Chapter 5 Mental health

Key statistics at a glance

**Emotional well-being**

- In 2008, the majority of children aged 8–9 years reported feeling happy a lot of the time.
  - A greater proportion of female children reported these feelings compared with male children.
- In 2007, almost all 16–17 year olds reported feeling happy or very happy with their lives as a whole.
  - The areas where these children felt less happy were in the work they do at study, home or in a job, their career prospects, and the money they get each week.

**Psychological distress**

- In 2008, 13.3% of 12–17 year old school students had experienced high levels of psychological distress in the last six months.
- A substantial number of school students aged 12–17 years who experienced distress did not talk to anyone about how they felt. When they did, most talked to family or friends; rarely did they seek support from a helpline or the internet.
  - A higher proportion of male students than female students did not talk to anyone about how they felt.
- Over the 12 year period to 2008 the proportion of 12–17 year old school students who had experienced high psychological distress in the last six months decreased significantly.

**Behaviour difficulties**

- In 2007–2008, fewer than 1 in 10 children aged 4–15 years were at risk of developing a clinically significant behavioural problem.
  - A higher proportion of male than female children were at risk.
- There was no significant change in the proportion of 4–15 year olds at risk between 2003–2004 and 2007–2008.

**Mental health disorders**
n In 2007, just under a quarter of children aged 16–17 years had a lifetime mental health disorder.

**Intentional self-harm**

n In 2009–2010, intentional self-harm resulted in 801 admissions to hospital for children aged 15–17 years, or 2.84 in every 1,000 children in that age group.

n Admission rates were 3–4 times greater among female children compared with male children.


**Suicide death**

n Over the period 1996–2010, 264 children aged 12–17 years died by suicide, or approximately 0.03 in every 1,000 children in that age group.

n Over the period 1996–2009:

n Male children were almost twice as likely to die by suicide compared with female children.

n Children aged 14–15 years and 16–17 years were significantly more likely to die by suicide compared with 12–13 year olds.

n The suicide mortality rate among Aboriginal children was not statistically different to non-Aboriginal children.

n Suicide mortality rates have been mostly constant since 1998.

**Introduction**

Mental health is a state of well-being in which individuals can realise their abilities, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community (WHO 2001). Conversely, mental health problems can affect perceptions, emotions, behaviour and social well-being. Mental disorders, as distinct from mental health problems, are characterised by a clinically recognisable set of symptoms or behaviours that interfere substantially with social, academic or occupational functioning (AIHW, 2009).

Multiple surveys confirm that up to 20 per cent of children and adolescents may have at least one
clinically significant mental health problem in a 12 month period (WHO, 2005), indicating that the prevalence of problems is as great as for adults. Mental health is one of the leading causes of non-fatal disease and injury in Australia (AIHW, 2011).

Children’s mental health plays a critical role in their physical, social and emotional well-being. It influences their ability to cope with change, adversity and stress (ARACY, 2008; Muir, et al., 2009; Sawyer, Miller-Lewis, & Clark, 2007).

Long-term mental health problems can place children at future risk of health and social problems, such as substance abuse (Smart & Sanson, 2005), long-term physical health problems (ABS, 2006b), exclusion from education and employment, and unstable housing (ABS, 2006a; Bassett, Lloyd, & King, 2003; Folsom & Jeste, 2002). Poor mental health is also a predecessor to self-harm and suicide as well as having a strong influence on later mental health disorders (Patel et al. 2007 cited in AIHW, 2008).

Good mental health is a priority area for all governments with the Fourth National Mental Health Plan (2009–2014) setting an agenda for collaborative government action in mental health for the next five years (Australian Government, 2009). There are currently a number of initiatives at both a Commonwealth and state level to improve policy and service responses to mental illness. There are three major Commonwealth initiatives.

The National Mental Health Strategy is a national commitment by Australian and State and Territory governments to improve the lives of people with a mental illness. It provides a framework for national reform from an institutionally based mental health system to one that is consumer focused with an emphasis on supporting the individual in their community. The framework of policies, actions and resources to achieve the aims of the Strategy are contained within the National Mental Health Policy 2008; the Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009–2014; and Mental Health Statement of Rights and Responsibilities. The Fourth National Mental Health Plan contains actions that relate to young people, under Priority Area 2: Prevention and Early Intervention.

