



AUSTRALIAN
MEDICAL STUDENTS'
ASSOCIATION

University Student Mental Health:

The Australian Context

Acknowledgements

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Welcome

In 2013, the Australian Medical Students' Association (AMSA) adopted a new Student Mental Health and Wellbeing Policy, which drew attention to the morbidity caused by mental health issues to young people Australia-wide:

“Students are less likely to perform well at university when suffering from mental ill health. Psychiatric illness has been shown to be associated with lower educational achievement, decreased employment, lower incomes and lower standard of living, and studies specifically of university students have found a correlation between mental health problems and poorer educational outcomes, as well as increased impairment and more days out of role... [The] Australian Institute of Health and Welfare (AIHW) data shows more than one quarter (26 per cent) of the 16-24 age group experience a mental health disorder in a 12-month period – the highest incidence of any age group. Anxiety disorders are the most common, followed by substance use disorders and then affective disorders.”

AMSA Student Mental Health and Wellbeing Policy 2013

Following the introduction of this policy, AMSA established the Student Mental Health and Wellbeing Committee in order to translate this policy into tangible and multifaceted action.

One of this committee's initial goals was to establish an 'Evidence Database' which consists of a range of reports focusing on various aspects relating to tertiary student mental health. The following report is one of a set of five that together provide a rationale upon which our committee and others may formulate future endeavours. These reports also play an incredibly valuable role in generating awareness of the current tertiary student mental health context. Consequently, we hope that through a greater knowledge of the facts, our readers will feel empowered to take actions to promote student mental health and wellbeing.

The current report focuses on setting the scene of student mental health in Australia. Our Committee sought to gain an evidence-based understanding of the important facets of mental health in Australian University students, such as which disorders they are most at risk of and why. What is clear from this report is that this is a surprisingly neglected area of research which urgently warrants further empirical investigation. Consequently, we may start to see more effective and targeted interventions for students, and better outcomes overall for their mental health and wellbeing.

Warm Regards,



Tasha Wahid



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Introduction

Mental health is one of the Australia's nine National Health Priority Areas, yet there is a dearth of enquiry into the state of mental health among our university students. This is not a consequence of lack of need, as evidenced by data from the Australian Institute of Health and Welfare, which indicates that the 16-24 age group exhibits the highest incidence of mental health disorder in a 12-month period (26%). In addition, compared with other age groups, people in younger age groups are less likely to access mental health services.ⁱ

This paper reviews the literature on the scope of mental health needs of Australian university students. It examines the prevalence, incidence, risk factors, predictive factors, and long-term impacts of mental illness on students and the broader community. There was a focus on the common mood and conduct disorders of depression, anxiety, and suicidal behaviour. The paper concludes with some recommendations for addressing mental health issues among Australian university students.

Prevalence

The 2008 National Mental Health Survey conducted by the Australian Bureau of Statistics indicated that the proportions of elevated distress met with by university health services (53%) were considerably higher than those met with by the health services in the general population (29%).ⁱⁱ A 2010 study by Stallman conducted on 6479 students from two major Australian universities showed an even greater difference, with the prevalence of elevated distress among the student health service sample double that of health service patients drawn from the general population.² In this study, the majority of Australian university students (83.9%) reported elevated distress levels, suggesting that university students are a very high-risk population.²

Figure 1. Comparison of level of psychological distress of university sample with general population [3].

Level of distress	Semester 1			Semester 2 [†]			General population [‡]	
	Male %	Female %	Total %	Male %	Female %	Total %	Male %	Female %
Low (10–19)	61.4	52.9	54.9	65.5	44.9	47.0	85.8	79.6
Moderate (20–24)	19.7	25.9	24.4	13.8	28.4	26.4	8.3	10.6
High (25–29)	10.8	12.1	11.8	12.1	16.2	15.8	3.1	5.5
Very high (30 – 50)	8.1	9.2	8.9	8.6	10.6	10.8	2.7	5.4

Note. [†]Stallman (2008); [‡]Australian Bureau of Statistics (2001).

