may have used more than one type of service.

In contrast, compared to those with self-reported major depressive disorder, fewer adolescents with mental disorders based on parent and carer report (13.0%) had used headspace services for emotional or behavioural problems in the previous 12 months although a similar proportion (8.2%) reported having visited a headspace centre.

A small proportion of adolescents (5.8%) with no mental disorders based on either adolescent or parent or carer report had used headspace services in the previous 12 months.

13.3 Telephone counselling and online services

This section reports on use of telephone helplines such as Kids Helpline and online services including services provided by headspace, Reachout and Youth beyondblue for emotional and behavioural problems.

13.3.1 All adolescents

Of all 13-17 year-olds, 3.6% reported using a telephone counselling line for help or information in the previous 12 months. The proportion was twice as high among females than males (4.8% compared with 2.4%).

Just over one fifth (22.2%) of 13-17 year-olds had used an online service in the previous 12 months for help or information about emotional or behavioural problems (Table 13-4). The proportion was almost twice as high among females than males (28.9% compared with 15.9%). In particular, females were twice as likely to seek information about mental health issues, to use an online assessment tool or online personal support or counselling.

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Table 13-4: Online service use for emotional or behavioural problems in past 12 months among 13-17 year-olds by sex and type of service

Type of online service	Males (%)	Females (%)	Persons (%)
Information about mental health issues	9.3	20.1	14.5
Information about services in the community	4.2	7.4	5.8
Assessment tool	6.1	14.0	10.0
Self-help	3.7	5.1	4.4
Chat room or support group	2.6	3.7	3.1
Personal support or counselling	1.5	2.7	2.1
Any online service (a)	15.9	28.9	22.2

(a) Any online service is not equal to the sum of individual online services because adolescents may have used more than one type of service.

13.3.2 Adolescents with mental disorders

Among all 13-17 year-olds with major depressive disorder based on adolescent report, 13.6% had used a telephone counselling service, such as Kids Helpline, in the previous 12 months. Less (7.1%) of those with mental disorders based on parent and carer report had used a telephone counselling service for emotional or behavioural problems in the previous 12 months.

Half (52.0%) of those with major depressive disorder based on adolescent report had used an online service including services provided by headspace, Reachout and Youth beyondblue, to get help or information about emotional or behavioural problems in the previous 12 months (Table 13-5).

The main use of online services by 13-17 year-olds with major depressive disorder was to find information about mental health issues (40.2%). Some websites provide access to an online assessment tool and 29.6% of 13-17 year-olds with a major depressive disorder had used such a tool (or questionnaire) to find out if they needed help. Others had participated in a chat room or support group (8.6%), received online personal support or counselling (7.4%) or self-help (14.8%).

Use of online services for emotional or behavioural problems was higher among adolescents with major depressive disorder than for those with mental disorders based on parent and carer report (29.9%). More than twice the proportion of 13-17 year-olds with self-reported major depressive disorder compared to those with mental disorders as reported by parents and carers had accessed information about mental health issues (40.2% compared with 20.9%), used an online assessment tool (29.6% compared to 12.4%) or online self-help (14.8% compared with 6.3%) in the previous 12 months.

One fifth (18.7%) of adolescents with no mental disorder based on either their own report or parent or carer report had used an online service in the past 12 months. The main use of online services by this group without mental disorders was for information about mental health issues (11.5%) and for access to an online assessment tool (8.0%).

Table 13-5: Online service use for emotional or behavioural problems in past 12 months among 13-17 year-olds by mental health status and type of service

Type of online service	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)	No disorder (%)
Information about mental health issues	40.2	20.9	11.5
Information about services in the community	13.3	8.6	4.8
Assessment tool	29.6	12.4	8.0
Self-help	14.8	6.3	3.4
Chat room or support group	8.6	5.4	2.6
Personal support or counselling	7.4	4.7	1.2
Any online service (a)	52.0	29.9	18.7

(a) Any online service is not equal to the sum of individual online services because adolescents may have used more than one type of service.

13.4 Informal help or support

Adolescents may often receive help with their problems from family members, friends, teachers at school or other adults in their lives.

13.4.1 All adolescents

Nearly two thirds (62.9%) of all adolescents had received informal help or support for emotional or behavioural problems in the previous 12 months (Table 13-6). This proportion was higher among females than males (74.3% compared with 52.1%). Most commonly young people received informal help or support from a friend (48.5%), a parent (46.1%) or a boyfriend or girlfriend (32.7%).

Table 13-6: Informal help or support received for emotional or behavioural problems in past 12 months among 13-17 year-olds by sex

Source of informal help or support	Males (%)	Females (%)	Persons (%)
Parent	37.7	54.8	46.1
Brother or sister	18.3	32.1	25.0
Other family member	14.1	24.8	19.3
Boyfriend or girlfriend	25.3	40.8	32.7
Friend	35.1	62.2	48.5
Teacher	14.4	19.1	16.7
Other school staff	9.4	17.0	13.1
Other unrelated adult	11.8	20.3	15.9
Any informal support	52.1	74.3	62.9

(a) Any type of informal support is not equal to the sum of individual types of informal support because adolescents may have received more than one type of support.

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13.4.2 Adolescents with mental disorders

Most 13-17 year-olds with major depressive disorder by adolescent report (93.9%) or with mental disorders by parent and carer report (80.3%) had received informal help or support for emotional or behavioural problems in the previous 12 months (Table 13-7).

Friends and parents were the most common sources of informal help or support for 13-17 year-olds with major depressive disorder, with 78.5% receiving help from a friend and 64.1% from a parent. Just over a quarter had received informal support from a teacher and one third from another school staff member, such as a counsellor or nurse (28.7% and 35.8% respectively).

Sources of support were similar for those with mental disorders by parent and carer report compared to those with major depressive disorder by adolescent report. The exception was lower proportions among those with any mental disorder receiving support from a friend (57.2%) or boyfriend or girlfriend if applicable (45.1%).

More than half (57.9%) of 13-17 year-olds without mental disorders had received informal support or help for emotional or behavioural problems in the previous 12 months.

Table 13-7: Informal help or support received for emotional or behavioural problems in past 12 months among 13-17 year-olds by mental health status

Source of informal help or support	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)	No disorder (%)
Parent	64.1	67.4	41.9
Brother or sister	36.8	33.6	22.9
Other family member	30.7	29.9	17.0
Boyfriend or girlfriend	67.4	45.1	27.4
Friend	78.5	57.2	44.8
Teacher	28.7	24.1	14.8
Other school staff	35.8	28.1	9.4
Other unrelated adult	31.0	31.3	12.5
Any informal support	93.9	80.3	57.9

(a) Any type of informal support is not equal to the sum of individual types of informal support because adolescents may have received more than one type of support.

13.5 Self-help strategies

Adolescents also reported other strategies they adopted to help them manage any emotional or behavioural problems that they may have had or to avoid having such problems.

13.5.1 All adolescents

Two thirds (66.4%) of all adolescents had adopted some kind of strategy to help themselves manage or avoid emotional or behavioural problems in the previous 12 months (Table 13-8). This proportion

was higher among females than males (73.2% compared with 59.9%). Most commonly, adolescents did more of the things that they enjoyed (45.1%), did more exercise or took up a sport (37.9%), sought support from friends (24.4%) and improved their diet (23.2%).

Table 13-8: Self-help strategies used for emotional or behavioural problems in past 12 months among 13-17 year-olds by sex

Type of self-help strategy	Males (%)	Females (%)	Persons (%)
Did more exercise or took up a sport	35.3	40.6	37.9
Improved your diet	18.2	28.4	23.2
Meditated or did relaxation therapy	6.4	12.1	9.2
Did more of the things you enjoy	43.7	46.6	45.1
Smoked cigarettes, or used alcohol or drugs	6.2	9.7	7.9
Stopped smoking, drinking alcohol or using drugs	1.6	1.5	1.6
Sought support from friends	17.1	32.0	24.4
Sought support through social networking	4.6	6.7	5.6
Joined a social group of some kind	4.6	4.8	4.7
Sought information in books, magazines or on TV	6.4	10.6	8.5
Any type of self-help strategy (a)	59.9	73.2	66.4

(a) Any type of self-help strategy is not equal to the sum of individual self-help strategies because adolescents may have used more than one type of strategy.

13.5.2 Adolescents with mental disorders

Among 13-17 year-olds with major depressive disorder by adolescent report, 84.2% had used some kind of strategy to help themselves with problems they were experiencing in the previous 12 months (Table 13-9).

To help manage their emotional or behavioural problems, adolescents with major depressive disorder most commonly did more exercise or took up a sport (44.3%), did more of the activities that they enjoyed (44.0%) and sought support from friends (42.5%). However, almost a third (31.5%) of adolescents with major depressive disorder smoked cigarettes or used alcohol or drugs to help manage their problems.

Three quarters (75.0%) of adolescents with mental disorders based on parent or carer report had adopted self-help strategies for emotional or behavioural problems. Mostly the types of strategies were similar although a higher proportion of those with major depressive disorder compared with those with any mental disorder had sought support from friends (42.5% compared with 24.6%) or smoked cigarettes, or used alcohol or drugs (31.5% compared with 19.1%) to help manage their own emotional or behavioural problems.

Nearly two thirds of those with no mental disorder by their own report or parent or carer report had used some kind of self-help strategy in the previous 12 months (63.5%).

Table 13-9: Self-help strategies used for emotional or behavioural problems in past 12 months among 13-17 year-olds by mental health status

Type of self-help strategy	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)	No disorder (%)
Did more exercise or took up a sport	44.3	38.3	37.1
Improved your diet	25.8	24.3	22.7
Meditated or did relaxation therapy	20.7	13.3	7.5
Did more of the things you enjoy	44.0	43.5	45.3
Smoked cigarettes, or used alcohol or drugs	31.5	19.1	4.6
Stopped smoking, drinking alcohol or using drugs	4.5	4.9	0.8
Sought support from friends	42.5	24.6	22.7
Sought support through social networking	12.4	9.9	4.6
Joined a social group of some kind	6.3	6.9	4.1
Sought information in books, magazines or on TV	14.9	8.4	8.0
Any type of self-help strategy (a)	84.2	75.0	63.5

(a) Any type of self-help strategy is not equal to the sum of individual self-help strategies because adolescents may have used more than one type of strategy.

13.6 Perceived need for help and barriers to receiving mental health care

Adolescents aged 13-17 years were asked about what help they needed with their emotional or behavioural problems and whether their needs for this kind of help had been met. The help was categorised into four types:

- Information about emotional or behavioural problems, treatment and available services;
- Prescribed medication for emotional or behavioural problems;
- Counselling or a talking therapy about problems or difficulties (either one-on-one, as a family, or in a group); and
- Courses or other counselling for life skills, self-esteem or motivation.

13.6.1 Perceived need for help for young people with disorders

Four fifths of adolescents with major depressive disorder (82.4%) reported a need for one or more types of help for emotional or behavioural problems in the previous 12 months (Table 13-10). Of those adolescents with major depressive disorder that reported a need for one or more types of help, three quarters (76.8%) reported that their needs were met either fully (28.1%) or partially (48.7%), while one quarter (23.2%) had needs that were unmet.

The most common type of help adolescents with major depressive disorder felt that they needed in the previous 12 months was counselling or a talking therapy (68.8%) and of these, 70.4% reported that their needs were met either fully (39.0%) or partially (31.4%).

More than half of adolescents with major depressive disorder (55.9%) reported a need for information about emotional or behavioural problems, treatment and available services of which one fifth (21.4%) reported that their needs were unmet.

The greatest areas of unmet need according to adolescents with major depressive disorder who had reported a need for help were for courses or other counselling for life skills, self-esteem or motivation (51.5%) and for prescribed medication (44.2%).

Table 13-10: Perceived need for services for emotional or behavioural problems in past 12 months among 13-17 year-olds with major depressive disorder by type of help

Level of perceived need	Information (%)	Medication (%)	Counselling (%)	Life skills (%)	Any type of help (%) (b)
No need	44.1	59.7	31.2	57.7	17.6
Any need—	55.9	40.3	68.8	42.3	82.4
Needs fully met (a)	47.4	28.6	39.0	25.6	28.1
Needs partially met (a)	31.2	27.2	31.4	22.9	48.7
Needs unmet (a)	21.4	44.2	29.6	51.5	23.2

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.
(b) Where need for more than one type of help was identified, level of perceived need for any type of help has been derived from the level of perceived need for each type of help needed (see glossary for details).

About half (56.4%) of adolescents with a mental disorder identified by parents and carers reported a need for one or more types of help for emotional or behavioural problems in the previous 12 months (Table 13-11).Of those adolescents with mental disorders that reported a need for one or more types of help, about nine out of ten (86.9%) reported that their needs were met either fully (47.5%) or partially (39.4%) while one tenth (13.1%) had needs that were unmet.

Counselling was the type of need most commonly reported (41.6%) by adolescents with mental disorders based on parent and carer report. Of those adolescents reporting a need for counselling or talking therapy, 84.8% reported that their needs were either fully met (57.7%) or partially met (27.1%).

One third of adolescents with mental disorders identified by parents and carers (35.7%) reported a need for information about emotional or behavioural problems, treatment and available services, of which four fifths (81.8%) reported that their needs were met either fully (55.8%) or partially (26.0%). About three in ten (28.3%) identified a need for medication, of which just under a third (31.5%) had unmet need. One fifth (22.8%) reported a need for counselling for life skills, counselling for life skills, self-esteem or motivation, of which nearly two fifths (37.9%) had unmet need.

Compared to 13-17 year-olds with a major depressive disorder by their own report, those with mental disorders identified by parent and carer report had lower levels of unmet need for all types of help.

Table 13-11: Perceived need for services for emotional or behavioural problems in past 12 months among 13-17 year-olds with mental disorders identified from parent or carer report by type of help

Level of perceived need	Information (%)	Medication (%)	Counselling (%)	Life skills (%)	Any type of help (%) (b)
No need	64.3	71.7	58.4	77.2	43.6
Any need—	35.7	28.3	41.6	22.8	56.4
Needs fully met (a)	55.8	47.5	57.7	43.5	47.5
Needs partially met (a)	26.0	20.9	27.1	18.6	39.4
Needs unmet (a)	18.3	31.5	15.2	37.9	13.1

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.
(b) Where need for more than one type of help was identified, level of perceived need for any type of help has been derived from the level of perceived need for each type of help needed (see glossary for details).

13.6.2 Perceived need by severity of impact

The extent to which 13-17 year-olds reported a perceived need for help with their emotional or behavioural problems increased with severity of disorder. Those with moderate and severe disorders had greater perceived need than those with mild disorders. For those with some need for assistance, the proportion of young people whose needs were fully or partially met also increased with the severity of their disorder, with more moderate and severe cases having these needs fully or partially met. These relationships were found regardless of whether the identification of mental disorders was based only on the young person’s self-report of major depressive disorder or on the information about a broader range of mental disorders provided by the parent or carer.

For adolescents identified as having a severe or moderate major depressive disorder based on their own self report, most indicated that they had a need for help with emotional and behavioural problems (90.7% and 94.8% respectively). A lower proportion (65.4%) of those with mild depressive disorder felt that they had a need for some type of help (Table 13-12).

Around nine in ten (87.9%) adolescents with a severe major depressive disorder who reported some type of need for help indicated that their needs were either fully (24.9%) or partially (63.0%) met. Lower rates of fully or partially met need were reported by adolescents with moderate (69.4%) and mild depressive disorders (70.2%).

Table 13-12: Perceived need for any type of help for emotional or behavioural problems in past 12 months among 13-17 year-olds with major depressive disorder by severity of impact

Level of perceived need	Mild (%)	Moderate (%)	Severe (%)	All major depressive disorder (%)
No need	34.6	5.2	9.3	17.6
Any need—	65.4	94.8	90.7	82.4
Needs fully met (a)	32.5	27.8	24.9	28.1
Needs partially met (a)	37.7	41.6	63.0	48.7
Needs unmet (a)	29.8	30.7	12.1	23.2

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.

For adolescents aged 13-17 years identified as having mental disorders based on the information provided by parents and carers, a larger percentage of those with severe (70.0%) and moderate disorders (67.8%) indicated a need for help than those with mild disorders (41.1%) (Table 13-13).

About nine in ten of those with a severe or moderate disorder (91.2% and 90.2% respectively) who reported some type of need for help indicated that their needs were either fully met (42.4% for severe disorders and 49.4% for moderate disorders) or partially met (48.8% for severe disorders and 40.8% for moderate disorders). Slightly lower rates (79.2%) of met need (fully or partially) were reported by adolescents identified as having mild disorders.

