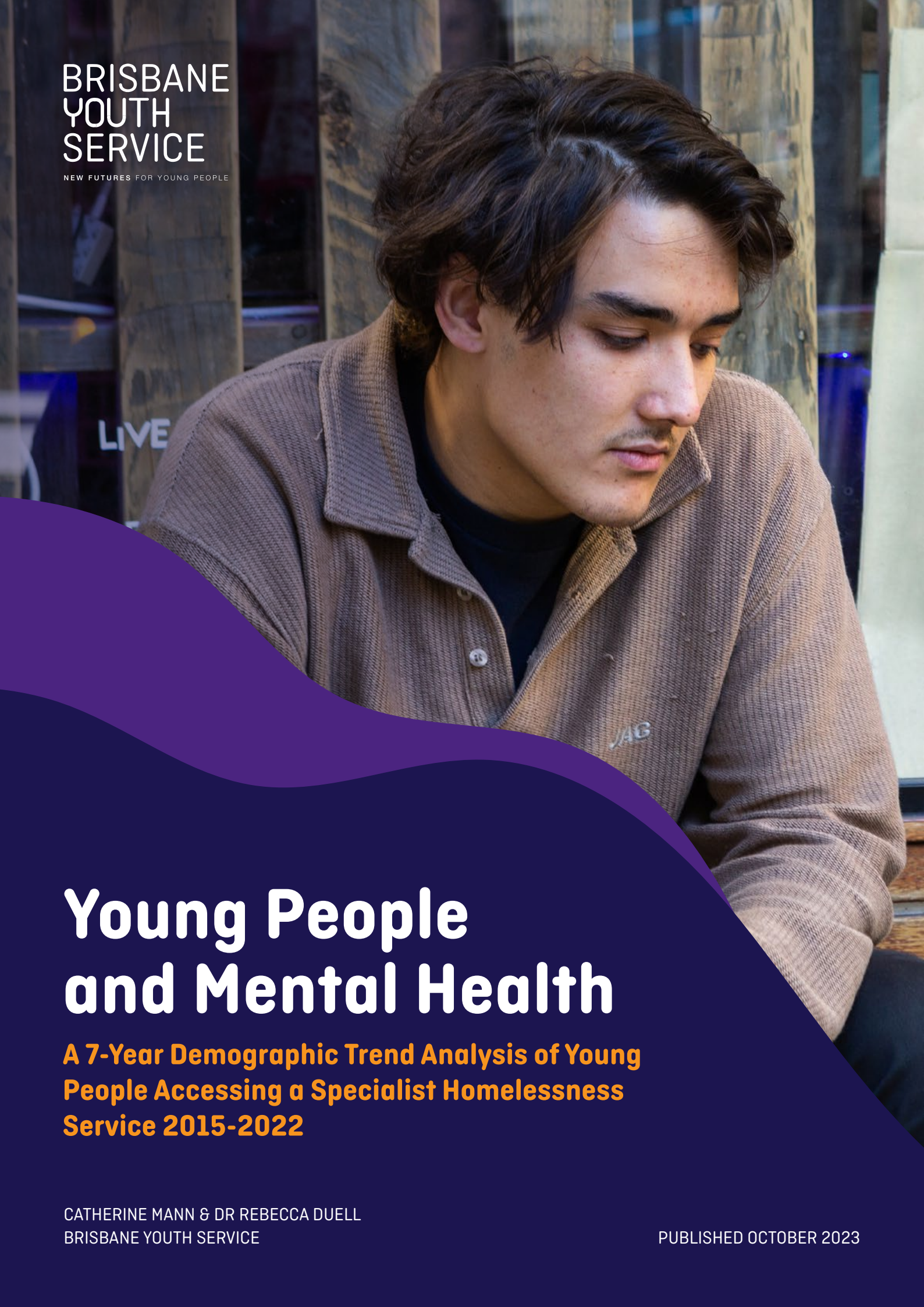

BRISBANE YOUTH SERVICE

NEW FUTURES FOR YOUNG PEOPLE

Young People and Mental Health

A 7-Year Demographic Trend Analysis of Young People Accessing a Specialist Homelessness Service 2015-2022

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BRISBANE YOUTH SERVICE

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ACKNOWLEDGEMENTS & ABOUT

Acknowledgements

Brisbane Youth Service (BYS) respectfully acknowledges the Turrbal and Jagera people as the Traditional Custodians of the lands where BYS operates. We pay respect to their Elders past and present, lores, customs and creation spirits. BYS acknowledges and celebrates the important role Aboriginal and Torres Strait Islander people play within BYS and the community.

We would like to thank the young people who consented to their data being collected and analysed. Their willingness to share has been invaluable in building the dataset used in this report and the insights that have been possible in the analysis.

We would also like to thank the BYS workers who collected the data. Without your efforts and commitment to quality data collection this report would not have been possible.

About Brisbane Youth Service

Since 1977, Brisbane Youth Service has worked to create new futures for young people and young families at risk or experiencing homelessness. We provide free, confidential services including crisis and transitional housing, emergency relief, physical and mental health services, alcohol and drug interventions, domestic and family violence support, and specialist programs for young women and young families.

BYS has a long history of developing innovative services to respond to the identified needs of young people and young families. We hope that by making this report publicly available, we can increase understanding and awareness of the challenges faced by vulnerable young people. We also hope that the insights offered in this report will contribute to further research and innovation by other organisations seeking to improve the wellbeing of young people.

This report may be cited as: Mann, C., and Duell, R. (2023). Young people and mental health: a 7-year demographic trend analysis of young people accessing a Specialist Homelessness Service 2015-2022. Brisbane Youth Service: Brisbane, QLD

The photos in this report are actors and staff depicting real scenarios BYS experiences day to day.

> I WAS IN AND OUT OF HOSPITAL BECAUSE OF A LOT OF CHANGE AND UNDIAGNOSED MH ISSUES, I WAS ON THE VERGE OF HOMELESSNESS AND MY RENTAL WASN'T SECURE. I HAD SO MUCH UNADDRESSED FAMILY TRAUMA THAT CAME TO THE SURFACE WHEN I MOVED OUT, BUT WHEN I STARTED WORKING WITH BYS, I WAS ABLE TO **GET EVERYTHING TOGETHER**.
>
> — Young Person

TABLE OF CONTENTS

LIST OF TABLES & FIGURES

EXECUTIVE SUMMARY

Brisbane Youth Service (BYS) has completed comprehensive intake assessments with all young people accessing the service for ongoing planned support over the past 7 years.

This report summarises the findings from an analysis of assessment data on young people's mental health diagnoses and self-rated mental health on intake, which compared key demographic factors such as age, gender, cultural identities, sexuality, experience of disability and parenthood. The overall aim of the report was to determine which, if any, demographic factors were related to experiences of poor/very poor mental health and/or mental health diagnoses.

The report focuses on data collected in the seven financial years between 2015-16 and 2021-22 inclusive. A total of 3,049 young people provided mental health diagnosis data and 3,017 provided self-rated mental health data. Analysis focused on demographic comparisons to determine which, if any, groups of young people had higher rate of mental health diagnosis and/or self-rated poor/very poor mental health. Analysis included year-by-year comparisons, and investigated if there were any notable fluctuations during the coronavirus (COVID-19) pandemic years.

Findings indicated young people's mental health has been deteriorating over the past 7 years with a substantial increase in mental health diagnoses and poor/very poor mental health since the COVID-19 pandemic.

Vulnerable and marginalised groups had a higher rate of mental health diagnosis and self-rated poor/very poor mental health.

- Gender diverse young people were statistically significantly more likely to have a diagnosed mental health issue (81%) compared to young women (51%) and young men (45%). They were also significantly more likely to self-rate their mental health as poor/very poor (57%) compared to young women (40%) and young men (34%).
- Sexuality diverse young people were statistically significantly more likely to have mental health diagnoses (72%) compared to straight young people (45%).
- Young people with identified disabilities were statistically significantly more likely to have mental health diagnoses (69%) compared to young people without disabilities (46%).

Age was statistically significantly associated with mental health diagnoses in older young people (22-25 years).

- Older young people in the 22–25-year age group, had the most frequent rate of mental health diagnosis, which was statistically significant compared to other age groups.
- Older young people in the 22–25-year age group, were also more likely to rate their mental health as poor/very poor compared to other age groups; however, the difference between groups was not statistically significant.
- Rate of mental health diagnosis showed a statistically significant increase with increase in age.

