

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

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Notes

1 Tables showing percentages

The row or column percentages may add to 99% or 101% because of rounding.

The varying positions of the percentage signs and bases in the tables denote the presentation of different types of information. Where there is a percentage sign at the head of a column and the base at the foot, the whole distribution is presented and the individual percentages add to between 99% and 101%. Where there is no percentage sign in the table and a note above the figures, the figures refer to the proportion of people who had the attribute being discussed, and the complementary proportion, to add to 100%, is not shown in the table.

The following conventions have been used within tables showing percentages:

..	data not available
-	no cases
0	values less than 0.5%
0.0	values less than 0.05%

2 Small bases

Very small bases have been avoided wherever possible because of the relatively high sampling errors that attach to small numbers. Often, where the numbers are not large enough to justify the use of all categories, classifications have been condensed. However, an item within a classification is occasionally shown separately, even though the base is small, because to combine it with another large category would detract from the value of the larger category. In general, percentage distributions are shown if the base is 30 or more. Where the base is lower, percentages are shown in brackets

3 Significant differences

Unless otherwise stated, all differences noted in the text are statistically significant at the 95 per cent confidence level ($p < 0.05$).

Summary of main findings

This report first describes the prevalence of mental disorders among 5- to 16- year-olds in 2004 and notes any changes since the previous survey in 1999. It then provides profiles of children in each of the main disorder categories (emotional, conduct, hyperkinetic and autistic spectrum disorders) and, where the sample size permits, profiles subgroups within these categories. The final chapters examine the characteristics of children with multiple disorders and present a selection of analyses for Scotland. Causal relationships should not be assumed for any of the results presented in this report.

Background, aims and coverage (Chapter 1)

- 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 extend the coverage in the 1999 survey of children with autistic spectrum disorder to provide more detailed information for this group.
- To examine the relationship between mental disorder and aspects of children's lives not covered in the previous national survey carried out in 1999, 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.
- 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.

Concepts and methods (Chapter 2)

- This report uses the term 'mental disorders', as defined by the ICD-10, to imply a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions.
- The assessment of mental disorder was based on both structured and open-ended questions. 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 young people themselves (if aged 11–16).
- A case vignette approach was used for analysing the survey data in which clinicians reviewed the responses to the precoded questions and the transcripts of informants' comments, particularly those which asked about the child's significant problems.

Sampling and survey procedures (Chapter 3)

- The sample was drawn from Child Benefit Records held by the Child Benefit Centre (CBC).
- 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.
- Information was collected for 76 per cent of the children approached, resulting in 7,977 achieved interviews.
- Among the co-operating families, almost all the parents and most of the children took part. Teacher questionnaires were obtained for 78 per cent of the children interviewed.

New topics in 2004 (Chapters 5–9)

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 mainly using non-pharmacological approaches with these families.

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 4 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.

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 (see Chapter 2). 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.

Prevalence of mental disorders¹ (Chapter 4)

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 (see Chapter 9).

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.
- The prevalence of mental disorders was greater among children:
 - in lone parent (16 per cent) compared with two parent families (8 per cent);
 - in reconstituted families (14 per cent) compared with families containing no stepchildren (9 per cent);
 - whose interviewed parent had no educational qualifications (17 per cent) compared with those who had a degree level qualification (4 per cent);
 - in families with neither parent working (20 per cent) compared with those in which both parents worked (8 per cent);
 - 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);
 - in households in which someone received disability benefit (24 per cent) compared with those that received no disability benefit (8 per cent);
 - 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);
 - living in the social or privately rented sector (17 per cent and 14 per cent) compared with those who owned accommodation (7 per cent); and
 - 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).

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.

Children with emotional disorders (Chapter 5)

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).
- 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).
- 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.

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

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 2 or more years behind, compared with 24 per cent and 9 per cent of other children.

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

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).
- 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 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 (that is, their positive attributes and behaviour). 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.

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.

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.

Children with conduct disorders (Chapter 6)

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

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 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 2 or more years behind. For other children, these proportions were 24 per cent and 9 per cent.
- 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: 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.

- 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).
- 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, 30 per cent of young people with conduct disorders were regular smokers and 28 per cent had taken drugs at some time. Among other young people, these proportions were 5 per cent and 8 per cent.

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.

Children with hyperkinetic disorders (Chapter 7)

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).
- 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).
- 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).

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

problem compared with just over a half (54 per cent) of other children.

- Two-thirds (66 per cent) of children with a hyperkinetic disorder also suffered from another of the main types of clinically diagnosed mental disorder, most commonly conduct disorder (62 per cent). One in eight (12 per cent) also had an emotional disorder.

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.
- 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).
- 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 mental 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).

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.

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 (Chapter 8)

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.

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).
- 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 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.
- 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).
- 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.

Children with multiple disorders (Chapter 9)

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 (Chapters 3, 5–9)

- Samples of the children interviewed in the 1999 and 2004 surveys were followed up six 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.

Chapter 1

**Background, aims
and coverage of
the survey**

Background

The survey of the mental health of children and young people living in private households in Great Britain 2004, is the second national survey on this topic carried out by ONS. It was commissioned by the Department of Health and the Scottish Executive Health Department.

The first survey, carried out in 1999, obtained information about the mental health of 10,500 young people living in private households in Great Britain. (Meltzer *et al*, 2000). The results from the 1999 survey highlighted the key public health significance of psychiatric disorders in childhood. Almost one in ten 5- to 15-year-olds were assessed as having a clinically recognisable mental disorder – with significant impact on the child's life and burden on the child's family (Meltzer *et al*, 2000). Longitudinal evidence has confirmed that many child psychiatric disorders persist, increasing risks for mental health problems and difficulties in social functioning well into adult life (Maughan, 2004).

Between 1999 and 2004, four additional mental health surveys were carried out by ONS focussing on particular groups of young people.

- Persistence, onset, risk factors and outcomes of childhood mental disorders (Meltzer *et al*, 2003a):
 - Fieldwork period: January 2002 to April 2002.
 - Achieved sample size: 2,587.
- The mental health of young people looked after by local authorities in England, (Meltzer *et al*, 2003b):
 - Fieldwork period: October 2001 to June 2002.
 - Achieved sample size: 1,038.
- The mental health of young people looked after by local authorities in Scotland, (Meltzer *et al*, 2004a):
 - Fieldwork period: October 2002 to June 2003.
 - Achieved sample size: 350.
- The mental health of young people looked after by local authorities in Wales (Meltzer *et al*, 2004b):
 - Fieldwork period: October 2002 to June 2003.
 - Achieved sample size: 150.

All these surveys represented the first tranche of studies whose aim was to describe the mental health of young people in Great Britain.

Aims of the 2004 survey

From a policy perspective, the 2004 private household survey was commissioned with a view to taking forward a number of key initiatives:

- To inform strategic service planning with health, social service and educational agencies.
- To examine protective as well as risk factors in relation to childhood mental disorders.
- To identify training and support requirements for parents, teachers and health and child welfare professionals.
- To monitor health inequality targets.
- To improve health outcomes of all children.

From a research perspective, the focus was on the extent to which the prevalence of the three common groups of childhood mental disorders changed over the five-year period between surveys, namely:

- Emotional problems involving anxiety, depression and obsessions.
- Conduct problems involving awkward and troublesome behaviour and aggressive and antisocial behaviours.
- Hyperactivity disorders involving inattention, impulsiveness and aggression.

Where there have not been substantial changes since the 1999 survey, data from the two surveys can be combined thereby increasing the sample size. With a larger sample, it is possible to examine the characteristics and behaviour of different subgroups of children within the main disorder categories.

The second survey in 2004 was also regarded as an opportunity to look more carefully and more systematically at the less common, childhood mental disorders and their co-morbidity with other disorders.

- Autistic spectrum (developmental) disorders.
- Tic disorders (motor and vocal tics).
- Eating disorders (anorexia nervosa and bulimia).

Protective and contextual factors were included for the first time in the 2004 survey relating to current governmental concerns on social inclusion and mental health improvement. These included questions measuring the child's resilience (for example, the extent of their social support networks), their ability to empathise with others and possible precursors of personality disorder. It was planned that the effectiveness of these factors would be determined by following up children interviewed in the main survey.

Other topics included for the first time in 2004 were:

- Medication commonly prescribed for childhood mental disorders.
- Services used by all children irrespective of psychopathology.
- Educational issues: number of schools attended, absences and exclusions.
- Deviant peer group pressure.

- Social context of drinking and smoking.
- Mental health of other children in the family.¹

Review of previous research

A literature review of previous epidemiological research on childhood psychopathology up to the end of the 1990s was included in the report of the first survey (Meltzer *et al*, 2000). Therefore, the review of previous research included here focuses on cross-sectional studies which compare psychiatric morbidity among young people over two time periods.

Repeated, national, cross-sectional studies focussing on the childhood mental health problems are far rarer than prospective or longitudinal studies. The latter are essential for examining the course of psychiatric problems and investigating persistence of disorders. Cross-sectional studies at different points in time answer a different question – what is the stability of childhood psychopathology in the population across decades or generations?

Achenbach and Howell (1993) looked at whether the prevalence of children's behavioural or emotional problems changed significantly over a 13-year period. Problems reported by parents and teachers for a random sample of 7- to 16-year-olds assessed in 1989 were compared with those reported by parents for a 1976 sample and by teachers for a 1981/1982 sample. Parent reports were obtained with the Child Behaviour Checklist; teacher reports were obtained with the Teacher's Report Form. They found problem scores were higher in 1989 than in the earlier assessments. The changes were small and did not differ significantly by age, gender, socio-economic status or black/white ethnicity.

Achenbach, Dumenci and Rescorla (2003) carried out another assessment in 1999 in order to comment on changes to the mental health of children over a 23-year period. Thus, Child Behaviour Checklists (Achenbach and Edelbrock) were completed in home interviews by parents of 7- to 16-year-olds in 1976, 1989, and 1999. Problem scores increased from 1976 to 1989 and decreased in 1999 but remained higher than in 1976. For the 114 problem items that were common to the 1976, 1989, and 1999 assessments, the Q correlation was 0.98 between the mean scores on the 114 items in 1976 versus 1989 and was 0.94 between the mean scores on the 114 items in 1976 compared with 1999. This indicated very high stability in the rank ordering of item scores across intervals up to 23 years. For all children, the 1-year prevalence rate for mental health services use was 13.2 per cent in 1989 versus 12.8 per cent in 1999.

The 10-year time trends in competencies and problem scores in children and young people were assessed by Verhulst, van der Ende and Rietbergen (1997). Children and young people randomly selected from the Dutch general population in 1983 were assessed with the Child Behaviour Checklist and the Teacher's Report Form. Their problem scores and competence scores were compared with those obtained by the same method 10 years later. No significant differences were found between the 1983 and 1993 total problem scores obtained from parents or teachers. On the level of problem items and scales, a few differences indicating an increase in problems were found. However, the magnitude of these differences was very small. The researchers concluded that their results did not provide evidence for a clear secular increase in malfunctioning of Dutch children and young people.

More recently, Sourander *et al*, (2004) studied the differences in children's psychiatric symptoms and child mental health service use at two time points: 1989 and 1999. Two cross-sectional representative samples of 8- to 9-year-old children from southern Finland were compared. The 1989 sample consisted of 985 children, of whom 95 per cent participated, and the 1999 sample consisted of 962 children, of whom 86 per cent participated. Information was gathered from parents and teachers using Rutter's questionnaires and other related determinants of service use, and from children using the Child Depression Inventory (Kovacs, 1985).

The overall rate of children's problems assessed by parents did not increase during the ten-year period. Boys had fewer psychiatric symptoms in 1999 than in 1989, whereas no clear change had occurred in girls' symptoms, except that, according to parents, girls in 1999 had more hyperactive symptoms. However, children themselves reported more depressive symptoms in the 1999 than in the 1989 sample. In 1989, 2.3 per cent and in 1999, 5.3 per cent of children had used child mental health services. The increase in service use among girls was fourfold. Parents preferred to seek help for their children's problems from teachers, school nurses, and school psychologists rather than from specialised child psychiatric services.

They concluded that there has been an increase in mental health service use especially among girls as well as a convergence of symptom levels by gender.

All four studies above indicate that the **overall** rate of childhood psychopathology has not changed considerably since the 1970s although there may have been small changes in specific symptomatology.

1. This data has not been analysed for this report.

Timetable

Although the 2004 survey was the second national survey in Great Britain a considerable amount of feasibility and pilot work was required because of the development of the sections on the less common disorders (pervasive developmental disorder, tics and eating disorders). Not only were new sections extensively piloted in the general population, they were also tested on clinical samples owing to the rarity of the conditions.

Figure 1.1 summarises the timetable for whole programme of research.

Figure 1.1 Timetable for survey

From	To	Activity
April 2003	Oct. 2003	Survey development – sample design and questionnaire, MREC application, selection of primary sampling units, design pilot survey – questionnaire and field documents.
Oct. 2003	Apr 2004	Pilot survey – interviews completed, report written and debriefing carried out; design of mainstage questionnaire and field documents.
Apr. 2004	Jul. 2004	Mainstage interviewing
Jun. 2004	Sep. 2004	Clinical assessment of survey data
Sep. 2004	Mar. 2005	Analysis, interpretation and report writing of main survey.

Coverage of the survey

Region

The surveyed population comprised young people living in private households in England, Scotland (including the Highlands and Islands) and Wales.

Age

The survey focused on the prevalence of mental disorders among young people aged 5–16. (The 1999 survey had the same minimum age but a maximum age of 15 rather than 16.) Young adults, aged 17 and above were included in the national adult psychiatric surveys in 1993 and 2000 (Meltzer *et al*, 1994; Singleton *et al*, 2001). Children under the age of 5 were still excluded in 2004 primarily because the assessment instruments for these children are different and not so well developed as those for older children.

The feasibility study for the 1999 survey which took place in January to March 1997 included a questionnaire for parents of 3- and 4-year-olds. The questions were based on the Richman questionnaire revised by Nichol for a study of pre-school children (Nichol *et al*, 1987). Fifty-seven families of 3- to 4-year-olds were interviewed.

The data were presented in terms of case studies which highlighted the areas where parents expressed concern about their children: eating habits, potty training, bedtime, indoor play etc. Discussions of the report on the feasibility study by an expert group recommended that 3- and 4-year-olds should not be included in the main survey because of the problems in finding an appropriately sensitive instrument.

Childhood psychopathology

Though children and young people can be affected by many different mental health problems, most of these are rare. As in the original 1999 survey, the three common groups of disorders were covered:

- Emotional disorders such as anxiety, depression and obsessions.
- Conduct disorders characterised by awkward, troublesome, aggressive and antisocial behaviours.
- Hyperactivity disorders involving inattention and overactivity.

However, in 2004 a greater effort was made to assess the less common disorders, including:

- Autistic spectrum disorders.
- Vocal and motor tics.
- Eating disorders.

Additional questions were included in the survey to measure the precursors to personality disorder, the aim being to follow up children in future surveys so as to identify those who develop this disorder.

Content of the survey

A brief summary of the sections of the questionnaire is shown below, subsumed under the headings of questionnaire content for parents, children and teachers. The rationale behind using three sources of information is described in Chapter 2.