Table 13-13: Perceived need for any type of help for emotional or behavioural problems in past 12 months among 13-17 year-olds with mental disorders by parent or carer report by severity of impact

Level of perceived need	Mild (%)	Moderate (%)	Severe (%)	Any mental disorder (%)
No need	58.9	32.2	30.0	43.6
Any need—	41.1	67.8	70.0	56.4
Needs fully met (a)	49.3	49.4	42.4	47.5
Needs partially met (a)	29.9	40.8	48.8	39.4
Needs unmet (a)	20.8	9.8	8.8	13.1

(a) The proportion of those reporting any need whose needs were fully met, partially met or unmet.

13.6.3 Comparing adolescent and parent or carer views about perceived need for help

Adolescents aged 13-17 years with mental disorders based on the information provided by their parent or carer were less likely to report a need for any help than parents and carers (56.4% compared to 84.8%) (Table 13-14). Parents and carers were more likely to report a need for help for all types of help except for prescribed medication where a similar proportion of adolescents reported a need for help.

Table 13-14: Perceived need for help for emotional or behavioural problems in past 12 months by parent or carer report and adolescent report among 13-17 year-olds with mental disorders by parent or carer report

Type of help	Proportion with a need as reported by parent or carer (%)	Proportion with a need as reported by the adolescent (%)
Information	50.6	35.7
Medication	28.9	28.3
Counselling	76.1	41.6
Life skills	41.8	22.8
Any type of help	84.8	56.4

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13.6.4 Barriers to seeking and receiving help

The most commonly identified reasons given by 13-17 year-olds with major depressive disorder by adolescent report for not seeking help or receiving more help for emotional or behavioural problems were being worried about what other people might think or not wanting to talk to a stranger (62.9%), thinking the problem would get better by itself (61.7%) and wanting to work out the problem on their own or with help from family or friends (57.1%) (Table 13-15).

Among adolescents with mental disorders based on information provided by their parents and carers, the most common reasons cited for not seeking help or receiving more help were similar to those with major depressive disorder but proportions identifying these reasons were lower for most categories.

Table 13-15: Barriers to help seeking or receiving more help for emotional or behavioural problems in past 12 months among 13-17 year-olds with major depressive disorder by adolescent report or any mental disorder by parent or carer report

Barriers	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)
Preferred to handle by self or with family/friends	57.1	43.6
Not sure if they needed help	49.9	44.1
Not sure where to get help	25.8	18.9
Thought problem would get better	61.7	47.1
Asked for help at school but didn't get it	9.2	13.8
Problem getting to a service that could help	4.6	7.6
Couldn't afford it	28.2	21.2
Couldn't get an appointment	6.9	5.9
Concerned about what people might think or didn't want to talk to a stranger	62.9	43.9

If adolescents reported more than one reason for not seeking help or receiving more help, they were also asked to identify the main reason. The most common main reasons for adolescents with major depressive disorder not seeking help or not receiving more help included not being sure if they needed help, where to get help or thinking that the problem would get better by itself, issues which could be broadly classified as mental health literacy (33.1%) (Table 13-16).

Just over one quarter of adolescents with major depressive disorder (26.2%) identified reasons related to them wishing to manage their problems themselves, and another quarter (27.9%) reported being worried about what other people might think or not wanting to talk about it with a stranger, as the main reason for not seeking help or receiving more help for emotional and behavioural problems. One eighth (12.8%) identified reasons that related to accessibility of services, such as thinking it might cost too much, having a problem getting to a service that could help or not being able to get an appointment when needed.

Among adolescents with a mental disorder identified by parents and carers, the main reason identified for not seeking help or receiving more help included not being sure if they needed help,

where to get help or thinking that the problem would get better by itself, primarily to do with issues of mental health literacy (42.3%). One quarter (26.7%) of adolescents with mental disorders identified the desire to manage their problem by themselves or with help from family or friends as being the main reason for not seeking help or receiving more help.

Table 13-16: Main barriers to seeking help or for receiving more help for emotional or behavioural problems in past 12 months among 13-17 year-olds with mental disorders

Main barrier	Major depressive disorder based on adolescent report (%)	Any mental disorder based on parent or carer report (%)
Self-management	26.2	26.7
Mental health literacy	33.1	42.3
Accessibility	12.8	14.2
Stigma/not wanting to talk to a stranger	27.9	16.7

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PART 5

Changes over time

Changes in the prevalence of mental disorders and service use among children and adolescents since 1998

Young Minds Matter was the second national child and adolescent survey of mental health and wellbeing conducted in Australia. The first survey was conducted in 1998. It was led by a consortium from the University of Adelaide and provided the first national data on the prevalence of mental disorders and service use in Australian children and adolescents.

Although there are a number of significant differences between the first and second surveys, many of the essential elements remain the same. Both surveys used the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) to assess mental disorders. Three disorders were common to both surveys and data on the prevalence of these disorders are compared.

Each survey determined the use of services by children and adolescents for their emotional and behavioural problems and, more specifically, the use by young people with mental disorders. The timeframe over which this was collected differed between the surveys and make comparisons difficult, but these data are explored further.

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14 COMPARISON WITH 1998 NATIONAL SURVEY OF MENTAL HEALTH AND WELLBEING

Young Minds Matter was the second national Child and Adolescent Survey of Mental Health and Wellbeing conducted in Australia. The first survey was conducted in 1998.

While it is possible to make some comparisons between the 1998 and 2013-14 surveys, these need to take into account the similarities and differences between the two surveys.

When the 1998 Child and Adolescent Survey of Mental Health and Wellbeing was conducted it was the first national survey of its type conducted anywhere in the world. The survey assessed five common disorders using the DISC version IV, namely — major depressive disorder, dysthymic disorder, attention-deficit /hyperactivity disorder, conduct disorder, and eating disorders. The DISC-IV was a recognised diagnostic tool developed under the auspices of the National Institute of Mental Health in the United States to assess whether children and adolescents had mental disorders according to the criteria of the standard diagnostic classification, the DSM-IV. In addition mental health problems were assessed using the *Child Behavior Checklist* (CBCL).

Young Minds Matter also used the DISC-IV to assess mental disorders. However, there were some changes to the list of disorders that were assessed. Major depressive disorder, ADHD, and conduct disorder were assessed as well as four anxiety disorders, that is — social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder. In addition, the Strengths and Difficulties Questionnaire (SDQ) was used in *Young Minds Matter* rather than the *Child Behavior Checklist*.

This chapter reports on changes in prevalence of mental disorders between 1998 and 2013-14 for the three mental disorders common to both surveys (major depressive disorder, ADHD, and conduct disorder). Comparisons were restricted to children and adolescents aged 6-17 years as the first survey did not administer the DISC-IV modules to parents and carers of children aged 4-5 years. This chapter also makes some comparison between use of services in 1998 and 2013-14, although this comparison needs to be interpreted with caution as the 1998 survey collected information on use of services in the 6 months prior to the survey while the 2013-14 survey collected information on use of services in the 12 months prior to the survey.

14.1 Prevalence of selected mental disorders by sex and age group

Between 1998 and 2013-14, the prevalence of major depressive disorder increased (from 2.1% to 3.2%), while the prevalence of conduct disorder and ADHD decreased (from 2.7% to 2.1% for conduct disorder and from 9.8% to 7.8% for ADHD). The proportion of 6-17 year-olds who had any of these three disorders decreased slightly from 12.2% to 11.1% (Table 14-1).

Although there was very little difference between the two surveys in the prevalence of the three disorders for females, the prevalences of ADHD and conduct disorders were somewhat lower for males in 2013-14 than in 1998. Among males aged from 6 to 17 years the prevalence of ADHD declined from 13.8% to 11.0% and the prevalence of conduct disorder declined from 4.0% to 2.6% (Table 14-2).

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There were changes in the prevalence of the three disorders concentrated in particular age groups. There was no change in the prevalence of major depressive disorder between 1998 and 2013-14 among children aged 6-11 years. However, the prevalence of major depressive disorder among 12-17 year-olds increased from 2.9% to 5.0% (Table 14-1).

For ADHD, the decrease in prevalence overall was due to the decrease in prevalence among children aged 6-11 years, from 16.7% to 12.3% in males and from 8.3% to 5.9% in females. The decrease in the prevalence of conduct disorder was predominantly due to a decrease in males aged 6-11 years from 4.6% to 2.6% (Table 14-2).

In summary, comparison of the three disorders included in both the 1998 and 2013-14 surveys suggests that overall prevalence has remained relatively stable, with modest declines in prevalence of ADHD and conduct disorder and a modest increase in the prevalence of major depressive disorder.

Table 14-1: 12-month prevalence of mental disorders among 6-17 year-olds in 1998 and 2013-14 by age group

Age group	Disorder	1998 (%)	2013-14 (%)
6-11 years	Major depressive disorder	1.4	1.4
	ADHD	12.6	9.2
	Conduct disorder	3.2	2.2
	Any of the above 3 disorders	14.2	10.9
12-17 years	Major depressive disorder	2.9	5.0
	ADHD	7.1	6.3
	Conduct disorder	2.2	2.1
	Any of the above 3 disorders	10.2	11.3
6-17 years	Major depressive disorder	2.1	3.2
	ADHD	9.8	7.8
	Conduct disorder	2.7	2.1
	Any of the above 3 disorders	12.2	11.1

Table 14-2: 12-month prevalence of mental disorders among 6-17 year-olds in 1998 and 2013-14 by sex and age group

Sex	Age group	Disorder	1998 (%)	2013-14 (%)
Males	6-11 years	Major depressive disorder	1.4	1.2
		ADHD	16.7	12.3
		Conduct disorder	4.6	2.6
		Any of the above 3 disorders	18.4	13.7
	12-17 years	Major depressive disorder	2.7	4.3
		ADHD	10.9	9.8
		Conduct disorder	3.3	2.6
		Any of the above 3 disorders	13.6	13.6
	6-17 years	Major depressive disorder	2.1	2.8
		ADHD	13.8	11.0
		Conduct disorder	4.0	2.6
		Any of the above 3 disorders	16.0	13.6
Females	6-11 years	Major depressive disorder	1.3	1.6
		ADHD	8.3	5.9
		Conduct disorder	1.8	1.8
		Any of the above 3 disorders	9.8	8.1
	12-17 years	Major depressive disorder	3.1	5.8
		ADHD	3.1	2.7
		Conduct disorder	0.9	1.6
		Any of the above 3 disorders	6.6	8.8
	6-17 years	Major depressive disorder	2.2	3.6
		ADHD	5.7	4.3
		Conduct disorder	1.3	1.7
		Any of the above 3 disorders	8.2	8.5

14.2 Use of services

Information on service use is not directly comparable between the two surveys. In 1998, parents and carers were asked about use of services in the previous 6 months, while in *Young Minds Matter* they were asked about use of services in the previous 12 months. The service use module was completely rewritten for *Young Minds Matter* based on the current Australian health care environment and there were several differences in the types of services included in both surveys.

In order to provide some comparison of service use between 1998 and 2013-14, services common to both surveys were identified. These included school services (counselling, a place in a special class or school or other school or education-based service for emotional or behavioural problems) and health services (GP, psychologist, psychiatrist, paediatrician, overnight stay in a hospital or longer, hospital outpatient or emergency services, community mental health clinic, or telephone counselling service).

Among children and adolescents aged 6-17 years with either major depressive disorder, ADHD or conduct disorder, 31.2% had used services in the six months prior to the 1998 survey, while 68.3% had used services in the 12 months prior to the 2013-14 survey. There was a greater apparent change in use of school services for emotional or behavioural problems. In the six months prior to the 1998 survey 19.2% of children or adolescents with one of the three mental disorders common to both surveys had used a school service, while 54.0% of children or adolescents had used a school service in the 12 months prior to the 2013-14 survey.

While differences in questions and time period make comparisons difficult, the increase in use of services is higher than is likely to be attributable to changes in methodology alone. On balance, the data suggest that there has been a significant increase in service use by children and adolescents with mental disorders in Australia between 1998 and 2013-14.

Table 14-3: Use of services for emotional or behavioural problems in 6-17 year-olds with major depressive disorder, ADHD or conduct disorder, 1998 and 2013-14 by age group and type of service

Type of service	Age group	1998 (%)	2013-14 (%)
School-based service	6-11 years	17.2	50.3
	12-17 years	22.1	57.5
	6-17 years	19.2	54.0
Health service	6-11 years	23.3	44.3
	12-17 years	28.9	57.2
	6-17 years	25.7	50.9
Any service	6-11 years	27.8	63.6
	12-17 years	35.8	72.8
	6-17 years	31.2	68.3

PART 6

Appendices

- 1. Conduct of the survey**
- 2. Survey reference group membership**
- 3. Glossary**
- 4. List of tables and figures**

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APPENDIX 1 - CONDUCT OF THE SURVEY

Young Minds Matter was based on a sample of over 6,000 children and adolescents aged 4-17 years recruited from across Australia. Information was collected from parents and carers and young people by trained lay interviewers from Roy Morgan Research using computer-assisted personal interviewing.

Parents and carers were interviewed in their homes about one randomly selected child or adolescent in the family. The interview was conducted with the parent or carer who identified as knowing most about the child or adolescent. If the selected child or adolescent was aged 11 years or older, the young person was asked to complete a confidential questionnaire on a tablet computer.

Fieldwork commenced on 30th May 2013 and concluded on 12th April 2014.

1. Process issues

Selection of survey content

The contents of both the parent and carer questionnaire and youth self-report questionnaire were decided by a set of principles determined at the beginning of the survey development process. These primarily addressed issues relating to the main aims of the survey, as well as what is desirable in the conduct of a household survey for maximising data quality.

The principal focus of the survey was on determining the prevalence of mental disorders and their impact, and on services used by children and adolescents with mental health problems and disorders. Determining whether someone has a mental disorder requires assessment against diagnostic criteria for that particular disorder. In terms of the survey, this means that diagnostic modules were required for each disorder. For the first survey, selected modules from the DISC-IV were used to assess mental disorders. These could be administered by lay interviewers, required no clinical assessment for diagnoses and were designed for epidemiological use. In 2013, the DISC-IV remained the most up-to-date version of the instrument and was still the best tool available world-wide for assessing the 12-month prevalence of disorders, as needed for national planning purposes and to complement data on adults.

The full DISC-IV covers 30 disorders and takes on average 70 minutes to complete. If all disorders were included in the survey, very little other content could be covered. Therefore specific modules of the DISC-IV covering selected disorders rather than all disorders were selected, as was the case for other National Surveys of Mental Health and Wellbeing undertaken in Australia. Decisions around what disorders were to be included were based strictly upon the relative prevalence and impact of disorders as indicated by previous population estimates from the first survey and more recent overseas surveys. Major depressive disorder, ADHD and conduct disorder, which were in the first national survey, were included once again because of their high prevalence and impact.

Although not included in the first survey, it was resolved that anxiety disorders should also be included in recognition not only of the high prevalence of these disorders, but also because of the high proportion of people with anxiety disorders in the 2007 National Survey of Mental Health and Wellbeing who reported first onset of their anxiety problems in childhood or adolescence. There is,

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however, not just one, but nine DISC-IV anxiety modules to align with the different types of anxiety disorders in the DSM-IV. Only four were chosen on the basis of their prevalence and impact. These were social phobia, separation anxiety disorder, generalised anxiety disorder and obsessive-compulsive disorder.

Another aim of the survey was to determine service use by children and adolescents with mental health problems and disorders — not only what proportion of young people was receiving services, but also where they got help. All the main types of services for young people with mental health problems were covered. These included health, school, telephone counselling, online services and informal services and supports. It was also important to understand if young people were getting all the services they needed and, if not, why. This content needed to be tailored to the Australian context.

In addition, there is some standard content that is required in any survey and some particular to surveys of children and adolescents. This included information necessary for obtaining informed consent, household information, demographics and family characteristics.

The limits on what can be included are set by the average time for interview and/or completion of a questionnaire. In the case of household surveys one of the main considerations when determining the length of surveys is the response burden — that is, what is reasonable from other epidemiological evidence to ask of participants without affecting data quality. The objective set was to keep the average time for the parent and carer interview to 75 minutes. This time was to cover household information, informed consents and the questionnaire itself. For adolescents completing their own questionnaire, the objective was to keep the average completion time to 20 minutes, with additional time on gaining the necessary consents that varied depending upon the age of the young person. In the actual survey the median time was very close to the target time for parents and carers, who spent 60 minutes on average on the questionnaire and five to ten minutes on administrative matters.

Young people were completing their questionnaires on a tablet computer by themselves and average timings were affected by some exceptionally long completion times, most likely due to prolonged breaks when the participant or interviewer did not sign out. The median time (35 minutes) provides the best indication of the average time taken to complete everything required on the adolescent self-report questionnaire.