The second imitative is the National Mental Health Commission which was established in January 2012. The role of the Commission is to:

- manage and administer the Annual National Report Card on Mental Health and Suicide Prevention
- monitor and report on the performance of the mental health system, including through ongoing evaluation of the Ten Year Roadmap for Mental Health Reform which is currently being developed
develop, collate and analyse data and reports from other sources including Commonwealth agencies reporting on progress – with a particular focus on ensuring a cross sectoral perspective is taken to mental health reform

provide mental health policy advice to Government in consultation with relevant agencies

engage consumers and carers in mental health policy and service improvements.

The third initiative is the *Youth Mental Health Initiative – Headspace*, specifically targeted at young people. *Headspace* aims to deliver youth-friendly mental health services for young people aged 12–25 years. Funded by the Australian Government, *Headspace* centres operate across NSW and offer health advice, support and information for young people. The centres are staffed by general practitioners, allied health, youth health and drug and alcohol workers who have specific expertise in working with young people.

There are two major initiatives at a state level. The NSW Government has established the Mental Health Commission in July 2012. This Commission will ensure that there is quarantined funding for mental health expenditure and that resources are directed to the most appropriate models of care. Other priorities for the Commission include: better managing the experience of mental health patients and carers; diverting mental health patients away from the prison system; and supporting the operation of the Mental Health Review Tribunal.

The second initiative is the *Youth Health Policy 2011–2016: Healthy bodies, healthy minds, vibrant futures*. This policy provides a guide for the NSW health system to encourage and support young people to achieve optimal health and well-being. Mental health is a focus area within the policy document.

The measurement of mental health is complex. There are a number of definitional and methodological problems associated with measuring these problems as these are subjective states and vary across time, cultures and groups of children (ARACY, 2008 and DEECD, 2009). The absence of mental illness cannot be diagnosed clinically. As a result, this chapter explores psychological distress, mental health disorders, self-harming behaviour and suicide deaths, and feelings of well-being among children. It paints a mixed picture of the mental health of the children in NSW. Some population groups, such as Aboriginal people, people who are homeless, refugees and those from low socioeconomic backgrounds are recognised as being at heightened risk of mental health problems (Australian Health Ministers, 2009:14). The limited data available on these risk factors means it is difficult to report on them.

The data presented here are drawn from existing collections and established state, national or international measures are reported. Some additional information is presented to fill data gaps identified through the work of the NSW Commission for Children and Young People.
The information is provided as a resource for policy and research professionals working in both government and non-government settings who may or may not have detailed knowledge about children’s mental health. Since the purpose of reporting on this data is to help inform the development of policy and service delivery responses, a deficit approach is taken in preference to a strengths-based one. While deficit measures miss the positive aspects of children’s lives, such reporting is intended to assist policy makers to target their efforts at addressing both equity and efficiency concerns.

**Emotional well-being**

Measurement of emotional and social well-being is a national priority and is one of the key areas for indicator development in Australia (AIHW, 2010).

Emotional well-being for children comprises a number of domains, in particular, the individual (incorporating self-esteem, anxiety, etc.) and the environmental (incorporating social relations) (ARACY and AIHW, 2010).

Emotional development includes skills that children need to develop in order to succeed. These skills form the basis for self-regulation, enabling children to withstand impulses, maintain focus and undertake tasks regardless of competing interests (AIHW, 2009).

The *Longitudinal Study of Australian Children* (LSAC) and the *Longitudinal Survey of Australian Youth* (LSAY) collect information on the emotional well-being of children in NSW. The collections currently provide the best source of data in this area.

The LSAC collects a range of information about children and their families, including children’s academic ability, their health and emotional well-being, parenting, family functioning, early childhood care, and education and schooling. LSAY is a program of annual surveys of young people that focus on their education and labour market experiences, beginning from their middle years of secondary schooling.

The LSAC and LSAY, as with any survey, are subject to error. The limitations of these surveys include non-sampling and sampling errors. The reader should keep these limitations in mind when interpreting the data. More information is in Appendix 1: Key survey sources and data reports.

**Results from the Longitudinal Study of Australian Children (LSAC)**

Children aged 8–9 years participating in the LSAC in 2008 were asked: ‘How often do you get
scared or worried?', ‘How often do you feel happy?', ‘How often do you feel sad?', and ‘How often do you get angry or mad?’

Almost two in three 8–9 year olds (64.8%) in NSW reported feeling happy a lot of the time, and one in twenty reported feeling scared or worried, or sad a lot of the time (5.1% and 5.7%). A higher proportion reported feeling angry or mad a lot of the time (12.7%) (Table A5.1 (XLSX 244.8KB)).