Questionnaire content for parents

The interview schedule for parents was asked of a parent of all selected children. It included the following sections:

Household composition and demographic characteristics

Details of child:

- General health.
- Social aptitudes.
- Friendships.
- Strengths and Difficulties Questionnaire (SDQ).
- Developmental disorders.
- Separation anxiety.
- Specific phobias.

- Social phobias.
- Panic attacks and agoraphobia.
- Post Traumatic Stress Disorder (PTSD).
- Compulsions and obsessions.
- Generalised anxiety.
- Depression.
- Attention and activity.
- Awkward and troublesome behaviour.
- Dieting, weight and body shape.
- Tics.
- Other concerns.
- Personality.
- Significant problems.
- Service use.
- Stressful life events.
- Education of young person.
- Strengths.

Details of interviewed parent/family:

- Education and employment (parent and partner).
- State Benefits.
- GHQ12 (Self-Completion).
- Family functioning (Self-Completion).

Questionnaire content for children and adolescents

Questions for children aged 11–16, by face-to-face interview, included the following topics:

- Strengths and Difficulties Questionnaire (SDQ).
- Separation anxiety.
- Specific Phobias.
- Social Phobia.
- Panic attacks and agoraphobia.
- Post Traumatic Stress Disorder (PTSD).
- Compulsions and Obsessions.
- Generalised Anxiety.
- Depression.
- Attention and activity.
- Awkward and troublesome behaviour.
- Dieting, Weight and Body shape.
- Less Common Disorders.
- Significant problems.
- Strengths.
- Social life (Neighbourhood, Trust, Care, Clubs).
- Social support.
- Educational attainment.
- Looked after by LA.

The self-completion element for the 11- to 16-year-olds included:

- Awkward and troublesome behaviour.
- Smoking cigarettes.
- Use of alcohol.
- Experience with drugs.

Questionnaire content for teachers

A postal questionnaire was sent to teachers covering scholastic achievement as well as assessments of behaviour and emotional well-being.

- Scholastic achievement and special needs.
- Strengths and Difficulties Questionnaire (SDQ).
- Emotions.
- Attention, activity and impulsiveness.
- Awkward and troublesome behaviour.
- Other concerns.
- Help from school.

Coverage of the report

One of the main purposes of this report is to examine the stability of the prevalence of mental disorders among children and young people aged 5–16 in Great Britain during the first half of 2004. Data for 1999 and 2004 are presented in Chapter 4.

In order to interpret these results, it is important to have an understanding of the concepts and methods adopted for this study; these are described in Chapter 2. Chapter 3 describes the sampling and interview procedures.

Each of the next three chapters focuses on a broad category of disorder: emotional disorders (Chapter 5), conduct disorders (Chapter 6) and hyperkinetic disorders (Chapter 7). Chapter 8 describes children with the less common disorders, in particular, autistic spectrum disorder and Chapter 9 presents a profile of those with multiple disorders. The last chapter provides selected analyses for Scotland.

The final part of the report contains the technical appendices and has five sections. The first gives details of the sampling design and shows how the data were weighted. The second section gives examples of standard errors from the prevalence tables. Section 3 describes the statistical terms used in the report and their interpretation. The last two sections comprise the survey documents and a glossary of terms.

Access to the data

Anonymised data from the survey will be lodged with the ESRC Data Archive, University of Essex, within three months of the

publication of this report. Independent researchers who wish to carry out their own analyses should apply to the Archive for access (www.data-archive.ac.uk)

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Chapter 2

Assessing mental disorders and their correlates

Introduction

Estimates of the prevalence of psychiatric morbidity among young people depend on the choice of concepts as well as how they are operationalised. These, in turn, depend on the particular purposes and aims of the study. This point needs emphasising because it means that estimates from this survey will not necessarily be comparable with those obtained from other studies using different concepts, sampling designs, assessment instruments or analytic methods. However, estimates from this 2004 study can be directly compared with those from the 1999 survey as all the methodological components were identical.

Therefore, this chapter begins with a discussion about the use of the term, mental disorder, in relation to young people and how it is defined in this report. This is followed by a description of the advantages of gathering information from multiple informants (parent, teacher and child) within a one-phase interview strategy. The third section of the chapter looks at the validity and reliability of the screening and diagnostic instruments used in the survey with a brief review of their use nationally and internationally. The chapter ends with a description of how a clinical input was added to the interpretation of the survey data.

Definitions of mental disorder

The Health Advisory Committee report (1995) stated that it was important to define terms relating to the mental health of children and young people because the lack of terminological clarity can lead to confusion and uncertainty about the suffering involved, the treatability of problems and disorders and the need to allocate resources.

This survey report deliberately uses the term, mental disorder, as distinct from psychiatric disorders or mental health problems. However, this should not be taken to indicate that the problem is entirely within the child. Disorders arise for a variety of reasons, often interacting. In certain circumstances, a mental disorder, which describes a constellation or syndrome of features, may indicate the reactions of a young person to external circumstances, which, if changed, could largely resolve the problem.

Because the questionnaires used in this survey were based on ICD10 diagnostic research criteria, mental disorders are defined for this report to imply a clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions.

Instruments used for clinical assessments of psychiatric disorders often allow for several possible diagnoses to be

made. Although it would be possible to impose a hierarchy among different disorders, the prevalence rates presented in subsequent chapters of this report do not have a hierarchy imposed on them. Thus children rated as having more than one disorder can be represented in several parts of a table. Nevertheless, the last section of Chapter 4 and Chapter 9 focus on the co-occurrences of childhood mental disorders.

Single versus multiple informants

While single-informant investigation characterised nearly all of the early epidemiological studies, more recent studies have broadened data collection to include information gathered from parents, teachers, and the subjects themselves. Hodges (1993) has pointed out that young people can respond to direct questions aimed at enquiring about their mental status and that there is no indication that asking these direct questions has any morbidity or mortality risks.

A well-established fact is that information from many sources is a better predictor of disorder than just one source. Many experienced clinicians and researchers in child psychiatry believe that information gleaned from multiple informants facilitates the best estimate of diagnosis in the individual case (Young *et al*, 1987). At the population level, information from multiple informants enhance the specificity of prevalence estimates.

Angold (1989) states:

“In general, parents often seem to have a limited knowledge of children’s internal mental states and to report less in the way of depressive and anxiety symptoms than their children would report. On the other hand adults seem to be better informants about externalised or conduct disorder items such as fighting and disobedience. Teachers are good informants about school behaviour and performance, whilst parents are informative about home life.”

Hodges (1993) comments that agreement between child and parent has varied depending on type of pathology:

“There appears to be more agreement for behavioural symptoms, moderate agreement for depressive symptoms, and poor agreement for anxiety”

One of the problems of collecting information from various sources is finding the best way to integrate the information which may show a lack of agreement. One method has been to accept a diagnosis irrespective of its source (Bird *et al*, 1992). Others have promoted ‘case vignette’ assessments where clinical judgements are made on detailed case histories from several sources. (Goodman *et al*, 1996)

Methods of assessing mental disorders

About half of the national surveys that have been carried out in other countries have used the multimethod-multiphase approach of Rutter *et al* (1970) to ascertain potential cases. In this approach, rating scales completed by children above a certain age and/or parents and/or teachers are used as first stage screening instruments. Subjects with scores above the cut-off score are identified as potential cases and further evaluated. A small sample of individuals with scores below the cut-off threshold are also selected for interview to assess the frequency of false negatives, i.e., those who have problems but whose rating scale scores were below the cut-off score.

In the second stage, children with scores above the cut-off score and a sample of those with scores below this value are interviewed using semi-structured or structured psychiatric interview instruments. At this stage categorical diagnoses are made. The overall prevalence of disorder is determined at the conclusion of this two-stage process.

The other method does not base caseness upon the multimethod-multiphase approach. All children and young people identified through the initial sampling procedure are eligible for diagnostic assessment. This approach was adopted in 1999 and was repeated in 2004. There are many advantages of such an approach:

- Detailed information is collected on all children. A sample distribution can be produced on all subscales even though only those with above-threshold score will have psychopathology.
- Because the survey aims to investigate service use, risk factors and protective factors, one needs to have information for all children to calculate relative risk.
- With the possibility of a longitudinal element in the survey, there is a large pool of children from which to select controls who could be matched on several characteristics to the children who exhibit significant psychiatric symptoms during the first interview stage.
- A one-stage design undoubtedly increases the overall response rate compared with a two-stage (screening plus clinical assessment) design.
- A one-stage design also reduces the burden put on respondents. Ideally, a two-stage design would require a screening questionnaire to be asked of a parent, a teacher as well as the child, followed up with an assessment interview administered to the child and the parent. A one-stage design only requires an interview with the parent and child and, if possible, the administration of a teacher questionnaire.
- A key advantage of a one-stage over a two-stage design is

that its implementation is cheaper and can be carried out in a far shorter time scale.

Screening instruments

The 1999 survey report (Meltzer *et al* 2000) included a review of the instruments commonly used for the first-stage, screening process in community-based studies of children: Goodman's Strengths and Difficulties Questionnaire, SDQ, (Goodman 1997) the Rutter Scales: A and B (Rutter *et al*, 1970) and the Child Behaviour Checklist (Achenbach and Edelbrock, 1983). The report also outlines the reasons for selecting the SDQ for the national survey in Great Britain.

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire that can be administered to the parents and teachers of 4- to 16-year-olds and also to 11- to 16-year-olds themselves. It covers common areas of emotional and behavioural difficulties, also enquiring whether the informant thinks that the child has a problem in these areas, and if so asking about resultant distress and social impairment.

Recent research on the Strengths and Difficulties Questionnaire (SDQ) is described in Appendix D.

Diagnostic instruments

Structured versus unstructured interviews

Hodges (1993) reviewed many structured interviews for assessing psychiatric morbidity among children: CAPA, CAS, DICA, DISC, ISC, K-SADS. She looked at their validity and reliability and what lessons had been learnt from their use. These were regarded as unsuitable for use in the GB studies because they required considerable clinical knowledge, were lengthy (some were estimated to last three to four hours) and were not validated for the whole age range covered here.

Therefore, the instrument used in the 2004 survey to produce the prevalence of clinically recognisable mental disorders among children was the Development and Well-Being Assessment (DAWBA). It was designed for use in the first national survey of childhood mental disorders in Great Britain in 1999. It was constructed in order to combine some of the best features of structured and semi-structured measures. Using existing semi-structured measures for a large national survey would have been impractical and prohibitively expensive since it would have required recruiting a team of several hundred clinically trained interviewers or providing prolonged additional training and supervision to lay interviewers. Therefore, it was clear that the main interview would need to be fully structured. However, we were aware at that time that

the disadvantage of relying entirely upon existing structured interviews was that the results are far less clinically convincing than the results of surveys based on semi-structured interviewing. To circumvent this problem, the new structured interview was supplemented with open-ended questions. When definite symptoms were identified by the structured questions, interviewers used open-ended questions and supplementary prompts to get parents to describe the problems in their own words. The specific prompts used were:

- Description of the problem.
- How often does the problem occur?
- How severe is the problem at it's worst?
- How long has it been going on for?
- Is the problem interfering with the child's quality of life? If so, how?
- Where appropriate, what does the parent/child think the problem is due to and what have they done about it?

Answers to these questions and any other information given were transcribed verbatim by the interviewers but not rated by them. Interviewers were also given the opportunity to make additional comments, where appropriate, on the respondents' understanding and motivation.

A small team of experienced clinicians reviewed the transcripts and interviewers' comments to ensure that the answers to structured questions were not misleading. The same clinical reviewers also considered clashes of information between different informants, deciding which account to prioritise. Furthermore, children with clinically relevant problems that did not quite meet the operationalised diagnostic criteria were assigned suitable diagnoses by the clinical raters.

In a study to test how well the DAWBA worked (Goodman *et al*, 2000), the questionnaire was administered to community (N = 491) and clinic (N = 39) samples. They found excellent discrimination between community and clinic samples in rates of diagnosed disorder. Within the community sample, subjects with and without diagnosed disorders differed markedly in external characteristics and prognosis. In the clinic sample, there was substantial agreement between DAWBA and case note diagnoses, though the DAWBA diagnosed more comorbid disorders. Overall, the DAWBA successfully combined the cheapness and simplicity of respondent-based measures with the clinical persuasiveness of investigator-based diagnoses.

Case vignettes in diagnostic assessment

One of the problems of collecting information from various sources is finding the best way to integrate the information which may show a lack of agreement. One method has been to accept a diagnosis irrespective of its source (Bird *et al*, 1992).

Others have promoted 'case vignette' assessments where clinical judgements are made on detailed case histories from several sources. (Goodman *et al*, 1996)

This case vignette approach for analysing survey data uses clinician ratings based on a review of all the information of each subject. This information includes not only the questionnaires and structured interviews but also any additional comments made by the interviewers, and the transcripts of informants' comments to open-ended questions particularly those which ask about the child's significant problems. The case vignette approach was extensively tested among community and clinical samples in the pre-pilot and pilot phases of the survey.

The clinical raters perform four major tasks. Firstly, they use the transcripts to check whether respondents appear to have understood the fully structured questions. This is particularly valuable for relatively unusual symptoms such as obsessions and compulsions – even when parents or young people say "yes" to items about such symptoms, their own description of the problem often makes it clear that they are not describing what a clinician would consider to be an obsession or compulsion.

Secondly, the clinical raters consider how to interpret conflicts of evidence between informants. Reviewing the transcripts and interviewers' comments often helps decide whose account to prioritise. Reviewing all of the evidence, it may be clear that one respondent gives a convincing account of symptoms, whereas the other respondent minimises all symptoms in a defensive way. Conversely, one respondent may clearly be exaggerating.

Thirdly, the clinical raters aim to catch those emotional, conduct and hyperactivity disorders that slip through the 'operationalised' net. When the child has a clinically significant problem that does not meet operationalised diagnostic criteria, the clinician can assign a 'not otherwise specified' diagnosis such as 'anxiety disorder, NOS' or 'disruptive behaviour disorder, NOS.'

Finally, the clinical raters rely primarily on the transcripts to diagnose less common disorders such as mutism, mania or schizophrenia. The relevant symptoms are so distinctive that respondents' descriptions are often unmistakable.

The following case vignettes from the pilot study provide illustrative examples of subjects where the clinical rating altered the diagnosis. In each case the 'computer-generated diagnosis' is the diagnosis arrived at by a computer algorithm based exclusively on the answers to fully structured questions. In these two illustrative instances, the computer-generated

diagnoses were changed by the clinical raters.

Subject 1: overturning a computer-generated diagnosis. A 13-year-old boy was given a computer diagnosis of a specific phobia because he had a fear that resulted in significant distress and avoidance. In his open-ended description of the fear, he explained that boys from another school had threatened him on his way home on several occasions. Since then, he had been afraid of this gang and had taken a considerably longer route home every day in order to avoid them. The clinical rater judged his fear and avoidance to be appropriate responses to a realistic danger and not a phobia.

Subject 2: including a diagnosis not made by the computer. A 7-year-old girl fell just short of the computer algorithm's threshold for a diagnosis of ADHD because the teacher reported that the problems with restlessness and inattentiveness resulted in very little impairment in learning and peer relationships at school. A review of all the evidence showed that the girl had officially recognised special educational needs as a result of hyperactivity problems, could not concentrate in class for more than 2 minutes at a time even on activities she enjoyed, and had been offered a trial of medication. The clinician concluded that the teacher's report of minimal impairment was an understatement, allowing a clinical diagnosis of ADHD to be made.