There was an increase in diagnosis rate and poor/very poor mental health for most groups over the COVID-19 pandemic.

- The rate of older young people (22-25 years) with mental health diagnoses and self-rated poor/very poor mental health increased considerably over the COVID-19 pandemic years.
- The rate of young men and young women with mental health diagnoses and self-rated poor/very poor mental health also increased considerably over the COVID-19 years. This pattern was not observed for gender diverse young people with rates of both diagnosis and self-rated mental health remaining high over the 7-year period.
- Self-rated poor/very poor mental health for young people with identified disabilities increased over the COVID-19 pandemic years but the same pattern was not seen for rate of mental health diagnosis.

Young people's rate of diagnosis and self-rated mental health has increased over the COVID-19 pandemic and has not returned to pre-pandemic levels.

The risk and protective factors driving young people's mental health are complex and mutable.

Improving young people's mental health requires solutions that focus not only on mild to moderate intervention, but long-term support, particularly for young people who are gender diverse, sexuality diverse, and/or who live with disability. Interventions must be safe for young people with a wide range of experiences and identities to target groups with the most complex, poor/very poor mental health.

STATISTICALLY SIGNIFICANT RELATIONSHIPS & EFFECT SIZE

	MENTAL HEALTH DIAGNOSES		POOR/VERY POOR MENTAL HEALTH	
12-15 Years	★	Small effect size	-	No significant relationship
16-18 Years	★	Small effect size	-	No significant relationship
19-21 Years	★	Small effect size	-	No significant relationship
22-25 Years	★	Small effect size	-	No significant relationship
Male	★	Small effect size	★	Small effect size
Female	★	Small effect size	★	Small effect size
Gender Diverse	★	Small effect size	★	Small effect size
Aboriginal and/or Torres Strait Islander	★	Small effect size	★	Small effect size
Culturally and Linguistically Diverse	★	Small effect size	★	Small effect size
Young Parents	★	Small effect size	★	Small effect size
Young People with Disability	★	Small to moderate effect size	★	Small effect size
Sexuality Diverse	★	Small to moderate effect size	★	Small effect size

Table 1. *Statistically Significant Relationships & Effect Size*

★ *identifies statistically significant relationships between variables.*

"–" identifies no significant relationship between variables

YOUNG PEOPLE'S MENTAL HEALTH

Mental health is a key factor that influences the positive development and overall wellbeing of young people. The National Study of Mental Health and Wellbeing reported that two in five people (40%) aged 16-24 years have experienced a mental health concern in the last 12-months, with anxiety as the most common concern (17%; Australian Bureau of Statistics [ABS], 2022).

Twenty percent of young people aged 11-17 had high/very high levels of psychological distress with a similar proportion of 18-24-year-olds (15%) also identifying high/very high psychological distress (Australian Institute of Health and Welfare [AIHW], 2021a). For those aged 15-24, 26% reported having a long-term mental or behavioural condition in the National Health Survey (ABS, 2018).

Since 2020, the world has been experiencing the coronavirus (COVID-19) pandemic and associated interventions aimed at reducing the spread of COVID-19 across the world and within countries. In Queensland, lockdowns and restrictions have particularly impacted young people, renters, unemployed and precariously employed people, and women (QCOSS, 2020). Lockdowns had a noted impact on financial wellbeing, employment uncertainty and mental health and wellbeing (QCOSS, 2020). A systematic review comparing the mental health of children and young people before and during the coronavirus (COVID-19) pandemic reported that there was a deterioration in the mental health of young people after the pandemic started (Kauhanen et al., 2022).

On a national scale, mental health statistics focus on young people identifying as cisgender, with a very limited focus on young people who identify as diverse genders (Rosenberg et al., 2021). Young women in Australia report a disproportionately high rate of mental health concerns, with almost half (47%) of young women aged 16-24 years and almost one third (31%) of young men aged 16-24 years identifying a mental health concern of at least 12-months duration (ABS, 2022). Young women (18%) were more likely than young men (12%) to have high/very high levels of psychological distress (AIHW, 2021a). Young women, aged 15-24, were more likely to report having a long-term mental or behavioural condition (30%) compared to young men (21%; ABS, 2018).

While data is less available on sexuality and gender diverse young people, one recent study reported that almost two thirds (64%) of sexuality and gender diverse young people in Australia report having a mental health diagnosis (Hill et al., 2021). Within this diverse group, different identities experience different mental health inequalities, such as gender diverse young people compared to their cisgender sexuality diverse peers (Jones et al., 2019). During the COVID-19 pandemic, some sexuality and gender diverse young people reported poorer mental health as they could not express their identity with those they were quarantining with (Gato et al., 2021).

Highly vulnerable groups of young people are at increased risk of reporting mental health concerns and these concerns increased over the COVID-19 pandemic. People with intellectual disabilities have a very high rate of mental health concerns and experience a range of barriers to accessing mental health support (Whittle et al., 2018). Nine in ten young people with disability noted a negative impact on their mental health over the COVID-19 pandemic (Theis et al., 2021).

Aboriginal and/or Torres Strait Islander young people aged 0-24 years died by suicide at triple the rate of non-Indigenous young people between 2017-2021 (16.6 per 100,000 compared to 5.3 per 100,000; AIHW, 2021b). Despite this, Aboriginal and/or Torres Strait Islander young people were less likely than non-Indigenous young people to identify their mental health as a concern (Mission Australia, 2019). There is however a lack of culturally appropriate and culturally validated mental health screening tools available for Aboriginal and/or Torres Strait Islander young people (Westerman & Johnson, 2019). This means that the true prevalence of poor mental health in young First Nations populations is unknown. Kilian and Williamson (2018) noted that inadequate mental health pathways lead to under-recognition/underdiagnosis for Aboriginal and/or Torres Strait Islander young people. For young people who do find a pathway to mental health support, Aboriginal and/or Torres Strait Islander identity was one of the risk factors for young people discontinuing headspace support (Seidler et al., 2020).

There is also very limited literature focusing on mental health for Culturally and Linguistically Diverse (CALD) young people in Australia (Minas et al., 2013). Nevertheless, it is well understood that CALD young people are exposed to many socially determined mental health risk factors such as social disadvantage, racial discrimination, and experiences of trauma prior to settlement in Australia. Harding and colleagues (2015) identified key barriers to effective mental healthcare for CALD populations as differences in illness presentation and downplaying mental health symptoms due to stigma.

For the last 7 years Brisbane Youth Service (BYS) has been tracking patterns of youth homelessness and the most common intersecting issues of family and relationship violence and primary and mental health.

BYS also collects comprehensive data on young people's financial wellbeing; engagement in education and employment; substance use; connection to supports; parenting and child safety concerns; and legal issues.

Data has been collected from more than 3,000 young people seeking support at BYS, as part of the intake and assessment process. Change/outcomes data is also collected as part of the process of young people exiting support.

A series of reports will share findings from the analysis of key trends within these data sets, with the aim of supporting improved policy and practice locally in Queensland, as well as to contribute to national and international responses to supporting young people's needs.

This report explored mental health concerns impacting young people who seek support at BYS, over the 7-year period 2015-2022. Analysis focused on changes over time including the impact of the COVID-19 pandemic on young people's mental health.

EXPLANATORY NOTES

1. In this report, the data analysis by year includes all young people who had their first contact with BYS in that year and who completed an intake assessment in that year. As such, the highest numbers of young people were in the first year when the client intake and assessment data set was introduced, and all current and new clients completed the assessment.
2. The reported client numbers each year, and all associated percentages, reflect the number of new intakes only, and do not include the many ongoing clients who continued to be supported over several years.
3. For each domain covered in this report, results are presented as a percentage of the total number of young people who completed that question in the intake assessment. For this reason, the total numbers differ for each domain (e.g. disability, parenting, age) since not all young people complete all questions in the assessment. For the purposes of data integrity, the numbers and percentages reported here exclude any young person who completed less than 40% of the total intake assessment questions.
4. There are times when young people have multiple episodes of support over several years. While their presenting concerns may have changed from one episode to the next (e.g. experience of violence), in order to not duplicate their demographic data (e.g. culture), only their first occasion of intake is included in this analysis.
5. For the current data set, no information is collected to verify mental health diagnoses, the data is based on self-report by young people. There is also no information collected about when the diagnosis was made or by whom (e.g. General Practitioner [GP], psychologist, psychiatrist).
6. Self-rated mental health is a current point in time subjective assessment.
7. The COVID-19 pandemic is mentioned throughout the report and is considered to have started halfway through the 2019-2020 financial year. This means that all data for that year includes the six months prior to the COVID-19 pandemic and the first six months of lockdowns, social and service restrictions. The impact of the COVID-19 pandemic is best viewed as a combined trend across the 2019-20, 2020-21, and 2021-22 years.
8. The statistical significance cut-off value in this report is p=0.05. Effect size cut-offs are described in Appendix A.

