



A survey carried out
by the Office for
National Statistics
on behalf of the
Department of
Health and the
Scottish Executive

Mental health of children and young people in Great Britain, 2004

Summary report

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ISBN 1-85774-609-0

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1

Focus of the survey

Background

The survey of the mental health of children and young people in Great Britain 2004 was carried out on behalf of the Department of Health and the Scottish Executive to provide up-to-date information about the prevalence of mental disorders in order to inform policy decisions about the need for child and adolescent mental health services. The surveyed population consisted of children and young people, aged 5–16, living in private households in Great Britain. Fieldwork for the survey took place between March and June 2004.

The 2004 survey was the second national survey of the mental health of children and young people. The first survey was carried out in 1999.¹

Aims of the survey

The main aims of the survey were:

- To examine whether there were any changes between 1999 and 2004 in the prevalence of the three main categories of mental disorder: conduct disorders, emotional disorders and hyperkinetic disorders.
- To describe the characteristics and behaviour patterns of children in each main disorder category and subgroups within those categories.
- To look in more detail at children with autistic spectrum disorder.

- To examine the relationship between mental disorder and aspects of children's lives not covered in the previous survey, for example, medication, absence from school, empathy and social capital.
- To collect baseline information to enable identification of the protective and risk factors associated with the main categories of disorder and the precursors of personality disorder through future follow-up surveys.

Coverage of the survey

This report uses the term mental disorder as defined by the ICD-10 (International Classification of Diseases, tenth revision) to imply a clinically recognisable set of symptoms or behaviours associated in most cases with considerable distress and substantial interference with personal functions. The survey focused on the three common groups of mental disorder: emotional disorders such as anxiety, depression and obsessions; conduct disorders characterised by awkward, troublesome, aggressive and antisocial behaviours; and hyperactivity disorders involving inattention and overactivity. The survey also examined the characteristics of children with less common disorders such as Autistic Spectrum Disorder and those with multiple disorders.

Assessment of mental disorders

The assessment of mental disorder was based on both structured and open-ended questions.

1. Meltzer H, Gatward R, Goodman R and Ford T (2000) *Mental health of children and adolescents in Great Britain*, TSO: London.

When definite symptoms were identified by the structured questions, interviewers used open-ended questions and supplementary prompts to get informants to describe the child's problems in their own words.

Data collection included information gathered from parents, teachers and the children themselves (if aged 11–16).

A case vignette approach was used for analysing the survey data in which clinicians reviewed the responses to the pre-coded questions and the transcripts of informants' comments, particularly those which asked about the child's significant problems.

A description of typical symptoms displayed by children with different types of mental disorders is given in the glossary. In order to illustrate the impact of the disorder on the child's life and that of his or her family, the symptoms are followed by a case vignette of a fictitious child.

Interpretation of results

The findings described in this summary report focus on the prevalence of mental disorders among 5- to 16-year-olds in 2004 and any changes since the previous survey in 1999. The report then provides profiles of children in each of the main disorder categories (emotional, conduct and hyperkinetic disorders). It also outlines the characteristics of children with autistic spectrum disorders and those with multiple disorders.

Causal relationships should not be assumed for any of the results presented in this report.

Further details on the survey can be found in the main report.²

Mental health of children and young people in Great Britain, 2004, £50, ISBN 1-4039-8637-1.

It can be also be found at:



www.statistics.gov.uk/statbase/product.asp?vlnk=14116

2. Green H, McGinnity A, Meltzer H, Ford T and Goodman R (2005) *Mental health of children and young people in Great Britain, 2004*, Palgrave Macmillan: London.

2

Sample design

The sample was drawn from Child Benefit records held by the Department for Work and Pensions' Child Benefit Centre (CBC). The use of centralised records as a sampling frame was preferred to the alternative designs of carrying out a large scale postal sift of the general population or sampling through schools. The design used enabled direct access to parents, which would not have been possible with a school-based sample, and it was more efficient than a sift.

The sample design consisted of a sample of postal sectors and, within these, a sample of addresses. The postal sectors were selected by ONS. In order to preserve the confidentiality of the respondents, the CBC selected the addresses following ONS instructions and then despatched a letter on behalf of ONS to each selected household explaining the purpose of the survey and giving parents an opportunity to opt-out.

Table 2.1
Response to initial opt-out letter

	Number	Per cent of all cases
Set Sample	12,294	100
Opt-outs	1,085	9
Moved no trace	631	5
Ineligible	82	1
All not approached	1,798	15
Approached for interview	10,496	85

Table 2.1 shows that 12,294 opt out letters were despatched by the Child Benefit Centre on behalf of ONS. After removing those addresses that opted out or were ineligible, 10,496 addresses were allocated to ONS interviewers. *(Table 2.1)*

Of the 12,294 sampled families, 9 per cent contacted ONS via a freephone number to opt-out. A further 5 per cent of the sample had moved and could not be traced. A small number of sampled families were ineligible because the child was in foster care, outside the age criteria of 5–16, had died, or the family had emigrated. Therefore, just under 10,500 addresses were allocated to interviewers

Information was collected from up to three sources (parents, children and teachers) on 76 per cent of the 10,496 families approached for interview, resulting in 8,000 achieved interviews. However, these included 23 cases for whom there was insufficient information for a diagnostic classification so the analysis is based on 7,977 cases. *(Table 2.2)*

Among the co-operating families, almost all the parents and most of the children (93 per cent) took part and the great majority provided full information (97 per cent). The information from the remaining 3 per cent was usable although incomplete. Of the 7,521 teachers contacted 83 per cent returned a completed questionnaire. Teacher information was available for 78 per cent of all interviews. *(Table 2.3)*

Table 2.2
Response to interview

	Number	Per cent of all cases	Per cent of cases approached
Set Sample	12,294	100	
Approached for interview	10,496	85	100
All interviews*	7,977	65	76
Refusals	2,183	18	21
Non-contacts	313	3	3

* Due to missing information we were unable to produce disorder

Table 2.3
Interviews achieved by type of respondent

	Number	Per cent of achieved interviews
Adult and child	3,344	42
Adult only (child under 11)	3,834	48
Adult only (child refused/ unable to be interviewed)	579	7
Teacher	6,236	78
Achieved interviews*	7,977	100

* Due to missing information we were unable to produce disorder classifications for 23 cases.

To improve the representativeness of the survey, the data were weighted first, to correct for the unequal sampling probabilities of the children which arose because of the delay between selecting the area and children samples, and second, to match the age/sex/region structure of the population at the time of the survey. Finally, the data were adjusted to take account of the missing teacher data.

3

New topics in the 2004 survey

Medication

The use of psychotropic drugs was largely confined to children with a hyperkinetic disorder of whom 43 per cent were taking some kind of medication, mainly Methylphenidate. Only seven per cent of the children with an emotional disorder and nine per cent of those with a conduct disorder were taking some form of medication and many of these had a hyperkinetic disorder as well. The very limited use of medication for children with non-hyperkinetic disorders suggests that clinicians are generally following recommended prescribing guidelines.

Absence from school

Children with mental disorders were much more likely than other children to have had time off school: 17 per cent of those with

emotional disorders, 14 per cent of those with conduct disorders and 11 per cent of those with hyperkinetic disorders had been away from school for over 15 days in the previous term. Among other children, the proportion was just 5 per cent. Children with mental disorders tended to have poorer general health than other children and at least some of these absences will have been health related. However, children with emotional disorders and those with conduct disorders were much more likely than other children to have had unauthorised absences and high proportions in all three disorder groups were thought by their teachers to have played truant at some time. As many as one in three children with a conduct disorder had been excluded from school and nearly a quarter had been excluded more than once. (Table 3.1)

Table 3.1

Absence from school, truancy and exclusions (teacher's report) by type of mental disorder, 1999 and 2004 combined

Children whose teacher completed a questionnaire Great Britain

	Emotional disorders	Conduct disorders	Hyperkinetic disorders	All
	%	%	%	%
Absent for 16 days or more in last term	17	14	11	5
<i>Base (weighted)</i>	387	495	131	10385
Certainly or possibly plays truant	16	22	11	3
<i>Base (weighted)</i>	545	712	195	14265
Has been excluded from school	12	33	29	4
<i>Base (weighted): 2004 data*</i>	274	398	107	7770

* This question was not asked in 1999.

Social aptitude

Parents were asked to assess the child's social aptitude to provide a measure of his or her ability to empathise with others. Children in all three of the main disorder groups had much lower scores than other children on this scale indicating poor ability to empathise. About a half (48 per cent) of those with emotional disorders, about two thirds (69 per cent) of those with conduct disorders and over four-fifths (83 per cent) of those with hyperkinetic disorders scored in the bottom quartile.

Social networks and social support

The 2004 survey showed that the relationship between availability of social support and mental health, which is well established for adults, also existed for young people.