Rationalisation of the number of diagnostic modules allowed for other content to be covered within the average target times. In particular a sufficiently detailed set of questions on service use and some questions on school services and performance were added, as well as contextual information from parents and carers. Information on self-harm, suicidality and risk taking behaviours were included for young people.

Age range

Children and adolescents aged from 4-17 years were surveyed. This is the same age range as was covered in the first national survey of children and adolescents.

Children under the age of four years were not included as the problems of younger children differ from those of older children and adolescents, as do the methods required to assess them. The main diagnostic instrument, the DISC-IV, would not be suitable. Indeed the developers of the instrument have recommended its use with young people aged 6-18 years. While six years is the lower

recommended limit, DISC-IV modules have been used in a few studies on children as young as four and five years, but no younger. In Australia about four fifths of four year-olds attend preschool or long day care, while the majority of five year-olds attend school. This provides some context for responses on these younger children. It was also considered desirable to use the same diagnostic instruments for four and five year-olds as for older children.

The 2007 National Survey of Mental Health and Wellbeing was a general population survey of adults, but, unlike the first adult survey in 1997, it surveyed persons aged 16 years and older. Overlap of the ages sampled for the two surveys, that is 16 and 17 year olds, was specifically designed to allow for subsequent comparison of the data.

Oversight of the survey

The Australian Government Department of Health and Ageing funded and managed the conduct of the survey as part of the National Survey of Mental Health and Wellbeing initiative. This is the sixth survey conducted under this initiative.

A Survey Reference Group of invited mental health, child and adolescent, education and epidemiological experts, as well as representatives of the Department and the Australian Bureau of Statistics, provided oversight in design, content and implementation of the survey.

Membership of the Survey Reference Group is provided at Appendix 2.

2. Sample, fieldwork and participant issues

Main sample

The survey sample was selected in two components. The first component was a randomly selected sample of 5,500 families with children aged 4-17 years from across the country.

The sample size was chosen to deliver reliable national estimates of the prevalence, burden and service use by sex and for the two age groups of 4-11 and 12-17 years.

In total 46,248 households were approached to achieve a calculated final sample of 5,500 based on an in-scope rate of 21% and a target response rate of 60%.

Oversample

In recognition of the increased risks for a range of emotional and behavioural problems in the older teenage years, the main survey sample was supplemented by a second component of 16 and 17 year-olds. This comprised an additional random sample of 800 families with children aged 16-17 years. The sample size was determined to be sufficiently large for separate analyses of the data and to produce specific estimates for this age group.

The oversample aimed to allow for the results for just 16 and 17 year-olds to be analysed together with that for 16 and 17 year olds from the 2007 adult survey. The combination of data from both surveys will provide two perspectives on mental health problems in this age group—one based on questions specifically designed for teenagers and one based on questions designed for adults.

An additional 30,358 households were approached to achieve the required 800 interviews.

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Sampling method

Area-based sampling was used to select both the main sample and oversample. This method involves selecting a sample of small geographic areas (in this case the *Statistical Area 1* or SA1 area, designed by the Australian Bureau of Statistics). A total of 225 SA1 areas were selected from those where there were at least ten families with children living at the time of the 2011 Census of Population and Housing conducted by the Australian Bureau of Statistics. SA1 areas in very remote areas were excluded.

The SA1s used for the main sample were also used for the oversample. A target of four interviews of randomly selected households in each of the 225 SA1s was predicted to deliver the required sample of 800 families. However, selection of an additional 41 SA1s was necessary to achieve the desired 800 interviews. In total 266 SA1s were selected.

Interviewers went to a randomly selected sample of houses in each SA1 to identify households that had one or more children aged from four to 17 years. In households where there was more than one resident child aged 4-17 years, the names of all children were entered into the interviewer's hand-held computer, which then selected a child at random as the study participant for the survey.

Exclusions

The one percent most remote SA1s in Australia were excluded from the survey for practical reasons. This is considered standard practice for surveys that aim to yield estimates at a national level.

The survey cannot produce estimates of mental disorders and service use for Indigenous peoples. Random sampling alone with the number of participants for this survey was not considered sufficient for generation of these data within acceptable confidence intervals. A separate Indigenous sample was not included as there are important cultural issues in appropriately measuring mental health and wellbeing in Aboriginal and Torres Strait Islander children that could not be addressed within the framework of the population survey. A separate study would need to be undertaken to assess the mental health of Aboriginal and Torres Strait Islander children and young people in a culturally appropriate manner.

The survey was based on a household sample and, as such, children who were homeless or in institutional care were not included. Although this is likely to be a small proportion of children and adolescents, these sub-populations are known to have a high-risk of mental health problems. However, the survey aimed to collect information on children who were temporarily away from home, such as at boarding school or in hospital. Parents and carers were asked to list all of the children who are usually part of the household, but were temporarily living away, along with those living there. These children had an equal chance of selection as the survey child as other children in the family due to the computerised random selection methodology. However, young people aged 11 years and older who were not living in the household at the time could not be asked to complete the self-report questionnaire and therefore there is no additional information from these young people themselves.

Interviewing process

Roy Morgan Research was contracted to conduct the survey fieldwork. A team of over 100 trained, lay interviewers were employed to complete fieldwork from 31 May 2013 through to 10 April 2014.

Interviewers were trained over three days prior to survey fieldwork. Training covered matters related to the conduct of the survey interviews, as well as some basic mental health literacy and information on the use of the diagnostic tool, the DISC-IV. A comprehensive training manual and standardised curriculum for the three days ensured uniformity of interviewer training across all Australian sites.

Interviewers were required to approach selected households in their areas up to six times or until they were able to gain contact with a resident adult. These contact attempts were required to be made over a mixture of weekday/weekend and day/evening calls. Once contact was made with an adult living in the household a short screener process was used to confirm that the household was in scope.

Strategies to encourage participation

There were a number of strategies used to provide information about the survey, encourage participation once contact had been made and, in turn, maximise the response rate. These were as follows:

- A primary approach letter was given to each household.
- Two information brochures — one for the parent or carer and one for the young person, were prepared.
- A letter of endorsement was signed by three survey ambassadors, namely Professor Fiona Stanley, founding director and patron of the Telethon Kids Institute and Australian of the Year 2003; Professor Fiona Wood, plastic surgeon specialising in burns and Australian of the Year 2005; and Jessica Watson, solo around-the-world sailor and Young Australian of the Year 2011.
- An 1800 number was staffed by Roy Morgan Research to answer any queries or concerns participants may have had about the survey.
- Information about the survey was available to participants through the Telethon Kids Institute website, which was listed on the brochures.
- A payment of \$40 was offered to parents and carers to compensate them for their time completing the interview and young people were offered \$20 to compensate them for their time completing the youth self-report questionnaire.

Consent

Participation in the survey was voluntary and written consent was required from all participants.

Initially, verbal consent was obtained from parents or carers to participate in the survey. If the child was 11 years or older, parents and carers were also asked for their consent to approach the young person to ask whether he or she would complete a youth self-report questionnaire. Verbal consent was also sought directly from the young person, if he or she were willing to participate.

Paper consent forms were completed by both parents or carers and young people at the completion of the household interviews.

Additionally, at the end of the household interview, consent was sought from parents and carers to access Medicare, Pharmaceutical Benefits Scheme (PBS) and National Assessment Program — Literacy and Numeracy (NAPLAN) information for the selected child or young person. Where the

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selected child was aged under 14 years, consent to access Medicare and PBS data was sought from the primary carer, while, with the parent or carer's permission, consent was sought from the young person directly if they were aged 14 years or older. For NAPLAN data, consent was sought from the primary carer, as NAPLAN testing covers school years 3, 5, 7, and 9. At the time of writing, the process of obtaining the Medicare, PBS and NAPLAN data for children and adolescents from the relevant data custodians is underway. These data will be used for future analysis subsequent to this report.

Participants were informed that they had the right to withdraw their consent for study participation or the use of their information at any time during the interview and up to 31 March 2014, at which time final validation was being completed and data would be de-identified for inclusion in the main unit record file. A decision was made to extend the period for fieldwork part way through the initial collection phase and, in turn, the cut-off for withdrawal of consent for use of information was extended to 30 April 2014 for participants in this later phase of fieldwork.

Duty of care

Specific protocols were developed to ensure that if any issues arose for participants in response to the survey, there were options available to assist them in receiving the information and support they required.

Training of interviewers included specific training in how to deal with difficult and distressing situations if these arose while the interviewer was in the household. Interviewers were instructed to give the participant space and offer to come back at another time to complete the interview. They were directed not to offer opinions or advice, but direct participants to services listed in the brochures and, if required, provide the 1800 number for the on-call study psychologist.

If the participant required support after the interviewer had left the household, a number of options were available. Brochures for both parents or carers and young people, which listed relevant helplines or other services accessible by phone or on the internet, were left with the household. The survey website provided further information about the survey and links to relevant mental health services. A 1800 telephone number staffed by Roy Morgan Research, which participants could call to discuss any aspect of the survey or issue arising from the interview, was available. In addition, the on-call study psychologist was available at all times.

State and territory child and adolescent specialised mental health services were notified when the survey was going to be in the field in case calls were received from participants.

The 1800 on-call study psychologist received a total of 5 calls over the duration of survey fieldwork. There were no adverse events reported as a result of the survey.

Interviewers also were supported, with access to the on-call study psychologist, specific debriefing procedures and support directly through Roy Morgan Research.

3. Questionnaires

Parent Interview

The median time to complete the parent and carer questionnaire was 60 minutes. All participants were asked questions in all modules. These were as follows:

- Family structure — sex, age, marital status, country of birth, language spoken for all family members and relationships between all members of the family;
- Child health — general health, chronic health conditions, disabilities and whether ever diagnosed with psychological, emotional or behavioural problems from a list provided;
- Diagnostic Interview Schedule for Children (DISC-IV) modules;
- Level of functional impairment questions;
- Strengths and Difficulties Questionnaire (SDQ) Parent Report Measure Baseline versions for Children (4-10 years) and for Youth (11-17 years);
- Service use in the past 12 months;
- Perceived need for services;
- Education — child's year in school, school attendance and performance in core subjects;
- Family characteristics - family functioning, life stress events, impact of separation on the child or adolescent, smoking and alcohol consumption of parents and carers, mental health of parents and carers;
- Kessler Psychological Distress Scale (K10) for primary parent or carer; and
- Demographics — education and employment of parents and carers, household income and housing tenure.

Youth self-report questionnaire

Young people aged 11 years and over were asked to complete a self-report questionnaire on a tablet computer in private. Median time to complete the questionnaire was 35 minutes. As some of the questions were considered inappropriate for younger children, some modules were only asked of young people older than a specified age. This questionnaire comprised the following modules:

- DISC-IV major depressive disorder module;
- Level of functional impairment questions;
- Presence of symptoms of psychosis;
- Strengths and Difficulties Questionnaire (SDQ) Youth Self Report Baseline version;
- Kessler Psychological Distress Scale (K10+), which has the basic ten questions about how the child is feeling and another four on how it affected him or her in the last four weeks;
- Child health utility-9D, which is composed of nine questions designed to measure quality of life for use in economic evaluation;
- Service use in past 12 months — health, school, telephone counselling and online services and informal supports (13 years and older);
- Perceived need for services;
- Education — school attendance, performance in core subjects, and school connectedness;
- Youth risk behaviours consisted of six sections, with questions varying for different ages — smoking (screening questions only for 11 and 12 year-olds); alcohol consumption (screening questions only for 11 and 12 year-olds) and use of other drugs (13 years and older); self-harm (12 years and older); suicidal behaviours (12 years and older); problem eating behaviours (11 years and older) and sexual behaviour (13 years and older);

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- Use of internet and electronic games;
- Experiences of bullying, both as victim and perpetrator; and
- Level of self-esteem.

4. Content issues

Assessment of mental disorders

Mental disorders were assessed using the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV). The DISC-IV implements the criteria for mental disorders set out in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition¹, produced by the American Psychiatric Association. These criteria are based on clinically significant sets of symptoms that are associated with impaired functioning by young people with disorders.

The tool was particularly suited to the survey as it was developed primarily for epidemiological research and can be administered by trained, lay interviewers. The most recent version, the DISC-IV, is able to address more than 30 psychiatric diagnoses based on DSM-IV criteria that occur in children and adolescents. Most questions are worded so that they can be answered 'yes', 'no', and 'somewhat' or 'sometimes', allowing for easy scoring and not requiring clinical assessment. Questions reference the four weeks and 12 months prior to the interview, allowing for the generation of prevalences for different periods. The 12-month prevalence is the primary measure produced by the DISC-IV modules, and this aligned with what has been produced from other National Survey of Mental Health and Wellbeing initiative surveys.

DISC-IV modules for seven disorders were included in the survey:

- Anxiety disorders:
 - Social phobia;
 - Separation anxiety disorder;
 - Generalised anxiety disorder; and
 - Obsessive-compulsive disorder;
- Major depressive disorder;
- Attention-Deficit/Hyperactivity Disorder (ADHD); and
- Conduct disorder.

In this report, the term *mental disorder* is used to refer to one or more of the seven disorders assessed using the DISC-IV.

The modules were completed by parents and carers in relation to their children's symptoms and the impact of these over the previous 12 months, which gave *12-month prevalence*.

¹ American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, Text Revision. Washington, DC, American Psychiatric Association, 2000.

Young people aged 11-17 years also completed the Major depressive disorder module in relation to their own symptoms and the impact of these in the previous 12 months. Where the prevalence or mental disorder status being reported is based on a diagnosis from information provided by young people themselves, as opposed to information from their parents and carers, this has been described as *major depressive disorder based on youth self-report*.

Additional content to assess severity

The DISC-IV assesses whether a child or adolescent has a particular mental disorder, but does not routinely measure the severity of the impact due to that disorder. Seventeen questions were included in the survey to assess the level of functional impairment of symptoms of mental disorders. These were designed to measure the impact of symptoms of mental disorders on the child or adolescent's functioning at school or work, with friends, with their family and with respect to distress to the child or adolescent him or herself. A graded response model was used to create a composite impact on function score. This score was standardised with a range from -3.0 to +3.0 where higher scores represent increasing severity of impact on functioning.

Children and adolescents were classified into three levels of impact on functioning by applying the national mental health service planning standard ratio of severity for mental disorders to the standardised score (1:2:4 for severe, moderate and mild cases). In addition suicide plans or attempts in the past 12 months were considered. The three levels are:

- *Severe:* A positive diagnosis plus an impact score greater than or equal to 1.75 and/or a history of suicide attempt in the 12 months prior to interview;
- *Moderate:* A positive diagnosis plus an impact score greater than or equal to 0.95 or a history of suicide plans in the 12 months prior to interview; and
- *Mild:* All other cases with a positive diagnosis.

Other measures of mental health problems

A variety of mental health problems were assessed as follows:

- *Oppositional problem behaviours*
Oppositional defiant disorder requires some clinical judgement in order to complete the diagnosis. This was not possible in the survey. However, oppositional problem behaviours were still assessed using the DISC-IV module for oppositional defiant disorder, but no formal diagnoses could be established.
- *Eating disorders*
Diagnostic modules for eating disorders were not included in the survey. Instead self-report Body Mass Index (BMI) was collected and questions were used to assess a broad range of behaviours that are indicative of eating-related problem behaviours.
- *Strengths and Difficulties Questionnaire (SDQ)*
The SDQ was included in the questionnaires for parents and carers and for young people. This measure is routinely used as a tool to assess young people receiving state/territory-administered specialised child and adolescent mental health services.

The SDQ provides a brief behavioural screening questionnaire comprised of five scales of five items each. Items in four of these scales, that is emotional problems, conduct

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problems, hyperactivity and peer problems, are added together to generate a total difficulties score. The SDQ was designed so that approximately 10% of children and adolescents fall into the 'abnormal' range on the total difficulties score, which indicates that they are at substantial risk of clinically significant problems. The SDQ also includes an impact scale that measures interference in life due to emotional and behavioural problems in the domains of home life, friendships, classroom learning and leisure activities.

- *Kessler 10 Psychological Distress Scale (K10+)*

An enhanced version of the K10+ with additional questions on anger, control, concentration and feeling calm and peaceful was completed by young people. This is a measure of psychological distress that has been shown to be highly correlated with the presence of depressive or anxiety disorders. The measure consists of the standard ten questions, together with four questions on days out of role and additional questions on anger, control, concentration and feeling calm or peaceful.

Scores are classified into four levels of psychological distress — low, moderate, high and very high distress.

- *Self esteem*

A set of 13 self-report questions were developed to measure the self-esteem of adolescents.

- *Bullying*

Questions on bullying were adapted from those used in the Cyber Friendly Schools Project. These covered its frequency and the level of distress it caused, as well as when the young person had been the perpetrator.

Service use and perceived need for services

One of the main aims of the survey was to determine the use of services by children and adolescents to assist them with any mental health problems they may have.