Measurement of correlates of mental disorders

Risk and protective factors can be regarded as key correlates of childhood psychopathology. Rather than describing the construction of these analytical variables in each chapter (where a scale has been constructed from answers to several questions) they are listed here for reference purposes.

Physical complaints

To what extent are physical complaints more commonly found in children with mental disorders, and conversely, to what extent are mental disorders more prevalent among children with specific physical complaints? In order to answer these two questions the parent was asked to say "yes" if the child had the health problem or condition presented on three lists. No further information was gathered on their onset, severity or chronicity. When constructing the measure 'any physical disorder', positive responses to the mental health conditions in list two were omitted.

Asthma	Hyperactivity	Diabetes
Eczema	Behavioural problems	Obesity
Hay fever	Emotional problems	Cystic fibrosis
Glue ear or otitis media or grommets	Learning difficulties	Spina bifida
Bed wetting	Dyslexia	Kidney, urinary tract problems
Soiling pants	Cerebral palsy	Missing fingers, hands, arms, toes, feet or legs
Stomach or digestive problems or tummy pains	Migraine or severe headaches	Any stiffness or deformity of the foot, leg, fingers, arms or back
A heart problem	Chronic Fatigue Syndrome	Any muscle disease or weakness
Any blood disorder	Eye or sight problems	Any difficulty with co-ordination
Epilepsy	Speech or language problems	A condition present since birth such as club foot or cleft palate
Food allergy	Hearing problems	Cancer
Some other allergy		

Mental health of parent

The parent who was interviewed about the child's mental health, in most cases the mother, was also asked about her own mental health by means of the GHQ-12 (General Health Questionnaire, Goldberg and Williams, 1988). The GHQ-12 is a self administered screening test of twelve questions designed to detect non-psychotic psychiatric disorders in community settings.

1. Have you recently been able to concentrate on whatever you're doing?
2. Have you recently lost much sleep over worry?
3. Have you recently felt that you are playing a useful part in things?
4. Have you recently felt capable about making decisions about things?
5. Have you recently felt constantly under strain?
6. Have you recently felt you couldn't overcome your difficulties?
7. Have you recently been able to enjoy your day to day activities?
8. Have you recently been able to face up to your problems?
9. Have you recently been feeling unhappy or depressed?

10. Have you recently been losing confidence in yourself?
11. Have you recently been thinking of yourself as a worthless person?
12. Have you recently been feeling happy, all things considered?

Each item is scored with a 1 according to whether it applied more than usual (for a negative item) or less than usual (for a positive item). A score in the range of 0 (no problem) to 12 (severe problem) was calculated for each person. In the present survey the threshold score was set at 3, i.e. all those with a score of 3 or more were deemed to have screened positive for an emotional disorder.

Family functioning

The instrument used to estimate family functioning was the General Functioning Scale of the MacMaster Family Activity Device (FAD). It comprises 12 statements that parents rate on a four point scale: strongly agree, agree, disagree and strongly disagree. The scale has been shown to have good reliability, internal consistency and validity in distinguishing between non-clinical families and families attending a psychiatric service. (Miller *et al*, 1985; Byles *et al*, 1988; Fristad M A, 1989).

1. Planning family activities is difficult because we misunderstand each other.
2. In times of crisis we can turn to each other for support.
3. We can not talk to each other about the sadness we feel.
4. Individuals are accepted for what they are.
5. We avoid discussing our fears and concerns.
6. We can express feelings to each other.
7. There is lots of bad feeling in the family.
8. We feel accepted for what we are.
9. Making decisions is a problem for our family.
10. We are able to make decisions on how to solve problems.
11. We don't get along well together.
12. We confide in each other.

A scoring system was used to calculate 'healthy' or 'unhealthy' family functioning. First, the answer to each question was scored on a scale of 1–4. Questions 2, 4, 6, 8, 10 and 12 are 'positive' items and were scored as follows: strongly agree = 1, agree = 2, disagree = 3 and strongly disagree = 4. Questions 1, 3, 5, 7, 9 and 11 are 'negative' items and the scores were therefore reversed. The scores for all twelve questions were then summed and divided by 12 to get an average family functioning score for each respondent. If the respondent's average score was between 0 and 2 they were considered to

have 'healthy' family functioning and if their average score was above 2.01 they were considered to have 'unhealthy' family functioning.

Child's social aptitudes

Parents were asked to rate their children in terms of how they compared with other children of their age on the following abilities:¹

1. Able to laugh around with others, for example accepting light-hearted teasing and responding appropriately.
2. Easy to chat with, even if it isn't on a topic that specially interests him/her.
3. Able to compromise and be flexible.
4. Finds the right thing to say or do in order to calm a tense or embarrassing situation.
5. Gracious when he/she doesn't win or get his/her own way. A good loser.
6. Other people feel at ease around him/her.
7. By reading between the lines of what people say, he/she can work out what they are really thinking and feeling.
8. After doing something wrong, he/she's able to say sorry and sort it out so that there are no hard feelings.
9. Can take the lead without others feeling they are being bossed about.
10. Aware of what is and isn't appropriate in different social situations.

Parents were asked to rate each item in terms of: (0) a lot worse than average, (1) a bit worse than average, (2) about average, (3) a bit better than average, (4) a lot better than average. A score in the range of 0–40 was calculated for each person by summing their responses to the ten items. These scores were then grouped into quartiles.

Child's social networks and social support

Adults who have extensive social networks or have people in whom they can confide are less likely to experience common mental disorders than those with less than three close friends or relatives or little or no social support (Brugha *et al*, 1993; Meltzer *et al*, 1995). To test whether these relationships exist for young people, questions on these topics were included in the 2004 survey. They were asked of young people aged 11–16.

Two sets of questions were asked to establish (a) the extent of the child's social networks, and (b) the child's support network. The latter questions were taken from the Health and Lifestyle Survey 1987 and were also asked in the Health Survey for England, 1992.

1. This scale is copyright to Robert Goodman at the Institute of Psychiatry, London.

- Questions about social networks

1. How many relatives in same household does child feel close to.
2. How many other relatives does child feel close to
3. How many friends would child describe as close or good friends.

The answer categories were 'None'(0), 'One'(1) and 'Two or more'(2).

- Statements about the availability of social support:

1. There are people I know who do things to make me feel happy.
2. There are people I know who make me feel loved.
3. There are people I know who can be relied on no matter what happens.
4. There are people I know who would see that I am taken care of if I need to be.
5. There are people I know who accept me just as I am.
6. There are people I know who make me feel an important part of their lives.
7. There are people I know who give me support and encouragement.

The answer categories for these questions were: 'Not true'(0), 'Partly true'(1) and 'Certainly true'(2).

Scores to the ten items were summed to create a scale ranging from 0–20, the total scores were then grouped into quartiles.

Child's strengths

Strengths may act as protective factors for young people in adverse circumstance, that is, factors or situations which are associated with increased odds of childhood mental disorder. Parents were asked to rate their children on two sets of 12 items, with response categories: (0) 'no', (1) 'a little', (2) 'a lot'.

1. Generous.
2. Lively.
3. Keen to learn.
4. Affectionate.
5. Reliable and responsible.
6. Easy-going.
7. Good fun, good sense of humour.
8. Interested in many things.
9. Caring, kind-hearted.
10. Bounces back quickly after set-backs.
11. Grateful, appreciative of what he/she gets.
12. Independent.

1. Helps around the home.
2. Gets on well with the rest of the family.
3. Does homework without needing to be reminded.
4. Creative activities: art, acting, music, making things.
5. Likes to be involved in family activities.
6. Takes care of his/her appearance.
7. Good at school work.
8. Polite.
9. Good at sports.
10. Helps keep his/her bedroom tidy.
11. Good with friends.
12. Well-behaved.

A score in the range of 0–48 was calculated for each person by summing their responses to the twenty-four items. These scores were then grouped into quartiles.

Young people aged 11–16 were also given the opportunity to rate what they thought were their own strengths on subsets of the above items, using the same response categories: (0) 'no', (1) 'a little', (2) 'a lot'.

1. Generous.
2. Out-going, sociable.
3. Nice personality.
4. Reliable and responsible.
5. Easy-going.
6. Good fun, good sense of humour.
7. Caring, kind-hearted.
8. Independent.

1. Good at sport.
2. Good with friends.
3. Helpful at home.
4. Good at music.
5. Well behaved.
6. Good with computers.
7. Good at drama, acting.
8. Raising money for charity, helping others.
9. Good at art, making things.
10. Polite.
11. Good at school work.

A score in the range of 0–38 was calculated for each young person by summing their responses to the nineteen items. These scores were then grouped into quartiles.

Stressful life events

Goodyer (1990) has suggested that moderately or highly undesirable recent life events exert potential or causal effects on the onset of emotional and behavioural symptoms in school aged children.

Parents were asked if their child experienced any of ten stressful life events with response categories (1) 'yes' and (2) 'no'. The items were chosen because they were thought to be highly (psychologically) threatening for the child.

1. Since child was born, parent had a separation due to marital difficulties or broken off a steady relationship.
2. Since child was born, parent (or partner) had a major financial crisis such as losing the equivalent to at least three months income.
3. Since child was born, parent (or partner) had a problem with the police involving a court appearance.
4. At some stage in the child's life, s/he had a serious illness which required a stay in hospital.
5. At any stage in the child's life, s/he had been in a serious accident or badly hurt in an accident.
6. At any stage in the child's life, a parent, brother or sister died.
7. At any stage in the child's life, a close friend died.
8. Since child was born, parent (or partner) had a serious physical illness such as cancer or a major heart attack.
9. Since child was born, parent (or partner) had a serious mental illness such as schizophrenia or major depression.
10. In the past year, close friendship has ended for child e.g. has broken off a steady relationship with a boy or girl friend or falling out with a best friend. (*applies if aged 13 or above*)
11. In the past year, close friendship has ended for child e.g. falling out with a best friend. (*applies if aged under 13*)

In the 1999 survey items 8 and 9 referred to the death of a grandparent and the death of a pet. Analysis of the 1999 data showed that these two life events lacked predictive power so in 2004 they were omitted and replaced with two events that seemed more likely to have a significant impact on the child's emotional wellbeing.

A stressful life event score in the range of 0–10 was calculated for each respondent by summing their responses to the 10 items.

Self-harm

Questions on self-harm were asked of all parents and young people aged 11–16. Different questions were asked depending on whether or not the child was feeling depressed, irritable or showing a lack of interest.

Parents of all children/children aged 11–16 who were feeling depressed, irritable or showing a lack of interest:

Over the whole of (child's) lifetime, has (child) ever tried to harm or kill him/herself?

During the period when (child) was sad, irritable or lacking in interest, did (child) ever try to harm or kill him/herself?

Other parents/other children aged 11–16:

Over the whole of (child's) lifetime, has (child) ever tried to harm or hurt him/herself?

During the last 4 weeks, has (child) ever try to harm or hurt him/herself?

Parents and children who answered 'Yes' to any of the above questions were counted as having harmed themselves. The questions do not distinguish between self-harm with the intention of taking one's life and that carried out for other reasons, such as self-mutilation.

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Chapter 3

Sampling and survey procedures

Introduction

This chapter describes the main features of the survey methodology: the sample design, operational procedures and response.

Sample design

The sample design was essentially the same as that used in the 1999 survey. The main difference was that the 2004 survey covered children aged 5–16 while the 1999 survey had a cut-off at age 15. 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.

There are some minor limitations to the use of Child Benefit records as a sampling frame. Over 98 per cent of the records have postcodes attributed to addresses. The DWP had no evidence that records with postcodes were different from those without. The addresses with missing postcodes probably represent a mixture of people who did not know their postcode at the time of applying for Child Benefit or simply forgot to enter the details on the form. There may be other factors which differentiate between households with and without postcoded addresses but, because these factors are not known, we do not know whether any biases have been introduced by omitting the non-postcoded addresses.

We also excluded from the original sampling frame those cases where 'action' was being invoked by the CBC, for example, because of the death of the child, a change of address, or the case was considered sensitive. These are simply administrative actions as distinct from some legal process concerning the child and hence should not bias the sample in any way.

The planned sample consisted of 29 children in each of 426 postal sectors. However, five of the postal sectors contained fewer than 29 families with children in the required age range.

In these sectors, all the eligible households were selected. These 'small' sectors gave an overall shortfall of 60 families. Therefore, the set sample consisted of 12,294 families.

The interviews

The first stage of the fieldwork was a face-to-face interview with the parent, which included a five minute self-completion component (GHQ-12 and Family Functioning Scale). If the parent had difficulties with the English language, a special two page self-completion questionnaire containing the Strengths and Difficulties Questionnaire was available in 40 languages as a replacement.

After the parent interview, permission was sought to ask questions of the sampled child if they were aged 11–16. These children then had a face-to-face interview and entered details of their smoking, drinking and drug-taking experiences via a self-completion questionnaire on a laptop. The subject matter was considered to be too complicated for younger children.

When the parent and, if appropriate, child interviews were completed, parents were asked for written consent to contact the child's teacher. Parents were asked to nominate the teacher who they felt knew the child best. Consent was only requested if an interview had been achieved with the parent (including cases where the parent completed the translated version of the questionnaire only). Contact names for teachers were still sought if the child had been expelled or excluded from school within the last few months.

Most of the psychiatric assessment was designed for children with a mental and language age of at least 3 or 4, and was therefore unsuitable for assessing children who are functioning below this level. (Also, it is distressing to parents of these children to be asked lots of questions that are inappropriate to someone of their child's ability level.) Consequently, the parent interview was adjusted so that when the initial questioning revealed that a child was severely disabled, parents were only asked those parts of the psychiatric interview that would be appropriate, for example, the section on developmental difficulties including autistic spectrum difficulties. No suitable teacher questionnaire was available for this group, and therefore teachers were not approached if the child was severely disabled.

Survey response rates

Table 3.1 shows the response among parents and children. Table 3.2 shows the response among teachers.

Table 3.1**Final response: Parents and children**

	Number	Per cent of all cases	Per cent of cases approached
Set Sample	12,294	100	
Not approached for interview			
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	100
Refusals			
Refusal to ONS HQ	401	3	4
Refusal to interviewer	1,733	14	17
Other (language/comprehension difficulties / ill health)	49	0	0
All refusals	2,183	18	21
Non-contact	313	3	3
Interviews achieved¹			
Adult and child	3,344	27	32
Adult only (child under 11)	3,834	31	37
Adult only (child refused/unable to be interviewed)	579	5	6
Other partial interviews	221	2	2
All interviews	7,977	65	76

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

Families not approached for interview

Of the 12,294 sampled families 9 per cent contacted ONS via a freephone number to opt-out. This group includes parents who telephoned the DWP to opt-out, as well as those who were considered by DWP to have sensitive circumstances and for whom an interview for this study was judged inappropriate. This proportion is higher than that recorded in the 1999 survey (6 per cent).

A further 5 per cent of the sample had moved and could not be traced. It had been hoped that the accuracy of the Child Benefit Register (CBR) would have been improved due to recent work to link claimants receiving different benefits. However, the proportion with untraceable addresses was actually slightly higher than in 1999 (4 per cent). 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.