Self-reported emotions differed by sex. A greater proportion of female children aged 8–9 years reported feeling happy a lot of the time compared with male children (70.0% compared with 59.9%). Similarly, a greater proportion of male children aged 8–9 years reported feeling angry or mad a lot of the time compared with female children (17.1% compared with 8.1%).

There was very little difference between the proportion of male and female children who reported feeling scared or worried, or sad (5.4% compared with 4.9%, and 5.5% compared with 5.9% respectively) (Figure 5.1) (Table A5.1 (XLSX 244.8KB)).

**Figure 5.1: Children 8–9 years self-reported well-being, NSW, 2008**

![Bar chart showing self-reported well-being among children 8–9 years, with higher percentage of females reporting feeling happy and males reporting feeling angry or mad.](source)

Source: Social Policy Research Centre, UNSW calculations based on LSAC 2008, Wave 3 data (Table A5.1 (XLSX 244.8KB)).

**Results from the Longitudinal Survey of Australian Youth (LSAY)**

In 2007, a telephone survey of children aged 16–17 years participating in LSAY asked: ‘I am going
to read out a list of different aspects of your life. As I read them tell me whether you are very happy, happy, unhappy, or very unhappy for each one: The work you do, at study, at home or in a job; What you do in your spare time; How you get on with people in general; The money you get each week; Your social life; Your independence – being able to do what you want; Your career prospects; Your future; Your life at home; Your standard of living; Where you live; and, Your life as a whole’.

Almost all 16–17 year olds reported feeling happy or very happy with their lives as a whole (98.6%). The areas where 16–17 year olds felt less happy were the work they do at study, home or in a job; their career prospects; and the money they get each week (Figure 5.2) (Table A5.2 (XLSX 244.8KB)).

Figure 5.2: Children aged 16–17 years who are very happy or happy with their life, NSW, 2007

Source: Social Policy Research Centre, UNSW calculations based on LSAY 2007, 2006 Cohort, Wave 2 data (Table A5.2 (XLSX 244.8KB)).

Psychological distress

Psychological distress is an indicator of an individual’s emotional state. High levels of psychological distress may also be indicative of a mental health issue, such as anxiety or mood disorders or situational stress, and has been associated with poor performance, behavioural problems and increased rates of alcohol, tobacco and substance use (Centre for Epidemiology and Research, 2009). Various tools exist to measure psychological distress, although the
The prevalence of psychological distress is a key national and international indicator of mental health (AIHW, 2010).

The NSW School Students Health Behaviours Survey (SSHBS) provides a reliable source of information including the psychological distress of NSW high school students aged 12–17 years and the demographic characteristics of these children. Characteristics of ongoing interest include Aboriginal children and children with a disability. The SSHBS does not collect information on children with a disability. While it collects information on Aboriginal children the small sample size limits regular reporting of Aboriginal children separately to non-Aboriginal children.

The survey covers three components of psychological distress, developed in NSW from a single question on stress in the Western Australian Child Health Survey. The three components are: feeling unhappy, sad or depressed during the last six months; feeling nervous, stressed or under pressure during the last six months; and being in trouble because of your behaviour during the last six months. The response options available to students were: almost more than I could take; quite bad; worse than usual; and about usual. Students were asked about any times this had occurred, whether it happened at home or school, about the severity, and any actions taken to solve the problem or people talked to about the problem.

Since 2008, an additional question about study problems that affected school performance in the last six months has also been asked.

The SSHBS, as with any survey, is subject to error. The limitations of this survey include non-sampling and sampling errors. The reader should keep these limitations in mind when interpreting the data. More information is in Appendix 1: Key survey sources and data reports.
Students who responded ‘almost more than I can take’ to one or more of the three components of psychological distress, were considered to experience high psychological distress.

In 2008, 13.3 per cent of students aged 12–17 years experienced high levels of psychological distress in the last six months (Table A5.3 (XLSX 244.8KB)).

When the statistical significance of age, sex, socioeconomic disadvantage and geographic location are considered:

- No difference was found between age groups and between students living in urban and rural health areas.
- A lower proportion of male students experienced high psychological distress compared with female students (11.6% and 15.0%).
- A lower proportion of children living in areas in the least socioeconomically disadvantaged group[1] (11.2%) and a significantly higher proportion of children in the most socioeconomically disadvantaged areas (14.9%) experienced high psychological distress in the last six months compared with the overall NSW population of students aged 12–17 years (13.3%) (Centre for Epidemiology and Research, 2009:63) (Figure 5.3) (Table A5.3 (XLSX 244.8KB)).

