Recording the Mental Ill-Health of Australian Students

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ABSTRACT: *The National Mental Health Commission notes that there is a direct link between the economic growth of Australia and people's psychological well-being. The commission reported that the cost of mental ill-health is four per cent of the national gross domestic product equating to approximately $60 billion a year or $4000 for every Australian taxpayer. The Australian National Survey of Mental Health and Well-being has highlighted that Australia has one of the highest recorded levels of mental health disorders. Health promotional models and mental health research has highlighted the importance of social networks on supporting individuals with a high risk of mental ill-health. This paper aims to further the discussion no how better to measure supportive environments, friends and family networks and the quality of the bonds developed between the students at university.*

KEYWORDS: *Psychological well-being, Mental health, Psychiatry.*

BACKGROUND

THE WELL-BEING OF AUSTRALIANS: In 1990, the World Health Organisation (WHO) generated the Composite International Diagnostic Interview (CIDI) method (World Health Organisation, 1992). The CIDI was developed and expanded from the Diagnostic Interview Schedule (DIS) generated by the National Institute of Health (NIH) and Robins et al. (Robins, et al. 1981; World Health Organisation, 2017b). The CIDI was developed to be used as a tool to diagnoses mental health conditions (World Health Organisation, 2017b). The DIS exclusively used the criteria and definitions from the Diagnostic and Statistical Manual of Mental Disorders to diagnose the mental ill-health of interviewees (Kessler, et al. 2004). This diagnostic tool was later expanded to include the WHO International Classification of Disease (ICD) (World Health Organisation, 2017b). Incorporating the ICD made it possible to conduct cross-national comparative research, and in 1997 WHO developed the International Consortium in Psychiatric Epidemiology (ICPE) intending to test and compare the results of different countries (World Health Organisation, 2017b).

However, after the translation and initial field-testing of CIDI in various countries, researchers noted that comparability of the results was hampered by only assessing the mental disorder of participants and not recording other risk factors, patterns or treatments (Kessler, et al. 2004; World Health

Organisation, 2017b). As a result, WHO developed the World Mental Health (WMH) Survey Initiative in 1998 (World Health Organisation, 2017b). The WMH survey intended to incorporate other risk factors associated with mental health into the research that was found in the first generation of the survey (Kessler, et al. 1998; World Health Organisation, 2017b). This generated and provided researchers with a tool for cross-cultural epidemiological studies and clinical research (Kessler, et al. 2004; World Health Organisation, 2017b).

Originally, WHO wanted to help psychiatric epidemiologists to develop a survey tool that could be easily applied (Kessler, et al. 2004). However, by modifying the diagnostic assessments of the CIDI and including the examination of the risk factors, treatments and consequences of mental illness into consideration, the WHO WMH-CIDI developed into a survey tool that enhanced the ability for researchers to conduct cross-national comparisons of the impacts and prevalence of mental health disorders globally (Kessler, et al. 2004; World Health Organisation, 2017b).

For over a decade now, WHO has been conducting the WMH-CIDI initiative and at least 28 countries have taken part in the mental health surveys, this includes Australia, China, France, Israel, India, Ukraine, United States, New Zealand and much more (World Health Organisation, 2017b). Unfortunately, in comparison to these other countries, Australia has one of the highest recorded levels of mental health disorders (Slade, et al. 2009).

The first National Survey of Mental Health and Well-being was conducted in Australia in 1997 as part of the WMH

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Survey Initiative (Slade, et al. 2009). The national survey was based on the elements of the WHM-CIDI; however, the survey was adapted to align with the Australian cultural setting (Slade, et al. 2009). The findings of the 1997 study revealed a new view of the mental illness landscape in Australia and led to changes in identifying and treating mental disorders (Slade,et al. 2009). The survey prompted substantial changes to mental health service delivery and increased funding (Slade, et al. 2009). An extended range of public mental health specialists, primary care professionals, were refocused on identifying and treating mental disorders (Slade, et al. 2009; Slade, et al. 2009). Medicare was adapted to include a range of services from psychologists and general practitioners to provide better access to mental health services (Meadows, et al. 2002; Slade, et al. 2009). However, it was noted that these changes were not adequate to improve mental health services and additional investments were needed (Slade, et al. 2009).