Parents and children

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.

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. They include the following situations:

- The parent completed a full interview but the child only completed a part of the interview due to difficulties in comprehension.
- The parent completed a translated SDQ questionnaire – with either a child interview, a teacher questionnaire or both.
- The parent completed the assessment part of the interview but chose to terminate the interview before the remainder was complete.
- The interview was terminated very early because the child was severely disabled, therefore making the interview inappropriate.

Refusals

Of the 10,496 families approached for interview, 3 per cent contacted ONS headquarters to say that they did not wish to participate and 14 per cent refused to take part when the interviewer called. Many of the refusals to ONS headquarters were from parents who claimed that they had not received the opt-out letter from the DWP but would certainly have opted-out if they had. There were also a number of cases where the parent called the field office claiming that they had opted-out but were contacted by an interviewer anyway. It is therefore likely that the true number of opt-outs is greater than the 9 per cent stated in Table 3.1.

A small number of respondents (less than 1 per cent) could not be interviewed because they had learning or language difficulties. The SDQ questionnaire had been translated into 40 different languages but this still did not cover all those required and could not be used by respondents who were not literate in their own language.

Teachers

Before the teachers' questionnaires were posted out, various steps were taken to maximise response:

- A paragraph describing the survey was inserted into a journal which goes to all teachers.
- Chief Education Officers were notified of the plans for the survey and the extent of teachers' involvement.
- A week before any postal questionnaires were sent out, the head teachers in all schools of the sampled children were notified that some of their teachers would be asked to complete a questionnaire.
- The sample was designed so that most teachers would not have to fill in more than two questionnaires.
- A reminder letter was sent two weeks after the initial mail out.

Table 3.2

Final response: Teachers

	Number	Per cent of all interviews	Per cent of all teachers contacted
All interviews	7,977	100	
Parental consent not sought	36	1	
Parental consent sought	7,965	99	
Parental consent received	7,521	94	100
Questionnaire Returned	6,236	78	83

The majority of parents interviewed (94 per cent) gave consent for their child's teacher to be contacted and only 5 per cent refused. Consent to the teacher questionnaire was not sought for children who did not attend school or any other educational institution (1 per cent) and for children for whom the parent interview was incomplete (0.5 per cent).

Of the 7,521 teachers contacted 83 per cent returned a completed questionnaire. Teacher information was therefore available for 78 per cent of all interviews. Within the past year, teachers have become more limited in the amount of administrative work which their contracts permit them to do. Comments from head teachers indicated that this is the reason why some teachers did not complete the questionnaire. In these circumstances, the response achieved was very high.

Interviewing procedures

Choice of parent to interview

In over 95 per cent of interviews, the parent interview was carried out with the mother as she tended to be available when the interviewer called. In some of the cases where the father was interviewed, the mother did not speak sufficient English to cope with the interview. The remainder were lone fathers or situations where the father was more accessible than the mother.

Interview length

The length of the parent's interview was highly variable, with most interviews ranging from 90 to 120 minutes. On average, the young person's interview lasted around 45 minutes.

Privacy

It was very important for parents and children to be interviewed alone. A technique successfully used by interviewers when parents refused to leave the room when their child was being interviewed, was to sit side by side with the child, reading out the questions but then asking the child to key in their own answers into the laptop computer.

Self-completion using laptop computers was particularly useful for questions addressed to children about awkward and troublesome behaviour, smoking, drinking and drug taking. However, the previous ONS Survey of Childhood Mental Disorders found that the usage of all types of substance use and abuse was under-reported compared with the national surveys of smoking and drinking carried out by group administration in school settings (Goddard and Higgins, 1999a; Goddard and Higgins, 1999b).

Follow-up study

Background and aims

A follow-up procedure using a self-completion postal questionnaire was incorporated into the study to examine the persistence or chronicity of disorders at about 6 months after the main interview.

The strength of follow up surveys is “that they allow a focus on chronic or persistent psychiatric disorders.... This is potentially important because a high proportion of otherwise normal children exhibit transient disorders at some time during their development” (Rutter, 1989). Emotional and behavioural problems which resolve rapidly and spontaneously are far less relevant for service planning than problems that persist unless help is provided.

A prospective approach to determine the prevalence of persistent disorders, asking parents on two separate occasions about symptoms and resultant impairments was regarded as preferable to asking them to recall how long symptoms (and resultant impairments) had been present at the time of interview.

Sampling strategy

The sample was selected from parents who had agreed to recall (96 per cent overall). The parents of all children who were diagnosed with a disorder at the main interview and who had agreed to recall (705 cases and a sample of those whose child had no disorder (926 cases) were allocated for follow up.

Content of interview

The self-completion questionnaire designed for the follow-up survey included a repeat of the two-sided Strengths and Difficulties Questionnaire (SDQ) and a question asking about any help or advice about the child's behaviour and emotions that had been received from professional or informal sources over the last six months.

Response to the follow up procedures

In order to increase response, three reminder letters with replacement copies of the questionnaire were sent to non-respondents. Overall, 72 per cent of the parents approached returned a completed questionnaire. The response rate among those whose child had a disorder, 66 per cent was lower than that among other parents, 77 per cent. (Table 3.3)

Table 3.3
Response to follow-up survey

	Questionnaires sent out	Questionnaires returned	Response rate
Children with a disorder	705	465	66%
Children with no disorder	926	709	77%
All children	1,631	1,174	72%

Analysis and results

For the analysis, data from the 2004 follow-up survey were combined with data from the 6 month follow-up to the 1999 survey (Meltzer). The research design of the latter was different to that of the 2004 follow-up. A random sample of one in three parents who had agreed to recall were asked to complete an SDQ and questionnaires were also sent to their children and a subsample of teachers. This means that the sample for the 1999 follow-up was larger than that of the 2004 survey but it contained a much lower proportion of children with a disorder.

The findings for children in each disorder category and for those with multiple disorders are presented at the end of the chapter pertaining to the disorder (Chapters 5–9). The graphs show the total symptoms, the disorder specific symptoms and the impact of the symptoms at the main interview and at follow-up. In general, the level of symptoms and impact was low for the children who did not have a disorder initially, and this low level was maintained over the next six months. By contrast, the level of symptoms and impact was high for the

children who did initially have a disorder. Over the following 6 months, this gap between them and the children without a 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.

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Chapter 4

Prevalence of mental disorders

Introduction

This chapter describes the prevalence of mental disorders among children and young people aged 5–16 in 2004 and examines any changes in the prevalence of childhood psychopathology since the previous ONS survey in 1999.

The first set of tables show four broad categories of childhood mental disorder and the subgroups within them, analysed by age and sex. The remaining tables show rates for the main categories only, analysed by other socio-demographic variables such as economic status and area classification. The last two tables show the results of modelling analyses to determine the significant factors associated with each of the main types of disorder.

Prevalence was based on a clinical evaluation of parent, child and teacher data collected by ONS interviewers from questionnaires designed by the Department of Child and Adolescent Psychiatry, Institute of Psychiatry, London. Chapter 2 describes the assessment process in detail and the questionnaires are reproduced in Appendix E.

Prevalence rates for all disorders are presented in the tables as percentages to one decimal point so that rates per thousand can be derived. The percentages in the text and figures which refer to numbers in the tables are usually rounded to the nearest integer. Sampling errors around these estimates are shown in Appendix C.

The figures in the tables are weighted to represent the age, sex and region structure of the total population and to correct for unequal sampling probabilities. They are also adjusted to account for missing teacher data. The weighting and adjustment procedures are described in Appendix A.

Prevalence of mental disorders by personal characteristics

In 2004, one in ten children and young people (10 per cent) aged 5–16 had a clinically diagnosed mental disorder. These include: 4 per cent with an emotional disorder (3 per cent anxiety disorders and 1 per cent depression), 6 per cent with a conduct disorder, 2 per cent with a hyperkinetic disorder, and 1 per cent with a less common disorder (including autism, tics, eating disorders and mutism). Some children had more than one type of disorder. (Table 4.1)

Sex and Age

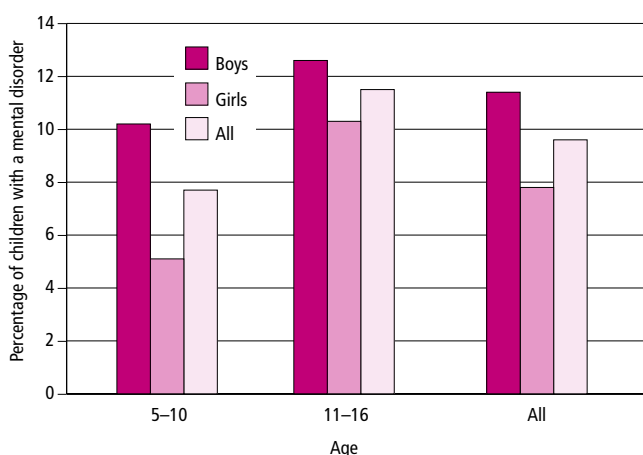
Boys were more likely than girls to have a mental disorder (11 per cent compared with 8 per cent). While boys were more

likely than girls to have a conduct disorder (8 per cent compared with 4 per cent), or a hyperkinetic disorder (3 per cent compared with 0.4 per cent), they were slightly less likely than girls to have an emotional disorder (3 per cent compared with 4 per cent). (Figure 4.1 and Table 4.1)

Overall, older children were more likely than younger children to have a mental disorder (12 per cent compared with 8 per cent). This variation was apparent for emotional (5 per cent and 2 per cent) and conduct disorders (7 per cent and 5 per cent) but there was no difference between older and younger children in the proportions with hyperkinetic and less common disorders. (Figure 4.1 and Table 4.1)

Figure 4.1
Prevalence of any mental disorder by age and sex, 2004

Great Britain



Changes in prevalence between 1999 and 2004 by sex and age

Table 4.2 shows prevalence rates for the three main disorder categories in 1999 and 2004 analysed by age and sex. Tables 4.3–4.5 show trends for the subcategories of these disorders. The tables refer to children aged 5–15 as 16-year-olds were not included in the 1999 survey. Therefore, the rates differ slightly from those presented in Table 4.1.

Data are not shown for the less common disorders because different questions were used to identify them in the two surveys and the prevalence figures are therefore not comparable. In 2004, more detailed questions were included to identify children with an Autistic Spectrum Disorder (ASD).¹ This change affects the prevalence rates for both the ‘common’ disorders (emotional, conduct and hyperkinetic) and those for the less common disorders which include ASD. To understand

1. More detailed questioning was also used to diagnose tics and eating disorders but the additional number of children identified in 2004 was very small.

the way that the more detailed questioning about ASDs in 2004 will have affected comparability with the 1999 results, it is worth thinking about four different groups of children with ASDs:

Group 1

These children would only have been diagnosed as having a common disorder in 1999, and this would switch in 2004 to only being diagnosed as having an ASD. For example, in 1999 they might have been diagnosed as having hyperkinesia, whereas in 2004 they might have been diagnosed as having autism. This happens because, in the international diagnostic systems, ASD takes precedence over all hyperkinesia diagnoses and some behavioural and emotional diagnoses. *Such children would lead to lower rates of common disorders in 2004 than 1999, but would not affect rates of total disorder (because the child would obtain a diagnosis, albeit a different one, in both 1999 and 2004).*

Group 2

These children would only have been diagnosed as having a common disorder in 1999, but would have been diagnosed as having *both* a common disorder and an ASD in 2004. For example, in 1999 they might just have been diagnosed as having depression, whereas in 2004 they might have been diagnosed as having depression and autism. (This combination is permitted by the international classifications.) Such children would not lead to any difference between 1999 and 2004 in the apparent prevalence of either common disorders or total disorders (because the child would only be counted once in the overall prevalence rate for total disorders whether they have one or two disorders).

Group 3

These children would not have received any diagnosis in 1999, but would have been diagnosed as having just an ASD in 2004 on the basis of the expanded interview. *Such children would lead to a higher rate of total disorders in 2004 than 1999, but would not affect rates for the common disorders.*

Group 4

These children would have received a diagnosis of an ASD (and nothing else) both in 1999 in 2004, reflecting symptoms that were sufficiently marked that the ASD was diagnosable even with the more restricted questioning used in 1999. Such children would not lead to any difference between 1999 and 2004 in the apparent prevalence of either common disorders or total disorders.

We cannot therefore produce totals with 'Any mental disorder'

that are strictly comparable in the two years. For the trend tables, we have provided two overall total figures. The first represents the proportion with an emotional, conduct or hyperkinetic disorder (i.e. excluding less common disorders). The 2004 figure will understate the proportion compared with 1999 because of the transfer of some children with common disorders to the ASD subgroup within the less common disorder category in 2004 (Group 1 above). This comparison does not show a statistically significant difference between 1999 and 2004 in the proportions with an emotional, conduct or hyperkinetic disorder (9.1 per cent and 8.7 per cent). To be absolutely comparable with 1999, the 2004 figure would be a little higher than 8.7 per cent so the actual difference is even smaller. Therefore, it is very unlikely that there was a change in the overall prevalence of the three main categories of disorder between 1999 and 2004.

The second total is the proportion with any disorder. In this case, the 2004 figure (9.6 per cent) overstates the proportion compared with 1999 (9.5 per cent) because of the additional children with ASD who were identified through the more extensive questioning (Group 3 above). The difference was not statistically significant. Thus, again, it is very unlikely that there was a change between 1999 and 2004 in the overall proportions of children with any mental disorder.

To summarise, there was not a statistically significant change in the rates either of common disorders or total disorders over the 5 years between 1999 and 2004. The small (statistically non-significant) changes that did occur were in opposite directions, namely an increase in total disorders but a decrease in common disorders – changes that can most straightforwardly be explained by increased detection of ASDs in 2004 as a result of improvements to the 2004 interview. Research by Collishaw *et al* (2004) indicates that rates of mental health problems among young people probably rose markedly between 1974 and 1999. The data presented here suggest that this upward trend was halted in the period between the 1999 and 2004 surveys.

Turning to the main categories of 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. There was a corresponding decrease among girls of this age but the difference was not statistically significant. [Table 4.3](#) shows that the decrease in emotional disorders among younger boys was attributable to a decrease in the proportion with anxiety disorders, particularly separation anxiety. There are no clinical reasons for expecting such a

decrease and the diagnostic classification method was the same in both years. However, the questions on anxiety disorders were positioned later in the interview in 2004 and this may have affected the reporting rate. (Tables 4.2–4.5)

In general, prevalence rates in 2004 showed similar patterns of variation with socio-demographic variables as those in 1999. Any differences are noted in the commentary.