Figure 5.3: Students aged 12–17 years experiencing high psychological distress by socioeconomic status, NSW, 2008
In the 12 years to 2008 the proportion of students who experienced high psychological distress in the last six months decreased significantly (15.4% to 13.3%). The decrease has been especially significant in students aged 16–17 years (17.3% to 14.0%) (Centre for Epidemiology and Research, 2009:63) (Figure 5.4) (Table A5.5 (XLSX 244.8KB)).

Source: NSW School Students Health Behaviours Survey 2008 (HOIST). Centre for Epidemiology and Research, NSW Department of Health (Table A5.3 (XLSX 244.8KB)).

Figure 5.4: Students aged 12–17 years with high psychological distress in the last six months by age, year and sex, NSW, 1996–2008
Unhappiness, sadness and depression

In 2008, one-third of students aged 12–17 years (36.4%) had not experienced feelings of unhappiness, sadness or depression in the last six months. Twenty-eight per cent experienced ‘about usual’ feelings, 14.6 per cent ‘worse than usual’ feelings, 12.5 per cent ‘quite bad’ feelings, and 8.2 per cent experienced levels of feelings that were ‘almost more than I could take’ (Table A5.6 (XLSX 244.8KB)).

Similar to rates of psychological distress, the incidence of feelings of unhappiness, sadness or depression increased with age. In 2008, 40.3 per cent of 12–15 year olds experienced no unhappiness, sadness or depression in the previous six months compared with just over a quarter of 16–17 year olds (26.6%) (Table A5.6 (XLSX 244.8KB)). This is consistent with literature which finds that the first onset of major depressive disorders often occurs in mid-to-late adolescence (DoHAC and AIHW, 1999).

A greater proportion of 16–17 year olds experienced levels of unhappiness, sadness or depression that were ‘quite bad’ or ‘almost more than I can take’ compared with 12–15 year olds (15.5% and 8.8% compared with 11.3% and 7.9%) (Table A5.6 (XLSX 244.8KB)).

A smaller proportion of female students experienced no unhappiness, sadness or depression in the six months prior to the survey compared with male students (26.9% compared with 45.9%).
A greater proportion of female students compared with male students felt ‘quite bad’ or levels of feelings that were ‘almost more than I could take’ (14.2% and 9.4%; 10.8% and 7.0% respectively) (Table A5.6 (XLSX 244.8KB)).

**Nervousness, stress and pressure**

In 2008, 29.8 per cent of high school students aged 12–17 years had not experienced feelings of nervousness, stress or pressure in the last six months. Thirty-five per cent had experienced ‘about usual’ feelings, 15.4 per cent ‘worse than usual’ feelings, 14.0 per cent ‘quite bad’ feelings, and 6.2 per cent experienced levels of feelings that were ‘almost more than I could take’ (Table A5.7 (XLSX 244.8KB)).

Of 12–15 year olds, 34.7 per cent experienced no nervousness, stress or pressure compared with 17.0 per cent of 16–17 year olds. A greater proportion of older students (16–17 year olds) felt ‘quite bad’ or ‘almost more than I could take’ levels of nervousness, stress or pressure compared with younger students (18.8% and 12.1%; 8.1% and 5.5% respectively) (Table A5.7 (XLSX 244.8KB)).

A smaller proportion of female students experienced no nervousness, stress or pressure in the six months prior to the survey compared with male students (21.4% and 38.1%). Consistent with this, a greater proportion of female students compared with male students felt ‘quite bad’ or levels of feelings that were ‘almost more that I could take’ (23.6% and 16.9%) (Table A5.7 (XLSX 244.8KB)).

**Study problems**

In 2008, children aged 12–17 years in high school were asked: ‘During the last six months was there a time when you had a problem at home or school that affected your performance in school tests and other work?’

Nearly 60 per cent (59.3%) of 12–17 year olds had no problems at home or school that affected their school performance in the last six months. Twenty per cent had experienced ‘about usual’ levels of problems that affected their school performance, 9.7 per cent ‘worse than usual’ levels, 8.4 per cent ‘quite bad’ levels, and 2.9 per cent experienced levels that were ‘almost more than I could take’ (Table A5.8 (XLSX 244.8KB)).