The service use module was developed specifically for the survey, and tailored both for use with young people and to the current Australian health care environment.

The term 'for emotional or behavioural problems' was used to capture service use for a broader range of mental health problems, not just by those with a mental disorder. The term was defined as meaning 'a number of things, for example, being anxious or stressed, feeling depressed, having problems concentrating, or being aggressive or hyperactive'.

Information was collected for the previous 12 months about the following:

- health services — any service provided by a qualified health professional regardless of where that service was provided (community, hospital inpatient and emergency, and private rooms);
- school services — any service provided by the school or other educational institution that a young person was attending, including individual or group counselling, a special class or school, or service provided by a school nurse;
- telephone counselling services; and
- other online services used for emotional and behavioural problems.

Perceived need for help was assessed in three ways as follows:

- Parents and carers were asked if they felt that their children needed any help with emotional or behavioural problems. If so, they were then asked whether their needs had been fully or partially met by the services they received, or were not met. When needs were not fully met information was collected on the barriers to seeking help or receiving more of the help they felt their children needed.
- Young people were directly asked the same set of questions about their own needs and any barriers to them seeking help or receiving more help if they felt they needed it.
- Parents and carers were also asked about the services they had received and their need for help for themselves and/or other family members to deal with the emotional and behavioural problems affecting their children.

All information on service use and perceived need was collected for the previous 12 months and restricted to 'services for emotional or behavioural problems'.

5. Data issues

Response rate

In total 6,310 parents and carers or 55% of eligible households participated in the survey. In addition 2,967 or 89% of young people aged 11-17 years for whom their parents or carers had given permission completed a questionnaire.

Based on data from the 2011 Census, about one in four Australian households contain one or more children aged 4-17 years. In calculating the response rate for the survey, it is necessary to account for the fact that not all households approached in the survey contained children within the sample age range. Interviewers approached each selected household at different times. However, there remained some households where it was not possible to make contact with anyone living in the household despite these attempts. Census data have been used to estimate the proportion of these households that would be likely to have contained children aged 4-17 years.

The survey was voluntary and some households refused to participate. When a householder refused to participate in the actual survey, the interviewer tried to obtain some basic demographic information, in particular whether there were any children living there. About two thirds of refusing householders would not provide this basic information. Again Census data have been used to estimate the proportion of these households that would have contained children aged 4-17 years.

The estimated number of non-contacts and refusals where eligibility could not be determined were added to the number of participants and the number of refusals who confirmed they had one or more children in order to estimate the overall response rate. Using this method, the overall response rate for the survey was estimated to be 55%. It is acknowledged that the inclusion of households where it was not possible to make contact makes this a strict, conservative estimate of the overall response rate. If this group of households is excluded from the estimate, the overall response rate increases to 60%.

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Sample representativeness

Several approaches were used to assess how representative the sample was of children and adolescents in the Australian population.

Firstly, the demographic characteristics of children, adolescents and families who participated in the survey were compared with those of the total population of Australian families with children aged 4-17 years. The survey included a number of questions that matched questions in the 2011 Census. This enabled a comparison to be made between the survey sample and the Census figures based on the age and sex of the child, family structure, parental education, income and employment, housing tenure and country of birth of both children and adolescents and their parents and carers.

Secondly, response rates were calculated for each individual SA1 area. Statistical models were then used to test for differences in response rates by characteristics of the area, including the Socio-Economic Indexes for each area, remoteness, state and part of state, and a range of census-derived measures, including proportion of overseas born, proportion of people speaking languages other than English, proportion with limited proficiency in English, proportion of sole parent families, proportion of families with low household income, highest level of schooling completed, and proportion of households living in rented accommodation.

Finally, the survey included the Strengths and Difficulties Questionnaire (SDQ), which is used internationally to measure mental health problems in children and adolescents. The SDQ is designed so that approximately 10% of children and adolescents fall into the 'abnormal' range on the total difficulties score. Analysis of the data revealed that 10.1% of young people in the second survey did so. In addition, the SDQ results on the various scales were compared with those from another national survey, the 2004 British Child and Adolescent Mental Health Survey. The distribution of the parent and carer reported SDQ scores was found to very closely match those from the British survey.

Only two of all the factors examined were found to be associated with participation in the survey:

- age of the child — participation was higher among families with children under 7 years; and
- number of children in the family — participation was higher among families with two or more children.

Survey data were weighted, based on information from the 2011 Census, to account for these patterns of participation in the survey.

The survey sample was representative of the population for all other demographic characteristics considered.

Data validation and coding

Data were collected for the survey using computer assisted interviewing. This ensures that questions were asked in the correct sequence, only valid answers were recorded, and that questions could not be inadvertently skipped and no answers recorded. Logic checks were programmed into the questionnaire to ensure that logically inconsistent answers could not be recorded. After data collection, a data editing phase was undertaken to check for any unusual values indicating possible data entry errors.

Participants had the option of answering ‘don’t know’ in some questions and they could refuse to answer any question in the survey. These responses were treated differently depending upon the section of the survey:

- According to the international standard for scoring the DISC-IV, responses recorded as ‘don’t know’ or ‘refused’ were treated as ‘no’ responses for all of the symptom questions within the DISC-IV diagnostic modules.
- ‘Don’t know’ is not a valid response and refusals are not allowed in response to any questions in the SDQ. If following additional prompts no response was given, the answer was recorded as the child not having any difficulties in that area.
- Responses of ‘don’t know’ and refusals to answer questions dealing with demographic and socio-economic measures were recorded as such, but not presented in the tables in this publication.
- For other questions ‘don’t know’ and ‘refused’ were also treated as ‘no’ responses, except when the question was a rating, such as for school performance, or a count, such as the number of times a service was used. In these cases ‘don’t know’ and ‘refused’ were treated as missing data and excluded from the counts when presenting data in this publication. In some cases where the proportion of ‘don’t know’ responses is particularly high, such as with parent and carer-reported use of online services for help-seeking, this is noted in the text.

There was a negligible amount of missing data for most data items in the parent and carer questionnaire. The main exception was in relation to household income, which had the largest proportion of missing values, with approximately 4% of families either responding ‘don’t know’ or refusing to provide their household income.

There was a negligible amount of missing data for most items in the youth self-report questionnaire, particularly as participants were mostly not given an option to respond with ‘don’t know’ or to refuse to answer a question. The main exceptions were in relation to the questions on self-harm and suicidal behaviours, for which participants were given the option of responding ‘prefer not to say’, and for height and weight. Young people who did not provide either their height or weight were excluded from analyses relating to Body Mass Index (BMI) and also low weight problem eating behaviour and binge eating or purging problem eating behaviour both of which include BMI status as part of the definition. There was no evidence that the individual eating behaviours that form part of the definition of these problem eating behaviours occurred any more or less frequently in young people who reported their height and weight compared with those who did not.

There were no open questions requiring data entry and no responses required clinical judgement.

Where cell sizes were less than five, these were suppressed when presenting data in the tables in this publication to ensure confidentiality.

Accuracy of estimates

Confidence intervals demonstrate the level of accuracy achieved by the survey. A 95% confidence interval has been calculated for every estimate included in this publication and only significant differences in the results noted in the text. Similarly, when numbers were relatively small and apparent differences are more likely to be due to chance alone, this is noted.

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Two age groups, 4-11 years and 12-17 years, were used throughout the report. The prevalence of mental disorders in children and adolescents for these two age groups and the 95% confidence intervals for these data are presented below (Table A-1).

Data with the 95% confidence intervals for the prevalence of mental disorders in all children and adolescents broken into four age groups are also provided below (Table A-2). These indicate that further examination of subgroups or disaggregation for single years of age cannot be undertaken with reasonable accuracy.

Table A-1: 12-month prevalence of mental disorders among 4-17 year-olds by two age groups with 95% confidence intervals

Disorder	4-11 years Per cent	4-11 years 95% CI	12-17 years Per cent	12-17 years 95% CI	4-17 years Per cent	4-17 years 95% CI
Any anxiety disorder	6.9	(6.0 - 7.8)	7.0	(5.9 - 8.1)	6.9	(6.2 - 7.6)
Depressive disorder	1.1	(0.8 - 1.5)	5.0	(4.2 - 5.9)	2.8	(2.4 - 3.2)
ADHD	8.2	(7.2 - 9.3)	6.3	(5.3 - 7.4)	7.4	(6.6 - 8.2)
Conduct disorder	2.0	(1.5 - 2.6)	2.1	(1.5 - 2.8)	2.1	(1.6 - 2.5)
Any mental disorder	13.6	(12.3 - 14.9)	14.4	(12.9 - 15.9)	13.9	(12.9 - 15.0)

Table A-2: 12-month prevalence of mental disorders among 4-17 year-olds by four age groups with 95% confidence intervals

Disorder	4-5 years Per cent	4-5 years 95% CI	6-11 years Per cent	6-11 years 95% CI	12-15 years Per cent	12-15 years 95% CI	16-17 years Per cent	16-17 years 95% CI
Any anxiety disorder	5.0	(3.5 - 6.5)	7.5	(6.4 - 8.6)	6.6	(5.2 - 7.9)	7.8	(6.4 - 9.2)
Depressive disorder	0.5	(0.0 - 1.0)	1.4	(0.9 - 1.9)	3.7	(2.6 - 4.7)	7.7	(6.3 - 9.1)
ADHD	5.6	(4.0 - 7.2)	9.2	(7.9 - 10.4)	7.5	(6.0 - 9.0)	4.0	(3.0 - 5.1)
Conduct disorder	1.7	(0.8 - 2.6)	2.2	(1.5 - 2.9)	2.3	(1.3 - 3.2)	1.8	(1.2 - 2.5)
Any mental disorder	9.4	(7.4 - 11.5)	15.1	(13.5 - 16.7)	14.2	(12.2 - 16.2)	14.7	(12.8 - 16.6)

Availability of data and its use

All tables presented in this report, together with information on the accuracy of estimates at the 95% confidence interval, are available through the Telethon Kids Institute, *Young Minds Matter* website: <http://youngmindsmatter.org.au/>

These tables or other materials contained in this report are able to be reproduced subject to there being no alterations and with appropriate citing of the source as follows:

Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (2015)

At the time of publication of this report, a confidentialised unit record file (CURF) of the survey data was being prepared for release to bona fide researchers and will be made available subject to completion of the necessary data release protocol. Details on its availability will be published on the *Young Minds Matter* website.

6. Comparability with 1998 survey

There are a number of substantive methodological and content differences between the first and second child and adolescent national surveys of mental health and wellbeing.

Diagnoses of mental disorders

The first survey used modules from the DISC-IV to assess four mental disorders — major depressive disorder, dysthymic disorder, attention-deficit/hyperactivity disorder and conduct disorder. These were completed by parents and carers.

There were similarities, but also significant differences in how mental disorders were assessed in the second survey. Firstly, the DISC-IV was the primary diagnostic tool for both surveys. Major depressive disorder, attention-deficit/hyperactivity disorder and conduct disorder were also assessed in the second survey. However, the second survey also assessed four anxiety disorders, namely social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder. Parents and carers completed DISC-IV modules for all seven disorders. Therefore direct comparisons of the overall 12-month prevalence of mental disorders cannot be made.

In the second survey young people completed the same DISC-IV major depressive disorder module as their parents and carers, providing an alternative perspective on whether they had the disorder.

The DISC-IV eating disorders module was included in the first survey. However, too few cases were identified for results to be published. For this reason the module was not included in the second survey, but rather problem eating behaviours were assessed using questions drawn from the *Avon Longitudinal Study of Parents and Children*.

Questions were also added to determine the impact of symptoms of particular mental disorders from which severity could be determined. This allows for comparison of the prevalence data by severity as is possible with the other National Surveys of Mental Health and Wellbeing, but was not possible with the first survey.

Problem behaviours

In the first survey mental health problems were assessed using three tools:

- Child Behavior Checklist (CBCL)² is a 113 item questionnaire designed to assess the emotional and behavioural problems in children and adolescents over the last six months, which is completed by parents and carers;
- Youth Self-Report, is a 112 item questionnaire, which is derived from the CBCL for completion by young people aged 13-17 years; and
- the Center for Epidemiologic Studies Depression Scale (CES-D)³ is a 20 item self-report scale designed to measure depressive symptomatology in the past week.

² Achenbach TM: Manual for the Child Behavior Checklist/4-18 and 1991 profile. Burlington, VT: University of Vermont Department of Psychiatry, University of Vermont, 1991.

³ Radloff LS: The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1: 385-401, 1977.

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The Strengths and Difficulties Questionnaire (SDQ) was included in this second survey and the Child Behavior Checklist (CBCL) and Youth Self-Report, used in the first survey, were not. There were several reasons for this change. The SDQ is substantially shorter than the CBCL for parents or carers to complete, while having equivalent measurement properties. This provided leeway for questions on other topics to be added to the survey. In addition, the SDQ has been included in a range of other collections in Australia, including as a routine measure in the National Outcomes and Casemix Collection used by state and territory mental health services and the Longitudinal Study of Australian Children. It has also been designated as the best source of information for developing a leading national Children's Headline Indicator for social and emotional wellbeing in children and young people by the Australian Institute of Health and Welfare.⁴

Young people aged 11-17 years also completed the Strengths and Difficulties Questionnaire (SDQ) Youth Self Report in the second survey rather than the Youth Self-Report based on the CBCL, which was used in the first survey.

Depression symptoms, which were collected in the first survey using the CES-D, were covered in more detail by the DISC-IV major depressive disorder module, which also provided a diagnosis.

Service use

Questions on service use were completely redesigned for the second survey. The approach taken was based on that used in the 2007 National Survey of Mental Health and Wellbeing of the Australian adult population. This approach is based on identifying if services have been used in the past 12 months, if parents and carers or young people feel they needed help or support, whether they received the level of support they needed, and what barriers may have prevented them from using services they felt they needed.

The first survey asked about services used in the six months prior to the survey. By contrast, the reference period in the second survey was 12 months to match the period over which mental disorders were assessed using the DISC-IV and also to align with service data from the other National Survey of Mental Health and Wellbeing initiative surveys, including the 2007 adult survey. Direct comparison of service use over these two different timeframes is not possible and data presented on services used by young people with mental disorders is also not comparable due to the differences in disorders.

The types of services covered in the second survey were also broader than those asked about in the first, reflecting significant changes in the types of services available to young people in 2013-14 compared with 1998. Questions were added about new health services, online services and information, and additional information was collected about services used in schools.

Scoring algorithms

There have been minor changes to the scoring algorithms used in the DISC-IV since 1998. The 1998 survey results for major depressive disorder, ADHD and conduct disorder have been recalculated using the latest algorithms to be comparable with the results from this second survey.

⁴ AIHW. Social and emotional wellbeing: development of a children's headline indicator. Cat. no. PHE 158. Canberra: AIHW. 2012.

