Key Messages

- Around 20% of children and adolescents are estimated to have mental health disorders or problems
- In a young person presenting with mental health problems, assessment of suicide risk should form part of the initial consultation and be re-evaluated during on-going monitoring
- A young person with serious suicidal intent, psychotic symptoms or severe self-neglect should be referred immediately to secondary care mental health services
- Every interaction with a young person in primary care should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing
- Structured psychosocial assessment tools such as HEEADDSSS and HEARTS may be useful in identifying problems that require further investigation
- More detailed assessment tools and tools for specific situations (e.g. substance misuse) may assist diagnosis and monitoring of the disorder
- A young person with mild or moderate depression should typically be managed within primary care services. A strength-based approach should be used in combination with problem solving and risk reduction.
- Young people with mild depression can be directed to **www.thelowdown.co.nz** for information, self help strategies and support from peers
- It is recommended that antidepressant treatment in a young person (less than 18 years) should not be initiated in primary care without consultation with a child and adolescent psychiatrist

Introduction

EVIDENCE INDICATES that early interventions in a number of mental health conditions for children and young people can result in better outcomes. Due to the high prevalence of mental health disorders in young people, every interaction or consultation should be regarded as an opportunity to assess their psychosocial as well as physical wellbeing.

Prevalence and epidemiology of common mental health disorders in young people in New Zealand

Mental disorders in young people are common

Around 20% of children and adolescents are estimated to have mental health disorders or problems, with similar types of disorders being reported across cultures. About half of mental health disorders begin before the age of 14 years.

From a general practice perspective, many children will have important psychological problems at a subclinical level which would benefit from intervention, and may be the precursors to adult disorders. These include behaviour and conduct problems, significant school refusal and the excessively anxious child.

A 2006 epidemiological study in New Zealanders found the 12-month prevalence for major mental health disorders, in the age band 16 to 24 years, to be 29% (Table 1).

The most prevalent mental health disorders among young people in New Zealand are anxiety disorders, depression, conduct disorder and substance abuse. The gender-specific prevalence of disorders varies with age, with an overall increase up to the age of 18 years (Table 2). In

Table 1: New Zealand mental Health Survey: 12-month prevalence of any disorder and severity by age. (Adapted from Oakley Browne 2006 [2])

Age group (years)	Twelve-month prevalence of any disorder % (95% CI)	Prevalence of serious disorder % (95% CI)
16–24	28.6 (25.1, 32.3)	7.2 (5.7, 9.0)
25–44	25.1 (23.2, 27.1)	5.8 (5.0, 6.6)
45–64	17.4 (15.7,19.2)	3.8 (3.1, 4.5)
65 and over	7.1 (5.7, 8.8)	1.1 (0.5, 2.0)

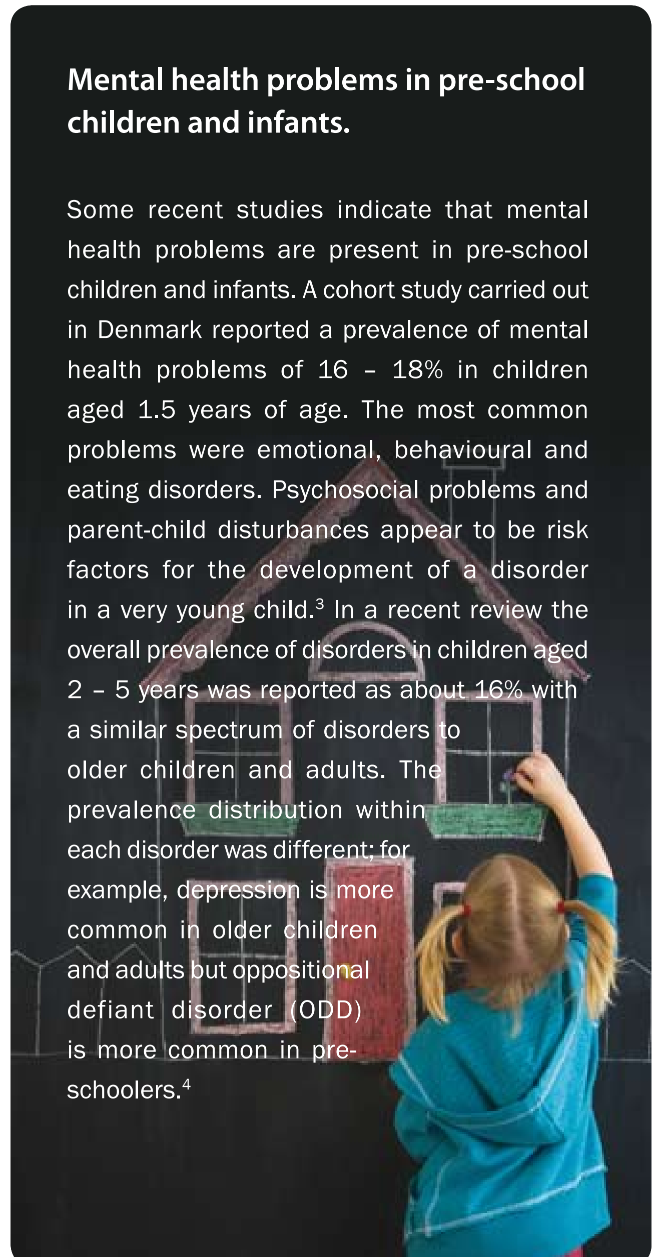
Disorder includes: anxiety disorders, mood disorders, substance use disorders and eating disorders.