The age and gender patterns noted previously persisted. A greater proportion of older students (16–17 year olds) felt ‘quite bad’ or ‘almost more than I could take’ compared with younger students (11.5% and 7.2%; 4.5% and 2.3% respectively) (Table A5.8 (XLSX 244.8KB)).
A smaller proportion of female students experienced no study problems at home or school that affected their performance at school in the last six months compared with male students (55.5% and 62.9% respectively). Consistent with this, a greater proportion of female students compared with male students felt ‘quite bad’ or levels of feelings that were ‘almost more that I could take’ (12.3% and 10.4%) (Table A5.8 (XLSX 244.8KB)).

In trouble because of behaviour

In 2008, 43.0 per cent of students aged 12–17 years had not been in trouble because of their behaviour in the last six months. Thirty-six per cent who had been in trouble ‘about usual’, 9.2 per cent ‘worse than usual’, 8.7 per cent ‘quite bad’, and for 3.2 per cent it was ‘almost more than I could take’ in the last six months because of their behaviour (Table A5.9 (XLSX 244.8KB)).

A smaller proportion of younger children (12–15 years) had no experience of being in trouble because of their behaviour compared with older children (40.0% and 50.7%). A greater proportion of younger students had been in trouble at levels that were ‘quite bad’ or ‘almost more than I could take’ in the last six months compared with older children (9.2% and 3.5% compared with 7.3% and 2.4%) (Table A5.9 (XLSX 244.8KB)).

The same proportion of female and male students had no experience of being in trouble in the six months prior to the survey (43.0%). However a greater proportion of male students compared with female students had been in trouble at levels that were ‘quite bad’ or ‘almost more than I could take’ (12.8% and 10.9%) (Table A5.9 (XLSX 244.8KB)).

Help-seeking behaviour

In 2008, over one in three high school students aged 12–17 years who had experienced any level of psychological distress (that is, ‘about usual’, ‘worse than usual’, ‘quite bad’ or ‘almost more than I could take’) did not speak with anyone about their distress (36.9%). This is consistent with other research that has found barriers to help-seeking (particularly professional help) among young people with mental health problems (see for example, Francis, Boyd, Aisbett, Newnham, & Newnham, 2006; Jorm, Morgan, & Wright, 2008; Sawyer, et al., 2007).

There were some differences, however, in help-seeking behaviour when the type of distress experienced, age and sex are considered.

For those students who spoke with someone about their distress the greatest proportion spoke with their friends, closely followed by their family. Only students experiencing study problems spoke with their family in preference to their friends (Figure 5.5) (Table A5.10 (XLSX 244.8KB), Table A5.12 (XLSX 244.8KB), Table A5.14 (XLSX 244.8KB) & Table A5.16 (XLSX 244.8KB)).
A smaller proportion of male students compared with female students spoke to anyone regardless of the type of distress experienced. Around half of all male students spoke to no one when they experienced:

- unhappiness, sadness or depression (48.5%) ([Table A5.11](https://example.com/tableA5.11.xls))
- nervousness, stress or pressure (51.4%) ([Table A5.13](https://example.com/tableA5.13.xls))
- being in trouble because of their behaviour (52.7%) ([Table A5.15](https://example.com/tableA5.15.xls))
- study problems (48.5%) ([Table A5.17](https://example.com/tableA5.17.xls)).

Compared to around one in three female students when they experienced:

- unhappiness, sadness or depression (28.4%) ([Table A5.11](https://example.com/tableA5.11.xls))
- nervousness, stress or pressure (29.9%) ([Table A5.13](https://example.com/tableA5.13.xls))
- being in trouble because of their behaviour (38.4%) ([Table A5.15](https://example.com/tableA5.15.xls))
- study problems (38.5% respectively) ([Table A5.17](https://example.com/tableA5.17.xls)).

After friends and family, teachers or school counsellors were the next group students talked to most frequently. A greater proportion of students spoke with teachers or school counsellors when they had study problems (10.9%) ([Table A5.16](https://example.com/tableA5.16.xls)). Students also spoke to teachers or school counsellors about:

- being trouble because of their behaviour (6.7%) ([Table A5.14](https://example.com/tableA5.14.xls))
- experiencing feelings of nervousness, stress or pressure (6.0%) ([Table A5.12](https://example.com/tableA5.12.xls))
- experiencing feelings of unhappiness, sadness or depression (5.6%) ([Table A5.10](https://example.com/tableA5.10.xls)).