MENTAL HEALTH DATA AT BYS

BYS collects mental health information from all young people completing an intake assessment. This is collected in the form of two questions:

A **Do you have a mental health diagnosis? (If so, what is your diagnosis?)**

B **How would you rate your mental health at the moment, on a scale of 1 (very poor) to 5 (great)?**

This report presents findings from analysis of new intake data each financial year for 7 years, from 1st July 2015 to 30th June 2022. Over that period:

- 3,049 young people provided information on their mental health diagnoses
- 3,017 young people provided a self-rating of their own mental health

This report examines and compares both mental health diagnoses rates and self-rated poor or very poor mental health for 10 groups of young people accessing support at BYS. These are those who are or identify as:

- 12-15 years old
- 16-18 years old
- 19-21 years old
- 22-25 years old
- Aboriginal and/or Torres Strait Islander
- CALD
- Male, female and gender diverse
- Sexuality diverse
- Have a disability
- Young parents

Data was collected by BYS workers in the first 3 contacts with a young person accessing ongoing planned support through interview-style survey collection. Data was extracted from the client record management system, was cleaned and coded, and analysed in Statistical Package for Social Sciences (SPSS). Table 2 and 3 to the right show the number of young people (n) and the percentage proportion they comprise within the total data set (N=3,255). The *p* value for statistical significance was set at 0.05. Effect size cut-offs are outlined in Appendix A.

Variable	n	%
2015-16	684	21%
2016-17	491	15%
2017-18	446	14%
2018-19	397	12%
2019-20	388	12%
2020-21	419	13%
2021-22	429	13%

Table 2. *Number and Percentage of Young People in Each Financial Year.*

Variable	n	%
12-15 years	209	6%
16-18 years	1,118	34%
19-21 years	1,050	32%
22-25 years	870	27%
Aboriginal	728	23%
Torres Strait Islander	31	1%
Both Aboriginal and/or Torres Strait Islander	48	2%
Non-Indigenous	2,433	75%
CALD	383	12%
Not CALD	2,872	88%
Female	1,688	56%
Male	1,222	40%
Gender Diverse	114	4%
Sexuality Diverse	513	21%
Straight	1,954	79%
Disability	517	18%
No Disability	2,315	82%
Parent	754	23%
Not Parent	2,474	77%

Table 3. *Demographic Characteristics of Data Set.*

MENTAL HEALTH DIAGNOSES

On average, 51% of young people had mental health diagnoses at intake. The proportion of young people reporting mental health diagnoses increased over the 7-year period from 44% to 61%.

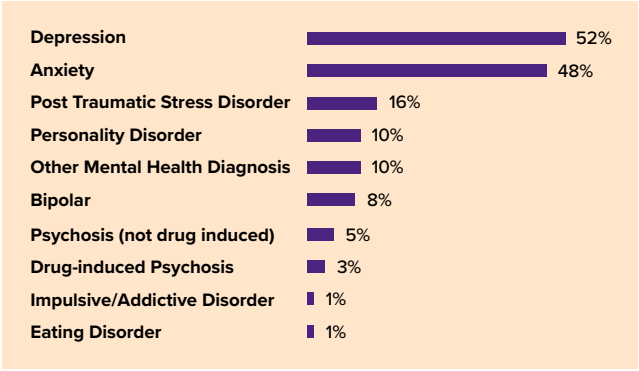


Figure 1. *Mental Health Diagnoses by Disorder Type (N=1,511)*

Looking at this year-by-year comparison, there was a clear increase in the proportion of young people with mental health diagnoses presenting for BYS support from 2019-20 to 2021-22 – the COVID-19 pandemic years (Figure 2).

With a 13% increase in diagnosis rate between 2018-19 and 2019-20 and a 33% increase between 2018-19 and 2020-21, it is clear the rate of diagnosis increased and remained high during the COVID-19 pandemic.

Of those who identified a mental health diagnosis, the most common diagnosis was depression (52%) with anxiety also frequently identified (48%; Figure 1).

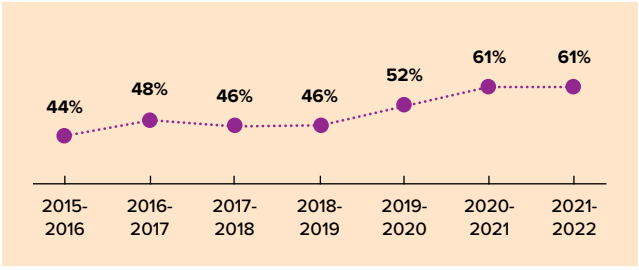


Figure 2. *Young People with Mental Health Diagnoses 2015-2022 (n=2,998)*

SELF-RATED MENTAL HEALTH

The proportion of young people self-rating their mental health as poor or very poor increased considerably over the 7-year period from 31% to 51% (Figure 3). On average, 40% of young people self-rated their mental health as poor or very poor at intake.

The most common mental health rating by young people is a 3 out of 5 (ok) followed by 2 (poor). Only an average of 4% of young people rate their mental health as a 5 (great).

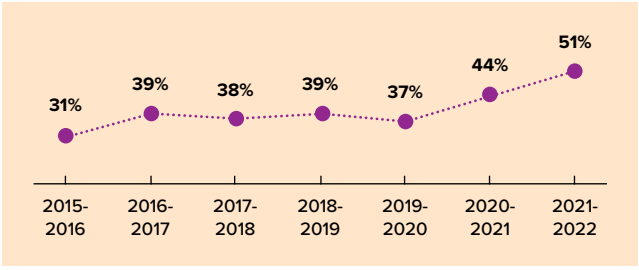


Figure 3. *Figure 3. Young People with Self-Rated Poor/Very Poor Mental Health 2015-2022 (n=2,942)*

1 / MENTAL HEALTH AND AGE

BYS supports young people between the ages of 12 years and 25 years old. Over the last 7 years, the majority (67%) of young people supported have been between the ages of 16 years and 21 years. A further 27% were aged between 22-25 years old when they first came to BYS and 6% were aged 12-15 years old

1A. AGE AND MENTAL HEALTH DIAGNOSES

Overall, and understandably, there was a statistically significant relationship between young people's age and already having mental health diagnoses at first presentation for support, however the effect size was small indicating a weak association.[1]

	12-15 years (n=188)	16-18 years (n=1,029)	19-21 years (n=982)	21-25 years (n=793)
% with Mental Health Diagnoses	36%	49%	52%	54%

Table 4. *7-year Mental Health Diagnosis Rate by Age-range.*

For those who complete intake between the ages of 12 and 15 years old, 36% already had mental health diagnoses (Table 4). This jumps to 49% when young people are aged 16-18 years old and steadily increases to 52% at 19-21 years and 54% at 22-25 years old.

The change in rate of mental health diagnoses by age range across the 7 years shows that the greatest increase in diagnosis rate was for the 22–25-year-old group (59% increase over the last 7 years; Figure 4).