A large cross-sectional web-based study conducted at the University of Newcastle investigated the prevalence of common mental health disorders like anxiety (13%), eating disorders (14%), and harmful drinking (8%). The study found that nearly one third of students reported at least one of these disorders.⁴ In another Australian study on 4-17 year olds, 14% of children and adolescents reported mental health problems. Many of these people also suffered from comorbidities and had a higher risk if suicidal behaviour. Only 25% had sought professional help in the last six months.⁵

Key Factors

The study found that students with reported financial stress have double the rate of reported mental illness compared with students with no financial stress.² As with all such incidences of reporting, however, it is important to keep in mind the role of self-selection in a self-reporting cohort. The majority (84.8%) of students reporting with mental disorders also reported financial stress, with 43.9% reporting occasional stress, 26.0% frequent stress, and 14.9% constant financial stress. The study also found that students living alone or in other off-campus accommodation had higher rates of psychological distress compared to students residing in university residential accommodation.² In Australian populations, the incidence of psychological distress did not vary significantly between domestic and international students,² nor was there a correlation with marital status, after controlling for age.²

The data from Australian populations is well complemented by comparative data from overseas. For instance, a study conducted in 2005 on a large public university in the United States found that students residing with parents or guardians were more likely to report suicidal thoughts.⁶ Students in financial difficulties, or those from a low socioeconomic background, were more likely to screen positive for depression and anxiety disorders.⁶

Low socioeconomic background is also a predictive factor for access to mental health services. Other predictors of low access stem from misinformation and low public awareness, such as a lack of perceived need, and skepticism concerning the value of mental health treatment.⁷

Parental education was not associated with disorder, nor was international versus domestic status.⁴

Figure 2. Proportions of the sample with depression, anxiety, eating disorder or harmful drinking [4].