In 2008, students rarely reported talking to a helpline or looking on the internet for help. This option was most often used by students who experienced feelings of unhappiness, sadness or depression (1.2%) ([Table A5.10](https://example.com/tableA5.10.xls)), followed by:

- students who were trouble because of their behaviour (0.7%) ([Table A5.14](https://example.com/tableA5.14.xls))
- students who experienced feelings of nervousness, stress or pressure (0.6%) ([Table A5.12](https://example.com/tableA5.12.xls))
- students with study problems (0.4%) ([Table A5.16](https://example.com/tableA5.16.xls)).
Figure 5.5: Who students aged 12–17 years talked to when they experienced negative emotions,

NSW, 2008

Notes: Respondents could include more than one response. Percentages may total more than 100 per cent.

Source: NSW School Students Health Behaviours Survey 2008 (HOIST). Centre for Epidemiology and Research, NSW Department of Health (Tables A5.10-Table A5.16 (XLSX 244.8KB)).

The NSW School-Link Initiative is a collaborative partnership between NSW Health and NSW Department of Education and Communities. It recognises the importance of working with school communities to promote good mental health, prevent mental illness and intervene early. School-Link aims to improve the mental health of children and young people in NSW. School-Link has three main areas of focus:

Assist in strengthening pathways to care between TAFE colleges, schools, TAFE and school counsellors, and child and adolescent mental health services

Provide training programs for mental health workers and TAFE and school counsellors to enhance skills in recognition, intervention planning, treatment, support and prevention of mental health problems in children and young people

Support the implementation of programs in schools for the prevention of, or early intervention in, mental health problems.
Behavioural difficulties

Childhood behaviour problems are not only disruptive and difficult for families, but may also interfere with children’s social, emotional and academic development. For example, behaviour problems may result in children becoming socially isolated, having poor academic outcomes and low self-esteem and depression (KidsMatter, 2009).

The NSW Population Health Survey (PHS) provides the best source of data on the behavioural difficulties of children aged 4–15 years and the demographic characteristics of the children. This survey used an adapted version of the parent-reported Strengths and Difficulty Questionnaire (SDQ) mandated for national use in Australia’s specialised mental health services (Centre for Epidemiology and Research, 2010). Demographic characteristics of ongoing interest include Aboriginal children and children with a disability. The PHS does not collect information on children with a disability. While it collects information on Aboriginal children the small sample size limits regular reporting of Aboriginal children separately to non-Aboriginal children.

The PHS, as with any survey, is subject to error. The limitations of this survey include non-sampling and sampling errors, and reporting by parents and not the child concerned. The reader should keep these limitations in mind when interpreting the data. More information is in Appendix 1: Key survey sources and data reports.

The PHS asks parents about their child’s behaviour in terms of emotional symptoms, conduct problems, hyperactivity or inattention, peer relationship problems and prosocial behaviour. Questionnaire responses are used to calculate a SDQ total difficulties score between 0 and 40. A child with a total difficulties score of 17 or above is considered to be at risk of developing a clinically significant behavioural problem.\(^2\)

In 2007–2008 the PHS found that for children aged 4–15 years:

- 11.9 per cent were at risk of emotional symptoms
- 8.9 per cent were at risk of conduct problems
- 10.9 per cent were at risk of hyperactivity or inattention
- 9.0 per cent were at risk of peer relationship problems
- 2.0 per cent were at risk of not developing prosocial behaviour\(^3\) (Centre for Epidemiology and Research, 2010) (Table A5.18 (XLSX 244.8KB)).
Fewer than 1 in 10 children aged 4–15 years (7.6%) were at risk of developing a clinically significant behavioural problem (7.3% of 4–8 year olds and 7.8% of 9–15 year olds) (Figure 5.6) (Table A5.19 (XLSX 244.8KB)).

When the statistical significance of age, sex and geographic location are considered:

- No difference was found between age groups, or between children living in rural and urban health areas (Table A5.19 (XLSX 244.8KB)).
- A higher proportion of male children were at risk of developing a clinically significant behavioural problem compared with female children (8.7% and 6.4%).
- A higher proportion of children living in the Greater Western Area Health Service[4] (11.2%) were at risk of developing a clinically significant behavioural problem, compared with the overall NSW child population (7.6%) (Table A5.20 (XLSX 244.8KB)).