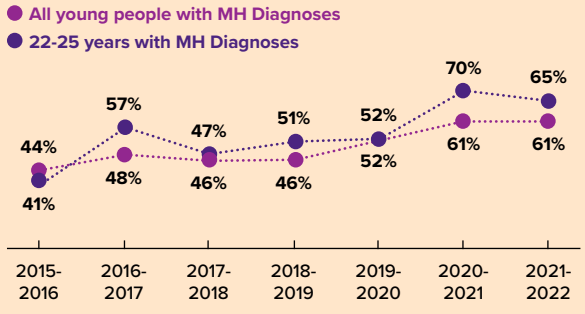


Figure 4. *22 to 25-year-olds with Mental Health Diagnoses 2015-2022*

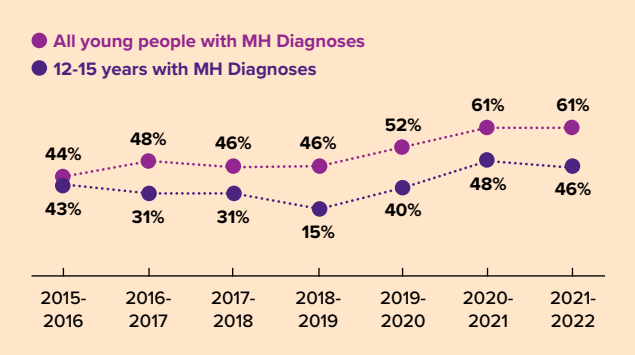


Figure 5. *12 to 15-year-olds with Mental Health Diagnoses 2015-2022*

The proportion of 12-15-year-olds with mental health diagnoses has fluctuated greatly – dropping to just 15% in 2018-19, increasing substantially to the top level at 48% in 2019-20 (COVID-19 onset period) before dropping again to the lowest rate of all the age ranges at 46% in 2021-22 (Figure 5).

Any mental health diagnosis in a 12-15-year-old is noteworthy given that diagnosis at this young age is rare (14% for 12-17 year olds; AIHW, 2021a). The global rate of onset of a mental health issue at 14 years old or under is less than half that of those aged 18-25 years old (Solmi et al, 2022).

1B. AGE AND SELF-RATED POOR OR VERY POOR MENTAL HEALTH

Overall, there was very little variation among age categories when young people self-rated their mental health (Table 5). The relationship between self-rated mental health and age was not statistically significant.[2] This indicates that younger young people are self-rating their mental health as poor/very poor at the same rate as older young people. Compared to the general population, young people accessing support at BYS were twice as likely to identify experiencing poor/very poor mental health (AIHW, 2021a).

	12-15 years (n=188)	16-18 years (n=1,029)	19-21 years (n=982)	21-25 years (n=793)
% with Poor/Very Poor Mental Health	37%	38%	40%	41%

Table 5. *7-year Poor/Very Poor Mental Health Rate by Age-range.*

Self-rated poor/very poor mental health did not vary substantially in the year-by-year comparison.

[1] X^2 (3, N=2,992) = 21.27, p=<0.001, v=0.07. [2] X^2 (3, N=2,936) = 3.09, p=0.38.

2 / MENTAL HEALTH AND CULTURE

Over the last 7 years, one in four (25%) young people supported by BYS identified as Aboriginal and/or Torres Strait Islander. Culturally and linguistically diverse (CALD) young people made up 12% of all young people supported.

2A. ABORIGINAL AND/OR TORRES STRAIT ISLANDER YOUNG PEOPLE AND MENTAL HEALTH DIAGNOSES

Just 38% of those identifying as Aboriginal and/or Torres Strait Islander reported mental health diagnoses when seeking support, compared to 54% of non-Indigenous young people (Figure 6).

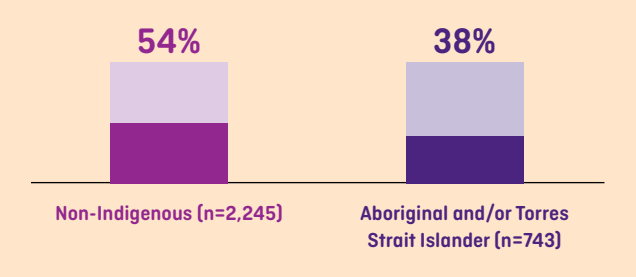


Figure 6. *Mental Health Diagnoses & Aboriginal and/or Torres Strait Islander Identity 2015-2022 (n=2,988)*

Aboriginal and/or Torres Strait Islander young people were significantly less likely to have mental health diagnoses than their non-Indigenous peers, however the effect size was small.[3]

Over the 7 years, there was considerable fluctuation across each year in terms of Aboriginal and/or Torres Strait Islander young people accessing support with mental health diagnoses, peaking in 2020-21 at 55% before returning to prior proportions (33%) in 2021-22 (Figure 7).

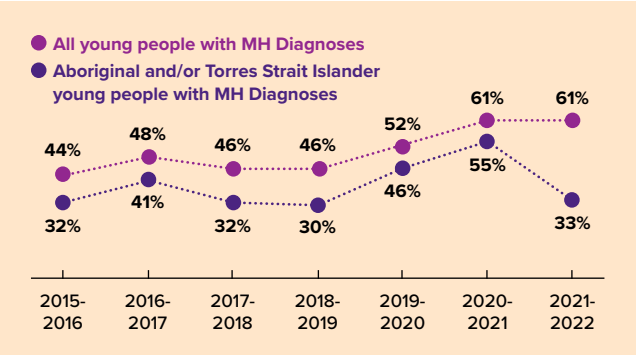


Figure 7. *Aboriginal and/or Torres Strait Islander Young People with Mental Health Diagnoses 2015-2022*

2B. ABORIGINAL AND/OR TORRES STRAIT ISLANDER YOUNG PEOPLE AND SELF-RATED POOR/VERY POOR MENTAL HEALTH

Similar to mental health diagnoses, Aboriginal and/or Torres Strait Islander young people were significantly less likely to report poor or very poor mental health when seeking support compared to non-Indigenous young people (Figure 8).[4]

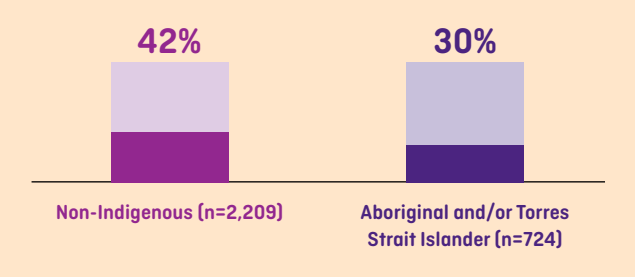


Figure 8. *Poor/Very Poor Mental Health & Aboriginal and/or Torres Strait Islander Identity 2015-2022 (n=2,933)*

There was little variation in the proportion of Aboriginal and/or Torres Strait Islander young people rating their mental health as poor/very poor over the 7-year period (Figure 9). There was a spike in 2020-21, with numbers returning to pre-COVID-19 rates in 2021-22.

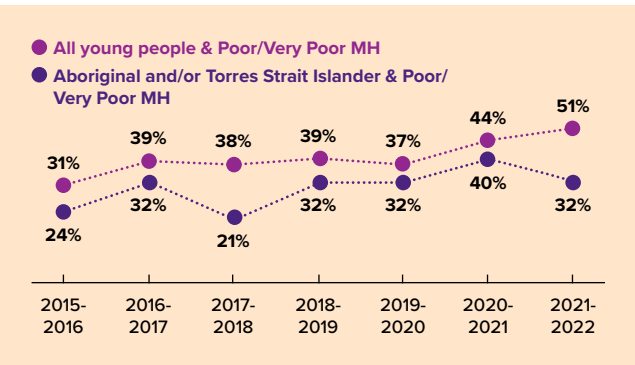


Figure 9. *Aboriginal and/or Torres Strait Islander Young People with Poor/Very Poor Mental Health 2015-2022*

[3] X^2 (1, N=2,988) = 59.65, p=<0.001, Φ^2_c=0.01. [4] X^2 (1, N=2,933) = 36.50, p=<0.001, Φ^2_c=0.01.

2C. CULTURALLY AND LINGUISTICALLY DIVERSE YOUNG PEOPLE AND MENTAL HEALTH DIAGNOSES

CALD young people were significantly less likely to present with mental health diagnoses when they seek support although the effect size was small.[5]

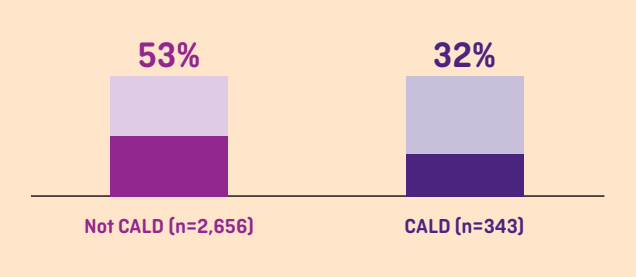


Figure 10. *Mental Health Diagnoses & CALD Identity 2015-2022 (n=2,999)*

Compared to non-CALD young people (53% with mental health diagnosis), just 32% of CALD young people had mental health diagnoses (Figure 10).