Ethnicity

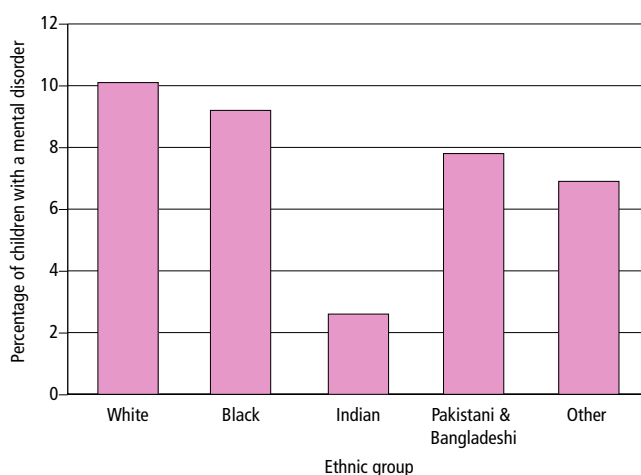
Ethnic differences are difficult to interpret because of the small numbers of minority ethnic children in the survey. When the ethnic differences are analysed by age and sex the bases are smaller still and make the differences between distributions correspondingly more difficult to interpret. Also, the diagnoses for some minority ethnic children with non-English speaking parents are based on less complete information than those for white children and English-speaking minorities because their parents were not able to answer the detailed diagnostic questions (although they were able to complete the SDQ in their own language). This affects particularly children of Bangladeshi and African origin.

The ethnicity question in the 2004 survey was the same as that used in the 2001 Census and was different from the question used in 1999. In particular, in 2004 various categories of 'Mixed origin' were specified on the show card (e.g. 'mixed white and black Caribbean'). In 1999, it is likely that the children of mixed origin will have been split across several of the other categories (for example, parents of mixed white and black Caribbean children could have classified them as being of 'White', 'Black Caribbean' or 'Other' origin.). This means that the 1999 and 2004 data are not comparable.

The data suggest that Indian children had a relatively low rate of mental disorder (3 per cent compared with 7–10 per cent in other groups). The prevalence of hyperkinetic disorders was low among all the non-white groups. Similar findings for Indian children and hyperkinesis were reported in 1999 and have been observed in clinical practice, suggesting that they are real variations. (Figure 4.2 and Table 4.6)

Figure 4.2
Prevalence of mental disorders by ethnicity, 2004

Great Britain



Prevalence of mental disorders by family characteristics

Family type and marital status

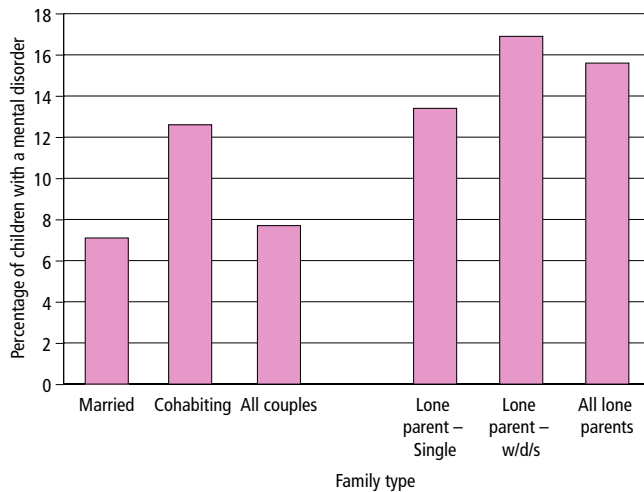
Children from lone parent and cohabiting couple families were about twice as likely as the children of married couples to have a mental disorder (16 per cent and 13 per cent compared with 7 per cent). This pattern was evident for girls and boys, both age groups and the three main types of disorder. However, the difference between the children of married and cohabiting couples is attributable to other factors. The modelling analysis at the end of the chapter shows that, when other variables are taken into account, children of cohabiting couples are no more likely to have a mental disorder than those of married couples.

Within the lone parent group, children whose parent was previously married were more likely to have an emotional disorder than those whose parent was single (8 per cent compared with 5 per cent) but there was no corresponding difference in the prevalence rates for conduct or hyperkinetic disorders. (Figure 4.3 and Table 4.7)

Almost one in five boys (18 per cent) living in lone parent families had a mental disorder, of whom about two thirds had a conduct disorder. The corresponding proportion for girls was 13 per cent, equally divided between emotional and conduct disorders. (Figure 4.3 and Table 4.7)

Figure 4.3
Prevalence of mental disorders by family type, 2004

Great Britain



Reconstituted families

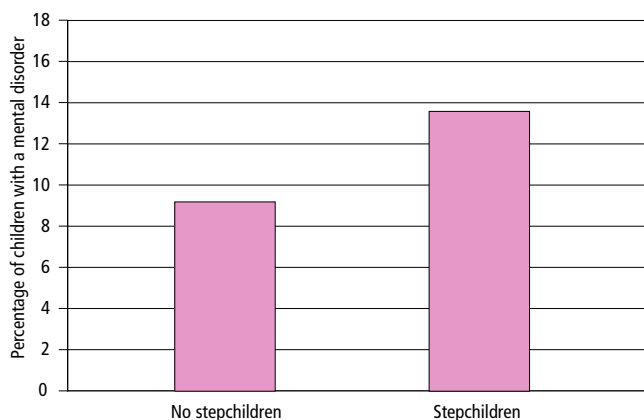
A family was regarded as 'reconstituted' if stepchildren were present. Overall, about one in ten children (11 per cent) lived in a reconstituted family.

Children living in reconstituted families were more likely to have a mental disorder than those living in a family without stepchildren (14 per cent compared with 9 per cent). The disparity was mainly due to differences in the proportions of children with conduct disorders (10 per cent compared with 5 per cent). This was apparent for boys and girls and for both age groups.

(Figure 4.4 and Table 4.8)

Figure 4.4
Prevalence of mental disorders by whether family contains stepchildren, 2004

Great Britain



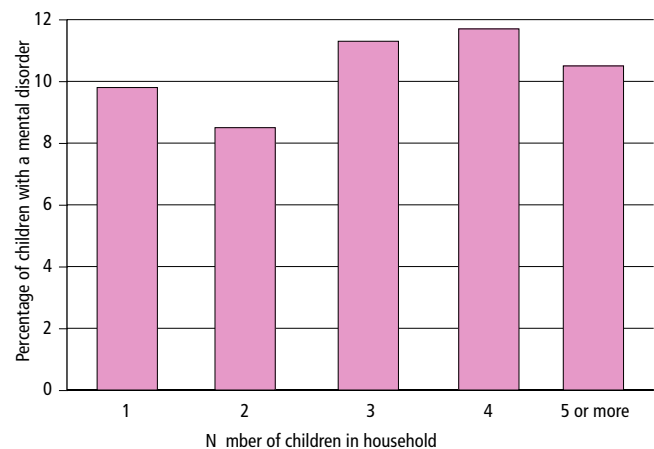
Number of children in the household

There was no consistent pattern of variation in the overall prevalence of mental disorder according to the number of children in the household. There are, however, indications that children in larger households were more likely to have a conduct disorder than those in smaller households (7 per cent and 9 per cent among children in households with three and four children compared with 5 per cent among those with one or two children). The figure for the largest households, with five or more children, was somewhat out of line at 7 per cent. More detailed inspection showed that the prevalence of conduct disorders among younger boys in such households was particularly low. The 1999 data showed a more consistent pattern suggesting that there is probably a genuine relationship between the presence of conduct disorders and the number of children in the household, though this may reflect socio-economic characteristics rather than household size *per se*.

(Figure 4.5 and Table 4.9)

Figure 4.5
Prevalence of mental disorders by number of children in household, 2004

Great Britain



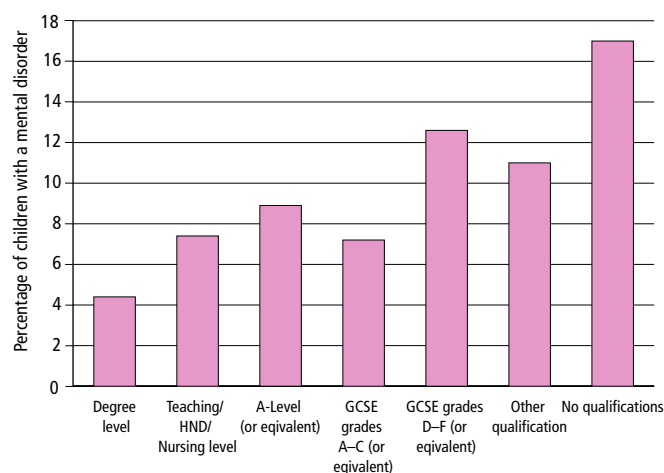
Educational qualifications of parent

There was a strong association between the presence of a mental disorder and the educational level of the interviewed parent, usually the mother. Similar relationships have been reported in the 1999 survey and other research. The overall prevalence of mental disorder increased from 4 per cent among children whose parent was educated to degree level to 17 per cent for those whose parent had no educational qualifications. There was not a consistent pattern of decrease between successive educational levels. However, there was a clear difference in prevalence rates between children whose interviewed parent had a qualification of some kind and those

whose parent had no qualifications. This general pattern was observed among boys and girls and in both age groups. The 1999 survey showed the same variation although the differential between the children whose parent had a degree and those whose parent had no qualification was not quite so large (6 per cent and 15 per cent) (Figure 4.6 and Table 4.10)

Figure 4.6
Prevalence of mental disorders by educational qualifications of parent, 2004

Great Britain



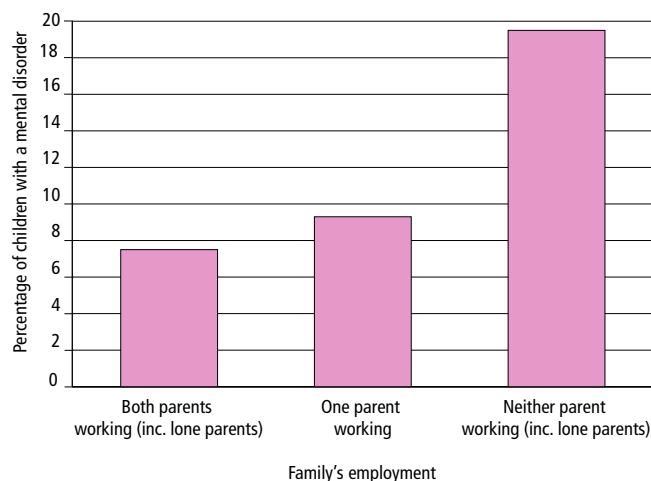
Prevalence of mental disorders by household characteristics

Family's employment situation

The relationship between unemployment and mental disorder among adults is well documented (Meltzer *et al*, 1995). The 2004 survey (and the previous survey) shows a similar association for the children of unemployed parents. Thus, in 2004, one-fifth (20 per cent) of children in families without a working parent had a mental disorder, more than twice the proportion among children with one or both parents working (9 per cent and 8 per cent). This pattern was repeated for all categories of mental disorder, for both boys and girls and for younger and older children. The highest prevalence was found among boys aged 11–16 with neither parent working of whom one quarter (25 per cent) had a mental disorder. Among boys of a similar age with both parents working, the proportion with a mental disorder was 10 per cent. For girls aged 11–16, prevalence rates were lower but the ratio was about the same, 21 per cent and 8 per cent. (Figure 4.7 and Table 4.11)

Figure 4.7
Prevalence of mental disorders by family's employment, 2004

Great Britain



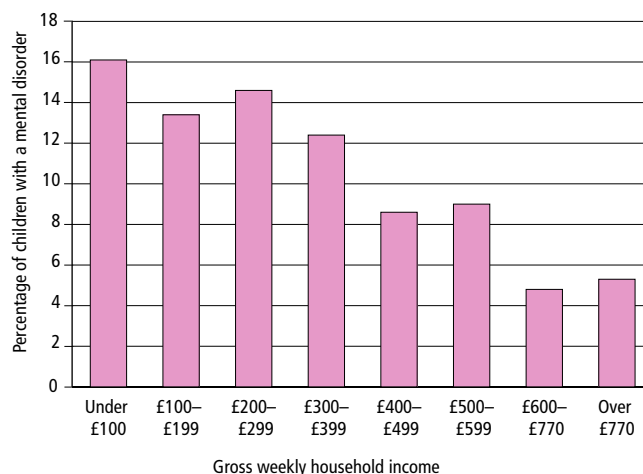
Household income

The close association between mental disorder and economic disadvantage is clearly illustrated in the income analysis. The proportion of children with a mental disorder decreased from 16 per cent among families with a gross weekly income of under £100 to 5 per cent for those earning £600 a week or more. This trend occurred for boys and girls, both age groups and the three main disorder categories. Thus, for example, among children aged 11–16 living in families with gross weekly incomes of less than £200, about 20 per cent had a mental disorder compared with 6 per cent of their contemporaries in families with incomes of at least £600.

(Figure 4.8 and Table 4.12)

Figure 4.8
Prevalence of mental disorders by gross weekly household income, 2004

Great Britain

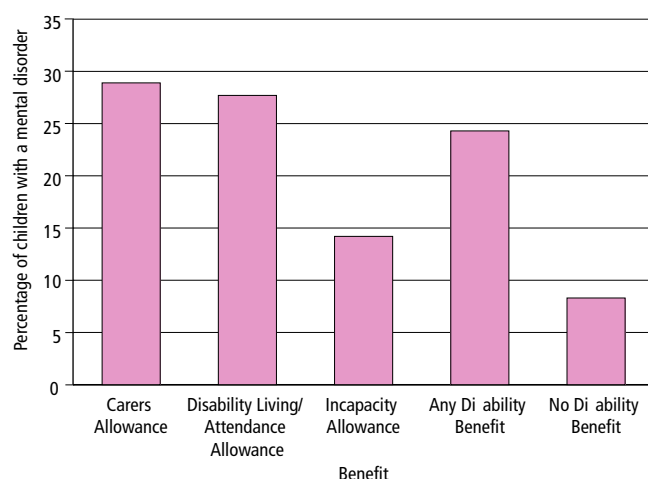


State Benefits

The benefits shown in Table 4.13 (Carers Allowance, Disability Living/Attendance Allowance and Incapacity Allowance) have been chosen to indicate disability among a member of the child's household. The prevalence rate of mental disorders in children in relation to means-tested benefits (e.g. lone parent benefit and working family credit) are not shown in the table as equivalent data have been presented earlier – for example, on family type and household income.

Figure 4.9
Prevalence of mental disorders by receipt of disability benefits, 2004

Great Britain



Children living in households who received one of these disability benefits were three times as likely as other children to have a mental disorder, 24 per cent compared with 8 per cent. Prevalence was high among children in families receiving Carers Allowance (29 per cent), and Disability Living Allowance/Attendance Allowance (28 per cent). In some cases it would have been the sampled child who was receiving the disability benefit so it would be expected that the rate of receipt would be higher among the children with a disorder. Since these cases cannot be distinguished from those in which another household member was receiving a disability benefit, we cannot conclude that children with a disorder were more likely to live in households in which another member was disabled.