childhood and early adolescence, males are at greater risk, with higher rates of conduct disorder, attention-deficit hyperactivity disorder, and depressive disorder (depression and dysthymia). In adolescence, the rates of depression/dysthymia and anxiety disorders increase dramatically in females, while the rate of substance abuse is higher in males.[1]

Childhood anxiety commonly precedes adolescent depression. In the presence of both anxiety and depression, there is an increased risk of developing a comorbid substance use disorder and treatment responsiveness is reduced.[1]

Late puberty is commonly associated with experimentation with drugs (usually alcohol and marijuana) and also with a three-fold increase in substance misuse. Multiple substance misuse is also common. Two-thirds of New Zealand adolescents with marijuana dependence are also alcohol dependent. Clinicians tend to underestimate adolescent substance-related pathology and this is probably the most commonly missed diagnosis in this age group.[1]

Mental disorders in young people lead to emotional distress, impaired functioning, physical ill-health and increased suicide risk. They also carry a high risk of a pattern of recovery and recurrence (more likely in females) or unremitting persistence (more likely in males) into adult life.[1]



Mental health problems in pre-school children and infants.

Some recent studies indicate that mental health problems are present in pre-school children and infants. A cohort study carried out in Denmark reported a prevalence of mental health problems of 16 – 18% in children aged 1.5 years of age. The most common problems were emotional, behavioural and eating disorders. Psychosocial problems and parent-child disturbances appear to be risk factors for the development of a disorder in a very young child.[3] In a recent review the overall prevalence of disorders in children aged 2 – 5 years was reported as about 16% with a similar spectrum of disorders to older children and adults. The prevalence distribution within each disorder was different; for example, depression is more common in older children and adults but oppositional defiant disorder (ODD) is more common in pre-schoolers.[4]

Table 2: Prevalence of common mental disorders in children and adolescents.[1]

Disorder (in order of prevalence)	Estimated population prevalence (%)		
	Total	Boys	Girls
Preschool (also see box previous page)			
Preschool mental health problems (parent rated)	16	17	14
Hyperactive behaviour disorder	2	2	2
Primary school age			
Attention-deficit hyperactivity disorder	14	19	9
Anxiety disorder (especially separation anxiety)	5	no data	no data
Conduct disorder	3	5	2
Depression/dysthymia	3	4	2
Pre-adolescence (11 years)			
Conduct/oppositional disorder	9	12	5
Attention-deficit hyperactivity disorder	5	no data	no data
Separation anxiety	4	2	5
Overanxious disorder	3	4	2
Depression/dysthymia	2	3	<1
Any mental disorder	18	20	17
Mid-adolescence (15 years)			
Anxiety disorder	13	7	19
Conduct disorder	5	7	3
Depression/dysthymia	6	3	9
Any mental disorder	22	16	18
Late adolescence (18 years)			
Alcohol or substance abuse/dependence	24	29	20
Depression/dysthymia	18	10	27
Anxiety disorder	17	12	22
Any mental disorder	42	39	45

NZ data have been used where available

Common mental disorders often co-exist

Young people presenting with one disorder (e.g. depression) are at increased risk of having other disorders (e.g. substance misuse or conduct disorder). Research conducted in New Zealand showed that 40% of 18 years olds who met the criteria for a mental disorder had more than one disorder.[1]

New Zealand Suicide rates

Every year approximately 100 young New Zealanders (aged 15–24 years) die by suicide. This accounts for about a fifth of the total number of suicides each year. While the rate of suicide for young people has declined by around 30% since its peak in the late 1990's, it continues to be a significant cause of death accounting for approximately 25% of all deaths in this age group.[5]

Men and Māori youth are particularly affected by suicide. Based on 2006 figures, young men have a rate of 31 per 100,000 population, which is significantly higher than the total population rate of 12 deaths per 100,000.[5] The Māori youth rate is 33 per 100,000 population compared with the non-Māori youth rate of 15 per 100,000.[6]

Suicide in children under the age of 10 is very rare, and uncommon in those aged 10–14 years.

International comparisons

New Zealand has one of the highest youth suicide rates among developed countries. This was highlighted in a 2009 WHO publication[7] which showed New Zealand teenagers (aged 15–19 years) had the highest rates of suicide in the OECD for both men and women. Caution needs to be taken when making international comparisons of suicide rates because many factors affect the recording and classification of suicide and can result in undercounting of suicide in other countries. Key factors influencing reporting rates are the level of proof that is required for classification of a suicide, which is very thorough in New Zealand and is made after a Coroner's investigation. This means compared to other countries New Zealand has a low number of "undetermined deaths". The stigma associated with suicide may also influence reporting rates as it deters the classification of a death as a suicide in some countries.

However, it is a significant concern that many young people die by suicide in this country and primary care needs to be responsive to ensuring young people are provided with best practice assessment, treatment and management of suicide risk and mental disorders.

For further information and resources about the treatment of depression including the previously published **Adult Depression Best Practice Special Edition** please visit our website:

www.bpac.org.nz