Although fewer CALD young people have mental health diagnoses compared to their non-CALD peers the 7-year trend of increased rate of diagnosis was evident for CALD young people, with a 73% increase in rate of diagnosis from 2015-16 to 2021-22 (Figure 11).

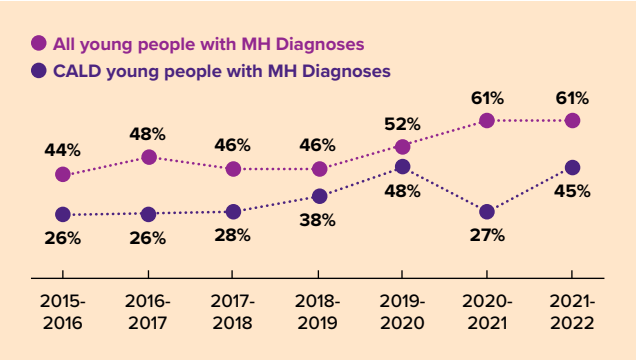


Figure 11. *CALD Young People with Mental Health Diagnoses 2015-2022*

2D. CULTURALLY AND LINGUISTICALLY DIVERSE YOUNG PEOPLE AND SELF-RATED POOR OR VERY POOR MENTAL HEALTH

CALD young people were significantly less likely to rate their mental health as poor/very poor compared to non-CALD young people, however the effect size was very small (Figure 12).[6]

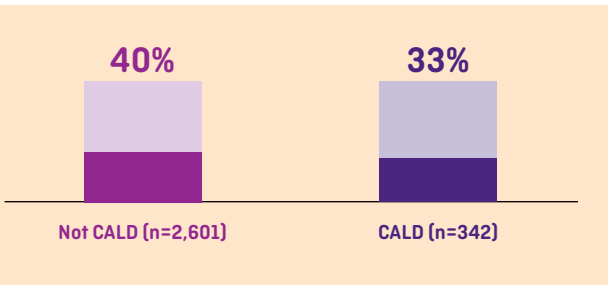


Figure 12. *Poor/Very Poor Mental Health & CALD Identity 2015-2022 (n=2,943)*

Interestingly, CALD young people showed a decrease in rate of poor mental health ratings during the COVID-19 impact period, deviating from the trend seen for all young people (Figure 13).

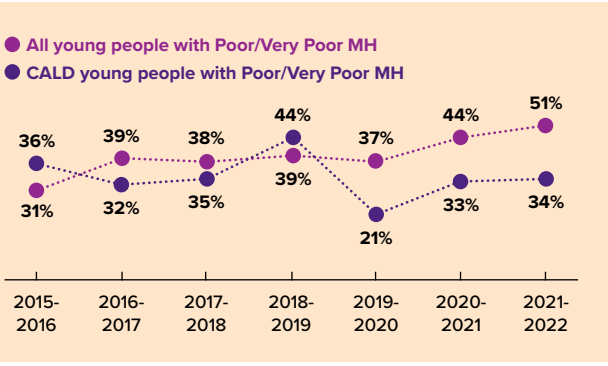


Figure 13. *CALD Young People with Poor/Very Poor Mental Health 2015-2022*

 [5] X^2 (1, *N*=2,999) = 55.32, *p*=<0.001, Φ^2_c=0.02. [6] X^2 (1, *N*=2,943) = 5.67, *p*=0.02, Φ^2_c=0.002.

3 / MENTAL HEALTH AND GENDER

Over the last 7 years, the majority of young people supported identified as female (56%) and two in five (40%) identified as male. Just 4% of all young people supported identified as gender diverse.

3A. GENDER AND MENTAL HEALTH DIAGNOSES

Gender was significantly associated with mental health diagnoses; however the association had a small effect size.[7] Gender diverse young people were the most likely to have mental health diagnoses (81%). Young women were more likely to have mental health diagnoses (51%) when compared to young men (45%; Figure 14).

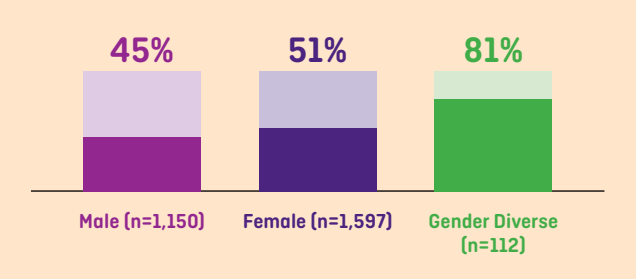


Figure 14. *Mental Health Diagnoses & Gender 2015-2022 (n=2,859)*

Amongst young people accessing BYS support, the disparity between mental health diagnoses for young women and young men was less substantial than national averages. Young women's rate of diagnosis was slightly higher than the national average (51% compared to 47%) but young men were substantially more likely to have mental health diagnoses than the general population of young people in Australia (45% compared to 31% nationally; ABS, 2022).[8]

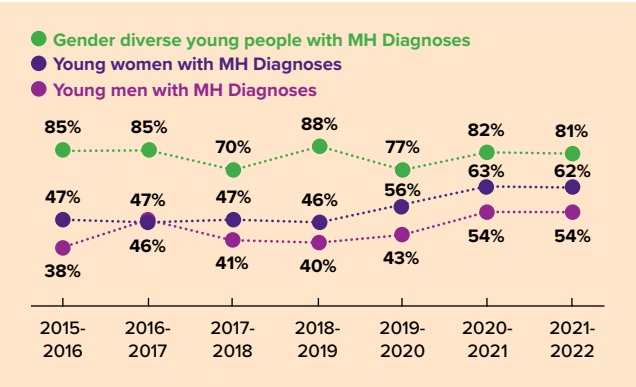


Figure 15. *Young People with Mental Health Diagnoses by Gender Identity 2015-2022*

Diagnosis rates have risen in the last 3 years for young women and men, matching the trend for all young people. For gender diverse young people, this steady increase in mental health diagnoses was not observed during the COVID-19 pandemic (Figure 15).

3B. GENDER AND SELF-RATED MENTAL HEALTH

Gender was significantly associated with self-rated poor/very poor mental health; however, the association had a moderate effect size.[9] Gender diverse young people were the most likely to have poor/very poor mental health (57%; Figure 16). Young women were more likely to have poor/very poor mental health (40%) when compared to young men (34%).

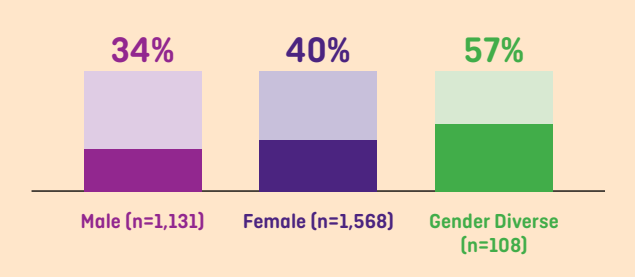


Figure 16. *Poor/Very Poor Mental Health & Gender 2015-2022 (n=2,807)*

Gender diverse young people showed a rapid escalation in likelihood of self-rating their mental health as poor or very poor in the lead up to the COVID-19 pandemic in 2019-2020.

While the rate of gender diverse young people reporting their mental health as poor or very poor dropped during 2020-21 and 2021-22, the self-reported mental health rates for all young people were climbing (Figure 17). Young people identifying as binary genders rated their mental health as poor/very poor at a similar rate to all young people.

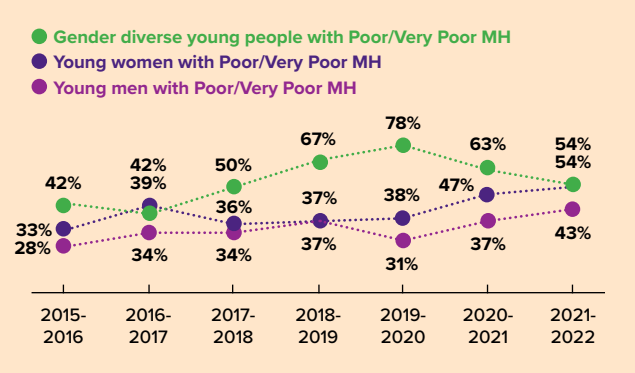


Figure 17. *Young People with Poor/Very Poor Mental Health by Gender Identity 2015-2022*

[7] X^2 (2, N=2,859) = 58.78, p=<0.001, v=0.02.
[8] National data does not include young people who identify as gender diverse.
[9] X^2 (2, N=2,807) = 28.30, p=<0.001, v=0.01.