	Depression	Anxiety	Eating disorder	Harmful drinking
Gender				
Male	5.7 % (118/2,080) ^a	7.9 % (163/2,069)	9.5 % (195/2,056)	13.4 % (280/2,095)
Female	9.2 % (374/4,083)	15.1 % (611/4,059)	16.0 % (643/4,012)	5.5 % (225/4,111)
Age				
17–24	7.6 % (288/3,777)	11.7 % (438/3,756)	13.3 % (496/3,723)	9.1 % (346/3,801)
25–34	9.4 % (121/1,281)	16.1 % (205/1,271)	15.2 % (191/1,254)	9.0 % (116/1,293)
35–44	8.1 % (52/641)	11.8 % (75/638)	13.2 % (83/631)	3.4 % (22/645)
45+	6.7 % (31/464)	12.1 % (56/463)	14.8 % (68/460)	4.5 % (21/467)
Student type				
Domestic students	8.2 % (462/5,610)	13.1 % (733/5,613)	14.4 % (802/5,579)	8.4 % (469/5,613)
International students	4.9 % (21/431)	8.4 % (36/431)	7.0 % (30/430)	4.4 % (19/431)
Degree type				
Undergraduate	8.5 % (445/5,264)	13.0 % (682/5,235)	14.1 % (730/5,185)	8.7 % (459/5,300)
Postgraduate	5.0 % (42/836)	9.6 % (80/830)	11.8 % (97/821)	4.7 % (40/843)
Year of Study				
1	10.1 % (217/2,147)	13.8 % (293/2,128)	13.8 % (291/2,109)	8.5 % (185/2,166)
2	8.5 % (124/1,457)	12.3 % (178/1,451)	13.3 % (190/1,431)	8.5 % (124/1,465)
3	5.3 % (67/1,274)	11.7 % (148/1,269)	14.0 % (176/1,260)	7.6 % (97/1,281)
4	7.9 % (55/694)	13.9 % (96/689)	14.6 % (99/680)	8.7 % (61/698)
5+	4.9 % (29/591)	10.0 % (59/591)	13.9 % (82/588)	6.4 % (38/596)
Country of birth				
Australia or NZ	8.2 % (437/5,299)	13.2 % (697/5,275)	14.5 % (755/5,222)	8.7 % (465/5,333)
Other	6.4 % (55/864)	9.0 % (77/853)	9.8 % (83/846)	4.6 % (40/873)
Healthcare card				
No	6.8 % (197/2,897)	11.5 % (332/2,882)	13.2 % (378/2,854)	7.7 % (225/2,917)
Yes ^b	9.0 % (295/3,266)	13.6 % (442/3,246)	14.3 % (460/3,214)	8.5 % (280/3,289)
Parent with highest education				
Completed degree	7.8 % (205/2,622)	12.1 % (315/2,605)	13.2 % (334/2,528)	8.1 % (214/2,638)
Other post school qualification ^c	7.9 % (117/1,475)	13.2 % (193/1,463)	13.3 % (192/1,446)	9.7 % (144/1,487)
Completed year 12	6.5 % (38/585)	11.7 % (68/582)	13.8 % (80/578)	7.0 % (41/587)
Completed year 10	8.0 % (83/1,037)	12.5 % (129/1,034)	15.3 % (156/1,019)	8.3 % (87/1,046)
Did not complete year 10	11.4 % (35/308)	16.9 % (52/308)	16.6 % (51/307)	4.5 % (14/311)
Hours in paid work				
0	9.3 % (199/2,141)	13.7 % (291/2,129)	12.6 % (266/2,107)	7.6 % (165/2,160)
1–5	6.5 % (29/447)	10.3 % (46/445)	12.3 % (54/440)	5.1 % (23/449)
6–10	6.5 % (59/901)	11.7 % (105/896)	12.8 % (114/890)	7.4 % (67/906)
11–20	7.3 % (101/1,390)	13.0 % (179/1,382)	15.7 % (215/1,368)	9.3 % (130/1,397)
20+	8.1 % (104/1,284)	12.0 % (153/1,276)	15.0 % (189/1,263)	9.3 % (120/1,294)
Sexual orientation				
Heterosexual	7.1 % (396/5,557)	11.9 % (659/5,560)	13.3 % (735/5,529)	7.7 % (426/5,560)
Homosexual	13.0 % (21/162)	19.1 % (31/162)	18.0 % (29/161)	13.6 % (22/162)
Bisexual	20.6 % (66/320)	24.4 % (78/320)	21.5 % (68/317)	12.5 % (40/320)
Drinking status (AUDIT)				
Non drinker	12.1 % (142/1,172)	15.3 % (178/1,164)	15.5 % (179/1,154)	–
Moderate drinker	6.3 % (184/2,940)	11.2 % (329/2,925)	10.8 % (312/2,888)	–
Hazardous drinker	6.5 % (101/1,549)	11.1 % (172/1,544)	15.7 % (241/1,534)	–
Harmful drinker	8.4 % (28/333)	14.3 % (47/329)	19.6 % (64/327)	–
Possibly alcohol dependent	21.9 % (37/169)	28.9 % (48/166)	25.5 % (42/165)	–

^a Total number with disorder/number who answered questions

^b Met means tested criteria for government healthcare card

^c e.g., trade, diploma, TAFE certificate

Alleviating Factors

Studies from the United States indicates that factors associated with fewer mental health problems include age greater than 25 years, living at a campus residence hall, and postgraduate status.⁶ The lower levels of distress in postgraduate students may be the product of self-selection, in that undergraduate students with good coping skills may be more likely to go on to postgraduate studies. The effect of age may also account for some of the differences.