No significant change was found in the proportion of children aged 4–15 years who were at substantial risk of developing a clinically significant behavioural problem between 2003–2004 and 2007–2008 (Centre for Epidemiology and Research, 2010:161) (Table A5.21 (XLSX 244.8KB)).

Figure 5.6: Children aged 4–15 years at risk of developing a clinically significant behavioural problem by age, sex and location, NSW, 2007–2008
Mental health disorders

Mental health is a state of emotional and social well-being. It influences how an individual copes with the normal stresses of life and whether they can achieve their potential (ABS, 2008). Good mental health is fundamental to the well-being of individuals, their families, and their communities (Australian Health Ministers, 2003).

Mental health disorders, as distinct from mental health problems, are clinically recognised symptoms or behaviours that impact on children’s social and educational functioning (AIHW, 2009b). The prevalence of mental health disorders, including attention deficit hyperactivity disorder (ADHD), depressive disorder and conduct disorder, is a key national and international indicator of mental health for children (AIHW, 2010).

There is limited data on mental health disorders among children in Australia. The **ABS National Survey of Mental Health and Well-being** provides one source of data on mental health disorders including anxiety disorders, affective disorders, and substance use disorders for persons aged 16–85 years. The sample of 16–17 year olds in NSW is too small to allow any analysis of risk factors of mental illness for this group. Demographic characteristics of ongoing interest include Aboriginal children and children with a disability. The **ABS National Survey of Mental Health and Well-being** does not collect information on either of these characteristics.

The **ABS National Survey of Mental Health and Well-being**, as with any survey, is subject to error. The limitations of this survey include non-sampling and sampling errors, reporting by parents or a household member and not the child concerned, and the relatively high standard error. The reader should keep these limitations in mind when interpreting the data. More information is in **Appendix 1: Key survey sources and data reports**.

In 2007, the **ABS National Survey of Mental Health and Well-being** found that just under a quarter (23.1%) of children aged 16–17 years have a lifetime mental health disorder (**Table A5.22 (XLSX 244.8KB)**).

**Intentional self-harm and suicide death**

Intentional self-harm and suicide deaths are significant public health issues and their prevalence
are key national and international indicators (AIHW, 2010).

The *Admitted Patient Data Collection* (APDC) is the key source of information on hospitalisations provided by NSW public and private hospitals and gives the most reliable information on self-harming behaviours for children in NSW.

The NSW Child Death Review Team (CDRT) collection holds the most reliable information on suicide deaths of NSW children. To address the issue of under-reporting of suicide deaths among children, the CDRT uses the extensive records it obtained to determine if a death resulted from suicide. For this reason, the rate of suicide deaths reported can be higher than reported from other collections.

The APDC and the CDRT collection, as with any administrative data collections, are subject to error. The APDC has some limitations in coverage. Most people who contact health services after an episode of intentional self-harm are seen by emergency departments. They may or may not be admitted to hospital, and the injury may or may not be recorded as intentional. In addition, many people who self-harm do not come to the attention of health professionals at all, so the data presented is likely to underestimate actual prevalence (Shiner, 2008). Both collections are subject to error including item non-response, transcription errors, coding errors, clerical and editing errors, and data conversion errors. The reader should keep these limitations in mind when interpreting the data. More information is in Appendix 1: *Key survey sources and data reports*.

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**The NSW Suicide Prevention Strategy 2010–2015** provides the basis for a coordinated whole of government approach to suicide prevention in NSW, and aligns with the national suicide prevention framework *Living Is For Everyone*. Young people are identified as a target group in both documents.


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**Intentional self-harm**

Self-harming is a behaviour not an illness and occurs when someone intentionally hurts or mutilates their body without intending to die, although it can result in hospitalisation or death. Self-harm often begins in teenage years and can be a way of communicating or coping with distress. Self-harming usually occurs as a way of asking for help, a way of coping with stress or emotional difficulties, or as a symptom of mental illness (Shiner, 2008; RANZCP 2005). A child’s risk of self-harm has been found to be linked to a child having suffered from depression, anxiety, impulsivity, low self-esteem and suicidal ideation (Lowenstein 2005).
In 2009–2010 there were 801 admissions to hospital of NSW children aged 15–17 years for intentional self-harm. This equates to a rate of 2.84 per 1,000 children aged 15–17 years. Over the period from, 2000–2001 to 2009–2010, hospitalisation rates for intentional self-harm peaked in 2005–2006 at 3.76 per 1,000 children aged 15–17 years (Table A5.23 (XLSX 244.8KB)).