4 / MENTAL HEALTH AND SEXUALITY

Over the last 7 years, over one in five (21%) young people supported by BYS identified as a diverse sexuality (not heterosexual).

4A. SEXUALITY AND MENTAL HEALTH DIAGNOSES

Sexuality had a statistically significant association with mental health diagnoses for young people and the association had a small-medium effect size.[10] Young people who identify as sexuality diverse were significantly more likely to have mental health diagnoses (72% compared to 45% for heterosexual young people; Figure 18).

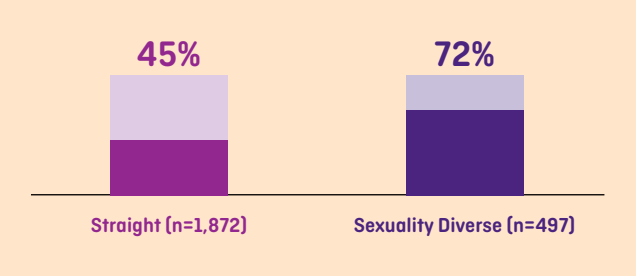


Figure 18. *Mental Health Diagnoses & Sexuality 2015-2022 (n=2,369)*

Over the last 7 years, rate of mental health diagnoses for sexuality diverse young people have remained higher than for all young people. Interestingly, the rate of mental health diagnosis for sexuality diverse young people did not change during the COVID-19 pandemic (Figure 19).

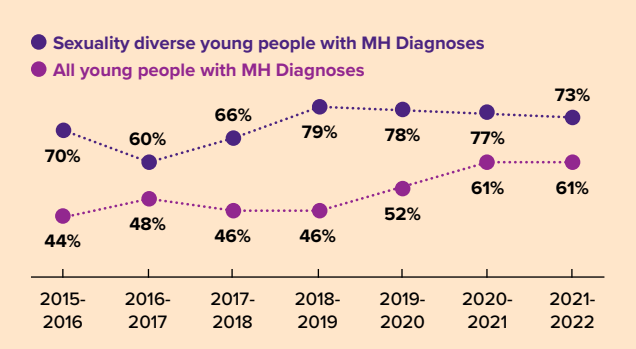


Figure 19. *Sexuality Diverse Young People with Mental Health Diagnoses 2015-2022*

4B. SEXUALITY AND SELF-RATED MENTAL HEALTH

Sexuality had a statistically significant association with self-rated poor/very poor mental health; however, the association had a small effect size.[11] Sexuality diverse young people were significantly more likely to have poor/very poor mental health (52% compared to 34% for straight young people; Figure 20).

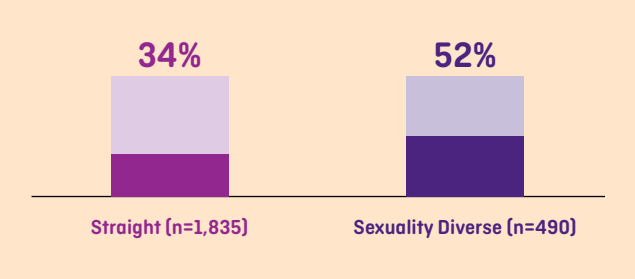


Figure 20. *Poor/Very Poor Mental Health & Sexuality 2015-2022 (n=2,325)*

The rate of sexuality diverse young people with poor/very poor mental health increased over the 7-year period with a less pronounced increase during the COVID-19 pandemic compared to all young people with poor/very poor mental health (Figure 21).

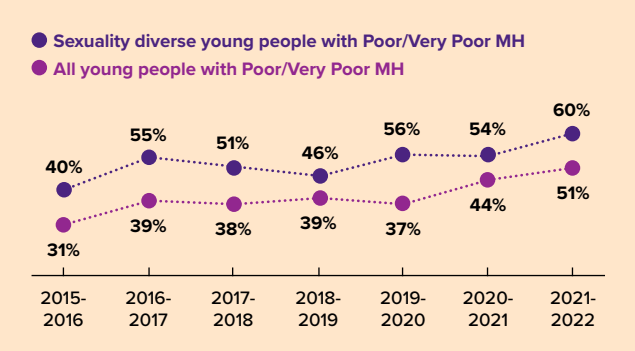


Figure 21. *Sexuality Diverse Young People with Poor/Very Poor Mental Health 2015-2022*

[10] X^2 (1, N=2,369) = 114.29, p<0.001, Φ^2_c=0.05. [11] X^2 (1, N=2,325) = 50.62, p<0.001, Φ^2_c=0.02.

5 / MENTAL HEALTH AND DISABILITY

Over the last 7 years, 18% of young people have identified, when seeking support, that they have a disability. While there has been minor fluctuation in proportions over time, consistently the most common disabilities are Learning/Behavioural followed by Intellectual/Developmental.

5A. DISABILITY AND MENTAL HEALTH DIAGNOSES

Disability had a statistically significant association with mental health diagnoses and the association had a medium effect size.[12] Young people with disability were significantly more likely to have mental health diagnoses (69% compared to 46% for young people without disability; Figure 22).

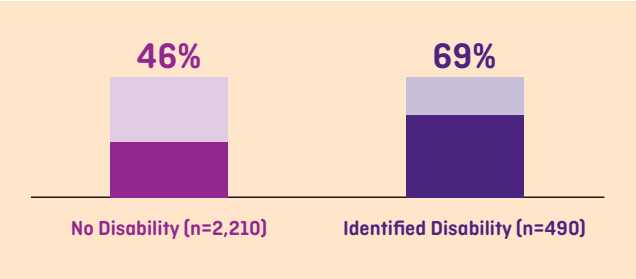


Figure 22. *Mental Health Diagnoses & Disability 2015-2022 (n=2,700)*

The rate of young people with disability and mental health diagnoses increased over the 7-year period with a less pronounced rise during the COVID-19 pandemic compared to all young people with mental health diagnoses (Figure 23).

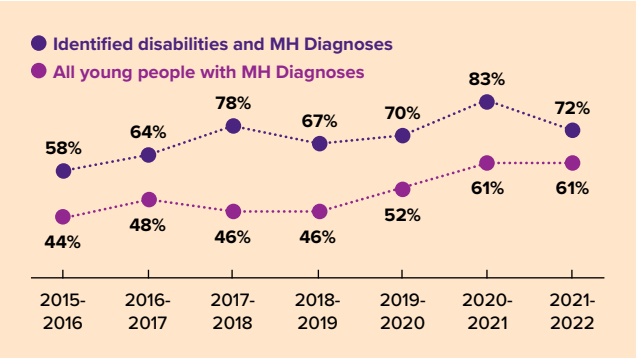


Figure 23. *Young People with Disability & Mental Health Diagnoses 2015-2022*

5B. DISABILITY AND SELF-RATED POOR OR VERY POOR MENTAL HEALTH

Disability had a statistically significant association with poor/very poor mental health and the association had a very small effect size.[13] Young people with disability were significantly more likely to rate their mental health as poor or very poor (42% compared to 37% for young people without disability; Figure 24).

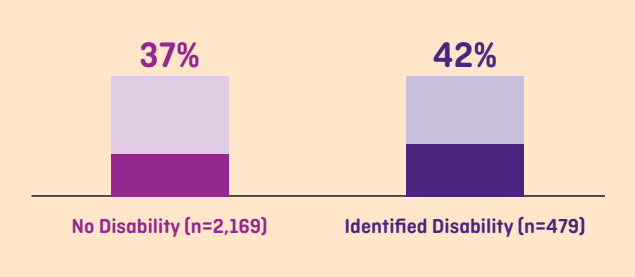


Figure 24. *Poor/Very Poor Mental Health & Disability 2015-2022 (n=2,648)*

The rate of young people with disability and poor/very poor mental health was consistent with the trend for all young people over the 7-year period (Figure 25).