APPENDIX 2 - SURVEY REFERENCE GROUP MEMBERSHIP

The Department of Health ran the survey with advice from the Survey Reference Group (SRG) who provided oversight in design, content and implementation of the survey. Membership of the SRG included¹:

Chairperson

Professor Harvey Whiteford, Kratzman Professor Department of Psychiatry and Population Health, University of Queensland

Members

Mr Brenton Alexander, Acting Assistant Secretary, System Improvement Branch, Mental Health and Drug Treatment Division, Australian Government Department of Health

Dr Paul Balnaves, Special Adviser, Engagement and Wellbeing Group at Department of Education

Mr Keiran Booth, Chief Executive Officer, ARAFMI NSW, Carer representative

Dr Peter Brann, Director of Research and Evaluation and Senior Clinical Psychologist, Eastern Health Child and Youth Mental Health Services, Victoria

Mr Bill Buckingham, Consultant/Technical Adviser, Mental Health and Drug Treatment Division, Australian Government Department of Health

Dr Brian Graetz, General Manager, Research, Child and Youth, beyondblue

Ms Colleen Krestensen, Assistant Secretary, Drug Strategy Branch, Population Health Division, Australian Government Department of Health

Mr David Mackay, Assistant Secretary, Early Intervention and Prevention Branch, Mental Health and Drug Treatment Division, Australian Government Department of Health

Associate Professor Cathrine Mihalopoulos, Head, Mental Health Economics Stream, Deakin University

Professor George Patton, Professor of Adolescent Health Research, Royal Children's Hospital, University of Melbourne

Ms Sue Phillips, Director, Disability and Mental Health, Australian Bureau of Statistics

Dr Helen Rogers, Director, Longitudinal Study of Australian Children, Australian Government Department of Social Services

¹ Position titles reflect the roles of the individuals at the commencement of the Survey Reference Group

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Associate Professor Lena Sanci, Deputy Head, Department of General Practice, University of Melbourne

Associate Professor James Scott, Consultant Psychiatrist, Centre for Clinical Research, University of Queensland

Associate Professor Tim Slade, National Drug and Alcohol Research Centre, University of New South Wales

Dr Titia Sprague, Associate Director, Clinical Service Development and Quality, MH-Kids, New South Wales Department of Health

Mr Gavin Stewart, Principal, Applied Epidemiology

Dr Sue Thomson, Head of Educational Monitoring and Research and Director of the National Surveys Research Program, Australian Council of Educational Research

Ms Vittoria Tonin, Management Resident (Graduate) at the Australian College of Health Service Management, Consumer Representative

APPENDIX 3 - GLOSSARY

Glossary term	Definition
12-month prevalence	Meeting diagnostic criteria according to the DSM-IV (for the purposes of this report) in the 12 months prior to interview. Prevalence includes both new cases, whose symptoms first developed during the 12 months prior to the interview and continuing cases whose symptoms were present prior to the 12 months, but persisted, and were at a level to meet the diagnostic criteria in the 12 months prior to interview.
Adolescent self-report questionnaire	<p>The questionnaire for completion by young people aged 11 years and older. Subject to the permission of their parents or carers, young people were asked to complete this in private using a tablet computer.</p> <p>The questionnaire comprised the following modules:</p> <ul style="list-style-type: none">• DISC-IV major depressive disorder module;• Presence of symptoms of psychosis;• Strengths and Difficulties Questionnaire (SDQ);• Kessler Psychological Distress Scale (K10+);• Use of services and perceived need for services;• Use of internet;• Youth health-risk behaviours, including self-harm, suicidal behaviours, substance use, disordered eating behaviours and sexual behaviour• Experience of bullying;• Level of education; and• Level of self-esteem. <p>Age criteria were set for some sections of the questionnaire. Questions about self-harm and suicidal behaviours were only asked of young people aged 12 years and older. Questions about use of services and perceived need for services, sexual behaviours, and smoking, alcohol and other drugs were asked of young people aged 13 years and older.</p>
Alcohol consumption	Young people aged 13 years and over were asked if they had ever had a drink of alcohol other than a few sips, if they had drunk alcohol in the past 30 days and if they had consumed more than four drinks in a row (that is within a couple of hours).
Anxiety disorders	<p>A class of mental disorders defined by the experience of intense and debilitating anxiety.</p> <p>The types of anxiety disorders covered in the survey were social phobia, separation anxiety disorder (SAD), generalized anxiety disorder (GAD), and obsessive-compulsive disorder (OCD).</p>

Glossary term**Definition**

Modules for each of these four anxiety disorders from the DISC-IV were completed by parents and carers and their responses used to determine if the young person met the diagnostic criteria for an anxiety disorder in the 12 months prior to interview.

Anxiety disorders were not included in the first survey in 1998.

Area of residence

Area of residence was categorised as either Greater capital cities or Rest of state based on the ABS Greater Capital City Statistical Area (GCCSA) classification. This classification represents the functional extent of the eight state and territory capital cities in Australia. Households within these areas were classified as Greater capital cities. The remainder were classed as Rest of state.

Attention-deficit/hyperactivity disorder (ADHD)

Persistent pattern of inattention and/or hyperactivity-impulsivity. Children and adolescents may find it difficult to pay attention and see tasks or activities through to the end or 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'.

There are three subtypes of ADHD based on the most common symptoms. Those with mostly inattentive symptoms are diagnosed with ADHD, predominantly inattentive type and individuals with primarily hyperactivity-impulsivity symptoms are diagnosed with ADHD, predominantly hyperactive-impulsive type. Those children and adolescents with symptoms of both inattentiveness and hyperactivity are diagnosed with ADHD, combined type.

To meet DSM-IV criteria symptoms must be more frequent and severe than in other individuals at a similar developmental stage, persist for at least six months and some impairment from the symptoms must be present in two or more settings (e.g. at school and at home).

The module for ADHD from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for ADHD in the 12 months prior to interview.

Binge eating and purging problem eating behaviour

Both binge eating and either vomiting or taking laxatives to control weight in adolescents with a Body Mass Index (BMI) that was not in the underweight range.

Bullying

When people tease, threaten, spread rumours about, hit, shove, or hurt other people over and over again.

Glossary term	Definition
Carer	<p>The primary carer was the individual in the household who knew the most about the child selected for interview in the survey. In a majority of cases this was the mother of the survey child. If a biological, adoptive or foster parent of the child was the primary carer and another biological, adoptive or foster parent of the child was present in the household, this person was designated as the secondary carer. Otherwise, if there was another person present in the household who was also responsible for caring for the study child, they were recorded as the secondary carer.</p>
Comorbidity	<p>Occurrence of more than one mental disorder within the same period.</p> <p>For the purposes of the survey this was defined as more than one of the disorders (an anxiety disorder, major depressive disorder, ADHD and conduct disorder) in the 12 months prior to interview.</p>
Conduct disorder	<p>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. Young people with conduct disorder exhibit a range of behaviours often including bullying, frequent physical fights, deliberately destroying other’s property, breaking into properties or cars, staying out late at night without permission, running away from home or frequent truancy from school.</p> <p>The DSM-IV criteria specify that at least three or more of these behaviours must have been present in the past 12 months, with at least one in the past 6 months. These behaviours must also cause clinically significant impairment in social, academic or occupational functioning.</p> <p>The module for conduct disorders from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for conduct disorder in the 12 months prior to interview.</p>
Cyber bullying	<p>When people use mobile phones or the internet to send nasty or threatening emails or messages, post mean or nasty comments or pictures on websites like Facebook, or have someone pretend to be them online to hurt other people over and over again.</p>

Glossary term	Definition
Days absent from school	<p>Number of days the study child was absent from school for any reason.</p> <p>Average days absent from school due to symptoms of mental disorder have been reported. Parents and carers were asked how many days their child had been absent from school in the past 12 months specifically due to the symptoms of each of the disorders that they reported symptoms. Averages were then calculated from all children and adolescents who met diagnostic criteria for the mental disorder, including those who did not miss any days of school due to their symptoms.</p>
Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV)	<p>Produced by the American Psychiatric Association the manual provides standard criteria for the classification of all mental disorders for children and adults. These criteria are based on clinically significant sets of symptoms that are associated with impaired functioning by young people with the disorders.</p>
Diagnostic Interview Schedule for Children Version IV (DISC-IV)	<p>Diagnostic tool comprised of a series of mental disorder modules that implements the criteria for mental disorders set out in the <i>Diagnostic and Statistical Manual of Mental disorders</i>, fourth edition (DSM-IV).</p> <p>Modules for seven disorders were used in the survey — social phobia, separation anxiety disorder, generalised anxiety disorder, obsessive-compulsive disorder, major depressive disorder, Attention-Deficit/Hyperactivity Disorder (ADHD) and conduct disorder.</p>
Drug use	<p>The survey asked whether young people aged 13 years and older had ever used cannabis or marijuana, whether they had used cannabis or marijuana in the last 30 days, and whether they had used other drugs. These included using prescription drugs for non-medical purposes; ecstasy; amphetamines and methamphetamines; cocaine; hallucinogens such as LSD; inhalants such as petrol, glue, aerosols, paint, solvents or nitrous; heroin; steroids; GHB or ketamine.</p>
Family functioning	<p>A shortened version of the General Functioning Subscale of the McMaster Family Assessment Device was used to classify families into four levels of functioning.¹ This ranged from very good through to poor, with poor indicating unhealthy family functioning likely to require clinical intervention. Of all families in the survey 3.7% had a poor level of family functioning.</p>

¹ Boterhoven de Haan KL, Hafekost J, Lawrence D, Sawyer MG, Zubrick SR (2014). Reliability and validity of a short version of the general functioning subscale of the McMaster Family Assessment Device. *Family Process*. doi: 10.1111/famp.12113

Glossary term**Definition****Family type**

Families were classified into families with two parents or carers and families with one parent or carer. Families with two parents or carers were further categorised into original, step, blended or other families corresponding to the Australian Bureau of Statistics family blending classification variable introduced in the 2006 Census. These are defined as follows:

- Original families contain at least one child who is the natural, adopted or foster child of both partners in the couple and no step children.

The Australian Bureau of Statistics refers to this category as 'intact families'.

- Step families have at least one resident step child, but no child who is the natural or adopted child of both partners.
- Blended families have two or more children; at least one child who is the natural or adopted child of both parents, and at least one who is the step child of one of them.
- Other families have no children who are the natural, adopted, foster or step child of either parent or carer. These include families with children being raised by their grandparents or other relatives.

Generalised anxiety disorder

An anxiety disorder characterised by excessive anxiety, worry or apprehension about a number of different events or activities.

To meet DSM-IV criteria, symptoms must occur more days than not for a period of at least six months. The constant worry causes distress to the individual. The child or adolescent has difficulty controlling the worry, and experiences impairment in social, academic or other important areas of functioning.

The module for generalised anxiety disorder from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for generalised anxiety disorder in the 12 months prior to interview.

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Glossary term	Definition
Health service provider	<p>Providers of health services regardless of the setting or medium in which that service is provided.</p> <p>Specific health service providers covered by the survey were:</p> <ul style="list-style-type: none"> - general practitioner; - paediatrician; - psychiatrist; - psychologist; - nurse; - social worker; - occupational therapist; and - counsellor or family therapist.
Impact on functioning	see Severity of impact on functioning.
Labour force status	<p>Classifies people as employed when working full-time, part-time or away from work, or not in employment when unemployed or not in the labour force. Employed includes casual, temporary or part-time work if it was for an hour or more in the reference week.</p> <p>For the purposes of the survey this was collected for both parents and carers for the previous week.</p>
Low weight problem eating behaviours	Body Mass Index (BMI) in the underweight range and young person dieted, fasted, vomited or used laxatives to lose weight or regularly exercised when they were supposed to be doing other things.
Major depressive disorder	<p>The key feature of major depressive disorder is the presence of either depressed mood, loss of interest or pleasure or being grouchy, irritable and in a bad mood. Symptoms may include significant weight loss or weight gain, loss of appetite, insomnia or hypersomnia, restlessness, fatigue and loss of energy, feelings of worthlessness and inability to concentrate.</p> <p>The DSM-IV criteria specify that at least five symptoms of depression must be present for a minimum of a two-week period, that these symptoms cause clinically significant distress to the child or adolescent and that they must interfere with the child or adolescent's normal functioning at school, at home or in social settings.</p> <p>The module for major depressive disorder from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for major depressive disorder in the 12 months prior to interview.</p>

Glossary term	Definition
	<p>Young people aged 11 years and older also completed this module and prevalence data based on their responses are reported as ‘Major depressive disorder based on adolescent report’.</p>
Mental disorder	<p>Defined according to the detailed diagnostic criteria within classification systems. This covers:</p> <ul style="list-style-type: none">- the nature, number and combination of symptoms;- a time period over which the symptoms have been continuously experienced;- the level of distress or impairment experienced; and- circumstances for exclusion of a diagnosis, such as it being due to a general medical condition or the symptoms being associated with another mental disorder. <p>The classification system used for mental disorders in this report was the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).</p>
Not in employment	<p>Both unemployed and not in the labour force.</p>
Obsessive-compulsive disorder	<p>An anxiety disorder characterised by recurrent obsessions or compulsions.</p> <p>Obsessions are persistent ideas, thoughts, impulses or images that are intrusive and difficult to control and that cause anxiety or distress. Common obsessions include worrying about things being dirty or having germs, or that the person might do something bad in public.</p> <p>Compulsions are repetitive behaviours, such as washing hands or changing clothes over and over, repetitively checking things, or counting or ordering things over and over.</p> <p>To meet DSM-IV criteria, the compulsions and obsessions must be severe enough to be time consuming and cause marked distress or significant impairment.</p> <p>The module for obsessive-compulsive disorder from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for obsessive compulsive disorder in the 12 months prior to interview.</p>

Glossary term	Definition
Oppositional problem behaviours	<p>Negativistic, hostile and defiant behaviours, such as often losing temper, arguing with adults, actively defying adults' requests and rules, being angry, resentful, spiteful or vindictive, lasting at least six months.</p> <p>The DISC-IV module for oppositional defiant disorder was included in the survey. However, unlike other disorders, the diagnosis for oppositional defiant disorder includes an element of clinical judgement that could not be implemented within the DISC-IV questions. In particular, for each symptom assessed in oppositional defiant disorder the DSM-IV specifies that the symptom criterion is met only if the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level. A clinician is required to make this judgement. The data collection for <i>Young Minds Matter</i> was undertaken by lay professional interviewers who were not specifically trained in psychology or psychiatry and expert clinical review of each child or adolescent in the survey was not undertaken. As such it was not possible to identify all criteria for assigning the diagnosis of oppositional defiant disorder. Instead these behaviours are referred to as oppositional problem behaviours to distinguish them from the diagnostic condition of oppositional defiant disorder.</p> <p>In this survey an exclusion criterion was defined so that children or adolescents who met the diagnostic criteria for conduct disorder were not considered to have oppositional problem behaviours.</p>
Perceived need for mental health care	<p>Extent to which people feel their need for mental health care has been met. The need for care was assessed across four types of help:</p> <ul style="list-style-type: none">- Information about emotional or behavioural problems, treatment and available services;- Prescribed medication for emotional or behavioural problems;- Counselling or a talking therapy about problems or difficulties (either one-on-one, as a family or in a group); and- Courses or other counselling for life skills, self-esteem or motivation. <p>This was measured in the survey by a separate module that determined whether the child or adolescent had any need for help with emotional or behavioural problems and whether that need was met. Both parents or carers and adolescents were asked the same questions.</p> <p>For each of the four types of help, the level of perceived need was classified as being either fully met, partially met, unmet or not needed. For those reporting a need for more than one type of help, perceived need for any type of help was based on a composite of the individual ratings for</p>

Glossary term

Definition

each type of help needed. Need for any type of help was rated as being fully met if for each type of help needed, that need was assessed as being fully met. Need for any type of help was partially met if any of the types of help were partially met or if there were combined ratings of fully met and unmet need. Need for any type of help was unmet if the level of need for all types of help needed was unmet.²

Problem eating behaviours

The survey did not assess DSM-IV criteria for eating disorders. Instead, the survey sought to identify eating behaviours that may be on the pathway to eating disorders. These were eating behaviours associated with low weight, and binge eating and purging.

Questions were taken from the *Avon Longitudinal Study of Parents and Children* to assess a range of activities young people may undertake to control their weight in the past 12 months. These were:

- i) if they had gone on a diet to lose weight or keep from gaining weight;
- ii) if there was a time when they had regularly exercised instead of doing other things that they were supposed to be doing, or while they were injured, in order to lose weight or to avoid gaining any weight;
- iii) how often they had fasted for at least a day to lose weight or to avoid gaining any weight;
- iv) how often they had made themselves throw up or vomit to lose weight or to avoid gaining any weight;
- v) how often they had taken laxatives or other tablets or medicines (diet pills or water tablets) to lose weight or to avoid gaining any weight; and
- vi) how often they had been on an eating binge (defined as eating so much food that it would be like eating two or more entire meals in one sitting, or eating so much of one particular food, like lollies or ice cream, that it would make most people feel sick).

Young people also self-reported their height and weight, and this was used to assess their Body Mass Index (BMI). BMI ranges specifically designed for children and adolescents were used to classify underweight

² Meadows G, Burgess P, Fossey E, Harvey C (2000). Perceived need for mental health care, findings form the Australian National Survey of Mental Health and Well-being. *Psychological Medicine*. 30: 645-656.

Glossary term

Definition

and overweight status.³

Young people were considered to have low-weight problem eating behaviour if their BMI was in the underweight range and they dieted, fasted, vomited or used laxatives to lose weight or regularly exercised when they were supposed to be doing other things.

Young people were considered to have binge eating and purging problem eating behaviour if their BMI was not in the underweight range and they reported both binge eating and either vomiting or taking laxatives to control weight.

Approximately 8% of young people did not provide either their height or weight. These young people were excluded from the calculations of BMI and low weight problem eating behaviour and binge eating and purging problem eating behaviour.

Problem internet or electronic gaming behaviours

Young people were asked about five specific behaviours that may be indicative of addiction to the internet, social media or electronic gaming:

- i) going without eating or sleeping in order to be on the internet or play electronic games
- ii) feeling bothered or upset if they are unable to be on the internet or gaming
- iii) catching themselves surfing the internet or playing games even when they are not interested
- iv) spending less time than they should with family or friends or doing school work or work because of the time they spend on the internet or gaming
- v) having tried unsuccessfully to reduce the time spent on the internet or playing electronic games.

Problem internet or electronic gaming behaviour has been defined as reporting four or five of these individual indicators.