An updated, and the most recent Australian, National Survey of Mental Health and Well-being was conducted in 2007 (Slade, et al. 2009). Similarly, to the goals of the 1997 survey, the 2007 survey aimed to evaluate the prevalence of mental health disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of Diseases (Kessler, et al. 2004; Slade, et al. 2009). The 2007 survey only included three classes of mental illnesses, namely anxiety, affective and substance abuse disorders (Slade, et al. 2009). Moreover, the survey did not include schizophrenia, personality, somatoform, eating, impulse-control or any other psychotic disorders as they were classified as low prevalence (Slade, et al. 2009).

The 2007 survey revealed that almost 9.5 million (45.5%) of the population experienced a mental disorder during their life and 3.2 million (20.0%) people had a mental health episode within the last 12 months (Slade, et al. 2009). However, only 11.9% of the population utilised mental health services in the past year (Slade, et al. 2009). This highlights that approximately 1.7 million (8.1% of the population) were experiencing mental health issues and not seeking help from mental health services (Slade, et al. 2009).

Furthermore, people who have experienced a mental health issue within the last 12 months are three times more likely to attempt suicide than the general population (Armstrong, et al. 2017; Slade,et al. 2009). Unfortunately, the study noted that 2.1 million Australians aged 16-85 years old had suicidal thoughts, 600,000 develop a suicide plan, and half a million people attempt suicide at some point in their life (Armstrong, et al. 2017; Slade,et al. 2009). A 2016 report by the Australian Bureau of Statistics (ABS) notes that death by suicide represents 1.9% of the population, this is the highest suicide rate in over a decade (Australian Bureau of Statistics, 2017). In 2015 over three thousand Australians died by suicide (Australian Bureau of Statistics, 2017). That represents 12.6 people per 100,000 or more than eight

suicides every day (Australian Bureau of Statistics, 2017). Surprisingly, suicide is a higher cause of death than skin, breast or pancreatic cancer (Australian Bureau of Statistics, 2010). Additionally, suicide is the leading cause of death in younger people aged 15-44 years old and accounts for more than one-third (33.9%) of the overall deaths at this age range (Australian Bureau of Statistics, 2017). Suicide is the second leading cause of death for people aged 45-54 years old, with a median age of 44.5 years (Australian Bureau of Statistics, 2017). The rates of suicide within the 15-44-year-old population correlates with the higher rates of mental disorder within young people (Australian Bureau of Statistics, 2017; Slade, et al. 2009). Approximately 671,000 (26%) of young Australians aged 16-24 years have a serious mental health issue and less than a quarter (23%) utilised any mental health services within the last 12 months (Australian Bureau of Statistics, 2010; Slade,et al., 2009). Furthermore, the highest risk age group of 16-24 years old, accounts for the highest percentage of university students in Australia (Australian Bureau of Statistics, 2007; Edwards, et al. 2012).

Furthermore, apart from the significant human cost of mental ill-health, the National Mental Health Commission notes that there is a direct link between the economic growth of the nation and peoples' psychological well-being (National Mental Health Comission, 2016). The Commission reported that the cost of mental ill-health is four per cent of the national gross domestic product (GDP) (National Mental Health Comission, 2016). This equates to approximately $60 billion a year or $4000 for every Australian taxpayer (National Mental Health Comission, 2016). Due to this cost, the Commission has placed mental ill-health on the Australian economic agenda. Commission Chair and Professor Allan Fels noted that early preventative interventions could reduce the cost of addressing mental ill-health issues rather than costly, more complex intervention (National Mental Health Comission, 2016).

THE WELL-BEING AND MENTAL HEALTH OF AUSTRALIAN STUDENTS: Regardless of the efforts to promote well-being and make university spaces healthier, numerous studies have shown that university students experience a higher rate of mental health problems in comparison to non-student counterparts (Andrews, et al. 2011; Edwards, et al. 2012; Hussain, et al. 2013; Kadison et al. 2004; Levecque, et al. 2017; Miri, et al. 2017; Stallman, et al. 2009; Walter, et al. 2013). Many studies have shown that more than 50% of the students experience a range of mental health issues (Hussain, et al. 2013; Kadison, et al. 2004; Levecque, et al. 2017; Stallman, et al. 2009; Zivin, et al. 2009).