(Figure 4.9 and Table 4.13)

Socio-economic classification

The National Statistics Socio-economic Class (NS-SEC) was measured by the occupation of the household reference person, usually the child's father. Children in families where the reference person was in semi-routine or routine occupational groups were about three times as likely to have a mental disorder as children whose reference person was in a higher professional group (13 per cent and 15 per cent compared with 4 per cent). Among children whose reference person was long-term unemployed or had never worked, 16 per cent had a mental disorder. The socio-economic gradient was observed among boys and girls, younger and older children and for the three main disorder categories but was particularly marked for conduct disorder. The proportion of children with a conduct

Figure 4.10
Prevalence of mental disorders by socio-economic classification, 2004

Great Britain



disorder in families whose reference person was in a routine occupational group was about five times that of children in families whose reference person was in a higher professional group (10 per cent and 2 per cent). (Figure 4.10 and Table 4.14)

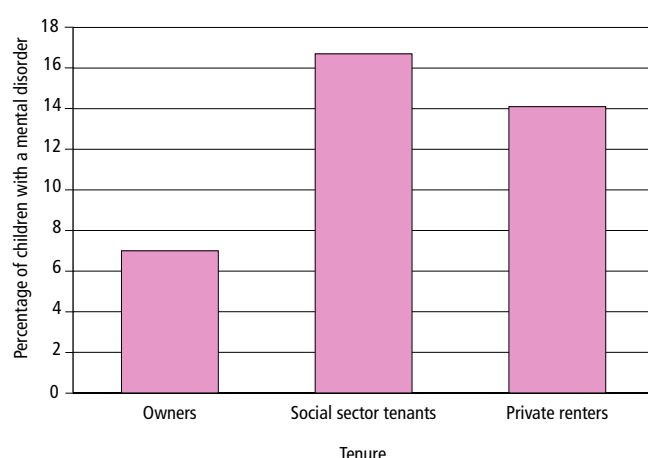
Although there was an overall negative association between the prevalence of mental disorder and socio-economic class, it was not a completely smooth gradient. In particular, the rates for older children whose family reference person was in the Intermediate occupational group had a disproportionately high rate of mental disorder. Further investigation showed that this was mainly due to a high prevalence rate among boys aged 11–16 in this group. A different social classification was used in 1999 so it is not possible to determine whether this is a persistent variation. (Figure 4.10 and Table 4.14)

Tenure

Tenure provides another socio-economic indicator and shows the expected relationship with mental disorder. Children living in rented accommodation, whether social or private sector, were twice as likely to have a mental disorder as those in owned accommodation (17 per cent and 14 per cent compared with 7 per cent). This general trend was evident for the three main disorders but the prevalence of conduct disorders was particularly high among older children, both boys and girls, living in social rented accommodation (17 per cent and 12 per cent). The corresponding proportions for boys and girls living in owned accommodation were 6 per cent and 3 per cent. (Figure 4.11 and Table 4.15)

Figure 4.11
Prevalence of mental disorders by tenure, 2004

Great Britain

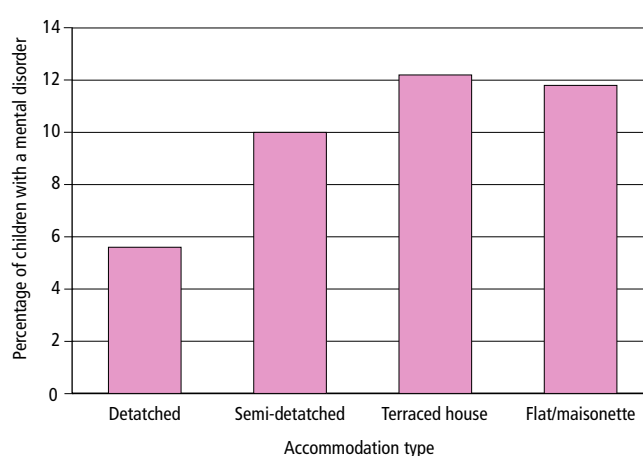


Type of accommodation

Variations in the prevalence of mental disorder by accommodation type again reflect affluence. The overall rate of mental disorder was lower among children living in detached houses, 6 per cent, than among those living in terraced or semi-detached houses and flats and maisonettes who had similar prevalence rates, 10–12 per cent. (Figure 4.12 and Table 4.16)

Figure 4.12
Prevalence of mental disorders by accommodation type, 2004

Great Britain



Prevalence of mental disorders by area characteristics

Region

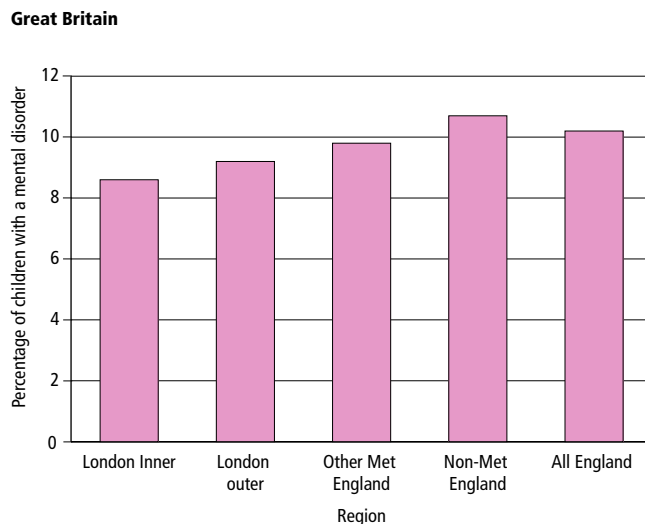
Table 4.17 shows prevalence rates for England and Scotland in 1999 and 2004 for the three main disorder types – emotional, conduct and hyperkinetic, for children aged 5–15.² In England, the only difference in the rates recorded by the two surveys was a decrease in emotional disorders among 5- to 10-year-olds. The decrease was small, however, from 3 per cent to 2 per cent, and only just reached statistical significance at the 95 per cent confidence level. In Scotland, there was also a decrease in the proportion with an emotional disorder, from 5 per cent to 3 per cent, but only among 11- to 15-year-old girls. (Table 4.17)

There were no differences in the prevalence of mental disorders between the metropolitan and non-metropolitan areas of England in 2004. A similar finding was reported in the 1999 survey. Some variations might have been expected given the associations between prevalence rates and socio-economic

2. The sample was not designed to provide separate data for Wales (see Appendix A).

measures discussed above. It may be that the area groupings cover such a heterogeneous range of areas that any variations with type of area are masked. Analysis by the ACORN classification in the following section provides a more direct examination of the relationship between mental disorder and area type. (Figure 4.13 and Table 4.18)

Figure 4.13
Prevalence of mental disorders by region, 2004



Type of area (ACORN)

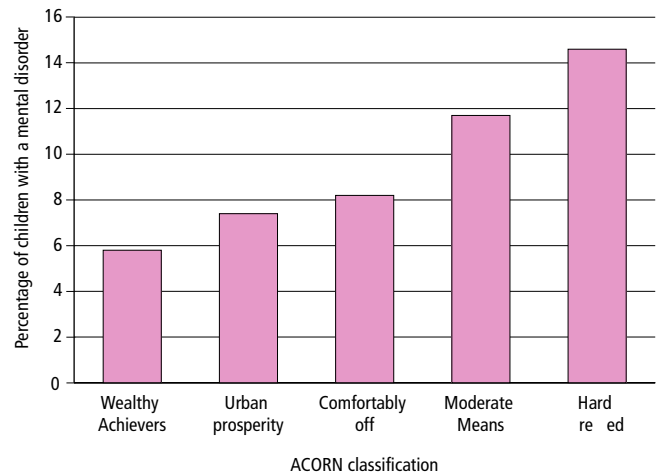
ACORN (A Classification of Residential Neighbourhoods) is a geo-demographic classification combining geographical and demographic characteristics to distinguish different types of people in different areas of Great Britain. The ACORN classification has five categories, 17 groups and 56 types. For the comparative analyses in this report, the highest level, i.e. the five broad categories, has been used.

Table 4.19 shows the pattern of variation that would be expected from previous analyses in this report. Children living in areas classed as 'Hard pressed' were the most likely to be assessed as having a mental disorder (15 per cent). This proportion was about twice as high as that for children living in areas classed as 'Wealthy achievers' or 'Urban prosperity' (6 per cent and 7 per cent). This trend was evident for the three main types of disorder, boys and girls and for younger and older children although, as with the socio-economic measure, the relationship was particularly strong for conduct disorders.

(Figure 4.14 and Table 4.19)

Figure 4.14
Prevalence of mental disorders by ACORN classification, 2004

Great Britain



Odds ratios of socio-demographic correlates of mental disorders

The previous sections have shown variations in the prevalence of mental disorders according to a range of socio-demographic variables. Many of these variables are inter-related – for example, we have presented analyses by various measures of affluence. Modelling analysis (logistic regression) allows the independent effects of predictor variables to be measured, that is, controlling for all other factors. The regression produces an odds ratio which shows the increase in odds that a child in a particular group (for example, an age or social group) will have a disorder when compared with a reference group.

Models were produced to identify the socio-demographic correlates of any disorder, the three principal subgroups – emotional disorders, conduct disorders and hyperkinetic disorders – and the two main types of emotional disorders: anxiety and depression.

Odds of having any mental disorder

The statistically significant odds ratios for the socio-demographic correlates of the child having any mental disorder (compared with no disorder) were: age, sex, ethnic group, family type, whether living in a reconstituted family, family's employment situation, socio-economic classification, household income, parental educational qualifications, type of area and country. In 1999, slightly fewer variables were entered into the model but all but one of the statistically significant variables in 1999 were also statistically significant in 2004.³

3. Number of children in the household was not significant in 2004. As explained earlier, this variable had an inconsistent distribution in 2004.

The odds of having any mental disorder increased by around 50 per cent for boys compared with girls (OR = 1.52) and by almost 75 per cent for older compared with younger children (OR = 1.73). Children of Black African, Indian or Pakistani ethnic origin had markedly lower odds of having a mental disorder than white children (ORs = 0.11, 0.21 and 0.47).

(Table 4.20)

The simple tabular analyses presented earlier showed marked variations in the prevalence of mental disorder by family type. The logistic regression analysis confirms the impact of living with a widowed, divorced or separated lone parent. The odds of having a mental disorder increased by 75 per cent for children of lone parents who had been previously married compared with children living with married parents (OR = 1.75). However, there were no differences in the odds for children living with married, cohabiting or single parents. This suggests that the variations between these groups that were apparent in the simple tables were due to other factors rather than to marital status per se. The presence of stepchildren in a family increased the odds of having a mental disorder by around 50 per cent compared with being in a family with no stepchildren (OR = 1.52).

(Table 4.20)

The modelling analysis confirmed the association between economic characteristics and mental disorder. The odds of having a mental disorder for children living in families in which both parents were working were 60 per cent of those for children who had neither parent working (OR = 0.61). Conversely, living in a family in which the gross weekly household income was less than £400 increased the odds of having a mental disorder by about a half compared with living in a family with an income of more than £600 per week (OR = 1.46). The effect of parental educational qualifications was also significant. The odds of having a mental disorder among children for whom the responding parent had no educational qualifications were one and a half times those of children whose parent had some qualifications (OR = 1.55).

(Table 4.20)

Type of area had a particularly large impact on the odds. Living in areas classified as 'Moderate means' or 'Hard pressed' increased the odds of having a mental disorder by up to three-quarters compared with living in 'Wealthy achiever' areas (ORs = 1.74 and 1.64).

(Table 4.20)

In the next sections, we look at the odds of having each of the three main types of disorder. In many cases the patterns are the same and the commentary focuses on differences from the pattern for any disorder.

Emotional disorder

Variables which had a significant effect on the odds of having an emotional disorder were: age, sex, family type, family's employment situation and parental educational qualifications.

The pattern for older children to have higher odds of having any mental disorder was particularly marked in relation to emotional disorders. Children aged 11–16 had more than twice the odds of those aged 5–10 (OR = 2.28). However, boys had lower odds than girls (OR = 0.70), reversing the overall pattern.

(Table 4.21)

Family type had a marked effect on the odds of having an emotional disorder. The odds for children living with a previously married lone parent were 2.5 times as high and those for children living with a single lone parent were 1.7 times as high as those for children living with a couple (ORs = 2.48 and 1.71)

(Table 4.21)

Separate analyses were run to model the odds for anxiety disorders and depression. These showed the same general pattern as those for emotional disorders overall. However, the higher odds for older children to have an emotional disorder was very marked in the case of depression (OR=6.20).

(Table 4.21)

Conduct disorders

All the variables entered into the model had a significant effect on the odds of having a conduct disorder: age, sex, ethnic group, family type, whether living in a reconstituted family, family's employment situation, parental educational qualifications, household income, type of area and country.

The odds of having a conduct disorder for boys were almost twice those for girls (OR=1.91). Children of Indian or Pakistani origin had considerably lower odds than those of white children (ORs = 0.13 and 0.37). The presence of stepchildren in the family almost doubled the odds compared with being in a family with no stepchildren. (OR=1.92).

(Table 4.20)

Type of area had a marked impact on the odds of having a conduct disorder. The odds for children living in areas classified as 'Moderate means' or 'Hard pressed' were more than twice those of children living in 'Wealthy achiever' areas (ORs =2.13 and 2.10).

(Table 4.20)

Hyperkinetic disorders

Only three variables had a significant effect on the odds of having a hyperkinetic disorder: sex, family's employment situation and household income.

The most notable feature of this model was the sex variation. The odds of having a hyperkinetic disorder for boys were six times those for girls (OR = 6.10). (Table 4.20)

References

- CACI Information Services (1993) *ACORN User Guide*, CACI Limited 1994. All Rights Reserved. Source: ONS and GRO (S) © Crown Copyright 1991. All Rights Reserved.
- Collishaw S, Maughan B, Goodman R and Pickles A (2004) Time trends in adolescent mental health. *Journal of Child Psychology and Psychiatry* **45**, 1350–1362.
- Meltzer H, Gatward R, Goodman R and Ford T (2000) *The mental health of children and adolescents in Great Britain*, TSO: London.