Psychological distress

Measured by the Kessler Psychological Distress Scale (K10), a widely used scale designed to detect the differing levels of psychological distress in the general population. While high levels of distress are often associated with mental illness, it is not uncommon for some people to experience psychological distress, but not meet criteria for a mental disorder.

³ Cole TJ, Flegal KM, Nicholls D, Jackson AA (2007). Body mass index cut offs to define thinness in children and adolescents: international survey. *British Medical Journal*. 335(7612): 194. doi: 10.1136/bmj.39238.399444.55

Glossary term

Definition

The K10 is based on 10 questions about negative emotional states in the four weeks prior to interview. The K10 is scored from 0 to 40, with higher scores indicating higher levels of distress. In this report, scores are categorised as follows:

- 0-5 Low levels of psychological distress;
- 6-11 Moderate levels of psychological distress;
- 12-19 High levels of psychological distress; and
- 20-40 Very high levels of psychological distress.

In this survey the K10 scale was administered to primary carers about themselves, and was also included in the adolescent self-report questionnaire.

Adolescents completed an enhanced version of the K10+ with additional questions on anger, control, concentration and feeling calm and peaceful. The K10+ also includes questions about whether as a result of any reported distress they had any days when they could not carry out their normal activities.

School services

Individual counselling, group counselling or support program, special class or school, school nurse or other services received from the school or other educational institution that the child or adolescent attends.

Self-harm

Deliberately hurting or injuring yourself without trying to end your life.

Young people aged 12 years and older were asked if they had ever done something to cause themselves harm or injury without trying to end their life. They were also given the option of not responding and were not asked any further questions about self-harm.

Separation anxiety disorder

An anxiety disorder characterised by excessive anxiety concerning separation from the home or from those to whom the child is attached.

To meet DSM-IV criteria, the anxiety must be beyond that which is expected for the child or adolescent’s developmental level, and cause significant distress in social, academic or other important areas of functioning for at least four weeks.

The module for separation anxiety disorder from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for separation anxiety disorder in the 12 months prior to interview.

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Glossary term	Definition
Service use	<p>The use of all health and school services, but only those telephone and online services where these provided structured or personalised information.</p> <p>Children or adolescents were defined as having used services when they had used at least one of the following services: a consultation with a health service provider, a hospital admission, a headspace service, a school service, a telephone counselling service and/or online assistance for emotional or behavioural problems in the 12 months prior to interview.</p>
Services	<p>Comprise all the health, school, telephone and online services defined as follows:</p> <ul style="list-style-type: none">- health services — any service provided by a qualified health professional regardless of where that service was provided (community, hospital inpatient and emergency, and private rooms);- school services — any service provided by the school or other educational institution that a young person was attending; and- telephone and online services where these provided structured or personalised assistance and not just generic information.

Glossary term

Definition

Severity of impact on functioning

A total of 17 items was administered to respondents to assess the impact of disorder symptoms on the child or adolescent’s functioning at school or work, with friends, with their family and with respect to distress to the child or adolescent him or herself. A graded response model was used to create a composite impact on function score. This score was standardised with a range from -3.0 to +3.0 where higher scores represent increasing severity of impact on functioning.

Children and adolescents were classified into three levels of impact on functioning by applying the national mental health service planning standard ratio of severity for mental disorders to the standardised score (1:2:4 for severe, moderate and mild cases). In addition suicide plans or attempts in the past 12 months were considered. The three levels are:

- Severe: A positive diagnosis plus an impact score greater than or equal to 1.75 and/or a history of suicide attempt in the 12 months prior to interview;
- Moderate: A positive diagnosis plus an impact score greater than or equal to 0.95 or a history of suicide plans in the 12 months prior to interview; and
- Mild: All other cases with a positive diagnosis.

To ease interpretation, throughout this publication, the terms “severity of impact on function”, “severity of impact”, and “severity of disorder” have been used interchangeably.

Smoking status

Young people aged 13 years and over were asked if they had ever smoked, and if they smoked in the past 30 days.

Young people were only asked if they had smoked in the past 30 days if they said yes to the question ‘was there ever a time in your life when you were smoking at least once per week?’ As such, smoking data are not directly comparable to those from other surveys.

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Glossary term	Definition
Social phobia	<p>An anxiety disorder characterised by a strong fear of social interaction or performance situations. People with social phobia avoid social situations in case of embarrassment or humiliation.</p> <p>To meet DSM-IV criteria symptoms must be present for at least six months and the fear or avoidance of social situations must interfere significantly with the child or adolescent’s normal routine, academic functioning, or social activities or relationships, or they must experience marked distress about the phobia.</p> <p>The module for social phobia from the DISC-IV was completed by parents and carers and their responses used to determine if the young person met the DSM-IV criteria for social phobia in the 12 months prior to interview.</p>
Sub-threshold level	<p>Sub-threshold level on the DISC-IV refers to when the symptoms reported for any mental disorder were sufficient in number to warrant further questioning about the impact of these, but which were not sufficient in number, with sufficient impact, or of sufficient duration to meet the DSM-IV diagnostic criteria for the mental disorder.</p>
Suicidal behaviours	<p>Suicidal ideation (serious thoughts about taking one’s own life), making suicide plans and suicide attempts where the self-injury is intended to end in death.</p> <p>Young people aged 12 years and over were asked if during the past 12 months they had seriously considered attempting suicide. Young people were also given the option of not answering and were then not asked any further questions about suicidal behaviours.</p>

APPENDIX 4 - LIST OF TABLES AND FIGURES IN MAIN REPORT

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Distribution of the Young Minds Matter survey sample

Table S-1: Parent or carer interview sample by sex and age group

Sex	Age group	Respondents	Proportion (%)
Males	4-11 years	1709	27.1
	12-17 years	1545	24.5
	4-17 years	3254	51.6
Females	4-11 years	1625	25.8
	12-17 years	1431	22.7
	4-17 years	3056	48.4
Persons	4-11 years	3334	52.8
	12-17 years	2976	47.2
	4-17 years	6310	100.0

Table S-2: Parent or carer interview sample by family type

Family type	Respondents	Proportion (%)
Families with two parents or carers	5060	80.2
Original family	4331	68.6
Step family	283	4.5
Blended family	392	6.2
Other family	54	0.9
Families with one parent or carer	1250	19.8
Total	6310	100.0

‘Original family’ has at least one child living with their natural, adoptive or foster parents, and no step children.
‘Other family’ is where all children are not the natural, adopted, foster or step child of one or both carers.

Table S-3: Parent or carer interview sample by household income

Household income before tax	Respondents	Proportion (%)
\$130,000 or more per year	1686	26.7
\$52,000-\$129,999 per year	2833	44.9
Less than \$52,000 per year	1479	23.4
Not stated	312	4.9
Total	6310	100.0

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

Table S-4: Parent or carer interview sample by parent or carer education level

Highest level of education of either primary or secondary parent or carer	Respondents	Proportion (%)
Bachelor degree or higher	2667	42.3
Diploma or certificate III/IV	2414	38.3
Year 11 or 12	756	12.0
Year 10 or below	473	7.5
Total	6310	100.0

Table S-5: Parent or carer interview sample by parent or carer labour force status

Parent or carer labour force status	Respondents	Proportion (%)
Both parents or carers employed	3413	54.1
One parent or carer employed, one parent or carer not in employment	1455	23.1
Both parents or carers not in employment	209	3.3
Sole parent or carer employed	740	11.7
Sole parent or carer not in employment	475	7.5
Not stated	18	0.3
Total	6310	100.0

‘Not in employment’ combines unemployed and not in the labour force.

Table S-6: Parent or carer interview sample by area of residence

Area of residence	Respondents	Proportion (%)
Greater capital cities	4044	64.1
Rest of state	2266	35.9
Total	6310	100.0

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

Table S-7: Parent or carer interview sample by country of birth of child or adolescent

Child or adolescent country of birth	Respondents	Proportion (%)
Australia	5540	87.8
Overseas	770	12.2
Total	6310	100.0

Table S-8: Parent or carer interview sample by country of birth of parents or carers

Parent or carer country of birth	Respondents	Proportion (%)
Both parents or carers born in Australia	2977	47.2
One parent or carer born in Australia, one parent or carer born overseas	929	14.7
Both parents or carers born overseas	1188	18.8
Sole parent or carer born in Australia	956	15.2
Sole parent or carer born overseas	259	4.1
Not stated	1	0.0
Total	6310	100.0

Table S-9: Parent or carer interview sample by housing tenure

Housing tenure	Respondents	Proportion (%)
Owned outright	777	12.3
Owned with a mortgage	3488	55.3
Rented — public housing	268	4.2
Rented — other	1677	26.6
Other	88	1.4
Not stated	12	0.2
Total	6310	100.0

Table S-10: Parent or carer interview sample by remoteness area

Remoteness area	Respondents	Proportion (%)
Major Cities of Australia	4134	65.5
Inner Regional Australia	1554	24.6
Outer Regional Australia	516	8.2
Remote Australia or Very Remote Australia	106	1.7
Total	6310	100.0

Table S-11: Parent or carer interview sample by index of relative socio-economic disadvantage

Index of relative socio-economic disadvantage	Respondents	Proportion (%)
Lowest quintile (most disadvantaged)	1055	16.7
Second quintile	1180	18.7
Third quintile	1188	18.8
Fourth quintile	1436	22.8
Highest quintile (least disadvantaged)	1451	23.0
Total	6310	100.0

Table S-12: 4-17 year-olds by level of family functioning

Level of family functioning	Proportion (%)
Very good	60.8
Good	23.0
Fair	12.5
Poor	3.7

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

Prevalence of mental disorders

Table S-13: 12-month prevalence of mental disorder among 4-17 year-olds by country of birth of child or adolescent

Child or adolescent country of birth	Prevalence (%)
Australia	14.8
Overseas	7.2

Table S-14: 12-month prevalence of mental disorder among 4-17 year-olds by country of birth of parents or carers

Parent or carer country of birth	Prevalence (%)
Both carers born in Australia	14.3
One carer born in Australia, one carer born overseas	12.9
Both carers born overseas	5.1
Sole carer born in Australia	24.6
Sole carer born overseas	13.4

Table S-15: 12-month prevalence of mental disorder among 4-17 year-olds by housing tenure

Housing tenure	Prevalence (%)
Owned outright	10.5
Owned with a mortgage	11.2
Rented — public housing	29.2
Rented — other	17.7
Other	18.2

Table S-16: 12-month prevalence of mental disorder among 4-17 year-olds by remoteness area

Remoteness area	Prevalence (%)
Major Cities of Australia	12.9
Inner Regional Australia	14.8
Outer Regional Australia	19.0
Remote Australia or Very Remote Australia	14.0

Table S-17: 12-month prevalence of mental disorder among 4-17 year-olds by index of relative socio-economic disadvantage

Index of relative socio-economic disadvantage	Prevalence (%)
Lowest quintile (most disadvantaged)	20.7
Second quintile	14.4
Third quintile	13.3
Fourth quintile	11.7
Highest quintile (least disadvantaged)	10.9

Principal condition

Table S-18: Principal condition by sex and age group

Disorder	Males 4-11 years (%)	Males 12-17 years (%)	Males 4-17 years (%)	Females 4-11 years (%)	Females 12-17 years (%)	Females 4-17 years (%)	Persons 4-11 years (%)	Persons 12-17 years (%)	Persons 4-17 years (%)
Social phobia	0.9	2.1	1.4	0.8	1.7	1.2	0.8	1.9	1.3
Separation anxiety	4.0	1.6	3.0	3.5	1.7	2.7	3.8	1.6	2.9
Generalised anxiety	1.1	0.8	1.0	0.7	1.6	1.1	0.9	1.2	1.0
Obsessive- compulsive disorder	np	np	0.2	np	np	0.1	0.1	0.2	0.2
Major depressive disorder	0.5	3.0	1.6	0.6	4.7	2.4	0.6	3.8	2.0
Conduct disorder	1.1	1.2	1.1	1.0	1.0	1.0	1.0	1.1	1.1
ADHD	8.6	6.9	7.9	4.0	1.8	3.1	6.3	4.5	5.5

np Not available for publication because of small cell size, but included in totals where applicable.

Major depressive disorder

Table S-19: 12-month prevalence of major depressive disorder among 4-17 year-olds by country of birth of child or adolescent

Child or adolescent country of birth	Prevalence (%)
Australia	3.0
Overseas	1.3

Table S-20: 12-month prevalence of major depressive disorder among 4-17 year-olds by country of birth of parents or carers

Parent or carer country of birth	Prevalence (%)
Both carers born in Australia	2.3
One carer born in Australia, one carer born overseas	2.8
Both carers born overseas	1.0
Sole carer born in Australia	6.2
Sole carer born overseas	3.0

Table S-21: 12-month prevalence of major depressive disorder among 4-17 year-olds by housing tenure

Housing tenure	Prevalence (%)
Owned outright	2.7
Owned with a mortgage	2.1
Rented — public housing	6.3
Rented — other	3.5
Other	4.4

Table S-22: 12-month prevalence of major depressive disorder among 4-17 year-olds by remoteness area

Remoteness area	Prevalence (%)
Major Cities of Australia	2.7
Inner Regional Australia	2.8
Outer Regional Australia	3.3
Remote Australia or Very Remote Australia	4.4

Table S-23: 12-month prevalence of major depressive disorder among 4-17 year-olds by index of relative socio-economic disadvantage

Index of relative socio-economic disadvantage	Prevalence (%)
Lowest quintile (most disadvantaged)	4.0
Second quintile	2.6
Third quintile	2.9
Fourth quintile	2.1
Highest quintile (least disadvantaged)	2.6

Anxiety disorders

Table S-24: 12-month prevalence of anxiety disorders among 4-17 year-olds by country of birth of child or adolescent

Child or adolescent country of birth	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Australia	2.5	4.6	2.4	0.8	7.4
Overseas	1.1	1.4	np	0.9	3.2

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-25: 12-month prevalence of anxiety disorders among 4-17 year-olds by country of birth of parents or carers

Parent or carer country of birth	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Both carers born in Australia	2.1	4.0	2.3	0.7	6.6
One carer born in Australia, one carer born overseas	2.4	3.0	2.1	0.4	6.1
Both carers born overseas	0.7	0.9	0.5	0.5	2.1
Sole carer born in Australia	4.9	10.3	4.2	2.0	14.8
Sole carer born overseas	2.5	4.5	np	np	5.7

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-26: 12-month prevalence of anxiety disorders among 4-17 year-olds by housing tenure

Housing tenure	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Owned outright	1.8	1.7	1.3	0.6	4.1
Owned with a mortgage	1.8	3.4	1.9	0.5	5.8
Rented — public housing	6.0	12.1	4.3	3.5	16.6
Rented — other	2.9	5.5	2.7	1.1	8.5
Other	np	6.5	np	np	8.4

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-27: 12-month prevalence of anxiety disorders among 4-17 year-olds by remoteness area

Remoteness area	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Major Cities of Australia	2.2	3.9	2.1	0.9	6.4
Inner Regional Australia	3.0	5.2	2.5	0.9	8.1
Outer Regional Australia	1.7	4.4	1.6	np	7.7
Remote Australia or Very Remote Australia	np	3.9	np	np	5.3

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-28: 12-month prevalence of anxiety disorders among 4-17 year-olds by index of relative socio-economic disadvantage

Index of relative socio-economic disadvantage	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Lowest quintile (most disadvantaged)	3.8	6.1	2.5	2.0	10.4
Second quintile	1.6	5.1	2.2	0.7	7.3
Third quintile	2.9	3.6	2.2	0.4	6.2
Fourth quintile	1.6	3.6	2.3	0.4	6.1
Highest quintile (least disadvantaged)	2.0	3.2	1.7	0.8	5.3

ADHD

Table S-29: 12-month prevalence of ADHD among 4-17 year-olds by country of birth of child or adolescent

Child or adolescent country of birth	Prevalence (%)
Australia	7.9
Overseas	3.9

Table S-30: 12-month prevalence of ADHD among 4-17 year-olds by country of birth of parents or carers

Parent or carer country of birth	Prevalence (%)
Both carers born in Australia	7.9
One carer born in Australia, one carer born overseas	6.9
Both carers born overseas	3.0
Sole carer born in Australia	12.1
Sole carer born overseas	6.4

Table S-31: 12-month prevalence of ADHD among 4-17 year-olds by housing tenure

Housing tenure	Prevalence (%)
Owned outright	5.3
Owned with a mortgage	5.8
Rented — public housing	17.2
Rented — other	9.6
Other	9.5

Table S-32: 12-month prevalence of ADHD among 4-17 year-olds by remoteness area

Remoteness area	Prevalence (%)
Major Cities of Australia	7.0
Inner Regional Australia	7.8
Outer Regional Australia	10.0
Remote Australia or Very Remote Australia	4.3