Interestingly, (Hussain, et al. 2013) noted that most students, in their study, proclaimed to be in good physical shape, despite reporting high levels of mental ill-health (Hussain, et al. 2013; Stallman, et al. 2009) found a high prevalence

mental health problem within the student populations of diverse Australian universities and noted rural, remote or urban universities had no significant difference in elevated levels of stress or psychological disorder (Stallman, et al. 2009). Several studies have noted that despite awareness of suitable support services, many students choose to conceal their emotional and mental health issues (Martin, 2010; Reavley, et al. 2017; Walter, et al. 2013).

Andrews and Chong's (2011) article acknowledge that the majority of students are transitioning out of a late adolescent's stage of life (Andrews, et al. 2011). During this transformational stage, (Andrews, et al. 2011) propose that a lack of parental guidance, the need for independent living, interpersonal and time management skills contribute to the high mental health and well-being levels found in Australian university students (Andrews, et al. 2011). Similarly, studies have shown that during this time students are exposed to risky behaviour such as drug and alcohol abuse, which has been correlated with student mental health problems (Crawford-Williams, et al. 2016; Hart, et al. 2016; Murugiaht, et al. 2014; Obst, et al. 2002; Tembo, et al. 2017).

There are approximately one million university students currently studying in Australian (Australian Bureau of Statistics, 2017). This includes 4% of students enrolled in enabling classes, 79% of students studying a bachelor degree, and 17% in post-graduation study (Australian Bureau of Statistics, 2017). However, 13% of postgraduate studies is coursework and only 4% is research conducted at PhD level (Australian Bureau of Statistics, 2017; Levecque, et al. 2017) observed that 51% of PhD students experienced psychological distress and were at risk of developing a range of psychiatric disorder. In comparison to other students, PhD students are 2.5 times more likely to develop psychiatric disorders, and 2.8 times more likely in comparison to the general population (Levecque, et al. 2017; Schillebeeckx, et al. 2013). Research has shown that between the ages of 10-24 years, any mental health illness that develops has the ability to become a lifelong problem (Kessler, et al. 2005; Mathers, et al. 2006). This highlights that student mental health and well-being is an important area to address as it can lead to a persistent life-long illness problem (Kessler, et al. 2005; Mathers, et al. 2006). Furthermore, PhD students are the most at-risk group of mental health and well-being issues within a university setting (Levecque, et al. 2017).

Researchers have recognised that transitioning to university can be a cause of stress and anxiety for students (Guney, et al. 2010; Kadison, et al. 2004; Montgomery, et al. 2003). Leaving family and friends, engaging in new social and academic surroundings and adjusting to living independently for the first time have been well documented to contribute to a student's overall well-being (Denovan, et al. 2013; Macaskill, 2018; Scanlon, et al. 2007). However, exited students are initially, the changes in circumstances can be very challenging (Folkman, et al. 1986). Students

financial situation and the use of student loans combined with government policies that require some universities to encourage students from lower social groups to participate in university education have been noted in broadening the participation of a diverse range of students (Macaskill, 2018). University students are not only from families with good financial support, and some researchers have suggested that this has increased the student populations vulnerability to manifest mental health issues (Macaskill, 2018; Steptoe, et al. 2007). However, these factors may be the case for first-year or undergraduate students, but there is little research on why postgraduate students would suffer significantly higher mental health issues than their undergraduate counterparts.

HEALTH PROMOTION AND HEALTH PROMOTING UNIVERSITIES: The World Health Organisation (WHO) defines health promotion as

- The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions (World Health Organisation, 2018).

Furthermore, the Australian Health Promotion Association state that

- The health promotion profession has evolved alongside, and in response to, the international health promotion movement and the broader new public health movement. Health promotion not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental, political and economic conditions to alleviate their impact on populations and individual health' (Australian Health Promotion Association, 2018).