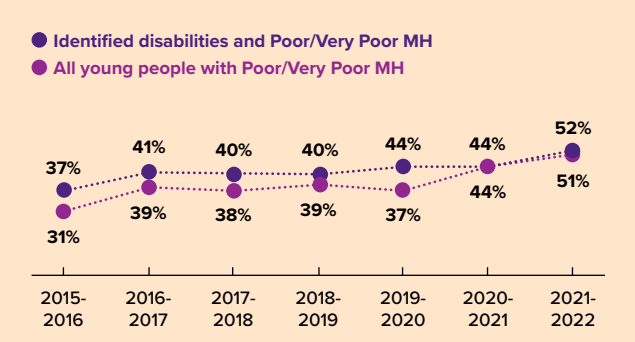


Figure 25. *Young People with Disability & Poor/Very Poor Mental Health 2015-2022*

[12] X^2 (1, N=2,700) = 86.76, p<0.001, Φ^2_c=0.03. [13] X^2 (1, N=2,648) = 3.87, p=0.05, Φ^2_c=0.001.

6 / MENTAL HEALTH AND YOUNG PARENTS

Over the last 7 years, 23% of young people presenting to BYS were young parents. The majority of young parent's children remained in their care (75%) with 12% of children in relative/ kin care and 8% in foster care at intake.

6A. YOUNG PARENTS AND MENTAL HEALTH DIAGNOSES

Parenthood had a statistically significant association with mental health diagnoses and the association had a small effect size.[14] Young parents were significantly less likely to have mental health diagnoses (42% compared to 53% for young people without children; Figure 26).

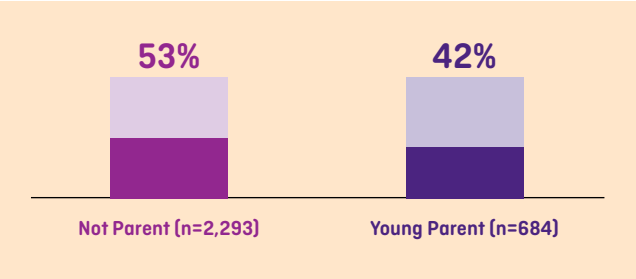


Figure 26. *Mental Health Diagnoses & Young Parents 2015-2022 (n=2,977)*

The rate of young parents with mental health diagnoses increased over the 7-year period with a more pronounced rise during 2020-21 before dropping slightly in 2021-22 compared to all young people with mental health diagnoses (Figure 27).

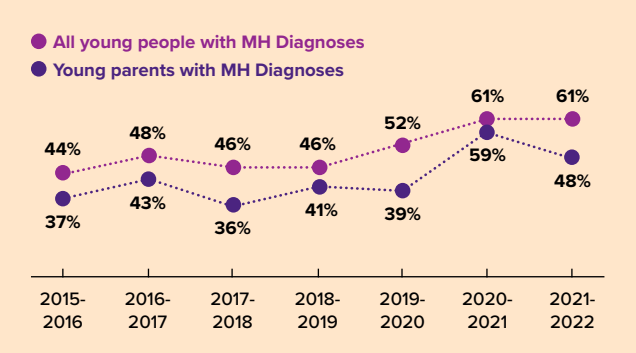


Figure 27. *Young Parents with Mental Health Diagnoses 2015-2022*

6B. YOUNG PARENTS AND SELF-RATED POOR OR VERY POOR MENTAL HEALTH

Parenthood had a statistically significant association with poor/very poor mental health and the association had a small effect size.[15] Young parents were significantly less likely to have poor/very poor mental health (31% compared to 42% for young people without children; Figure 28).

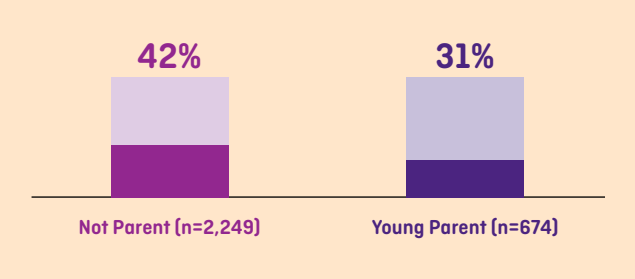


Figure 28. *Poor/Very Poor Mental Health & Young Parents 2015-2022 (n=2,923)*

The rate of young parents with poor/very poor mental health remained lower but matched the rising trend during the COVID-19 pandemic for young people over the 7-year period (Figure 29).

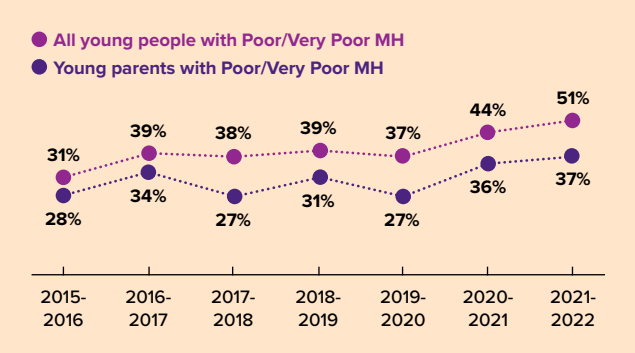


Figure 29. *Young Parents with Poor/Very Poor Mental Health 2015-2022*

[14] X^2 (1, N=2,977) = 22.29, p<0.001, Φ^2_c=0.01. [15] X^2 (1, N=2,923) = 23.62, p<0.001, Φ^2_c=0.01.

7 / OVERALL PATTERNS OF MENTAL HEALTH ISSUES

7A. OVERALL PATTERNS FOR MENTAL HEALTH DIAGNOSES

For most groups of young people seeking support at BYS, the likelihood of mental health diagnoses is well above the estimated rate of mental health concerns in the broader youth population (Figure 30). The National Health Survey (2017-18) indicates that 26% of young people in Australia identified mental health diagnoses in comparison to 51% of young people within the total BYS 7-year cohort (AIHW, 2021a).

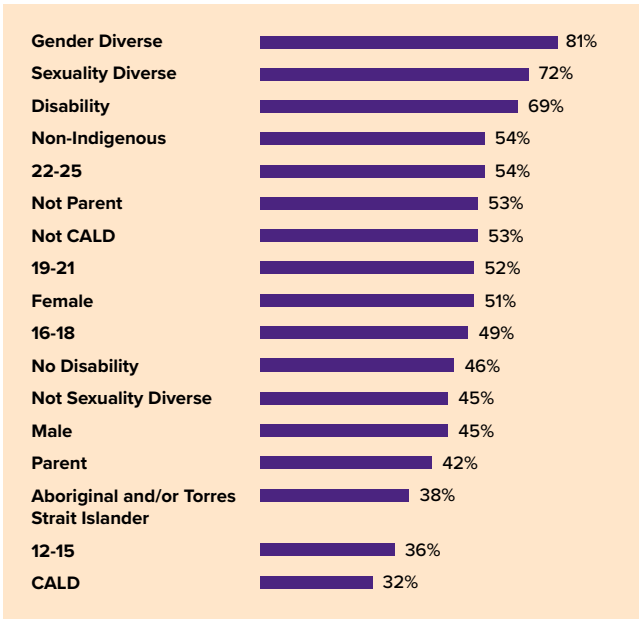
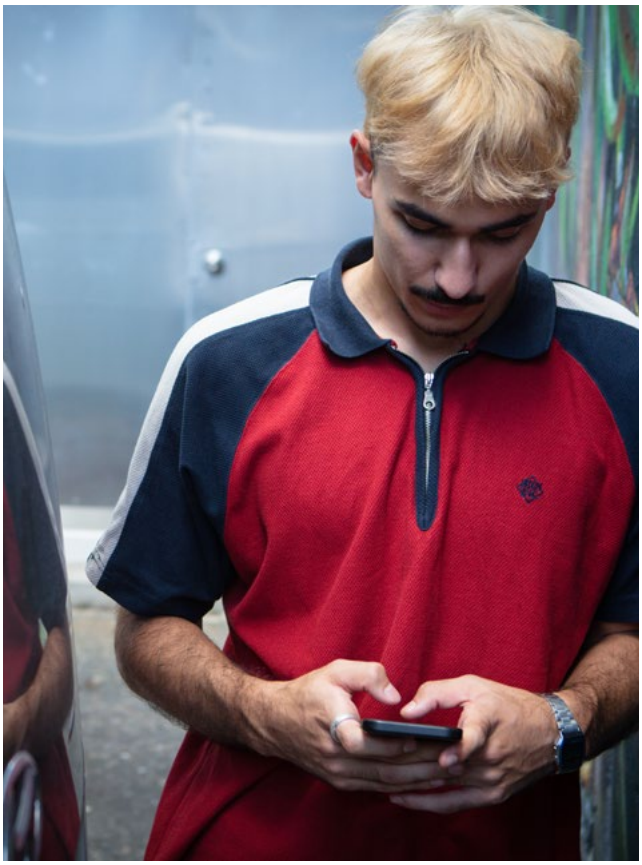


Figure 30. *Mental Health Diagnoses by Demographics*



Over the last 7 years there has been a steady escalation in mental health diagnoses across most groups of young people accessing support at BYS, with a notable increase during the period of time that COVID-19 has impacted the local community.