Table S-33: 12-month prevalence of ADHD among 4-17 year-olds by index of relative socio-economic disadvantage

Index of relative socio-economic disadvantage	Prevalence (%)
Lowest quintile (most disadvantaged)	12.2
Second quintile	8.1
Third quintile	7.0
Fourth quintile	5.6
Highest quintile (least disadvantaged)	5.2

Conduct disorder

Table S-34: 12-month prevalence of conduct disorder among 4-17 year-olds by country of birth of child or adolescent

Child or adolescent country of birth	Prevalence (%)
Australia	2.3
Overseas	0.5

Table S-35: 12-month prevalence of conduct disorder among 4-17 year-olds by country of birth of parents or carers

Parent or carer country of birth	Prevalence (%)
Both carers born in Australia	2.0
One carer born in Australia, one carer born overseas	1.0
Both carers born overseas	np
Sole carer born in Australia	5.2
Sole carer born overseas	4.3

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-36: 12-month prevalence of conduct disorder among 4-17 year-olds by housing tenure

Housing tenure	Prevalence (%)
Owned outright	0.6
Owned with a mortgage	1.2
Rented — public housing	10.8
Rented — other	3.0
Other	np

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-37: 12-month prevalence of conduct disorder among 4-17 year-olds by remoteness area

Remoteness area	Prevalence (%)
Major Cities of Australia	1.6
Inner Regional Australia	3.0
Outer Regional Australia	2.6
Remote Australia or Very Remote Australia	np

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-38: 12-month prevalence of conduct disorder among 4-17 year-olds by index of relative socio-economic disadvantage

Index of relative socio-economic disadvantage	Prevalence (%)
Lowest quintile (most disadvantaged)	5.7
Second quintile	1.4
Third quintile	1.6
Fourth quintile	1.1
Highest quintile (least disadvantaged)	1.1

Mental disorders in adolescents aged 16-17 years

Table S-39: 12-month prevalence of mental disorders among 16-17 year-olds by type of disorder and sex

Disorder	Males (%)	Females (%)	Persons (%)
Social phobia	2.8	4.8	3.8
Separation anxiety disorder	2.2	4.3	3.2
Generalised anxiety disorder	2.5	5.3	3.9
Obsessive-compulsive disorder	np	1.2	0.8
Any anxiety disorder	5.4	10.2	7.8
Major depressive disorder	5.4	10.0	7.7
ADHD	5.3	2.8	4.0
Conduct disorder	2.5	1.2	1.8
Any mental disorder	14.1	15.3	14.7

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-40: 12-month prevalence of mental disorders among 16-17 year-olds by type of disorder and severity of impact

Disorder	Mild (%)	Moderate (%)	Severe (%)	Total (%)
Social phobia	1.1	1.0	1.7	3.8
Separation anxiety disorder	0.8	1.0	1.4	3.2
Generalised anxiety disorder	1.1	1.5	1.3	3.9
Obsessive-compulsive disorder	np	np	0.3	0.8
Any anxiety disorder	2.6	2.6	2.7	7.8
Major depressive disorder	1.5	3.1	3.1	7.7
ADHD	2.2	1.4	0.4	4.0
Conduct disorder	0.6	0.9	0.3	1.8
Any mental disorder	5.2	5.8	3.7	14.7

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-41: 12-month prevalence of oppositional problem behaviours among 16-17 year-olds by sex

Sex	Per cent
Males	4.5
Females	6.6
Persons	5.5

Table S-42: Average days absent from school in past 12 months due to symptoms of mental disorders among 16-17 year-olds with mental disorders by type of disorder

Disorder	Average (days)
Social phobia	19
Separation anxiety disorder	41
Generalised anxiety disorder	19
Obsessive-compulsive disorder	15
Any anxiety disorder	24
Major depressive disorder	26
ADHD	8
Conduct disorder	7

Strengths and Difficulties Questionnaire

Table S-43: Prevalence of parent or carer reported Strengths and Difficulties Questionnaire (SDQ) total difficulties score in the abnormal range among 4-17 year-olds by sex and age group

Sex	Age group	Prevalence (%)	Population estimate
Males	4-11 years	11.8	140,000
	12-17 years	12.3	107,000
	4-17 years	12.0	247,000
Females	4-11 years	7.8	88,200
	12-17 years	8.3	68,900
	4-17 years	8.0	157,000
Persons	4-11 years	9.9	228,000
	12-17 years	10.3	176,000
	4-17 years	10.1	404,000

Table S-44: Prevalence of parent or carer reported SDQ scale scores in the abnormal range among 4-17 year-olds by SDQ scale, sex and age group

SDQ scale	Males 4-11 years (%)	Males 12-17 years (%)	Females 4-11 years (%)	Females 12-17 years (%)	Persons 4-17 years (%)
Emotional problems	10.2	13.7	11.8	19.3	13.3
Conduct problems	12.5	11.6	9.5	7.9	10.5
Hyperactivity	19.0	14.9	10.2	6.4	13.0
Peer problems	12.6	16.4	9.6	13.4	12.7
Prosocial behaviour	2.9	4.5	1.9	1.8	2.7
Total difficulties	11.8	12.3	7.8	8.3	10.1

Table S-45: Prevalence of parent or carer reported SDQ scale scores in the abnormal range among 4-17 year-olds by SDQ scale and household income

Household income before tax	Emotional problems	Conduct problems	Hyperactivity	Peer problems	Prosocial behaviour	Total difficulties
\$130,000 or more per year	10.4	7.2	10.8	8.4	2.2	6.4
\$52,000-\$129,999 per year	13.0	9.7	11.4	11.6	2.3	9.0
Less than \$52,000 per year	16.5	15.2	18.2	18.5	4.0	15.2

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

Table S-46: Prevalence of parent or carer reported SDQ scale scores in the abnormal range among 4-17 year-olds by SDQ scale and highest level of education of either primary or secondary parent or carer

Highest level of education of either primary or secondary parent or carer	Emotional problems	Conduct problems	Hyperactivity	Peer problems	Prosocial behaviour	Total difficulties
Bachelor degree or higher	10.1	6.7	10.2	9.2	2.4	6.1
Diploma or certificate III/IV	14.9	12.5	14.2	14.0	2.7	11.8
Year 11 or 12	15.2	13.3	14.8	15.7	2.4	12.2
Year 10 or below	19.0	16.4	19.4	20.1	5.0	18.6

Table S-47: Prevalence of parent or carer reported SDQ scale scores in the abnormal range among 4-17 year-olds by SDQ scale and labour force status of parents or carers

Parent or carer labour force status	Emotional problems	Conduct problems	Hyperactivity	Peer problems	Prosocial behaviour	Total difficulties
Both parents or carers employed	11.2	7.7	10.6	10.2	2.3	7.4
One parent or carer employed, one parent or carer not in employment	13.4	11.6	13.3	12.9	2.3	10.6
Both parents or carers not in employment	17.0	19.6	18.8	17.5	4.9	15.9
Sole parent or carer employed	16.5	11.3	13.5	13.1	3.3	10.8
Sole parent or carer not in employment	20.8	19.8	24.5	25.5	5.2	22.0

Table S-48: Prevalence of parent or carer reported SDQ scale scores in the abnormal range among 4-17 year-olds by SDQ scale and area of residence

Area of residence	Emotional problems	Conduct problems	Hyperactivity	Peer problems	Prosocial behaviour	Total difficulties
Greater capital cities	13.1	9.5	12.7	11.0	2.5	9.5
Rest of state	13.7	12.2	13.7	15.6	3.1	11.1

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

Table S-49: 4-17 year-olds by parent or carer reported SDQ total difficulties score and SDQ impact score

Total Difficulties	SDQ impact — Normal	SDQ impact — Borderline	SDQ impact — Abnormal
Normal	89.4	4.7	5.9
Borderline	39.6	17.5	42.9
Abnormal	16.7	11.2	72.0

K10+ days out of role

Table S-50: Number of days out of role (K10+) among 11-17 year-olds by sex

Days out of role	Males (%)	Females (%)
0 days	75.7	65.6
1 day	7.8	8.3
2 days	5.5	8.7
3 days	3.0	4.8
4 days	2.6	4.6
5-9 days	3.4	5.0
10 or more days	1.9	3.0

Self-harm

Table S-51: Self harm among 12-17 year-olds by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)	Received medical treatment for self-harm in previous 12 months (%)
Males	Total difficulties rating—				
	Normal	4.5	1.5	2.5	np
	Borderline	10.2	5.1	6.3	np
	Abnormal	23.4	11.3	15.1	np
	Subscales in abnormal range—				
	Emotional symptoms	22.5	11.3	16.7	np
	Conduct problems	19.8	8.5	12.5	np
Females	Hyperactivity	9.4	4.4	7.5	np
	Peer problems	32.4	12.0	19.4	np
	Total difficulties rating—				
	Normal	7.2	3.1	5.0	np
	Borderline	27.7	15.0	23.6	np
	Abnormal	46.7	36.4	40.2	6.9
	Subscales in abnormal range—				
	Emotional symptoms	41.4	29.0	36.9	4.8
	Conduct problems	38.7	30.0	36.6	6.9
	Hyperactivity	31.0	21.5	25.1	3.3
	Peer problems	52.2	39.2	46.4	6.9

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-52: Self-harm among 12-17 year-olds by adolescent reported major depressive disorder status and family type

Major depressive disorder status	Family type	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)
Major depressive disorder based on adolescent report	Families with two parents or carers	50.1	37.3	44.7
	Original family	46.3	36.5	40.4
	Step family	55.5	33.1	50.3
	Blended family	66.5	49.8	63.0
	Other family (a)	54.5	np	54.5
	Families with one parent or carer	62.3	42.9	50.3
No major depressive disorder based on adolescent report	Families with two parents or carers	6.4	2.5	4.2
	Original family	5.4	1.8	3.6
	Step family	14.7	7.8	8.0
	Blended family	9.2	4.8	6.3
	Other family (a)	np	np	np
	Families with one parent or carer	8.4	3.6	5.1
All persons	Families with two parents or carers	9.7	5.1	7.3
	Original family	8.0	4.0	5.9
	Step family	21.8	12.2	15.4
	Blended family	13.9	8.4	11.0
	Other family (a)	21.4	15.1	21.4
	Families with one parent or carer	14.9	8.3	10.5

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-53: Self-harm among 12-17 year-olds by adolescent reported major depressive disorder status and household income

Major depressive disorder status	Household income before tax	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)
Major depressive disorder based on adolescent report	\$130,000 or more per year	47.5	38.9	41.9
	\$52,000-\$129,999 per year	51.4	36.1	46.2
	Less than \$52,000 per year	63.7	44.5	52.1
No major depressive disorder based on adolescent report	\$130,000 or more per year	6.1	2.8	4.3
	\$52,000-\$129,999 per year	7.3	2.6	4.5
	Less than \$52,000 per year	7.0	2.6	4.4
All persons	\$130,000 or more per year	8.8	5.2	6.7
	\$52,000-\$129,999 per year	11.0	5.5	8.0
	Less than \$52,000 per year	13.3	7.2	9.7

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

Table S-54: Self-harm among 12-17 year-olds by adolescent reported major depressive disorder status and parent or carer education

Major depressive disorder status	Highest level of education of either primary or secondary parent or carer	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)
Major depressive disorder based on adolescent report	Bachelor degree or higher	48.5	35.7	43.1
	Diploma or certificate III/IV	63.1	46.8	53.9
	Year 11 or 12	59.2	41.9	47.6
	Year 10 or below	36.1	21.8	31.5
No major depressive disorder based on adolescent report	Bachelor degree or higher	6.3	2.4	3.9
	Diploma or certificate III/IV	7.4	2.9	4.5
	Year 11 or 12	5.5	1.9	4.3
	Year 10 or below	8.9	4.8	6.0
All persons	Bachelor degree or higher	9.8	5.1	7.1
	Diploma or certificate III/IV	12.2	6.7	8.8
	Year 11 or 12	9.3	4.7	7.3
	Year 10 or below	12.2	6.9	9.2

Table S-55: Self-harm among 12-17 year-olds by adolescent reported major depressive disorder status and parent or carer labour force status

Major depressive disorder status	Parent or carer labour force status	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)
Major depressive disorder based on adolescent report	Both parents or carers employed	51.7	40.0	45.8
	One parent or carer employed, one parent or carer not in employment	44.7	33.0	37.4
	Both parents or carers not in employment	60.7	np	60.7
	Sole parent or carer employed	59.9	36.4	48.7
	Sole parent or carer not in employment	61.2	50.4	51.5
No major depressive disorder based on adolescent report	Both parents or carers employed	6.5	2.6	4.4
	One parent or carer employed, one parent or carer not in employment	6.4	2.0	4.0
	Both parents or carers not in employment	6.1	np	np
	Sole parent or carer employed	8.2	3.5	4.9
	Sole parent or carer not in employment	7.8	4.0	4.3
All persons	Both parents or carers employed	9.5	5.2	7.2
	One parent or carer employed, one parent or carer not in employment	9.3	4.3	6.4
	Both parents or carers not in employment	14.0	6.7	11.3
	Sole parent or carer employed	14.6	7.6	10.4
	Sole parent or carer not in employment	15.8	11.0	11.4

'Not in employment' combines unemployed and not in the labour force.

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-56: Self-harm among 12-17 year-olds by adolescent reported major depressive disorder status and area of residence

Major depressive disorder status	Area of residence	Self-harm ever (%)	Self-harm 4 or more times (%)	Self-harm in previous 12 months (%)
Major depressive disorder based on adolescent report	Greater capital cities	51.5	37.7	45.4
	Rest of state	58.7	41.8	48.6
No major depressive disorder based on adolescent report	Greater capital cities	6.7	2.5	4.3
	Rest of state	7.0	3.2	4.4
All persons	Greater capital cities	10.7	5.6	8.0
	Rest of state	11.2	6.3	8.1

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

Suicidal behaviours

Table S-57: Suicide ideation, suicide plans and suicide attempts among 12-17 year-olds by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Suicidal ideation past 12 months (%)	Suicide plan past 12 months (%)	Suicide attempt in past 12 months (%)
Males	Total difficulties rating—			
	Normal	2.6	1.4	0.6
	Borderline	8.9	6.0	3.6
	Abnormal	15.5	12.6	6.4
	Subscales in abnormal range—			
	Emotional symptoms	17.0	16.3	9.7
	Conduct problems	15.3	11.1	5.1
Females	Hyperactivity	9.7	7.4	3.1
	Peer problems	16.5	14.0	7.8
	Total difficulties rating—			
	Normal	4.5	2.8	0.8
	Borderline	18.8	13.4	3.1
	Abnormal	36.3	28.1	18.3
	Subscales in abnormal range—			
	Emotional symptoms	33.4	25.9	13.7
	Conduct problems	33.2	28.4	19.2
	Hyperactivity	19.5	15.6	8.0
	Peer problems	39.8	34.4	19.4

Table S-58: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds by adolescent reported major depressive disorder status and family type

Major depressive disorder status	Family type	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Major depressive disorder based on adolescent report	Families with two parents or carers	47.0	37.4	17.4
	Original family	46.9	36.5	16.1
	Step family	36.8	34.1	np
	Blended family	68.5	54.9	np
	Other family (a)	np	np	np
	Families with one parent or carer	52.0	44.5	24.6
No major depressive disorder based on adolescent report	Families with two parents or carers	3.6	2.0	0.7
	Original family	3.5	1.9	0.7
	Step family	5.1	np	np
	Blended family	3.9	np	np
	Other family (a)	np	np	np
	Families with one parent or carer	3.6	1.7	1.0
All persons	Families with two parents or carers	6.9	4.7	2.0
	Original family	6.3	4.1	1.7
	Step family	10.7	8.0	3.4
	Blended family	9.2	6.6	3.4
	Other family (a)	12.7	np	np
	Families with one parent or carer	9.5	6.8	3.8

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

np Not available for publication because of small cell size, but included in totals where applicable.