For example, 42 per cent of children with emotional disorders and 54 per cent of those with conduct or hyperkinetic disorders scored in the bottom quartile on a scale measuring the extent of the network of family and friends to whom the child felt close. Similarly, about one fifth (22 per cent) of children with emotional disorders, one third (33 per cent) of those with conduct disorders and about one half (44 per cent) of those with hyperkinetic disorders found it more difficult than average to keep friends compared with only 5 per cent of other children. Moreover, the parents of children with mental disorders were much more likely than other parents to express some reservations about their child's friends.

4

Prevalence of mental disorders¹

Prevalence in 2004

- In 2004, one in ten children and young people (10 per cent) aged 5–16 had a clinically diagnosed mental disorder: 4 per cent had an emotional disorder (anxiety or depression), 6 per cent had a conduct disorder, 2 per cent had a hyperkinetic disorder, and 1 per cent had a less common disorder (including autism, tics, eating disorders and selective mutism). Some children (2 per cent) had more than one type of disorder. *(Table 4.1)*

Changes between 1999 and 2004

- There were no differences in prevalence between 1999 and 2004 in the overall proportions of children with a mental disorder.

- There were no changes between 1999 and 2004 in the prevalence of conduct or hyperkinetic disorders among children aged 5–15 as a whole. The only change that was statistically significant was a decrease in the proportion of boys aged 5–10 who had an emotional disorder, which declined from 3 per cent in 1999 to 2 per cent in 2004.

Socio-demographic variations in prevalence (2004)

Boys were more likely to have a mental disorder than girls. Among 5- to 10-year-olds, 10 per cent of boys and 5 per cent of girls had a mental disorder. In the older age group (11-to 16-year-olds), the proportions were 13 per cent for boys and 10 per cent for girls. *(Table 4.1)*

Table 4.1

Prevalence of mental disorders by age and sex, 2004

All children
Great Britain

	5- to 10-year-olds			11- to 16-year-olds			All children		
	Boys	Girls	All	Boys	Girls	All	Boys	Girls	All
	<i>Percentage of children with each disorder</i>								
Type of disorder									
Emotional disorders	2.2	2.5	2.4	4.0	6.1	5.0	3.1	4.3	3.7
Conduct disorders	6.9	2.8	4.9	8.1	5.1	6.6	7.5	3.9	5.8
Hyperkinetic disorders	2.7	0.4	1.6	2.4	0.4	1.4	2.6	0.4	1.5
Less common disorders	2.2	0.4	1.3	1.6	1.1	1.4	1.9	0.8	1.3
Any disorder	10.2	5.1	7.7	12.6	10.3	11.5	11.4	7.8	9.6
<i>Base (weighted)</i>	<i>2010</i>	<i>1916</i>	<i>3926</i>	<i>2101</i>	<i>1950</i>	<i>4051</i>	<i>4111</i>	<i>3866</i>	<i>7977</i>

¹ Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life.

The prevalence of mental disorders was greater among children:

- in lone parent (16 per cent) compared with two parent families (8 per cent) (Figure 4.1)
- in reconstituted families (14 per cent) compared with families containing no stepchildren (9 per cent) (Figure 4.2)
- whose interviewed parent had no educational qualifications (17 per cent) compared with those who had a degree level qualification (4 per cent) (Figure 4.3)
- in families with neither parent working (20 per cent) compared with those in which both parents worked (8 per cent) (Figure 4.4)

Figure 4.1
Prevalence of mental disorders by family type, 2004
Great Britain

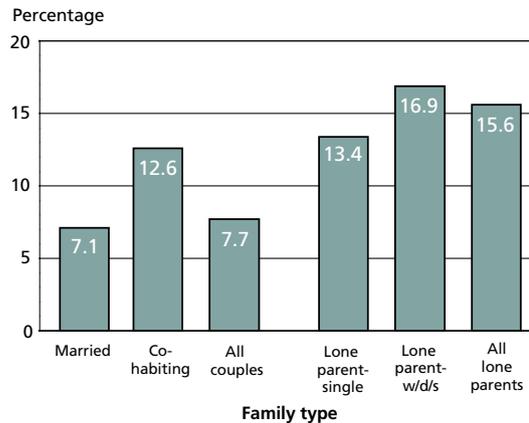


Figure 4.2
Prevalence of mental disorders by whether family contains stepchildren, 2004
Great Britain

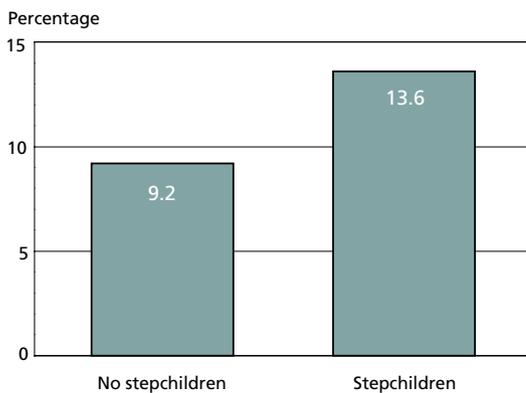


Figure 4.3
Prevalence of mental disorders by educational qualifications of parent, 2004
Great Britain

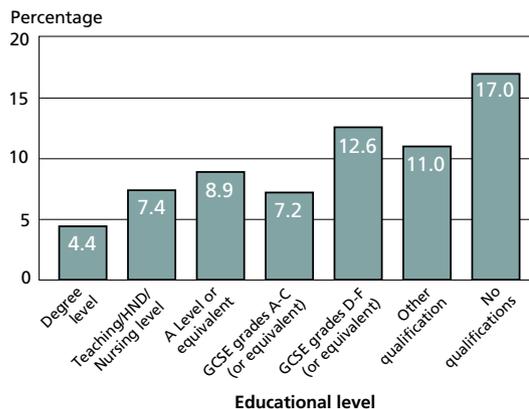


Figure 4.4
Prevalence of mental disorders by family's employment, 2004
 Great Britain

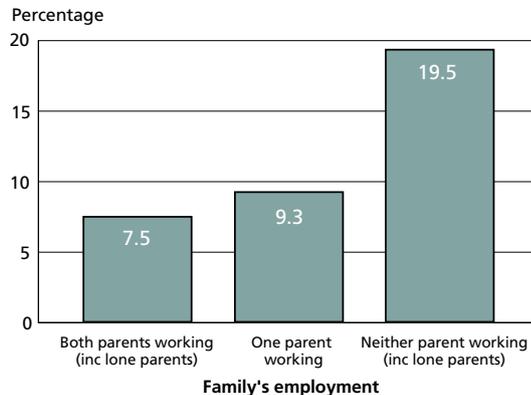


Figure 4.5
Prevalence of mental disorders by gross weekly household income, 2004
 Great Britain

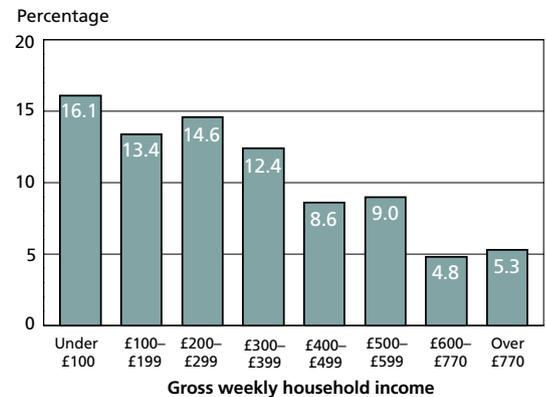
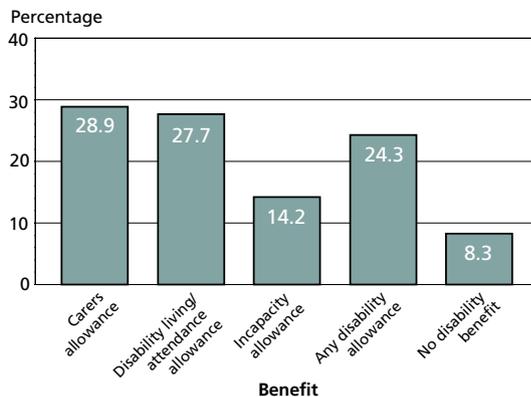


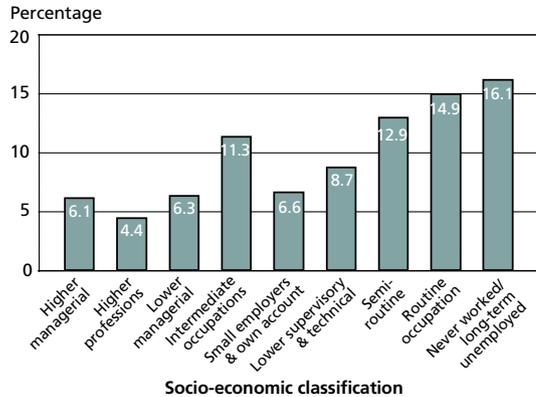
Figure 4.6
Prevalence of mental disorders by receipt of disability benefits, 2004
 Great Britain



- in families with a gross weekly household income of less than £100 (16 per cent) compared with those with an income of £600 or more (5 per cent) *(Figure 4.5)*
- in households in which someone received disability benefit (24 per cent) compared with those that received no disability benefit (8 per cent) *(Figure 4.6)*
- in families where the household reference person was in a routine occupational group (15 per cent) compared with those with a reference person in the higher professional group (4 per cent) *(Figure 4.7)*

1 Prevalence rates are based on the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causing distress to the child or having a considerable impact on the child's day to day life.