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>									
Emotional disorders	2.2	2.5	2.4	4.0	6.1	5.0	3.1	4.3	3.7
Anxiety disorders	2.1	2.4	2.2	3.6	5.2	4.4	2.9	3.8	3.3
Separation anxiety	0.4	0.7	0.6	0.3	0.4	0.3	0.3	0.5	0.4
Specific phobia	0.8	0.7	0.7	0.8	0.9	0.9	0.8	0.8	0.8
Social phobia	0.1	0.1	0.1	0.5	0.6	0.5	0.3	0.3	0.3
Panic	-	-	-	0.2	0.5	0.4	0.1	0.3	0.2
Agoraphobia	-	-	-	0.2	0.4	0.3	0.1	0.2	0.1
Post traumatic stress	-	0.1	0.0	0.1	0.5	0.3	0.0	0.3	0.2
Obsessive compulsive	0.1	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.2
Generalised anxiety	0.2	0.3	0.3	0.9	1.6	1.2	0.6	1.0	0.8
Other anxiety	0.6	0.7	0.7	0.9	1.5	1.2	0.8	1.1	0.9
Depression	0.2	0.3	0.2	1.0	1.9	1.4	0.6	1.1	0.9
Depressive episode (full ICD criteria)	0.1	0.2	0.2	0.8	1.4	1.1	0.5	0.8	0.6
Other depressive episode	0.0	0.1	0.1	0.3	0.5	0.4	0.2	0.3	0.2
Conduct disorders	6.9	2.8	4.9	8.1	5.1	6.6	7.5	3.9	5.8
Oppositional defiant disorder	4.5	2.4	3.5	3.5	1.7	2.6	4.0	2.0	3.0
Unsocialised conduct disorder	0.9	0.3	0.6	1.2	0.8	1.0	1.1	0.5	0.8
Socialised conduct disorder	0.6	-	0.3	2.6	1.9	2.2	1.6	0.9	1.3
Other conduct disorder	0.9	0.1	0.5	0.7	0.8	0.8	0.8	0.4	0.6
Hyperkinetic disorder	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
Autistic Spectrum Disorder	1.9	0.1	1.0	1.0	0.5	0.8	1.4	0.3	0.9
Tic disorders	0.0	0.1	0.1	-	-	-	0.0	0.1	0.0
Eating disorders	0.5	0.2	0.3	0.6	0.1	0.4	0.5	0.1	0.3
Mutism	-	0.1	0.0	0.1	0.4	0.3	0.0	0.2	0.1
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>

Table 4.2**Prevalence of mental disorders by age and sex, 1999 and 2004**

All children aged 5–15

Great Britain

	Boys		Girls		All	
	1999	2004	1999	2004	1999	2004
<i>Percentage of children with each disorder</i>						
Children aged 5–10						
Emotional disorders	3.3	2.2	3.3	2.5	3.3	2.4
Conduct disorders	6.5	6.9	2.7	2.8	4.6	4.9
Hyperkinetic disorder	2.6	2.7	0.4	0.4	1.5	1.6
Any emotional, conduct or hyperkinetic disorder	9.7	8.6	5.8	4.8	7.7	6.7
Any disorder	10.4	10.2	5.9	5.1	8.2	7.7
<i>Base (weighted)</i>	<i>2909</i>	<i>2010</i>	<i>2921</i>	<i>1916</i>	<i>5830</i>	<i>3926</i>
Children aged 11–15						
Emotional disorders	5.1	3.9	6.1	6.0	5.6	4.9
Conduct disorders	8.6	8.8	3.8	5.1	6.2	7.0
Hyperkinetic disorder	2.3	2.6	0.5	0.3	1.4	1.5
Any emotional, conduct or hyperkinetic disorder	12.5	12.1	9.2	9.8	10.8	11.0
Any disorder	12.8	13.1	9.6	10.2	11.2	11.7
<i>Base (weighted)</i>	<i>2310</i>	<i>1783</i>	<i>2299</i>	<i>1654</i>	<i>4609</i>	<i>3437</i>
All children aged 5–15						
Emotional disorders	4.1	3.0	4.5	4.1	4.3	3.5
Conduct disorders	7.4	7.8	3.2	3.8	5.3	5.9
Hyperkinetic disorder	2.4	2.7	0.4	0.4	1.4	1.5
Any emotional, conduct or hyperkinetic disorder	10.9	10.2	7.3	7.1	9.1	8.7
Any disorder ¹	11.4	11.6	7.6	7.5	9.5	9.6
<i>Base (weighted)</i>	<i>5219</i>	<i>3793</i>	<i>5219</i>	<i>3570</i>	<i>10438</i>	<i>7363</i>

The shaded boxes indicate figures where the difference between the 1999 and 2004 prevalence is statistically significant at the 95% confidence level.
 1. Includes less common disorders not shown in the table.

Table 4.3**Prevalence of subcategories of mental disorders: children aged 5–10, 1999 and 2004**

Children aged 5–10

Great Britain

	Boys		Girls		All	
	1999	2004	1999	2004	1999	2004
<i>Percentage of children with each disorder</i>						
Emotional disorders	3.3	2.2	3.3	2.5	3.3	2.4
Anxiety disorders	3.2	2.1	3.1	2.4	3.1	2.2
Separation anxiety	1.0	0.4	1.0	0.7	1.0	0.6
Specific phobia	1.1	0.8	1.1	0.7	1.1	0.7
Social phobia	0.4	0.1	0.2	0.1	0.3	0.1
Panic	-	-	-	-	-	-
Agoraphobia	-	-	-	-	-	-
Post traumatic stress	0.0	-	-	0.1	0.0	0.0
Obsessive compulsive	0.1	0.1	0.1	0.2	0.1	0.2
Generalised anxiety	0.3	0.2	0.4	0.3	0.4	0.3
Other anxiety	0.9	0.6	0.5	0.7	0.7	0.7
Depression	0.2	0.2	0.3	0.3	0.2	0.2
Depressive episode (full ICD criteria)	0.2	0.1	0.2	0.2	0.2	0.2
Other depressive episode	-	0.0	0.1	0.1	0.1	0.1
Conduct disorders	6.5	6.9	2.7	2.8	4.6	4.9
Oppositional defiant disorder	4.8	4.5	2.1	2.4	3.5	3.5
Unsocialised conduct disorder	0.5	0.9	0.2	0.3	0.4	0.6
Socialised conduct disorder	0.6	0.6	0.0	-	0.3	0.3
Other conduct disorder	0.6	0.9	0.3	0.1	0.4	0.5
Hyperkinetic disorder	2.6	2.7	0.4	0.4	1.5	1.6
Any emotional, conduct or hyperkinetic disorder	9.7	8.6	5.8	4.8	7.7	6.7
Any disorder¹	10.4	10.2	5.9	5.1	8.2	7.7
<i>Base (weighted)</i>	<i>2909</i>	<i>2010</i>	<i>2921</i>	<i>1916</i>	<i>5830</i>	<i>3926</i>

The shaded boxes indicate figures where the difference between the 1999 and 2004 prevalence is statistically significant at the 95% confidence level.
 1. Includes less common disorders not shown in the table.

Table 4.4**Prevalence of subcategories of mental disorders: children aged 11–15, 1999 and 2004**

Children aged 11–15						Great Britain
	Boys		Girls		All	
	1999	2004	1999	2004	1999	2004
<i>Percentage of children with each disorder</i>						
Emotional disorders	5.1	3.9	6.1	6.0	5.6	4.9
Anxiety disorders	3.9	3.5	5.3	5.3	4.6	4.4
Separation anxiety	0.7	0.3	0.3	0.4	0.5	0.4
Specific phobia	0.7	0.8	1.1	1.0	0.9	0.9
Social phobia	0.3	0.3	0.4	0.5	0.4	0.4
Panic	0.4	0.2	0.3	0.4	0.3	0.3
Agoraphobia	0.1	0.1	0.2	0.4	0.2	0.2
Post traumatic stress	0.2	0.1	0.5	0.4	0.4	0.2
Obsessive compulsive	0.5	0.2	0.5	0.2	0.5	0.2
Generalised anxiety	0.8	1.0	1.1	1.4	0.9	1.2
Other anxiety	1.3	1.0	2.3	1.6	1.8	1.3
Depression	1.7	1.0	1.9	1.6	1.8	1.3
Depressive episode (full ICD criteria)	1.2	0.7	1.4	1.2	1.3	1.0
Other depressive episode	0.5	0.2	0.5	0.4	0.5	0.3
Conduct disorders	8.6	8.8	3.8	5.1	6.2	7.0
Oppositional defiant disorder	2.8	3.9	1.3	1.8	2.1	2.9
Unsocialised conduct disorder	1.0	1.5	0.3	0.8	0.6	1.2
Socialised conduct disorder	2.8	2.6	1.1	1.6	1.9	2.1
Other conduct disorder	2.0	0.9	0.7	0.7	1.4	0.8
Hyperkinetic disorder	2.3	2.6	0.5	0.3	1.4	1.5
Any emotional, conduct or hyperkinetic disorder	12.5	12.1	9.2	9.8	10.8	11.0
Any disorder¹	12.8	13.1	9.6	10.2	11.2	11.7
<i>Base (weighted)</i>	<i>2310</i>	<i>1783</i>	<i>2299</i>	<i>1654</i>	<i>4609</i>	<i>3437</i>

1. Includes less common disorders not shown in the table.

Table 4.5**Prevalence of subcategories of mental disorders: all children, 1999 and 2004**

All children aged 5–15

Great Britain

	Boys		Girls		All	
	1999	2004	1999	2004	1999	2004
<i>Percentage of children with each disorder</i>						
Emotional disorders	4.1	3.0	4.5	4.1	4.3	3.5
Anxiety disorders	3.5	2.8	4.0	3.7	3.8	3.2
Separation anxiety	0.9	0.4	0.7	0.6	0.8	0.5
Specific phobia	0.9	0.8	1.1	0.8	1.0	0.8
Social phobia	0.4	0.2	0.3	0.3	0.3	0.2
Panic	0.2	0.1	0.1	0.2	0.1	0.1
Agoraphobia	0.1	0.1	0.1	0.2	0.1	0.1
Post traumatic stress	0.1	0.1	0.2	0.2	0.2	0.1
Obsessive compulsive	0.3	0.1	0.2	0.2	0.2	0.2
Generalised anxiety	0.5	0.6	0.7	0.8	0.6	0.7
Other anxiety	1.1	0.8	1.3	1.1	1.2	1.0
Depression	0.9	0.6	1.0	0.9	0.9	0.7
Depressive episode (full ICD criteria)	0.6	0.4	0.7	0.7	0.7	0.5
Other depressive episode	0.2	0.1	0.3	0.3	0.2	0.2
Conduct disorders	7.4	7.8	3.2	3.8	5.3	5.9
Oppositional defiant disorder	3.9	4.2	1.8	2.1	2.9	3.2
Unsocialised conduct disorder	0.7	1.2	0.2	0.5	0.5	0.9
Socialised conduct disorder	1.5	1.5	0.5	0.8	1.0	1.1
Other conduct disorder	1.2	0.9	0.5	0.4	0.9	0.7
Hyperkinetic disorder	2.4	2.7	0.4	0.4	1.4	1.5
Any emotional, conduct or hyperkinetic disorder	10.9	10.2	7.3	7.1	9.1	8.7
Any disorder¹	11.4	11.6	7.6	7.5	9.5	9.6
<i>Base (weighted)</i>	<i>5219</i>	<i>3793</i>	<i>5219</i>	<i>3570</i>	<i>10438</i>	<i>7363</i>

The shaded boxes indicate figures where the difference between the 1999 and 2004 prevalence is statistically significant at the 95% confidence level.
 1. Includes less common disorders not shown in the table.

Table 4.6

Prevalence of mental disorders by ethnicity, age and sex, 2004

All children

Great Britain

	Ethnic Group					
	White	Black ¹	Indian	Pakistani and Bangladeshi	Other	All
Percentage of children with each disorder						
BOYS						
5- to 10-year-olds						
Emotional disorders	2.3	1.3	-	3.3	-	2.2
Conduct disorders	7.1	6.7	3.0	6.5	3.8	6.9
Hyperkinetic disorder	3.2	-	-	-	-	2.7
Less common disorders	2.3	1.3	2.5	1.2	1.8	2.2
Any disorder	10.6	7.6	5.4	9.6	5.5	10.2
Base (weighted)	1736	86	42	85	59	2008
11- to 16-year-olds						
Emotional disorders	4.0	3.4	2.4	3.1	7.0	4.0
Conduct disorders	8.5	7.7	-	4.7	5.3	8.1
Hyperkinetic disorder	2.6	1.3	-	-	3.6	2.4
Less common disorders	1.7	1.2	-	-	3.5	1.6
Any disorder	13.0	11.9	2.4	7.6	15.9	12.6
Base (weighted)	1827	91	49	71	62	2100
All boys						
Emotional disorders	3.2	2.3	1.3	3.2	3.6	3.1
Conduct disorders	7.9	7.2	1.4	5.7	4.6	7.5
Hyperkinetic disorder	2.9	0.7	-	-	1.8	2.6
Less common disorders	2.0	1.2	1.2	0.7	2.7	1.9
Any disorder	11.8	9.8	3.8	8.7	10.8	11.4
Base (weighted)	3562	178	92	156	121	4108
GIRLS						
5- to 10-year-olds						
Emotional disorders	2.6	2.1	-	3.8	1.9	2.5
Conduct disorders	3.0	1.3	-	2.6	2.0	2.8
Hyperkinetic disorder	0.4	-	-	-	2.0	0.4
Less common disorders	0.5	-	-	-	-	0.4
Any disorder	5.5	3.3	-	6.4	1.9	5.1
Base (weighted)	1604	112	53	88	59	1916
11- to 16-year-olds						
Emotional disorders	6.2	7.6	3.1	7.5	2.0	6.1
Conduct disorders	5.3	9.9	-	1.7	-	5.1
Hyperkinetic disorder	0.4	1.5	-	-	-	0.4
Less common disorders	1.1	-	-	1.1	1.8	1.1
Any disorder	10.6	17.1	3.2	7.6	3.8	10.3
Base (weighted)	1707	68	56	63	55	1949

1. The black ethnic group includes people of mixed origin.

Table 4.6 (contd)**Prevalence of mental disorders by ethnicity, age and sex, 2004**

All children						Great Britain
Ethnic Group						
	White	Black ¹	Indian	Pakistani and Bangladeshi	Other	All
<i>Percentage of children with each disorder</i>						
All girls						
Emotional disorders	4.5	4.2	1.6	5.4	1.9	4.3
Conduct disorders	4.2	4.5	-	2.2	1.0	3.9
Hyperkinetic disorder	0.4	0.6	-	-	1.0	0.4
Less common disorders	0.8	-	-	0.5	0.9	0.8
Any disorder	8.1	8.5	1.6	6.9	2.8	7.8
<i>Base (weighted)</i>	<i>3311</i>	<i>181</i>	<i>109</i>	<i>151</i>	<i>114</i>	<i>3865</i>
ALL						
5- to 10-year-olds						
Emotional disorders	2.5	1.7	-	3.6	0.9	2.4
Conduct disorders	5.1	3.6	1.3	4.5	2.9	4.9
Hyperkinetic disorder	1.8	-	-	-	1.0	1.6
Less common disorders	1.4	0.6	1.1	0.6	0.9	1.3
Any disorder	8.1	5.2	2.4	8.0	3.7	7.7
<i>Base (weighted)</i>	<i>3340</i>	<i>199</i>	<i>96</i>	<i>172</i>	<i>118</i>	<i>3924</i>
11- to 16-year-olds						
Emotional disorders	5.1	5.2	2.8	5.1	4.7	5.0
Conduct disorders	7.0	8.6	-	3.3	2.8	6.6
Hyperkinetic disorder	1.5	1.4	-	-	1.9	1.4
Less common disorders	1.4	0.7	-	0.5	2.7	1.4
Any disorder	11.9	14.1	2.8	7.6	10.2	11.5
<i>Base (weighted)</i>	<i>3534</i>	<i>160</i>	<i>105</i>	<i>134</i>	<i>117</i>	<i>4049</i>
All children						
Emotional disorders	3.8	3.3	1.4	4.3	2.8	3.7
Conduct disorders	6.1	5.9	0.6	4.0	2.9	5.8
Hyperkinetic disorder	1.7	0.6	-	-	1.4	1.5
Less common disorders	1.4	0.6	0.5	0.6	1.8	1.3
Any disorder	10.1	9.2	2.6	7.8	6.9	9.6
<i>Base (weighted)</i>	<i>6873</i>	<i>358</i>	<i>201</i>	<i>306</i>	<i>235</i>	<i>7973</i>