210 The Mental Health of Children and Adolescents**Table S-59: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds by adolescent reported major depressive disorder status and household income**

Major depressive disorder status	Household income before tax	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Major depressive disorder based on adolescent report	\$130,000 or more per year	47.1	37.3	8.7
	\$52,000-\$129,999 per year	46.7	37.5	19.1
	Less than \$52,000 per year	56.8	47.8	28.6
No major depressive disorder based on adolescent report	\$130,000 or more per year	3.0	1.8	0.4
	\$52,000-\$129,999 per year	3.9	1.9	0.7
	Less than \$52,000 per year	4.2	2.3	1.4
All persons	\$130,000 or more per year	5.9	4.1	1.0
	\$52,000-\$129,999 per year	7.5	4.9	2.3
	Less than \$52,000 per year	10.0	7.3	4.4

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

Table S-60: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds by adolescent reported major depressive disorder status and parent or carer education

Major depressive disorder status	Highest level of education of either primary or secondary parent or carer	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Major depressive disorder based on adolescent report	Bachelor degree or higher	43.6	31.8	14.3
	Diploma or certificate III/IV	54.7	47.0	20.6
	Year 11 or 12	44.0	41.5	25.8
	Year 10 or below	47.3	37.6	27.3
No major depressive disorder based on adolescent report	Bachelor degree or higher	3.3	1.9	0.7
	Diploma or certificate III/IV	3.4	1.2	0.7
	Year 11 or 12	3.8	2.9	np
	Year 10 or below	6.1	3.8	np
All persons	Bachelor degree or higher	6.6	4.4	1.8
	Diploma or certificate III/IV	7.9	5.2	2.4
	Year 11 or 12	6.6	5.7	2.3
	Year 10 or below	11.2	8.0	5.3

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-61: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds by adolescent reported major depressive disorder status and parent or carer labour force status

Major depressive disorder status	Parent or carer labour force status	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Major depressive disorder based on adolescent report	Both parents or carers employed	49.6	39.3	17.1
	One parent or carer employed, one parent or carer not in employment	35.8	29.9	12.4
	Both parents or carers not in employment	75.1	68.2	55.2
	Sole parent or carer employed	51.7	38.8	21.8
	Sole parent or carer not in employment	46.8	44.5	20.6
No major depressive disorder based on adolescent report	Both parents or carers employed	3.2	1.9	0.6
	One parent or carer employed, one parent or carer not in employment	5.2	2.1	1.3
	Both parents or carers not in employment	5.3	np	np
	Sole parent or carer employed	1.9	1.2	np
	Sole parent or carer not in employment	5.7	np	np
All persons	Both parents or carers employed	6.3	4.4	1.7
	One parent or carer employed, one parent or carer not in employment	7.5	4.1	2.1
	Both parents or carers not in employment	15.3	12.6	7.9
	Sole parent or carer employed	8.1	5.9	3.1
	Sole parent or carer not in employment	11.9	9.0	5.0

‘Not in employment’ combines unemployed and not in the labour force.
 np Not available for publication because of small cell size, but included in totals where applicable.

Table S-62: Suicidal ideation, suicide plans and suicide attempts among 12-17 year-olds by adolescent reported major depressive disorder status and area of residence

Major depressive disorder status	Area of residence	Suicidal ideation (%)	Suicide plan (%)	Suicide attempt (%)
Major depressive disorder based on adolescent report	Greater capital cities	46.3	34.9	16.3
	Rest of state	52.8	48.5	25.9
No major depressive disorder based on adolescent report	Greater capital cities	3.3	1.7	0.8
	Rest of state	4.2	2.3	0.8
All persons	Greater capital cities	7.1	4.7	2.2
	Rest of state	8.2	6.0	2.8

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

Smoking, alcohol, and cannabis use and sexual behaviours by Strengths and Difficulties Questionnaire scales

Table S-63: Smoking among 13-17 year-olds by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Ever smoked at least once a week (%)	Smoked in last 30 days (%)
Males	Total difficulties rating—		
	Normal	7.2	5.2
	Borderline	14.2	9.6
	Abnormal	13.5	10.4
	Subscales in abnormal range—		
	Emotional symptoms	8.9	8.9
	Conduct problems	23.5	15.4
Females	Hyperactivity	15.5	11.3
	Peer problems	np	np
	Total difficulties rating—		
	Normal	6.0	3.5
	Borderline	12.5	10.6
	Abnormal	35.6	28.9
	Subscales in abnormal range—		
	Emotional symptoms	23.3	18.9
	Conduct problems	37.1	30.1
	Hyperactivity	24.1	18.2
	Peer problems	30.0	25.9

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-64: Alcohol consumption among 13-17 year-olds by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Ever drunk alcohol (%)	Drunk alcohol in last 30 days (%)	More than 4 drinks in a row in last 30 days (%)
Males	Total difficulties rating—			
	Normal	35.7	17.1	11.9
	Borderline	42.7	20.0	13.9
	Abnormal	41.4	21.9	17.6
	Subscales in abnormal range—			
	Emotional symptoms	34.7	14.8	9.6
	Conduct problems	50.7	28.2	22.8
Females	Hyperactivity	45.9	24.2	16.0
	Peer problems	31.6	13.4	7.8
	Total difficulties rating—			
	Normal	33.5	14.5	9.4
	Borderline	42.5	23.7	17.6
	Abnormal	60.3	31.2	22.3
	Subscales in abnormal range—			
	Emotional symptoms	53.9	27.2	20.5
	Conduct problems	63.4	34.9	25.7
	Hyperactivity	52.0	26.8	18.8
	Peer problems	51.6	23.0	14.2

Table S-65: Cannabis and other drug use among 13-17 year-olds by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Ever used cannabis (%)	Used cannabis in last 30 days (%)	Ever used other drugs (%)	Used other drugs in last 30 days (%)
Males	Total difficulties rating—				
	Normal	10.1	4.0	2.7	0.5
	Borderline	15.7	8.9	7.4	np
	Abnormal	25.2	14.6	9.6	4.3
	Subscales in abnormal range—				
	Emotional symptoms	18.3	7.8	7.2	np
	Conduct problems	28.1	21.2	13.6	5.0
Females	Hyperactivity	21.8	12.4	8.2	3.4
	Peer problems	12.5	np	np	np
	Total difficulties rating—				
	Normal	7.6	2.1	2.3	0.7
	Borderline	11.0	6.4	7.2	5.5
	Abnormal	28.3	13.6	17.3	5.7
	Subscales in abnormal range—				
	Emotional symptoms	21.6	9.0	11.1	4.0
	Conduct problems	30.9	12.0	20.3	6.2
	Hyperactivity	20.2	9.9	14.8	7.4
	Peer problems	21.4	9.9	11.1	np

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-66: Sexual behaviours among 13-17 year-olds by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Ever had sexual intercourse (%)	Had sexual intercourse with 4 or more persons (%)
Males	Total difficulties rating—		
	Normal	12.6	3.2
	Borderline	14.1	8.2
	Abnormal	17.5	8.3
	Subscales in abnormal range—		
	Emotional symptoms	18.2	5.7
	Conduct problems	17.5	11.0
	Hyperactivity	14.6	7.5
Females	Peer problems	13.4	np
	Total difficulties rating—		
	Normal	12.5	2.1
	Borderline	18.2	3.8
	Abnormal	35.6	14.3
	Subscales in abnormal range—		
	Emotional symptoms	29.8	8.9
	Conduct problems	31.9	16.0
	Hyperactivity	24.4	10.1
	Peer problems	33.0	15.5

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-67: Use of protection during last sexual intercourse or consumption of alcohol or drugs prior to last sexual intercourse among 13-17 year-olds who have ever had sexual intercourse by sex and adolescent self-reported SDQ rating

Sex	SDQ scale rating and subscales	Used a condom (%)	Used birth control pills (%)	Did not use any method to prevent pregnancy or sexually transmitted infections (%)	Drank alcohol or used drugs (%)
Males	Total difficulties rating—				
	Normal	76.8	31.9	7.5	21.1
	Borderline	47.1	26.5	24.7	37.8
	Abnormal	49.9	44.9	np	49.2
	Subscales in abnormal range—				
	Emotional symptoms	53.8	41.0	np	42.6
	Conduct problems	45.9	26.4	24.3	45.9
Females	Hyperactivity	51.4	30.0	16.6	43.6
	Peer problems	np	np	np	57.6
	Total difficulties rating—				
	Normal	69.3	41.9	11.1	15.4
	Borderline	64.4	54.6	np	25.4
	Abnormal	51.0	47.5	13.8	30.8
	Subscales in abnormal range—				
	Emotional symptoms	50.1	47.9	15.3	25.7
	Conduct problems	47.1	34.2	23.9	32.7
	Hyperactivity	61.1	43.1	22.3	37.4
	Peer problems	35.7	38.6	19.1	20.7

np Not available for publication because of small cell size, but included in totals where applicable.

Problem eating behaviours

Table S-68: Problem eating behaviours and weight control behaviours in the past 12 months among 11-17 year-olds by sex and age group

Age group	Eating behaviour	Males (%)	Females (%)	Persons (%)
11-15 years	Went on a diet to control weight	20.7	31.7	25.9
	Went on an eating binge	23.2	25.7	24.4
	Went on an eating binge, at least once a week	3.4	4.3	3.8
	Regularly exercised when supposed to be doing other things, or while injured, in order to control weight	35.8	39.1	37.3
	Fasted for at least a day to control weight	12.4	15.4	13.8
	Fasted for at least a day to control weight, at least once a week	4.1	5.3	4.7
	Vomited to control weight	3.4	4.5	3.9
	Vomited to control weight, at least once a week	0.7	1.2	0.9
	Took laxatives to control weight	2.9	2.7	2.8
	Took laxatives to control weight, at least once a week	0.7	1.0	0.9
	Vomited or took laxatives to control weight	5.5	6.1	5.8
	Vomited or took laxatives to control weight, at least once a week	1.3	1.8	1.5
	Low weight problem eating behaviours	0.8	1.3	1.1
	Binge eating and purging problem eating behaviours	1.0	1.1	1.0
16-17 years	Went on a diet to control weight	15.2	45.1	30.6
	Went on an eating binge	35.1	37.8	36.5
	Went on an eating binge, at least once a week	6.7	10.0	8.4
	Regularly exercised when supposed to be doing other things, or while injured, in order to control weight	28.4	38.9	33.8
	Fasted for at least a day to control weight	9.9	24.5	17.4
	Fasted for at least a day to control weight, at least once a week	1.8	7.6	4.8
	Vomited to control weight	1.7	10.8	6.4
	Vomited to control weight, at least once a week	np	3.0	1.9
	Took laxatives to control weight	1.6	5.3	3.5
	Took laxatives to control weight, at least once a week	np	1.9	1.3
	Vomited or took laxatives to control weight	2.3	13.5	8.1

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Age group	Eating behaviour	Males (%)	Females (%)	Persons (%)
	Vomited or took laxatives to control weight, at least once a week	1.0	4.7	2.9
	Low weight problem eating behaviours	np	2.0	1.1
	Binge eating and purging problem eating behaviours	np	3.0	1.8
11-17 years	Went on a diet to control weight	19.2	35.8	27.2
	Went on an eating binge	26.5	29.4	27.9
	Went on an eating binge, at least once a week	4.3	6.0	5.1
	Regularly exercised when supposed to be doing other things, or while injured, in order to control weight	33.7	39.0	36.3
	Fasted for at least a day to control weight	11.7	18.2	14.9
	Fasted for at least a day to control weight, at least once a week	3.5	6.0	4.7
	Vomited to control weight	3.0	6.4	4.6
	Vomited to control weight, at least once a week	0.7	1.8	1.2
	Took laxatives to control weight	2.5	3.5	3.0
	Took laxatives to control weight, at least once a week	0.7	1.3	1.0
	Vomited or took laxatives to control weight	4.6	8.4	6.5
	Vomited or took laxatives to control weight, at least once a week	1.2	2.7	1.9
	Low weight problem eating behaviours	0.7	1.5	1.1
	Binge eating and purging problem eating behaviours	0.9	1.7	1.3

np Not available for publication because of small cell size, but included in totals where applicable.

Bullying

Table S-69: Frequency of bullying in previous 12 months in 11-17 year-olds by sex and age group

Age group	Frequency of bullying	Males (%)	Females (%)	Persons (%)
11-15 years	I was not bullied in the last 12 months	65.8	60.2	63.2
	Once or twice in the last 12 months	19.9	20.3	20.1
	I was bullied every few months	4.6	6.7	5.6
	I was bullied every few weeks	3.0	4.7	3.8
	I was bullied about once a week	2.9	2.6	2.8
	I was bullied most days	3.8	5.4	4.6
16-17 years	I was not bullied in the last 12 months	75.3	68.9	72.0
	Once or twice in the last 12 months	14.4	18.7	16.6
	I was bullied every few months	3.8	4.6	4.2
	I was bullied every few weeks	2.9	2.6	2.7
	I was bullied about once a week	1.1	2.4	1.8
	I was bullied most days	2.5	2.7	2.6
11-17 years	I was not bullied in the last 12 months	68.4	62.9	65.7
	Once or twice in the last 12 months	18.4	19.8	19.1
	I was bullied every few months	4.4	6.0	5.2
	I was bullied every few weeks	3.0	4.1	3.5
	I was bullied about once a week	2.4	2.6	2.5
	I was bullied most days	3.5	4.6	4.0

Internet use and electronic games

Table S-70: Time spent using the internet or playing electronic games among 11-17 year-olds by sex and age group

Sex	Age group	Average time spent per day	Internet use on weekdays (%)	Internet use on weekends (%)	Electronic games on weekdays (%)	Electronic games on weekends (%)
Males	11-15 years	Doesn't use	1.2	1.2	3.7	3.7
		1-2 hours	52.8	41.2	64.6	40.8
		3-4 hours	23.0	27.2	16.1	27.6
		5-8 hours	13.8	20.0	11.0	19.7
		9 hours or more	9.1	10.4	4.5	8.2
	16-17 years	Doesn't use	np	np	9.4	9.4
		1-2 hours	33.4	29.1	62.6	43.2
		3-4 hours	27.9	21.6	15.2	23.0
		5-8 hours	22.0	31.8	9.8	17.5
		9 hours or more	16.1	16.9	3.0	6.9
Females	11-15 years	Doesn't use	1.5	1.5	19.0	19.0
		1-2 hours	52.5	42.6	67.1	59.7
		3-4 hours	22.6	25.5	9.9	14.6
		5-8 hours	16.5	20.9	3.0	5.4
		9 hours or more	6.9	9.5	1.0	1.3
	16-17 years	Doesn't use	np	np	37.6	37.6
		1-2 hours	27.5	22.8	54.1	47.5
		3-4 hours	32.1	27.8	4.9	8.5
		5-8 hours	25.2	31.5	2.7	4.6
		9 hours or more	15.0	17.6	np	1.8
Persons	11-15 years	Doesn't use	1.3	1.3	11.0	11.0
		1-2 hours	52.7	41.9	65.8	49.7
		3-4 hours	22.8	26.4	13.2	21.5
		5-8 hours	15.1	20.4	7.2	12.9
		9 hours or more	8.1	10.0	2.8	4.9
	16-17 years	Doesn't use	0.4	0.4	23.9	23.9
		1-2 hours	30.3	25.9	58.2	45.4
		3-4 hours	30.0	24.8	9.9	15.6
		5-8 hours	23.7	31.7	6.1	10.8
		9 hours or more	15.5	17.3	1.8	4.2

np Not available for publication because of small cell size, but included in totals where applicable.

Table S-71: Problem internet or electronic gaming behaviours among 11-17 year-olds by sex and age group

Age group	Indicators of problem behaviour related to internet use or electronic gaming	Males (%)	Females (%)	Persons (%)
11-15 years	Went without eating or sleeping	5.2	4.8	5.0
	Feel bothered when not doing	22.0	18.2	20.2
	Use when not really interested	29.0	26.3	27.7
	Spent less time than should with family or friends, doing school work or work	20.1	16.9	18.6
	Tried unsuccessfully to spend less time	25.2	24.3	24.8
	Problem internet or electronic gaming behaviours	3.5	3.0	3.3
16-17 years	Went without eating or sleeping	8.4	7.7	8.1
	Feel bothered when not doing	20.2	23.4	21.8
	Use when not really interested	39.6	44.8	42.3
	Spent less time than should with family or friends, doing school work or work	24.5	32.8	28.8
	Tried unsuccessfully to spend less time	17.6	22.7	20.2
	Problem internet or electronic gaming behaviours	4.4	6.5	5.5
11-17 years	Went without eating or sleeping	6.1	5.7	5.9
	Feel bothered when not doing	21.5	19.8	20.7
	Use when not really interested	31.9	32.0	32.0
	Spent less time than should with family or friends, doing school work or work	21.3	21.8	21.6
	Tried unsuccessfully to spend less time	23.1	23.8	23.5
	Problem internet or electronic gaming behaviours	3.8	4.1	3.9

Table S-72: Problem internet use or electronic gaming behaviours among 11-17 year-olds by sex and adolescent self-reported SDQ rating

SDQ scale rating and subscales	Males (%)	Females (%)	Persons (%)
Total difficulties rating—			
Normal	2.0	2.2	2.1
Borderline	7.3	6.6	7.0
Abnormal	14.3	12.9	13.5
Subscales in abnormal range—			
Emotional symptoms	16.8	12.2	13.4
Conduct problems	11.3	12.3	11.8
Hyperactivity	11.6	10.7	11.2
Peer problems	6.7	10.8	9.1

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