Figure 4.7
Prevalence of mental disorders by socio-economic classification, 2004
Great Britain



- living in the social or privately rented sector (17 per cent and 14 per cent) compared with those who owned accommodation (7 per cent) (Figure 4.8)
- living in areas classed as 'hard pressed' (15 per cent) compared with areas classed as 'wealthy achievers' or 'urban prosperity' (6 per cent and 7 per cent). (Figure 4.9)

Figure 4.8
Prevalence of mental disorders by tenure, 2004
Great Britain

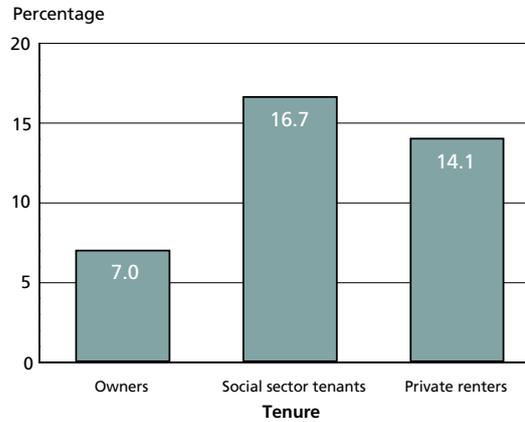
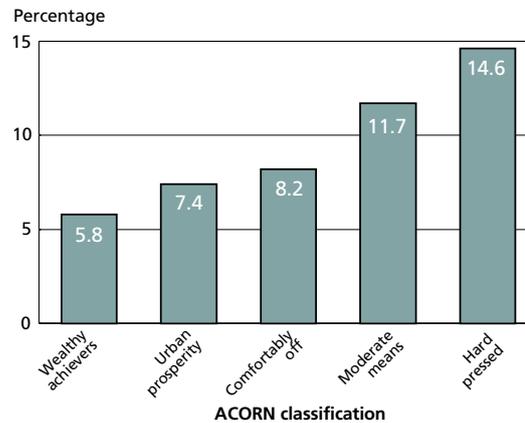


Figure 4.9
Prevalence of mental disorders by ACORN
Great Britain



5

Children with emotional disorders

Demographic and socio-economic characteristics

- Children with emotional disorders were more likely than those with no emotional disorders to be girls (54 per cent compared with 49 per cent) and to be in the older age group, 11–16 (62 per cent compared with 46 per cent). *(Figure 5.1)*
- The proportion of children with emotional disorders living with a widowed, divorced or separated lone parent was twice that among those with no such disorder (31 per cent compared with 15 per cent). *(Figure 5.2)*
- Among children with generalised anxiety disorder, 19 per cent lived in a family containing stepchildren compared with 11 per cent among children with no emotional disorder.
- Children with emotional disorders were more likely than other children to have parents who had no educational qualifications (35 per cent compared with 20 per cent) and to live in low income families: 54 per cent lived in households with gross incomes under £300 per week compared with 33 per cent of other children.
- There was a fairly consistent pattern for children with separation anxiety to live in the poorest economic circumstances across a range of measures.

Figure 5.1

Age by type of emotional disorder, 1999 and 2004 combined

Great Britain

Percentage

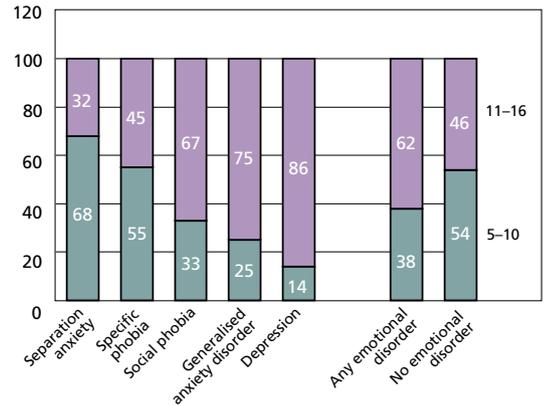


Figure 5.2

Family type by type of emotional disorder, 1999 and 2004 combined

Great Britain

Percentage

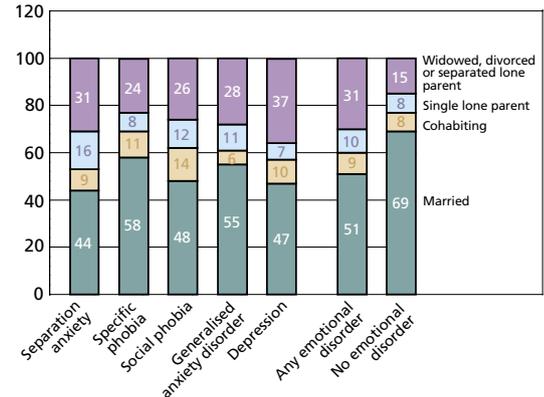


Figure 5.3
Child's general health by type of emotional disorder, 1999 and 2004 combined
 Great Britain

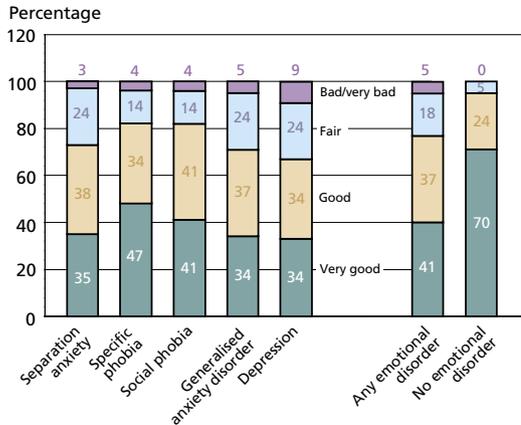
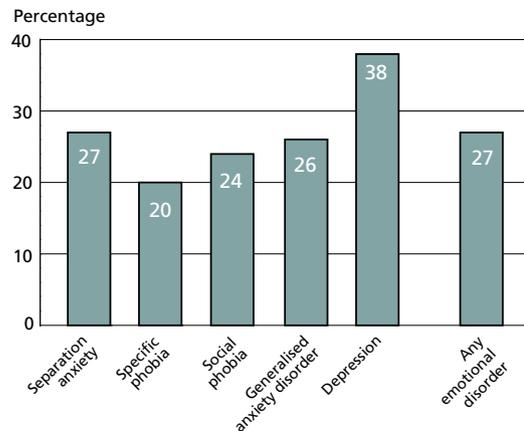


Figure 5.4
Proportion of children with an emotional disorder who had another type of mental disorder, 1999 and 2004 combined
 Great Britain



Child's general, physical and mental health

- The parents of children with an emotional disorder were more than four times as likely as other parents to say that their child's general health was fair or bad (23 per cent compared with 5 per cent) and a higher proportion reported that their child had a specific physical or developmental problem (72 per cent compared with 53 per cent).

(Figure 5.3)

- Over a quarter (27 per cent) of children with an emotional disorder also suffered from another of the main types of clinically recognisable mental disorders, most commonly conduct disorder.

(Figure 5.4)

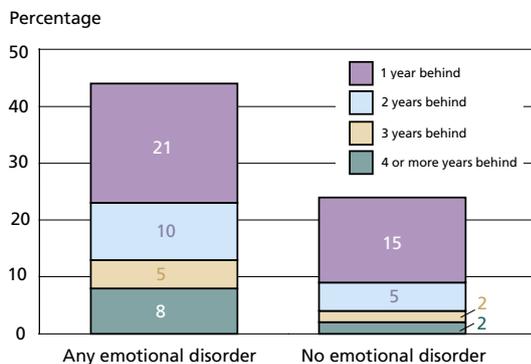
Use of services

- In the year before interview, nearly three quarters (73 per cent) of parents of children with an emotional disorder had sought some form of advice or help because of concerns about their child's mental health. Just under two thirds (64 per cent) had contacted a professional source, usually a teacher (47 per cent).