The key findings from the mental health diagnosis data are:

- Those who are gender and/or sexuality diverse or had disability were the most likely groups of young people accessing support at BYS between 2015-2022 to have mental health diagnoses.
- Likelihood of diagnoses increases with age.
- CALD young people, Aboriginal and/or Torres Strait Islander, young parents and younger young people (12-15 years) were least likely to have mental health diagnoses.

7 / OVERALL PATTERNS OF MENTAL HEALTH ISSUES

7B. OVERALL PATTERNS OF SELF-RATED POOR OR VERY POOR MENTAL HEALTH

When looking at the demographic groups, young people's likelihood of self-rating their mental health as poor or very poor follows similar patterns to the rate at which each group had mental health diagnoses, with some notable differences. Compared to mental health diagnosis, there was less variation between groups (ranging from 30% to 57%; Figure 31).

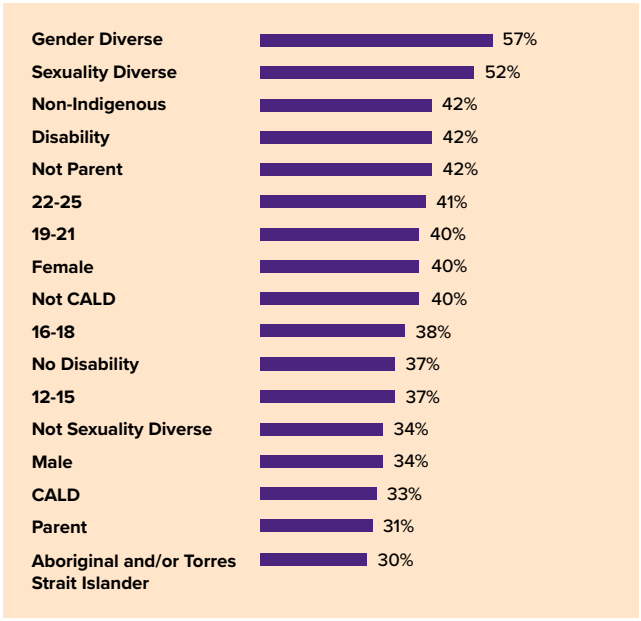


Figure 31. *Poor/Very Poor Mental Health by Demographics*

The key findings from the analysis of self-rated mental health are:

- Gender diverse and sexuality diverse young people had the highest rate of self-reported poor mental health.
- Young people with disability were equal third highest in frequency of self-rated poor mental health and had the third highest rate of mental health diagnosis.
- Aboriginal and/or Torres Strait Islander young people, young parents, and CALD young people are the groups least likely to describe their mental health as poor.

It is interesting to note that when young people were asked to rate the quality of their mental health, the proportion who indicate that it is poor or very poor when they are first seeking support is substantially lower than the proportion who have mental health diagnoses. This may be a result of positive management of mental health symptoms post-diagnosis, or it may indicate that young people's past diagnoses are not an indicator of current psychological wellbeing and mental health.

There are many possible explanations for the divergence including:

- Diagnoses related to access to Medicare funded psychological support or National Disability Insurance Scheme (NDIS),
- Young people who are in crisis when they are seeking support may down-play or inaccurately self-assess their mental health,
- Young people's mental health diagnoses may not cause them to feel "poor" on a day-to-day basis,
- Young people are asked if they have ever had a mental health diagnosis, whereas the self-ratings of mental health refer to the point in time that they are seeking support only.

CONCLUSION AND CALL TO ACTION

The findings from this 7-year analysis clearly demonstrate that young people supported by BYS have mental health diagnosis rates far greater than the general population.

In response, BYS will need to explore innovative ways to support subjective mental health and treat mental health diagnoses of the young people we support. This data also highlights how important it is for BYS to continue to actively develop referral pathways to appropriate, safe mental health supports for the most vulnerable young people (i.e. young people with disability, gender and/or sexuality diverse young people).

Aboriginal and/or Torres Strait Islander young people make up almost one third of those accessing support and 38% of those with a mental health diagnosis at intake. BYS should explore culturally validated, accessible ways of screening for mental health concerns as well as potential barriers to mental health care for young people. BYS should also explore having identified positions within the mental health team and developing and implementing a culturally specific framework for supporting Aboriginal and/or Torres Strait Islander young people's mental health. This has the potential to provide good, culturally safe mental health care breaking down barriers and facilitating pathways to support.

This report has outlined that mental health diagnoses and self-rated mental health has not returned to pre-pandemic levels. Mental health concerns have almost certainly been exacerbated by the housing crisis. It is now more important than ever to advocate for housing and support services for young people that are affordable, accessible and delivered in a timely manner.

For the broader youth and mental health sectors, the findings in this report highlight the need for expanded mental health supports for young people. There are mild/moderate early intervention supports and acute mental health crisis services available, but little to no free, accessible and timely support for young people who fit between acute crisis and early intervention in Brisbane. This report especially provides evidence for the need to provide services for the most vulnerable groups of young people, specifically young people with disability, gender diverse and sexuality diverse young people.

The literature outlines a high suicide rate but low rate of mental health diagnosis for Aboriginal and/or Torres Strait Islander young people, as well as barriers to diagnosis and support. One opportunity for further research arising from this report is to dive deeper into why Aboriginal and/or Torres Strait Islander young people have a smaller incidence of mental health diagnoses and better self-rated mental health compared to non-Indigenous young people. Further research should be done in partnerships with Aboriginal and/or Torres Strait Islander researchers and research organisations to ensure activities are culturally safe, meaningful, and useful for communities.

This report also highlighted a gap in the literature concerning CALD young people's mental health diagnosis rates and utilisation of mental health supports. There is an opportunity to explore this topic further and develop research partnerships with CALD research organisations. This could allow us to better understand the rates of mental health diagnosis and experience of accessing mental health support for CALD young people in Queensland and therefore develop appropriate interventions and frameworks for support.

Further analysis on other variables is also an area for further exploration. All statistically significant findings had a small or small-moderate effect size suggesting that only a small proportion of the variance found between groups was due to the specific demographic factors. It would be of interest to compare experience of violence, homelessness and other key risk factors for poor/very poor mental health to explore whether other variables have a greater effect size.

Key limitations from this report and analysis include:

- Only the first presentation to BYS was included in the analysis. This does not account for diagnoses that occur during support or in between support periods potentially underestimating the rate of mental health diagnosis.
- BYS do not collect data to validate the source of mental health diagnosis. This may lead to an overestimation in rate of mental health diagnosis.
- Self-rated mental health is a point in time assessment, only capturing subjective mental health when the question was asked at intake.
- The tool used has not been culturally validated by Aboriginal and/or Torres Strait Islander communities or CALD communities. It has also not been tested for reliability and validity for young people with disability.

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APPENDIX A
EFFECT SIZE INTERPRETATION

Interpretation	Cut-off for v (IBM, 2023)	Guideline for Φ^2_c (Cohen, 1988)
Small Effect Size	≤0.2	0.01
Medium Effect Size	>0.2 to ≤0.6	0.09
Large Effect Size	>0.6	0.25

Table 6. *Effect Size Interpretation for Cramér's V (v) and Squared Cramer's Phi Coefficient (Φ^2_c)*

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