Mood and Conduct Disorders: Anxiety, Depression, and Suicide

The lack of extant literature on Australian populations in this area warrants investigations of data from other countries. The Eisenberg study, a large cross-sectional study from the United States, indicated that 15.6% of undergraduates and 13.0% of graduate students reported suffering a depressive or anxiety disorder. Depression alone was reported by 13.8% of undergraduates and 11.3% of graduate students, with no major difference between males and females. Anxiety disorders were less common, being prevalent in 4.2% of undergraduates and 3.8% of graduate students. Out of those reporting anxiety disorders, the majority indicated that they were suffering from generalised anxiety disorder (2.9% of undergraduates, 3.1% of graduate students) rather than panic disorder (1.8%, 1.1%). The prevalence of anxiety disorders in females was twice that of males.⁶ However, this may be due to higher incidences of reporting among females than males. Further research is required to confirm the gender differences in levels of reporting.

In the Eisenberg study, 2.5% of undergraduates and 1.6% of graduate students reported having suicidal thoughts in the past 4 weeks. However, less than 1% of both groups reported making a suicidal plan in the past 4 weeks. 1 student in the study reported a suicide attempt.⁶ More research is required in this area on Australian student populations.

Comorbidities

In the Eisenberg study, there was a strong association between anxiety disorder and depression, and between suicidal thoughts and depression. 50.1% of those who reported generalised anxiety disorder also screened positive for major depression. 42.8% of those with reporting suicidal thoughts also reported major depression, and 24.1% screened positive for other depression.⁶

Note that anxiety disorders were categorised as "generalised anxiety disorders" or "panic disorders", while depression was categorised as "major" or "other". The criteria for a major depressive disorder was determined using the PHQ-9, a nine-item instrument based on the *Diagnostic and Statistical Manual for Mental Disorders*.¹³

Literature on mental disorder comorbidities is lacking for Australian student populations. Future research should centre on comorbidity within the spectrum of mental disorders, including:

- Depression (major and minor)
- Anxiety disorders
- Obsessive-compulsive disorder
- Post traumatic stress disorder
- Substance abuse disorders
- Personality disorders

Impacts of Student Mental Illness

The Stallman study indicated that a reduced capacity for work or study increased significantly with levels of psychological distress among Australian university students. Students who reported high levels of psychological distress experienced reduced capacity or total impairment for more than 10 days on average in the previous month.² However, more longitudinal studies are required to construct an accurate picture of the long term impact of mental disorders, both on the individual on the broader community.

Comparative data from the United States sheds further light on the issue. There is a significant link between high levels of psychological distress among college students and academic performance.⁸ It is estimated that 4.29 million people in the United States, representing 5% of college students, have terminated their college due to mental illness.⁹ Studies have also shown that students with high levels of psychological distress experience trouble with time and resource management. These students were also less likely to seeking academic assistance.¹⁰

College counselling centres in the United States have found a trend in the demands of students in the last 10 years, from simple information-seeking to much more severe psychological issues. According to the National Survey of Counselling Centre Directors at 274 institutions, 85% of centres reported an increase in the severity of presenting psychological disorders over the last 5 years. 94% of centres also found an increase in the number of students seeking counselling who were already taking psychiatric medication, from 9% in 1994 to 17% in 2005.¹¹

As early as 1998, a study conducted by Levine demonstrated a dramatic rise in serious mental health issues among college students in the United States over the last decade. The study found a 58% increase in eating disorders, a 42% rise in drug abuse, a 35% hike in alcohol abuse, and a 23% increase in suicide Attempts.¹² These figures point strongly to the fact that students are coming to college “overwhelmed and more damaged than those of previous years”.¹²

Perhaps in response to this dramatic rise, the same study found a large increase in demand for college counselling centres.¹² For example, Columbia University reported a 40% increase in the use of counselling services since 1995; MIT experienced a 50% increase in the use of counselling services between 1995–2000; the State University of New York, and the University

of Cincinnati reported a 55% increase in the number of students seeking counselling over the last 6 years.¹⁰

Recommendations for Future Research

In Australia, broad multilevel programs to address the mental health and wellbeing of university students are required alongside extant interventions developed to address specific areas of importance like alcohol abuse. The Queensland University of Technology and Beyondblue are currently developing an online program to promote resilience in university students.² More programs like these are required to promote the concept of mental health and wellbeing to the Australian population. A comprehensive review of possible interventions strategy is provided in AMSA's global mental health report on university students.