Kumar and Preetha view health promotion as a relevant tool to address health issues effectively using a holistic approach to empower individuals and communities to be proactive in fostering public health policies (Kumar, et al. 2012). Kumar and Preetha acknowledge that there is a worldwide acceptance that socioeconomic conditions and the social fabric of societies influence health (Kumar, et al. 2012). Health promotion research has historically been dominated by individual risks factors, unhealthy behaviours and lifestyle choices of the individual. However, the establishment of the Ottawa Charter in 1986 and the World Health Organisation's 2005 commission on social determinants of health have invigorated interest in empowering communities and developing healthy social environments. The Ottawa Charter notes that creating supportive environments, strengthening community actions and reorienting health services are some of the key action areas for health promotion (World Health Organisation, 1986).

In 1995 the University of Central Lancashire in the UK was the first university to introduce the Health Promoting

University Initiative (World Health Organisation, 2017a). The initiative utilised the WHO Health Promoting Universities framework to promote health and well-being using the structures and processes within the university to establish a supportive environment for the students, staff and the wider community (World Health Organisation, 2017a). Over two decades later, In March 2016, at an inaugural Health Promoting Universities meeting, 25 representatives from Australian university's initiated the Health Promoting Universities Network (The University of Sydney, 2016).

The Health Promoting Universities Network intends to follow the success of comparable networks in the United States, Canada and United Kingdom (The University of Sydney, 2016). The Health Promoting Universities Network aims to establish a collaborative effort to share best practice principles and work towards improving the well-being and health of Australian students, and the wider community (The University of Sydney, 2016). The universities that make up the Health Promoting Universities Network intend to become signatories of the Okanagan Charter (The University of Sydney, 2016). The Charter advocates for universities to entrench health into all facets of university life and encourage promoting healthy activities in the community (Charter, 2013).

Regarding the generation of the Network, Chair of Universities Australia and Vice-Chancellor of Western Sydney University, Professor Barney Glover, noted that

'Universities must be at the forefront of addressing major health challenges'(The University of Sydney, 2016).

Similarly, Dr Michael Spence noted that

'Universities are uniquely placed to become champions for physical and mental health for the benefit of the entire community' (The University of Sydney, 2016).

Historically, universities served as useful settings in which to deliver health promotion intervention/projects. The congregation of diverse groups in the one setting made it the ideal space for interventions and to inform students and staff on a range of topics from alcohol use, drugs and well-being. However, there is an increasing shift to focusing on a more whole university-wide strategic approach rather than focusing on a single health issue. Research has shown that the whole setting, multi-component methods provide a range of imbedded structural support mechanisms that are more likely to be effective rather than promoting discrete fragmented activities (Shinde, et al. 2017).

Healthy Universities adopts this holistic approach and applies it to the university setting. Additionally, by adopting the principles in the Ottawa Charter, the concept of Healthy Universities acknowledges that health is created within the context of everyday life and involves the generation of policies, supportive environments, strengthening community action, development of personal skills and reorienting health care services toward the prevention of illness and promotion of health.

Future health promotion research into how to better support student in university could focus on whole university-wide strategic approach. However, any health campaign needs to be measurable. Constructing health campaigns around the principals of the Ottawa charter is a noble pursuit and has been the framework for numerous health promotional activities (Potvin, et al. 2011). However, measuring how the Ottawa charters principles are altered to suit health promotional campaigns is almost implausible. How does one efficiently measure supportive environments or strength of communities within a health promotional campaign? The supportive environment and strength of a community need to become a measurable factor. Health campaigns, especially health promotional activities aiming to address mental ill-health, must focus on the support networks available to the participants and not only supportive environments at the university setting but also the students' friends and family network. The measurement of the quality of the bonds developed between the student and the university and the prior existing social relationships would give greater insight into the support framework that a student has access too. Health promotional activities can then be better tailored to include and measure the supportive environment and strengthening community principles of the Ottawa charter.

CONCLUSION

For Australia to improve the mental health and well-being of its population, as measured by the National Survey of Mental Health and Well-being, more preventative interventions and support structures are needed in everyday settings, such as universities. Not only will this be more cost-effective but may elevate the stigma associated with seeking out and utilising health services. Furthermore, health promotional activities, at the university level, should acknowledge that unhealthy behaviours are constructed by an amalgamation of complex social, behavioural and environmental circumstances. Any attempts to help promote and modify health and well-being needs to factor in these components into their design and measurements. The use of social capital measurement being integrated into health promotional activities and measures has the potential to improve the design health campaigns better and broaden the understanding of mental ill-health.

DECLARATIONS

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