

## **PART 6**

# **Appendices**

- 1. Conduct of the survey**
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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,

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.

### 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

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 (screeener questions only for 11 and 12 year-olds); alcohol consumption (screeener 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);

- 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 edition<sup>1</sup>, 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*.

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<sup>1</sup> 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

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%.

### 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.

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)
<b>Any mental disorder</b>	<b>13.6</b>	<b>(12.3 - 14.9)</b>	<b>14.4</b>	<b>(12.9 - 15.9)</b>	<b>13.9</b>	<b>(12.9 - 15.0)</b>

**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		6-11 years		12-15 years		16-17 years	
	Per cent	95% CI	Per cent	95% CI	Per cent	95% CI	Per cent	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)
<b>Any mental disorder</b>	<b>9.4</b>	<b>(7.4 - 11.5)</b>	<b>15.1</b>	<b>(13.5 - 16.7)</b>	<b>14.2</b>	<b>(12.2 - 16.2)</b>	<b>14.7</b>	<b>(12.8 - 16.6)</b>

### 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)<sup>2</sup> 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)<sup>3</sup> is a 20 item self-report scale designed to measure depressive symptomatology in the past week.

<sup>2</sup> 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.

<sup>3</sup> Radloff LS: The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*. 1: 385-401, 1977.

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.<sup>4</sup>

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.

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<sup>4</sup> 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 included<sup>1</sup>:

### 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

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<sup>1</sup> Position titles reflect the roles of the individuals at the commencement of the Survey Reference Group

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

<b>Glossary term</b>	<b>Definition</b>
<b>12-month prevalence</b>	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.
<b>Adolescent self-report questionnaire</b>	<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"> <li>• DISC-IV major depressive disorder module;</li> <li>• Presence of symptoms of psychosis;</li> <li>• Strengths and Difficulties Questionnaire (SDQ);</li> <li>• Kessler Psychological Distress Scale (K10+);</li> <li>• Use of services and perceived need for services;</li> <li>• Use of internet;</li> <li>• Youth health-risk behaviours, including self-harm, suicidal behaviours, substance use, disordered eating behaviours and sexual behaviour</li> <li>• Experience of bullying;</li> <li>• Level of education; and</li> <li>• Level of self-esteem.</li> </ul> <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>
<b>Alcohol consumption</b>	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).
<b>Anxiety disorders</b>	<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>

<b>Glossary term</b>	<b>Definition</b>
	<p>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.</p> <p>Anxiety disorders were not included in the first survey in 1998.</p>
<b>Area of residence</b>	<p>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.</p>
<b>Attention-deficit/hyperactivity disorder (ADHD)</b>	<p>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’.</p> <p>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.</p> <p>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).</p> <p>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.</p>
<b>Binge eating and purging problem eating behaviour</b>	<p>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.</p>
<b>Bullying</b>	<p>When people tease, threaten, spread rumours about, hit, shove, or hurt other people over and over again.</p>

<b>Glossary term</b>	<b>Definition</b>
<b>Carer</b>	<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>
<b>Comorbidity</b>	<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>
<b>Conduct disorder</b>	<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>
<b>Cyber bullying</b>	<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.<sup>1</sup> 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>

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<sup>1</sup> 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

<b>Glossary term</b>	<b>Definition</b>
<b>Family type</b>	<p>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:</p> <ul style="list-style-type: none"><li>- 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'.</li><li>- Step families have at least one resident step child, but no child who is the natural or adopted child of both partners.</li><li>- 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.</li><li>- 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.</li></ul>
<b>Generalised anxiety disorder</b>	<p>An anxiety disorder characterised by excessive anxiety, worry or apprehension about a number of different events or activities.</p> <p>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.</p> <p>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.</p>

<b>Glossary term</b>	<b>Definition</b>
<b>Health service provider</b>	<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"><li>- general practitioner;</li><li>- paediatrician;</li><li>- psychiatrist;</li><li>- psychologist;</li><li>- nurse;</li><li>- social worker;</li><li>- occupational therapist; and</li><li>- counsellor or family therapist.</li></ul>
<b>Impact on functioning</b>	<p>see Severity of impact on functioning.</p>
<b>Labour force status</b>	<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>
<b>Low weight problem eating behaviours</b>	<p>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.</p>
<b>Major depressive disorder</b>	<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>

<b>Glossary term</b>	<b>Definition</b>
	<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>
<b>Mental disorder</b>	<p>Defined according to the detailed diagnostic criteria within classification systems. This covers:</p> <ul style="list-style-type: none"> <li>- the nature, number and combination of symptoms;</li> <li>- a time period over which the symptoms have been continuously experienced;</li> <li>- the level of distress or impairment experienced; and</li> <li>- 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.</li> </ul> <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>
<b>Not in employment</b>	Both unemployed and not in the labour force.
<b>Obsessive-compulsive disorder</b>	<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**

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.

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 *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 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.

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.

**Perceived need for mental health care**

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:

- 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.

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.

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

**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.<sup>2</sup>

**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

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<sup>2</sup> Meadows G, Burgess P, Fossey E, Harvey C (2000). Perceived need for mental health care, findings from the Australian National Survey of Mental Health and Well-being. *Psychological Medicine*. 30: 645-656.

<b>Glossary term</b>	<b>Definition</b>
	<p>and overweight status.<sup>3</sup></p> <p>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.</p> <p>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.</p> <p>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.</p>
<b>Problem internet or electronic gaming behaviours</b>	<p>Young people were asked about five specific behaviours that may be indicative of addiction to the internet, social media or electronic gaming:</p> <ul style="list-style-type: none"> <li>i) going without eating or sleeping in order to be on the internet or play electronic games</li> <li>ii) feeling bothered or upset if they are unable to be on the internet or gaming</li> <li>iii) catching themselves surfing the internet or playing games even when they are not interested</li> <li>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</li> <li>v) having tried unsuccessfully to reduce the time spent on the internet or playing electronic games.</li> </ul> <p>Problem internet or electronic gaming behaviour has been defined as reporting four or five of these individual indicators.</p>
<b>Psychological distress</b>	<p>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.</p>

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<sup>3</sup> 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.

<b>Glossary term</b>	<b>Definition</b>
<b>Service use</b>	<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>
<b>Services</b>	<p>Comprise all the health, school, telephone and online services defined as follows:</p> <ul style="list-style-type: none"><li>- 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);</li><li>- school services — any service provided by the school or other educational institution that a young person was attending; and</li><li>- telephone and online services where these provided structured or personalised assistance and not just generic information.</li></ul>

**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.

<b>Glossary term</b>	<b>Definition</b>
<b>Social phobia</b>	<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>
<b>Sub-threshold level</b>	<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>
<b>Suicidal behaviours</b>	<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>

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