Scholastic ability and attendance at school

- Over two-fifths (44 per cent) of children with an emotional disorder were behind in their intellectual development with 23 per cent being two or more years behind, compared

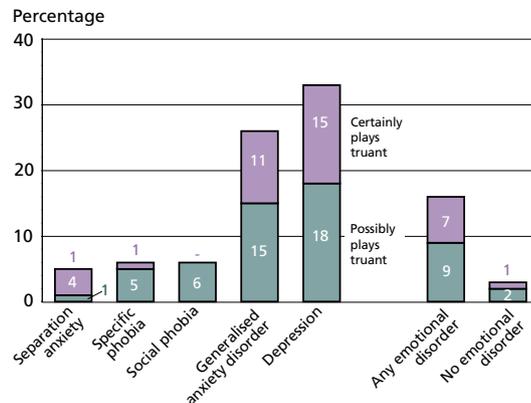
Figure 5.5
Proportion of children who were behind in their overall scholastic ability by whether they had an emotional disorder, 1999 and 2004 combined
 Great Britain



with 24 per cent and 9 per cent of other children. (Figure 5.5)

- Children with an emotional disorder were twice as likely as other children to have special educational needs (35 per cent compared with 16 per cent).
- Children with an emotional disorder had more time off school than other children: 43 per cent had had more than 5 days absence and 17 per cent had had more than 15 days absence in the previous term. Among those with no disorder, these proportions were much lower (21 per cent and 4 per cent).
- Children with generalised anxiety disorder and those with depression had the most days away from school – a quarter had had more than 15 days absence in the previous term. These groups were much more likely than other children to be considered definite or

Figure 5.6
Proportion of children whose teacher thought they played truant by type of emotional disorder, 1999 and 2004 combined
 Great Britain



possible truants (26 per cent and 33 per cent compared with 3 per cent among those with no disorder). (Figure 5.6)

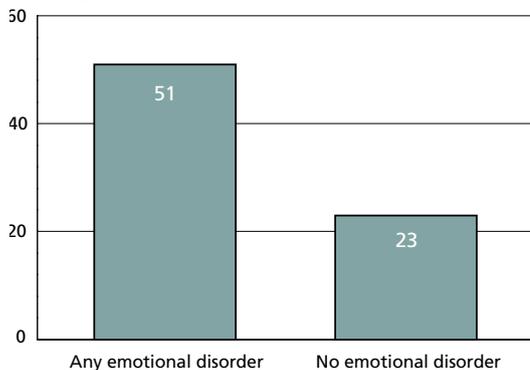
Social functioning of the family

- Parents of children with an emotional disorder were more than twice as likely as other parents to have a score on the General Health Questionnaire (GHQ-12) indicative of an emotional disorder (51 per cent compared with 23 per cent among other parents). (Figure 5.7)
- One-third (33 per cent) of families containing children with an emotional disorder were assessed as having unhealthy functioning. Among other families, the proportion was 18 per cent.
- Over a half (55 per cent) of children with an emotional disorder had experienced their parents' separation and over a quarter (28 per cent) had a parent who had had a

Figure 5.7
Proportion of children whose parent's scored 3 or more on the GHQ-12, 2004

Great Britain

Percentage



serious mental illness. For other children the proportions were 30 per cent and 7 per cent.

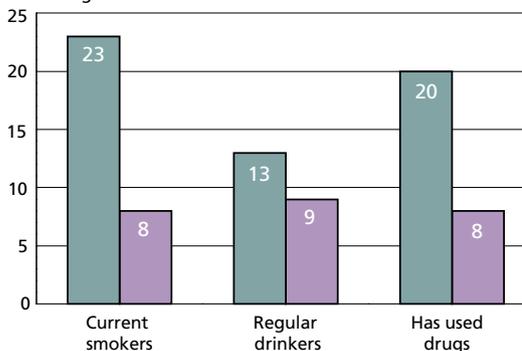
Child's social functioning

- Over a half (58 per cent) of parents of children with an emotional disorder rated their child in the lowest quartile on a scale measuring their strengths. About a half (48 per cent) rated their child in the lowest quartile on a scale measuring their social aptitude.
- Parents of children with an emotional disorder were four times as likely as other parents to give a negative assessment when asked about their child's ability to make and keep friends: 35 per cent compared with 9 per cent said it was harder than average for their child to make friends and 22 per cent compared with 5 per cent said it was harder than average for him or her to keep friends.

Figure 5.8
Smoking, drinking and drug use by whether has an emotional disorder: children aged 11–16, 1999 and 2004 combined

Great Britain

Percentage



Smoking, drinking and drug use

- Among young people aged 11–16, those with an emotional disorder were more likely to smoke, drink and use drugs than other children. The largest differences were for smoking and drug use. Among young people with an emotional disorder, 23 per cent were smokers and 20 per cent had taken drugs at some time. Among other young people, the proportions were 8 per cent for both.

(Figure 5.8)

Self-harm

- Among young people aged 11–16 who had an emotional disorder, 28 per cent said that they had tried to harm or kill themselves.

6

Children with conduct disorders

Demographic and socio-economic characteristics

- Children with a conduct disorder were more likely than other children to be boys (69 per cent compared with 50 per cent) and more likely to be in the older age group, 11–16 (55 per cent compared with 47 per cent). *(Figure 6.1)*
- Among children with conduct disorders, the proportions living with cohabiting, single or previously married lone parents were higher than those among children with no such disorder (12 per cent compared with 8 per cent, 14 per cent compared with 7 per cent and 27 per cent compared with 15 per cent). *(Figure 6.2)*
- Children with conduct disorders were more likely than other children to live in households containing a large number of children: 17 per cent lived in households containing 4 or more children compared with 10 per cent of children with no conduct disorder.
- Children with unsocialised conduct disorder were particularly likely to have a large number of siblings: 26 per cent lived in households containing 4 or more children.
- Children with conduct disorders were more likely than other children to have parents with no educational qualifications (39 per cent compared with 20 per cent) and to live in low-income families: 58 per cent of children with a conduct disorder lived in households

Figure 6.1
Age by type of conduct disorder, 1999 and 2004 combined
Great Britain

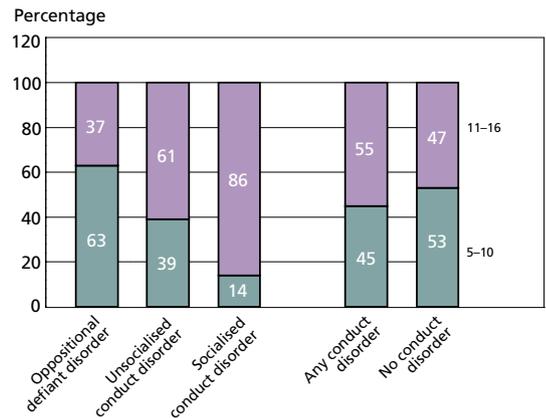


Figure 6.2
Family type by type of conduct disorder, 1999 and 2004 combined
Great Britain

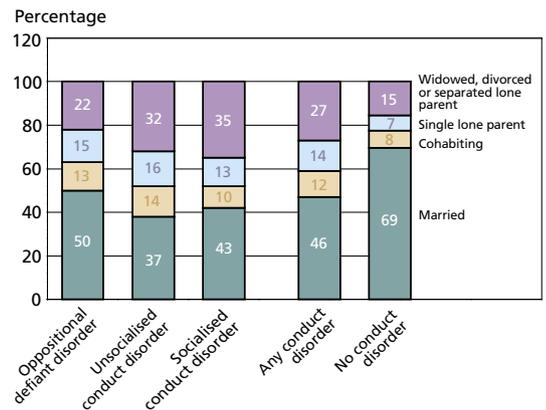
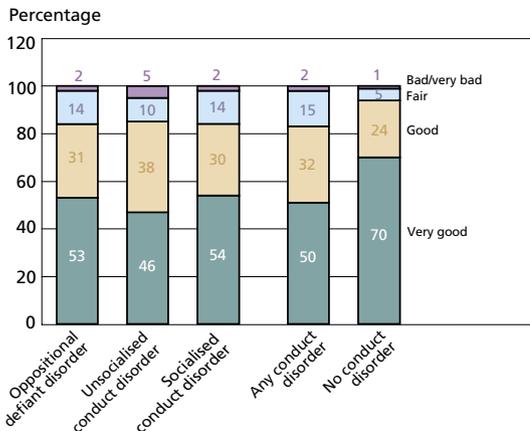


Figure 6.3
Child's general health by type of conduct disorder, 1999 and 2004 combined
 Great Britain



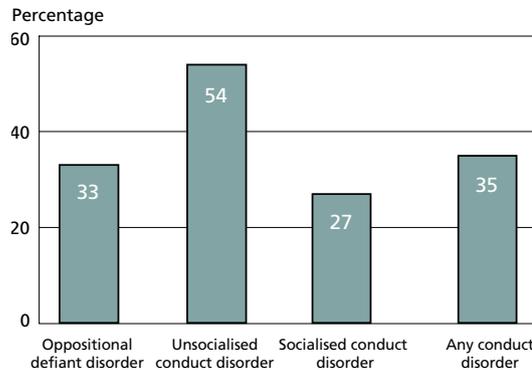
with a gross weekly income of less than £300 compared with 33 per cent of other children.