In 2009–2010 the number of female children hospitalised for self-harm was 612 compared with 189 for male children. Over the period 2000–2001 to 2009–2010 hospitalisation rates for intentional self-harm were three to four times greater in female children compared with male children. The rate of hospitalisation for female children has decreased after a peak in 2004–2005 of 6.22 per 1,000 children aged 15–17 years (Figure 5.7) (Table A5.23 (XLSX 244.8KB)).

Figure 5.7: Children aged 15–17 years hospitalised for intentional self-harm by sex, NSW, 2000–2001 to 2009–2010

Suicide death

In some instances mental health issues can lead to death by suicide. Over the period 1996–2010, the CDRT collection found that 264 children aged 12–17 years died by suicide, a mortality rate of approximately 0.03 per 1,000 children aged 12–17 years. The suicide mortality rates for children aged 12–17 years have been mostly constant since 1998. Over this same period three
children aged 10–11 years died by suicide (Figure 5.8) (Table A5.24 (XLSX 244.8KB) & Table A5.25 (XLSX 244.8KB)).

Figure 5.8: Children aged 12–17 years who died as a result of suicide by year, NSW, 1996–2010

![Graph showing suicide rates by year from 1996 to 2010.]

Notes: The directly standardised mortality rate (DSMR) is used to adjust for changes in the age profile of the population. The base count for 2010 is different to previous years and included children whose deaths were registered in NSW rather than children who usually lived in NSW and died in the given year, and a 95 per cent Confidence Interval was used.

Sources: NSW Child Death Review Team (2010) Annual Report 2009 and NSW Child Death Review Team (2011) Annual Report 2010 (Table A5.24 (XLSX 244.8KB)).

When the statistical significance of age, sex, Aboriginal identity and geographic location are considered, during the period 1996–2009:

- Male children were just under twice as likely to die by suicide compared with female children (0.043 per 1,000 male children compared with 0.023 per 1,000 female children) (Table A5.25 (XLSX 244.8KB)). This is consistent with national data (ABS, 2009).
- Children aged 14–15 years and 16–17 years were more likely to die by suicide compared with 12–13 year olds (0.023 and 0.070 per 1,000 respectively, compared to 0.006 per 1,000) (Figure 5.9) (Table A5.25 (XLSX 244.8KB)).
The suicide mortality rate for Aboriginal children was not statistically different to the rate for non-Aboriginal children (0.040 per 1,000 compared with 0.033 per 1,000).

Outer and remote areas of NSW have the highest suicide mortality rate among children aged 12–17 years compared with major cities and inner regional areas (0.040 per 1,000 children aged 12–17 years compared with 0.027 and 0.039 per 1,000). The difference between inner regional areas and major cities is also significant (0.39 per 1,000 compared with 0.27 per 1,000) (Figure 5.10) (Table A5.25) (XLSX 244.8KB).

Figure 5.10: Children aged 12–17 years who died as a result of suicide by location, NSW, 1996–2009
Note: Three children aged 10–11 years died by suicide over this period and have been excluded from this figure due to the small number.

Source: NSW Child Death Review Team (2010) Annual Report 2009 (Table A5.25 (XLSX 244.8KB)).

References


AIHW. (2010). Health and well-being of young Australians: technical paper on operational definitions and data issues for key national indicators. Cat. No. WP 63. Canberra: AIHW.


ARACY and AIHW. (2010). *Conceptualisation of social and emotional well-being for children and young people, and policy implication*. Australian Research Alliance for Children and Youth and Australian Institute of Health and Welfare, NSW.


[1] Certain socioeconomic characteristics of a geographic area can be used to determine its
socioeconomic disadvantage (ABS, 2006). Areas can be ranked and then grouped according to their socioeconomic disadvantage. The NSW Department of Health uses five groupings (quintiles): the least disadvantaged areas are in the first group and the most disadvantaged areas are in the fifth group.

[2] For further information about the SDQ, visit www.sdqinfo.org

[3] Prosocial behaviour is caring about the welfare and rights of others, feeling concern and empathy for them, and acting in ways that benefit others.

[4] On 1 January 2011 Local Health Districts (LHD) replaced Area Health Services (AHS) as the NSW Health geographic areas.