Currently, there are large gaps in the literature concerning mental health issues in the Australian youth population. There is limited evidence on the causes of mental health issues. While a number of risk factors for, and protective factors against, developing psychiatric disorders have been identified, further investigation is required into why certain characteristics such as gender or age affect the progression of mental illness.

More statistics are required on the prevalence of anxiety, depression and suicide in Australian populations, as well the prevalence of comorbid psychiatric conditions. In addition, literature on the burden and cost of mental health problems is limited. This is significant given that mental health is one of the nation's National Health Priority Areas.

There is a clear gap in the literature about evidence-based recommendations for the management of depression in young people. Existing literature indicates a need for integration between broad multilevel programs to address the mental health and wellbeing of university students and extant interventions developed to address specific areas of mental health. In addition, research is required into the feasibility of interventions in an Australian setting, as many preventative and management strategies derive from overseas settings.

Conclusions

This paper highlights the significance of psychiatric issues amongst youths, particularly university students, not only in Australia but also around the world. The impact of mental health problems on Australian youths is significant. Psychological distress has been associated with termination of university education, difficulty with time and resource management, and a decreased likelihood to seek academic assistance. More is required, not only in terms of research, but also concrete action, in order to pioneer a path for mental health as an accepted, openly-discussed, and actively-addressed issue within Australian universities.

References

1. Veness, B., *Universities a unique opportunity to improve mental health*. Australian Medicine, 2013(4).
2. Stallman, H.M., *Psychological distress in university students: A comparison with general population data*. Australian Psychologist, 2010. **45**(4): p. 249-257.
3. Stallman, H.M. and I. Shochet, *Prevalence of mental health problems in Australian university health services*. Australian Psychologist, 2009. **44**(2): p. 122-127.
4. Said, D., K. Kypri, and J. Bowman, *Risk factors for mental disorder among university students in Australia: findings from a web-based cross-sectional survey*. Soc Psychiatry Psychiatr Epidemiol, 2013. **48**(6): p. 935-44.
5. Sawyer, M.G., et al., *The Mental Health of Young People in Australia: Key Findings from the Child and Adolescent Component of the National Survey of Mental Health and Well-Being*. Australian and New Zealand Journal of Psychiatry, 2001. **35**(6): p. 806-814.
6. Eisenberg, D., et al., *Prevalence and correlates of depression, anxiety, and suicidality among university students*. American Journal of Orthopsychiatry, 2007. **77**(4): p. 534-542.
7. Eisenberg, D., E. Golberstein, and S.E. Gollust, *Help-Seeking and Access to Mental Health Care in a University Student Population*. Medical Care, 2007. **45**(7): p. 594-601.
8. Brackney, B.E. and S.A. Karabenick, *Psychopathology and academic performance: The role of motivation and learning strategies*. Journal of Counseling Psychology, 1995. **42**(4): p. 456.
9. Kessler, R.C., et al., *Social consequences of psychiatric disorders, I: Educational attainment*. American journal of psychiatry, 1995. **152**(7): p. 1026-1032.
10. Kitzrow, M.A., *The mental health needs of today's college students: Challenges and recommendations*. NASPA journal, 2003. **41**(1): p. 167-181.
11. Gallagher, R.P., *National survey of counseling center directors*. Alexandria, VA: International Association of Counseling Services, 2004.
12. Levine, A. and J.S. Cureton, *When Hope and Fear Collide: A Portrait of Today's College Student*. *The Jossey-Bass Higher and Adult Education Series*. 1998: ERIC.
13. American Psychiatric Association. *Diagnostic and Statistical Manual for Mental Disorders*. 1994.