- Children with unsocialised conduct disorder lived in the most economically disadvantaged circumstances, as indicated by a range of measures. Well over a half (57 per cent) had parents with no educational qualifications and nearly a third (31 per cent) lived in households which received a disability benefit.

Child's general, physical and mental health

- The parents of children with a conduct disorder were more than three times as likely as other parents to say that their child's general health was fair or bad (17 per cent compared with 5 per cent) and a higher proportion reported that their child had

Figure 6.4
Proportion of children with a conduct disorder who had another type of mental disorder, 1999 and 2004 combined
 Great Britain



a specific physical or developmental problem (65 per cent compared with 53 per cent).

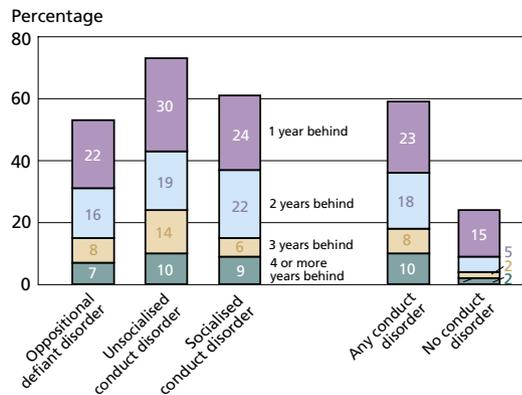
(Figure 6.3)

- About one-third (35 per cent) of children with a conduct disorder had another clinically recognisable disorder as well. This group was fairly evenly split between those who had an emotional disorder and those who had a hyperkinetic disorder. (Figure 6.4)

Use of services

- In the year before interview, over three-quarters (81 per cent) of parents of children with a conduct disorder had sought some form of advice or help because of concerns about their child's mental health. The majority of these (76 per cent) had approached a

Figure 6.5
Proportion of children who were behind in their overall scholastic ability by whether they had a conduct disorder, 1999 and 2004 combined
 Great Britain

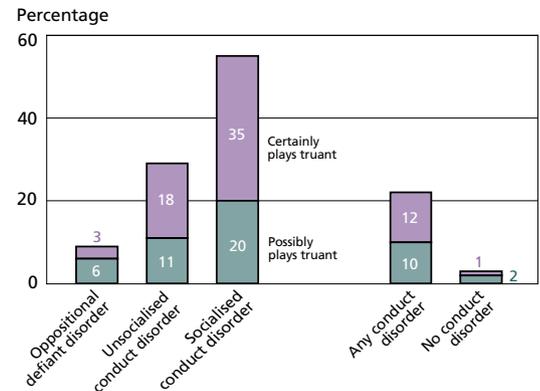


professional source, most commonly a teacher (60 per cent) but substantial minorities had sought specialist advice, 28 per cent from a mental health specialist and 24 per cent from special educational services such as psychologists.

Scholastic ability and attendance at school

- 59 per cent of children with conduct disorders were rated as being behind with their schooling, with 36 per cent being two or more years behind. For other children, these proportions were 24 per cent and 9 per cent. (Figure 6.5)
- About a half (52 per cent) of children with conduct disorders were considered by their teachers to have special educational needs.
- Children with conduct disorders had more time away from school than other children:

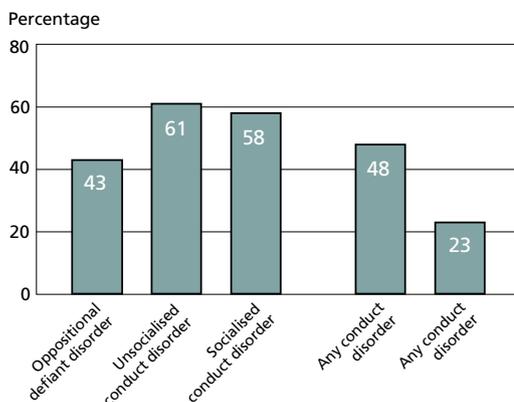
Figure 6.6
Proportion of children whose teacher thought that they played truant by type of conduct disorder, 1999 and 2004 combined
 Great Britain



42 per cent had had more than 5 days absence and 14 per cent had had more than 15 days absence in the previous term. Among those with no such disorder, these proportions were much lower, 21 per cent and 4 per cent.

- Nearly one-quarter (22 per cent) of children with a conduct disorder had possibly or certainly played truant. The corresponding proportion for other children was just 3 per cent.
- Absenteeism and truancy rates were particularly high among those with socialised conduct disorder: 87 per cent had been absent in the previous term; 55 per cent had had an unauthorised absence; and 55 per cent were considered by their teachers to be definite or possible truants. (Figure 6.6)

Figure 6.7
Proportion of children whose parent's scored 3 or more on the GHQ-12, 1999 and 2004 combined
Great Britain



- A third (33 per cent) of children with conduct disorders had been excluded from school at some time and nearly a quarter (22 per cent) had been excluded more than once. For children with no conduct disorder, these proportions were 2 per cent and 1 per cent.
- Among children with unsocialised or socialised conduct disorders, nearly a half (46 per cent and 48 per cent) had been excluded and over a quarter had been excluded more than once (27 per cent and 28 per cent).

Social functioning of the family

- Nearly a half (48 per cent) of the parents of children with conduct disorders had a score on the General Health Questionnaire (GHQ-12) indicative of an emotional disorder, twice the proportion among other parents (23 per cent).

(Figure 6.7)

- Children with conduct disorders were much more likely than other children to live in families classified as having unhealthy functioning (42 per cent compared with 17 per cent).
- Over a half (54 per cent) of children with conduct disorders had experienced their parents' separation compared with less than a third of those with no such disorder (30 per cent). There were also large differences in the proportions whose parents had experienced a major financial crisis (22 per cent and 13 per cent), who had been in trouble with the police (15 per cent and 5 per cent), or who had had a serious mental illness (17 per cent and 7 per cent).
- A fifth (21 per cent) of the parents of children with unsocialised conduct disorder had been in trouble with the police and a quarter (24 per cent) had had a serious mental illness.

Child's social functioning

- About three-quarters (77 per cent) of children with conduct disorders had scores in the bottom quartile on a scale measuring their strengths. About two-thirds (69 per cent) had scores in the bottom quartile on a scale measuring their social aptitude.
- A quarter (24 per cent) of children with a conduct disorder found it harder than average to make friends and a third (33 per cent) found it harder than average to keep friends. The proportions for children with no conduct disorder were 9 per cent and 4 per cent.

- Children with unsocialised conduct disorders who tended to have solitary behaviour patterns, fared particularly badly on measures of friendship. About a half had difficulty making and keeping friends (47 per cent and 54 per cent).

Smoking, drinking and drug use

- Young people with conduct disorders were much more likely than other young people to smoke, drink and take drugs. As was the case with emotional disorders, the largest differences were in smoking and drug taking. Among those aged 11–16, 34 per cent of young people with conduct disorders were smokers and 28 per cent had taken drugs at some time. Among other young people, these proportions were 8 per cent and 8 per cent. *(Figure 6.8)*

Self-harm

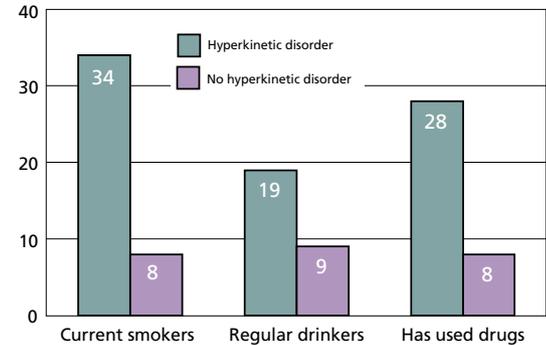
- Among young people aged 11–16 who had a conduct disorder, 21 per cent said that they had tried to harm or kill themselves.

Figure 6.8

Smoking, drinking and drug use by whether has a conduct disorder: children aged 11–16, 1999 and 2004 combined

Great Britain

Percentage



Children with hyperkinetic disorders

Demographic and socio-economic characteristics

- Children with hyperkinetic disorders were predominantly boys (86 per cent compared with 50 per cent of other children) and almost all were white (97 per cent compared with 89 per cent of other children). *(Figure 7.1)*
- Children with hyperkinetic disorders were more likely than other children to live with single or previously married lone parents (38 per cent compared with 24 per cent). *(Figure 7.2)*
- Over a third (36 per cent) of children with hyperkinetic disorders had parents with no educational qualifications compared with about a fifth (21 per cent) of other children and over half (52 per cent) lived in households with a gross weekly income of less than £300 compared with a third (34 per cent) of other children.
- The proportions of children with hyperkinetic disorders living in a household in which no parent was working was over twice that among those with no such disorder (31 per cent compared with 14 per cent).
- Children with hyperkinetic disorders were more likely than other children to live in households in which someone received a disability benefit (27 per cent compared with 8 per cent).

Figure 7.1
Sex by whether has a hyperkinetic disorder, 1999 and 2004 combined
Great Britain

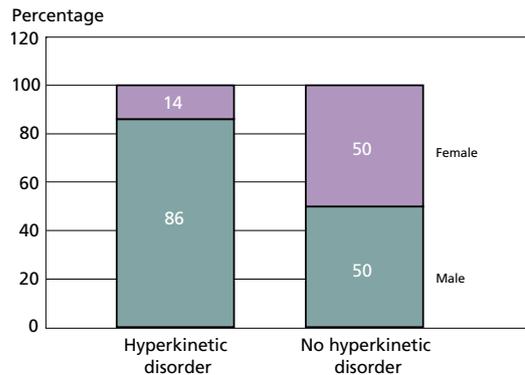


Figure 7.2
Family type by whether has a hyperkinetic disorder, 1999 and 2004 combined
Great Britain

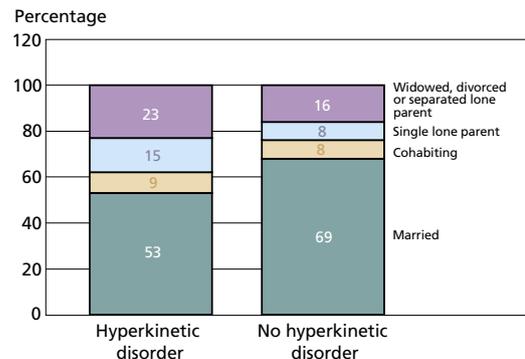
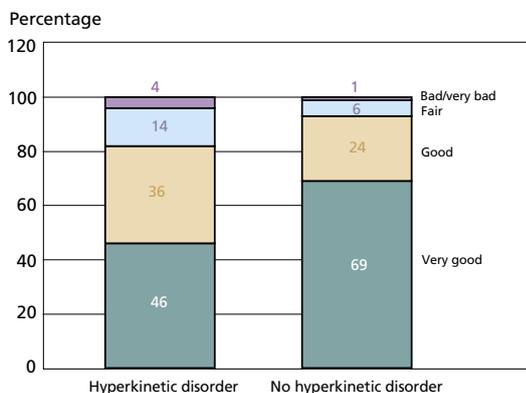


Figure 7.3
Child's general health by whether has a hyperkinetic disorder, 1999 and 2004 combined

Great Britain

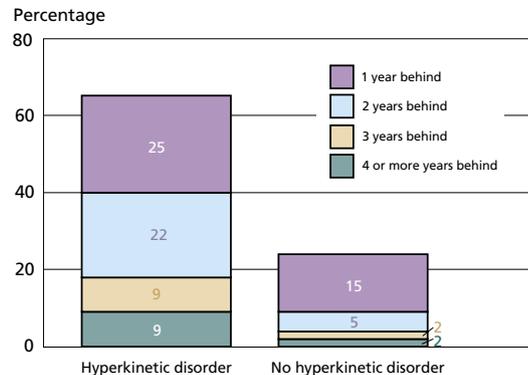


Child's general, physical and mental health

- Parents of children with hyperkinetic disorders were more than twice as likely as other parents to report that their child's general health was fair or bad (18 per cent compared with 7 per cent). Just over two-thirds (70 per cent) reported that their child had a specific physical or developmental problems compared with just over a half (54 per cent) of other children. *(Figure 7.3)*
- Two-thirds (66 per cent) of children with a hyperkinetic disorder also suffered from another of the main types of clinically recognisable mental disorder, most commonly conduct disorder (62 per cent). One in eight (12 per cent) also had an emotional disorder.

Figure 7.4
Proportion of children who were behind in their overall scholastic ability by whether they had a hyperkinetic disorder, 1999 and 2004 combined

Great Britain



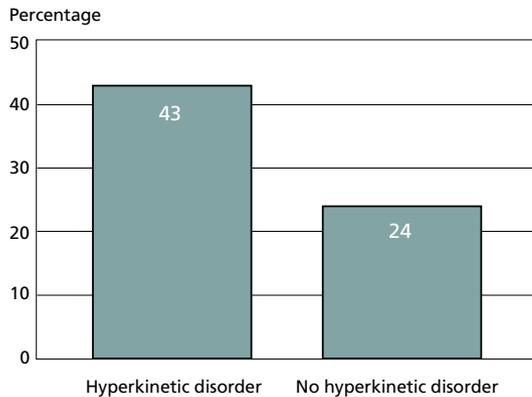
Use of services

- Almost all (95 per cent) parents of children with hyperkinetic disorders had sought some form of help in the past year because of concerns about their child's mental health. Most (93 per cent) had contacted a professional source, usually a teacher (70 per cent).

Scholastic ability and attendance at school

- Almost two-thirds (65 per cent) of children with hyperkinetic disorders were rated as being behind in their overall scholastic ability and 18 per cent were three or more years behind, compared with 24 per cent and 4 per cent of other children. *(Figure 7.4)*

Figure 7.5
Proportion of children whose parent's scored 3 or more on the GHQ-12, 1999 and 2004 combined
Great Britain



- Children with hyperkinetic disorders were more than 4 times as likely as other children to have officially recognised special educational needs (71 per cent compared with 16 per cent).
- Children with hyperkinetic disorders were more likely than other children to have been absent from school for long periods: 11 per cent had missed more than fifteen days, compared with 5 per cent of other children.

Social functioning of the family

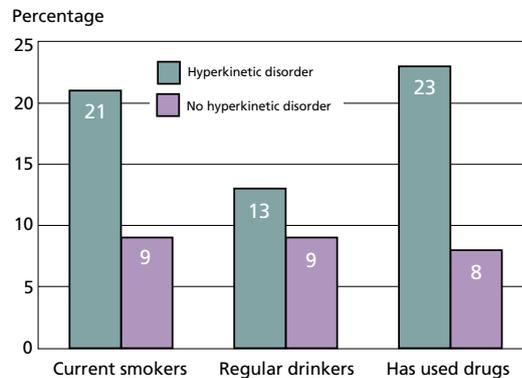
- Over two-fifths (43 per cent) of parents of children with hyperkinetic disorders had a score on the General Health Questionnaire (GHQ-12) indicative of an emotional disorder (compared with 24 per cent among other parents). *(Figure 7.5)*

- Over one-third (36 per cent) of families containing children with a hyperkinetic disorder were assessed as having unhealthy family functioning. Among other families, the proportion was 18 per cent.
- Almost half (49 per cent) of children with hyperkinetic disorders had experienced their parents' separation and almost a quarter (23 per cent) had had a serious illness that required a stay in hospital. The proportions for other children were 31 per cent and 13 per cent.

Child's social functioning

- Over four-fifths (84 per cent) of the parents of children with hyperkinetic disorders rated their child in the lowest quartile on a scale measuring strengths. A similar proportion of parents (83 per cent) rated their child in the lowest quartile on a scale measuring social aptitude.
- Almost a third (32 per cent) of children with hyperkinetic disorders found it harder than average to make friends and two-fifths (44 per cent) found it harder to keep friends.
- Young people aged 11–16, who had a hyperkinetic disorder were about twice as likely as other young people to have a score in the lowest quartile on a scale measuring social support (54 per cent compared with 28 per cent).

Figure 7.6
Smoking, drinking and drug use by whether has a hyperkinetic disorder: children aged 11–16, 1999 and 2004 combined
 Great Britain



Smoking, drinking and drug use

- Young people with hyperkinetic disorders were more likely than other young people to smoke and take drugs. However, they were no more likely than other young people to drink alcohol. Among young people with a hyperkinetic disorder, 21 per cent were smokers and 23 per cent had taken drugs at some time. Among other young people, 9 per cent were smokers and 8 per cent had taken drugs. *(Figure 7.6)*

Self-harm

- Among young people aged 11–16 who had a hyperkinetic disorder, 18 per cent said they had tried to harm or kill themselves.

Children with autistic spectrum disorder

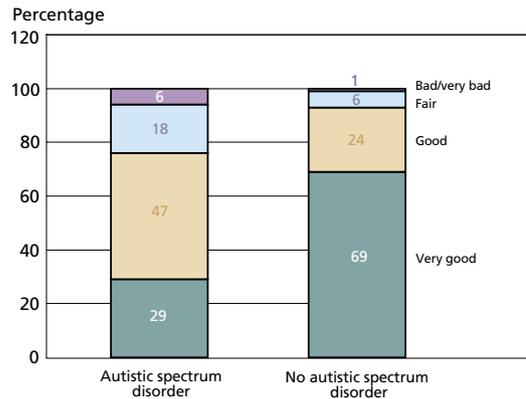
Demographic and socio-economic characteristics

- Children with autistic spectrum disorder were predominantly boys, 82 per cent.
- Unlike children with the more common disorders, autistic children tended to have more highly qualified parents than other children: 46 per cent had parents with qualifications above GCSE compared with 35 per cent of other children. Similarly, autistic children were slightly less likely to live in low income families: only 9 per cent compared with 20 per cent of other children lived in households with a gross weekly income of less than £200 per week.
- Autistic children were, however, similar to children with other types of disorder in that a relatively high proportion lived in families in which neither parent worked (30 per cent compared with 14 per cent of other children). The unusual combination of high educational status and low economic activity rate among the parents of autistic children probably reflects their heavy caring responsibilities.
- Over a half (56 per cent) of families containing autistic children were receiving a disability benefit.

Figure 8.1

Child's general health by whether they had autistic spectrum disorder, 1999 and 2004 combined

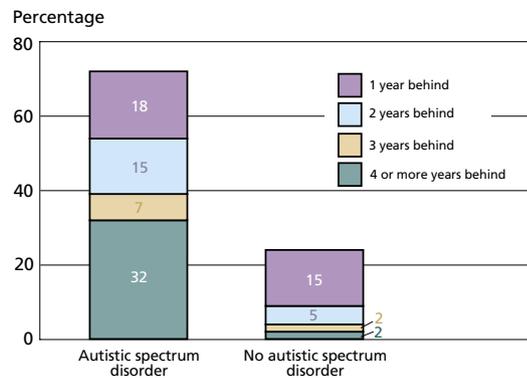
Great Britain



Child's general, physical and mental health

- The parents of children with autistic spectrum disorder were much more likely than the parents of other children to say that their child's health was fair or bad (24 per cent compared with 7 per cent) and almost all the children had a physical or developmental problem as well (89 per cent compared with 54 per cent of other children). (Figure 8.1)
- Just under one third (30 per cent) of autistic children had another clinically recognisable mental disorder: 16 per cent had an emotional disorder, usually an anxiety disorder; and

Figure 8.2
Proportion of children who were behind in their overall scholastic ability by whether they had autistic spectrum disorder, 1999 and 2004 combined
Great Britain



19 per cent had an additional diagnosis of conduct disorder, often made on the basis of severely challenging behaviour.

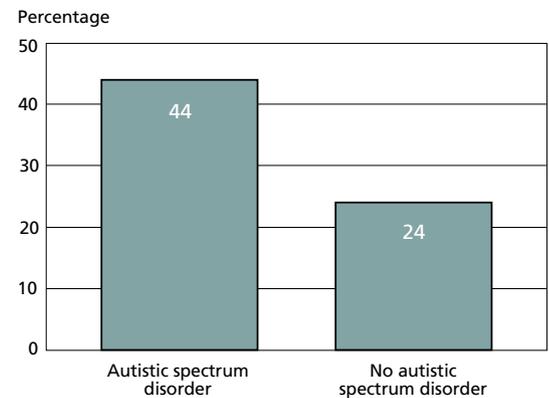
Use of services

- Nine out of ten parents (89 per cent) of children with autistic spectrum disorder had sought help for their child's mental health problems and almost all of these had approached professional sources for advice (86 per cent).

Scholastic ability and attendance at school

- Autistic children were three times as likely as other children to be behind in terms of their scholastic ability (72 per cent compared with 24 per cent). Two-fifths (39 per cent) were more than two years behind. (Figure 8.2)

Figure 8.3
Proportion of children whose parent's scored 3 or more on the GHQ-12, 1999 and 2004 combined
Great Britain



- Almost all children with autistic spectrum disorder were reported to have special educational needs (97 per cent compared with 16 per cent of other children).
- Over a quarter (27 per cent) of autistic children had been excluded from school at some point and most of these (23 per cent overall) had been excluded on more than one occasion.

Social functioning of the family

- The parents of autistic children were almost twice as likely as other parents to have scores on the General Health Questionnaire (GHQ-12) indicative of an emotional disorder (44 per cent compared with 24 per cent).

(Figure 8.3)

- Autistic children were twice as likely as other children to live in families classified as having unhealthy functioning (37 per cent compared with 18 per cent).

Child's social functioning

- Almost all of the children with autistic spectrum disorder fell into the bottom quartiles on scales measuring strengths (96 per cent compared with 25 per cent of other children) and social aptitude (96 per cent compared with 24 per cent)
- Over two-thirds of autistic children found it harder than average to make and keep friends, 71 and 73 per cent compared with 10 and 5 per cent of other children. Two-fifths (42 per cent) had no friends whereas hardly any other children (1 per cent) were in this position.

Self-harm

- A quarter (25 per cent) of parents of autistic children reported that their child had tried to harm or kill themselves.

9

Children with multiple disorders

Prevalence of multiple disorders

One in five of the children with a disorder were diagnosed with more than one of the main categories of mental disorder (emotional, conduct, hyperkinetic or less common disorders). This figure represents 1.9 per cent of all children.

The most common combinations were conduct and emotional disorder and conduct and hyperkinetic disorder (0.7 per cent in each case).

Characteristics and behaviour patterns of children with multiple disorders

- Nearly three-quarters (72 per cent) of children with multiple disorders were boys reflecting the high proportion of children with conduct disorder in this group.
- About three-quarters (76 per cent) of children with multiple disorders had a physical or developmental problem as well compared with two-thirds (66 per cent) of those with a single disorder.
- Almost all parents of children with multiple disorders had sought help with their child's mental health problems (96 per cent) and most had sought some form of professional advice (93 per cent).
- Nearly two-thirds (63 per cent) of children with multiple disorders were behind with their schooling and 40 per cent were more than a year behind. Among children with a single disorder, these proportions were 49 per cent and 27 per cent.
- Nearly four-fifths (88 per cent) of children with multiple disorders had scores in the bottom quartile on a scale measuring strengths compared with three-fifths (61 per cent) of those with a single disorder. The pattern for scores on an empathy scale was similar.

The six-month follow-up study

Samples of the children interviewed in the 1999 and 2004 surveys were followed up 6 months later by means of a postal questionnaire sent to their parents. The analysis compared the total symptoms, the disorder specific symptoms and the impact of the symptoms at the main interview and at follow-up.

Over the six months between main survey and follow up, the gap between the children with a disorder and those with no disorder narrowed by 10–50 per cent but did not disappear. Improvement in disorder specific symptoms was most marked for children with an emotional disorder and least marked for children with an autistic spectrum disorder.

11

Glossary: Typical behaviour patterns of children with mental disorders and case vignettes

A description of typical symptoms displayed by children with different types of mental disorders is given below. Many children display the symptoms listed to some degree. To count as a disorder they have to be sufficiently severe to cause distress to the child or impairment in functioning. In order to illustrate the impact of the disorder on the child's life and that of his or her family, the symptoms are followed by a case vignette of a fictitious child.¹

Emotional Disorders

Separation anxiety

Typical symptoms are concerns about: separation from an attachment figure, for example, because of loss of or harm to that person or the child being taken away; not wanting to go to school; being afraid of sleeping or being at home alone. The child may feel sick, anxious or have nightmares about the possibility of separation.

He gets frantic if left on his own at all – he follows me from room to room, he doesn't want me to have my own life. He won't stay with his friends or even stay the night with his gran like all his cousins do. He won't even stay over with his dad (we're divorced and I've remarried). It is not always easy to get him to go to school and he has to phone me at lunch time to check up on me. I feel like a prisoner

at times, with him as my warder. He is reluctant to let me go to the bathroom by myself, waiting outside the door until I come out. He gets upset if I want to go out with my new husband, and needs to know when I'll be back, and waits up for me.

Specific phobia

This disorder is characterised by excessive fears about particular objects or situations, for example: animals, storms, the dark, loud noises, blood, infections or injuries, dentists or doctors, vomiting, choking or diseases, types of transport, enclosed spaces, toilets, people who look unusual, monsters, etc. The child becomes very upset each time the stimulus is triggered and tries to avoid such situations.

He is really terrified of dogs. I know lots of children are afraid of big dogs or aggressive dogs, but this is different. He is afraid of any dog, no matter how friendly or well-behaved it is. He doesn't want one to come near him and if one does, then he screams and grabs me tight or tries to run away. On several occasions, he has run into the road without looking just to get out of the way. He won't go to the house of his best friend or his grandparents because they have dogs. He's old enough to go places on his own, but he won't just in case he meets a dog.

1. The symptoms and vignettes are based on descriptions of a 'made up' child created by Youthmind to illustrate the diagnostic classification system.

Social phobia

Typical symptoms are anxiety about: meeting new or large groups of people, eating, reading or writing in front of others, speaking in class. The child may be able to socialise with familiar people in small numbers but is frightened of interacting with other adults or children. The anxiety is typically due to fear of embarrassment. The child becomes distressed (for example, blushes or feels sick) and tries to avoid such social situations.

She doesn't like being with people she doesn't know, she is extremely shy. Once she's used to people, she's alright with them, just so long as she's with them one-to-one. But she doesn't even like family parties with her cousins and uncles and aunts, even though she's OK with them individually. At school, she doesn't want to do anything that will make her noticed. She's never yet acted in a school play, or anything like that. Her teacher says she's very quiet in class.

Generalised anxiety

The child worries about a wide range of past, present or future events and situations, for example: past behaviour, school work and exams, disasters and accidents, his/her own health, weight or appearance, bad things happening to others, the future, making and keeping friends, death and dying, being bullied and teased. The anxiety is accompanied by physical symptoms such as restlessness, fatigue, poor concentration, irritability, muscular tension or insomnia.

I can't think of anything that he doesn't worry about. If it's not worry about his health, it's worry about whether he might have upset people at school, or about his homework, or about asteroids hitting the Earth, or about them burning down the rainforest. He'll worry himself sick about the slightest little thing, like whether he might have made a spelling mistake in a school essay he's just handed in. Just that will stop him going to sleep - I'll be going to bed and he'll call me into his room needing yet more reassurance before he can get to sleep.

Depression

Depression is characterised by feelings of sadness, irritability and loss of interest which last for most of the day and persist over a period of time. Associated features may be: tiredness, changed appetite, weight loss or gain, insomnia, hypersomnia, agitation, feelings of worthlessness or guilt, poor concentration, thoughts of death, recent talk or experience of deliberate self harm.

This last month or so she seems really down in the dumps. She has been crying about the slightest little thing. If you say anything to her, she is likely to snap back at you. A few times I've heard her being really grumpy with her friends when they have called up to speak to her. They don't call up any more. She used to have many interests, like her favourite soap operas, playing on the computer, listening to her music. But now she's just not interested in any of it. She just stays in her room and only comes down if we insist. She is waking up really early in the morning, and she then often wakes the rest of us up too. She's stopped eating even her favourite meals, and she looks a lot thinner. I don't know if it's due to being tired or

eating less, but she doesn't have her usually energy any more. It's hard getting her off to school, and when she's home again, I doubt if she gets much homework done since she's tired and she can't seem to focus on anything.

Conduct Disorders

Oppositional defiant disorder

This is characterised by: temper outbursts, arguing with adults, disobedience, deliberately annoying others, passing on blame, being easily annoyed, angry, resentful, spiteful and vindictive. The behaviour is likely to have caused complaints from parents and teachers.

He just will not do what he is told. He answers back and throws huge temper tantrums if he cannot get his own way. He has always been like this, but it is getting more of a problem now he has started junior school. He winds others up, particularly his younger brothers, and is glad when he gets other children into trouble because he has provoked them into shouting at him or hitting him. He is just the same at school; he is always in trouble for being rude, doing things that he has been asked not to and upsetting other children. He just will not admit when he is in the wrong. He is so stropky, it does not take much to set him off and it feels like we all tip toe around him to avoid arguments.

Unsocialised and socialised conduct disorders

Typical behaviour includes: telling lies, fighting, bullying, staying out late, running away from home, playing truant, being cruel to people or animals, criminal behaviour such as robbery,

rape, using weapons. This type of behaviour would often have resulted in complaints from school staff or contact with the police.

In *socialised* conduct disorder, the young person has friends (though usually antisocial friends). They may engage in antisocial behaviours such as shoplifting or stealing cars together. In *unsocialised* conduct disorder, the young person lacks any real friends and typically engages in solitary antisocial activities. These are the opposite ends of a spectrum, so dividing conduct disorder into these two categories is somewhat arbitrary.

Socialised conduct disorder

She used to bunk off school with her friends to go shop lifting, and they sold what they stole to buy drugs, alcohol and cigarettes. Once she started secondary school, I lost all control over her. She would stay out late with these friends, some of whom were much older than her. When she did go to school she was constantly in trouble because she would swear at teachers and refuse to do any work. She was finally permanently excluded from school because she was caught selling drugs to other pupils. She was first in contact with the police for trespassing when she was 12 years old, but now has several cautions for taking and driving away, shop lifting and the possession of drugs. Social services became involved when she had a baby aged 14.

Unsocialised conduct disorder

He has never had any friends, and he doesn't like school. He walks out if he does not like a lesson and wanders round town on his own.

He was horribly bullied when he was younger, and now he gets into trouble for bullying younger children. When his teachers told him off for this, he vandalised the school toilets and ended up being excluded. He has also tried setting fire to a shed in the local park – he was caught and has been cautioned by the police. We have also caught him being really cruel to our cat and he just doesn't seem to understand that this is a bad thing to do.

Hyperkinetic disorder

The child is *hyperactive* (for example, fidgeting, running around, climbing on furniture, always making a lot of noise), *impulsive* (for example, blurts out answers, cannot wait his/her turn, butts into conversations or games, cannot stop talking) and *inattentive* (for example, cannot concentrate on a task, makes careless mistakes, loses interest, does not listen, is disorganised, forgetful and easily distracted). The child's teachers are likely to have complained about his/her overactivity, impulsiveness and poor attention.

He is all over the place – always on the move. He won't sit still at the table while we are eating – it's fidgeting the whole time, getting up between courses. He'd get up between mouthfuls if I let him. If there's a task that needs doing, whether it's homework or tidying his room, he'll start willingly but within a few minutes he's been distracted and begun doing something else instead. Sometimes, it is just an excuse and he never really wanted to do it anyway, but there are many times when I'm sure he couldn't help it. The teachers complain too, but I think they agree that it's the way he is made. Outside the family he is quite shy, and this keeps him a bit under control. But within the family,

he has no inhibitions. He's forever interrupting, poking his nose in, acting without thinking of the consequences. At home, we try to make allowances, but there are still times when it leads to family rows – when he has yet again broken a pen or a remote control as a result of his ceaseless fidgeting, or when it's bedtime and he still hasn't finished homework that anyone else could have finished ages ago. At school, they can't make as many allowances as we can, and I think it has been stopping him doing as well as he should in his lessons.

Autistic spectrum disorder

Typical symptoms include: impaired social interaction (e.g. abnormal eye contact, inability to pick up non-verbal cues, difficulty making friends), lack of social or emotional reciprocity (e.g. difficulty sharing or co-operating with others), delayed or absent speech, repetitive language, impoverished play, inflexible routines and rituals, repetitive mannerisms and preoccupation with unusual parts of objects.

He was late learning to talk and he still speaks in a slightly odd way now – he can understand and people understand him, but his voice and the words he chooses are a bit strange. He insists on doing everything his way and is really cross if he can't have his way. When he was little, he just liked lining up his toy cars or bricks into rows or other patterns. The other thing he'd do was sniff everything or hold it to his cheek. His eye contact was never very good, but it has got better over the years, perhaps because I reminded him about it all the time. Now it's gone too much to the opposite extreme and he makes so much eye contact that people think he is staring. He used to flap his arms

whenever he was excited, but that has mostly gone now. He still likes fiddling with a favourite bit of string that he has had for ages, but he knows not to do that too much in public. He never took part in any sort of pretend play when he was younger, and his interests still focus on facts and objects rather than people or stories.

He has a lot of fixed routines in his life. He has to go the same way to school everyday – if the traffic is bad the normal way and I try to take a short cut, he gets very upset and I don't hear the end of it for days. Every day he gets up at the same time, even when it is the weekend or a holiday. He wants to wear the same clothes every day. When they have holes in them and can't be repaired any more, it leads to a massive tantrum when I finally throw clothes away even if I have bought him a replacement as close to the original as possible.

He collects old packets that used to have food in them and he stores them in the spare room (it's full of them!) and catalogues them. There are hundreds of old packets but he knows every one of them and can talk for hours on the differences between packets that look pretty much the same to anyone else.

He's never really made proper friends. Now he does want to have friends, but he can't make and keep ordinary friends. The people he now describes as his friends put up with him for as long as he is useful to them. I think this lack of friends is the worst thing about his life. In addition, his interests are so different from everybody else's that he doesn't get to do many leisure activities. His fixed routines make him hard to live with – and there is often friction at home as a result.