1. The black ethnic group includes people of mixed origin.

Table 4.7

Prevalence of mental disorders by family type, age and sex, 2004

All children							Great Britain
	Child's family type						
	Married	Cohabiting	All couples	Lone parent – Single	Lone parent – widowed, divorced, separated	All lone parents	All
Percentage of children with each disorder							
BOYS							
5- to 10-year-olds							
Emotional disorders	1.0	2.6	1.2	2.9	7.8	5.6	2.2
Conduct disorders	5.4	8.2	5.7	8.3	12.7	10.7	6.9
Hyperkinetic disorder	2.3	3.5	2.4	3.4	4.0	3.7	2.7
Less common disorders	2.0	2.9	2.1	1.0	3.5	2.4	2.2
Any disorder	7.9	13.4	8.6	11.8	18.5	15.5	10.2
Base (weighted)	1361	183	1543	211	256	466	2010
11- to 16-year-olds							
Emotional disorders	2.5	4.3	2.7	6.7	8.3	7.8	4.0
Conduct disorders	5.2	13.5	6.0	12.8	14.4	13.9	8.1
Hyperkinetic disorder	1.5	3.6	1.7	5.3	4.3	4.6	2.4
Less common disorders	1.5	0.7	1.4	2.6	1.9	2.1	1.6
Any disorder	9.0	17.9	9.9	17.9	21.7	20.5	12.6
Base (weighted)	1399	156	1555	163	383	546	2101
All Boys							
Emotional disorders	1.8	3.4	1.9	4.6	8.1	6.8	3.1
Conduct disorders	5.3	10.7	5.9	10.2	13.7	12.4	7.5
Hyperkinetic disorder	1.9	3.5	2.1	4.2	4.2	4.2	2.6
Less common disorders	1.8	1.9	1.8	1.7	2.5	2.2	1.9
Any disorder	8.4	15.5	9.2	14.4	20.4	18.2	11.4
Base (weighted)	2760	339	3098	374	639	1013	4111
GIRLS							
5- to 10-year-olds							
Emotional disorders	1.8	2.2	1.8	3.9	5.4	4.7	2.5
Conduct disorders	1.9	3.5	2.1	5.8	4.2	4.9	2.8
Hyperkinetic disorder	0.3	0.6	0.3	0.5	0.8	0.6	0.4
Less common disorders	0.4	0.7	0.5	0.9	-	0.4	0.4
Any disorder	3.7	5.2	3.9	8.5	9.0	8.8	5.1
Base (weighted)	1261	186	1447	215	254	469	1916
11- to 16-year-olds							
Emotional disorders	4.5	8.3	4.9	8.1	10.4	9.8	6.1
Conduct disorders	3.0	9.3	3.8	14.6	7.4	9.1	5.1
Hyperkinetic disorder	0.4	-	0.3	1.0	0.3	0.5	0.4
Less common disorders	0.9	0.5	0.8	2.6	1.7	1.9	1.1
Any disorder	7.3	15.0	8.2	19.4	16.1	16.9	10.3
Base (weighted)	1304	173	1476	112	361	474	1950

Table 4.7 (contd)**Prevalence of mental disorders by family type, age and sex, 2004**

All children							Great Britain
	Child's family type						
	Married	Cohabiting	All couples	Lone parent – Single	Lone parent – widowed, divorced, separated	All lone parents	All
Percentage of children with each disorder							
All Girls							
Emotional disorders	3.1	5.2	3.4	5.3	8.3	7.3	4.3
Conduct disorders	2.5	6.3	2.9	8.8	6.0	7.0	3.9
Hyperkinetic disorder	0.3	0.3	0.3	0.7	0.5	0.6	0.4
Less common disorders	0.6	0.6	0.6	1.5	1.0	1.2	0.8
Any disorder	5.6	9.9	6.1	12.2	13.2	12.9	7.8
Base (weighted)	2564	359	2923	328	615	943	3866
ALL							
5- to 10-year-olds							
Emotional disorders	1.4	2.4	1.5	3.4	6.6	5.1	2.4
Conduct disorders	3.7	5.8	4.0	7.0	8.5	7.8	4.9
Hyperkinetic disorder	1.3	2.1	1.4	1.9	2.4	2.2	1.6
Less common disorders	1.3	1.8	1.3	1.0	1.8	1.4	1.3
Any disorder	5.9	9.2	6.3	10.1	13.8	12.1	7.7
Base (weighted)	2621	369	2990	426	509	936	3926
11- to 16-year-olds							
Emotional disorders	3.4	6.4	3.8	7.3	9.3	8.8	5.0
Conduct disorders	4.1	11.3	4.9	13.5	11.0	11.7	6.6
Hyperkinetic disorder	1.1	1.9	1.2	2.6	2.4	2.4	1.5
Less common disorders	1.2	0.6	1.1	2.6	1.8	2.0	1.4
Any disorder	8.2	16.4	9.1	18.5	19.0	18.8	11.5
Base (weighted)	2702	329	3031	275	745	1020	4051
All children							
Emotional disorders	2.4	4.3	2.6	4.9	8.2	7.0	3.7
Conduct disorders	3.9	8.4	4.4	9.6	10.0	9.8	5.8
Hyperkinetic disorder	1.1	1.9	1.2	2.6	2.4	2.4	1.5
Less common disorders	1.2	1.2	1.2	1.6	1.8	1.7	1.3
Any disorder	7.1	12.6	7.7	13.4	16.9	15.6	9.6
Base (weighted)	5324	697	6021	702	1254	1956	7977

Table 4.8**Prevalence of mental disorders by whether family contains stepchildren, age and sex, 2004**

All children	Great Britain		
	No stepchildren	Stepchildren	All
<i>Percentage of children with each disorder</i>			
BOYS			
5- to 10-year-olds			
Emotional disorders	2.3	1.0	2.2
Conduct disorders	6.4	11.2	6.9
Hyperkinetic disorder	2.5	5.5	2.7
Less common disorders	2.0	3.8	2.2
Any disorder	9.7	14.4	10.2
<i>Base (weighted)</i>	<i>1820</i>	<i>189</i>	<i>2010</i>
11- to 16-year-olds			
Emotional disorders	4.2	2.8	4.0
Conduct disorders	7.7	11.4	8.1
Hyperkinetic disorder	2.4	2.7	2.4
Less common disorders	1.6	1.7	1.6
Any disorder	12.2	16.2	12.6
<i>Base (weighted)</i>	<i>1862</i>	<i>239</i>	<i>2101</i>
All Boys			
Emotional disorders	3.3	2.0	3.1
Conduct disorders	7.1	11.3	7.5
Hyperkinetic disorder	2.4	3.9	2.6
Less common disorders	1.8	2.7	1.9
Any disorder	11.0	15.4	11.4
<i>Base (weighted)</i>	<i>3683</i>	<i>428</i>	<i>4111</i>
GIRLS			
5- to 10-year-olds			
Emotional disorders	2.4	4.1	2.5
Conduct disorders	2.5	5.7	2.8
Hyperkinetic disorder	0.4	0.7	0.4
Less common disorders	0.4	0.6	0.4
Any disorder	4.8	8.3	5.1
<i>Base (weighted)</i>	<i>1742</i>	<i>174</i>	<i>1916</i>
11- to 16-year-olds			
Emotional disorders	5.9	7.3	6.1
Conduct disorders	4.3	10.3	5.1
Hyperkinetic disorder	0.4	-	0.4
Less common disorders	1.1	0.7	1.1
Any disorder	9.7	14.3	10.3
<i>Base (weighted)</i>	<i>1694</i>	<i>256</i>	<i>1950</i>

Table 4.8 (contd)**Prevalence of mental disorders by whether family contains stepchildren, age and sex, 2004**

All children	Great Britain		
	No stepchildren	Stepchildren	All
<i>Percentage of children with each disorder</i>			
All Girls			
Emotional disorders	4.1	6.0	4.3
Conduct disorders	3.4	8.4	3.9
Hyperkinetic disorder	0.4	0.3	0.4
Less common disorders	0.8	0.7	0.8
Any disorder	7.2	11.9	7.8
<i>Base (weighted)</i>	<i>3436</i>	<i>430</i>	<i>3866</i>
ALL			
5- to 10-year-olds			
Emotional disorders	2.4	2.5	2.4
Conduct disorders	4.5	8.6	4.9
Hyperkinetic disorder	1.4	3.2	1.6
Less common disorders	1.2	2.3	1.3
Any disorder	7.3	11.4	7.7
<i>Base (weighted)</i>	<i>3562</i>	<i>364</i>	<i>3926</i>
11- to 16-year-olds			
Emotional disorders	5.0	5.1	5.0
Conduct disorders	6.0	10.8	6.6
Hyperkinetic disorder	1.5	1.3	1.4
Less common disorders	1.4	1.2	1.4
Any disorder	11.0	15.2	11.5
<i>Base (weighted)</i>	<i>3556</i>	<i>495</i>	<i>4051</i>
All children			
Emotional disorders	3.7	4.0	3.7
Conduct disorders	5.3	9.9	5.8
Hyperkinetic disorder	1.4	2.1	1.5
Less common disorders	1.3	1.7	1.3
Any disorder	9.2	13.6	9.6
<i>Base (weighted)</i>	<i>7119</i>	<i>858</i>	<i>7977</i>

Table 4.9**Prevalence of mental disorders by number of children in household, age and sex, 2004**

All children						Great Britain
Number of children in household						
	1	2	3	4	5 or more	All
<i>Percentage of children with each disorder</i>						
BOYS						
5- to 10-year-olds						
Emotional disorders	2.6	1.7	3.0	2.6	1.9	2.2
Conduct disorders	5.2	5.6	9.7	10.8	4.1	6.9
Hyperkinetic disorder	4.3	2.1	3.1	2.9	2.2	2.7
Less common disorders	2.3	1.8	3.0	2.7	-	2.2
Any disorder	10.7	8.1	13.5	13.5	6.0	10.2
<i>Base (weighted)</i>	<i>308</i>	<i>1017</i>	<i>484</i>	<i>152</i>	<i>50</i>	<i>2101</i>
11- to 16-year-olds						
Emotional disorders	4.4	3.9	3.8	3.2	4.4	4.0
Conduct disorders	7.3	6.7	10.4	15.7	11.2	8.1
Hyperkinetic disorder	2.9	2.3	2.5	1.0	-	2.4
Less common disorders	0.9	2.3	1.7	-	4.1	1.6
Any disorder	12.0	11.9	14.5	15.8	15.0	12.6
<i>Base (weighted)</i>	<i>785</i>	<i>818</i>	<i>352</i>	<i>100</i>	<i>47</i>	<i>2101</i>
All Boys						
Emotional disorders	3.8	2.6	3.4	2.8	3.1	3.1
Conduct disorders	6.7	6.1	10.0	12.7	7.6	7.5
Hyperkinetic disorder	3.3	2.2	2.9	2.2	1.1	2.6
Less common disorders	1.3	2.0	2.4	1.6	2.0	1.9
Any disorder	11.6	9.8	13.9	14.5	10.4	11.4
<i>Base (weighted)</i>	<i>1093</i>	<i>1835</i>	<i>835</i>	<i>252</i>	<i>97</i>	<i>4111</i>
GIRLS						
5- to 10-year-olds						
Emotional disorders	2.1	1.9	3.6	3.2	5.0	2.5
Conduct disorders	2.3	2.0	3.1	6.0	7.0	2.8
Hyperkinetic disorder	0.3	0.4	-	0.7	1.7	0.4
Less common disorders	0.4	0.4	0.5	-	1.6	0.4
Any disorder	4.2	4.3	6.3	7.0	10.1	5.1
<i>Base (weighted)</i>	<i>319</i>	<i>948</i>	<i>422</i>	<i>168</i>	<i>59</i>	<i>1916</i>
11- to 16-year-olds						
Emotional disorders	6.0	5.3	7.5	7.8	6.4	6.1
Conduct disorders	3.7	6.0	5.4	5.8	6.8	5.1
Hyperkinetic disorder	0.3	0.4	0.3	-	1.6	0.4
Less common disorders	1.3	0.9	1.1	1.7	-	1.1
Any disorder	9.5	10.4	11.2	12.5	11.1	10.3
<i>Base (weighted)</i>	<i>701</i>	<i>739</i>	<i>338</i>	<i>108</i>	<i>64</i>	<i>1950</i>

Table 4.9 (contd)

Prevalence of mental disorders by number of children in household, age and sex, 2004

All children						Great Britain
Number of children in household						
	1	2	3	4	5 or more	All
Percentage of children with each disorder						
All Girls						
Emotional disorders	4.8	3.4	5.3	5.0	5.7	4.3
Conduct disorders	3.3	3.7	4.1	5.9	6.9	3.9
Hyperkinetic disorder	0.3	0.4	0.1	0.4	1.7	0.4
Less common disorders	1.0	0.6	0.7	0.7	0.8	0.8
Any disorder	7.8	7.0	8.4	9.1	10.6	7.8
<i>Base (weighted)</i>	<i>1020</i>	<i>1687</i>	<i>760</i>	<i>276</i>	<i>123</i>	<i>3866</i>
ALL						
5- to 10-year-olds						
Emotional disorders	2.3	1.8	3.3	2.9	3.6	2.4
Conduct disorders	3.7	3.9	6.6	8.2	5.7	4.9
Hyperkinetic disorder	2.3	1.3	1.7	1.7	1.9	1.6
Less common disorders	1.4	1.2	1.8	1.3	0.9	1.3
Any disorder	7.4	6.3	10.1	10.1	8.2	7.7
<i>Base (weighted)</i>	<i>626</i>	<i>1965</i>	<i>906</i>	<i>320</i>	<i>109</i>	<i>3926</i>
11- to 16-year-olds						
Emotional disorders	5.2	4.5	5.6	5.6	5.5	5.0
Conduct disorders	5.6	6.3	8.0	10.6	8.7	6.6
Hyperkinetic disorder	1.7	1.4	1.4	0.5	0.9	1.4
Less common disorders	1.1	1.6	1.4	0.9	1.7	1.4
Any disorder	10.8	11.2	12.9	14.1	12.8	11.5
<i>Base (weighted)</i>	<i>1487</i>	<i>1557</i>	<i>689</i>	<i>207</i>	<i>111</i>	<i>4051</i>
All children						
Emotional disorders	4.3	3.0	4.3	3.9	4.5	3.7
Conduct disorders	5.0	5.0	7.2	9.2	7.2	5.8
Hyperkinetic disorder	1.8	1.3	1.6	1.2	1.4	1.5
Less common disorders	1.2	1.4	1.6	1.1	1.3	1.3
Any disorder	9.8	8.5	11.3	11.7	10.5	9.6
<i>Base (weighted)</i>	<i>2113</i>	<i>3522</i>	<i>1595</i>	<i>527</i>	<i>220</i>	<i>7977</i>

Table 4.10**Prevalence of mental disorders by educational qualifications of parent, age and sex, 2004**

All children

Great Britain

	Educational level (interviewed parent)							
	Degree level	Teaching/ HND/ Nursing level	A-Level (or equivalent)	GCSE grades A-C (or equivalent)	GCSE grades D-F (or equivalent)	Other qualification	No qualification	All
Percentage of children with each disorder								
BOYS								
5- to 10-year-olds								
Emotional disorders	1.0	0.4	3.0	1.5	2.8	1.5	4.9	2.2
Conduct disorders	3.7	4.0	7.2	5.0	10.4	12.4	11.4	6.8
Hyperkinetic disorder	1.1	1.3	2.4	2.6	3.0	5.1	5.3	2.8
Less common disorders	1.1	2.2	2.7	1.6	2.4	-	2.8	2.0
Any disorder	5.4	6.4	11.2	7.9	13.3	13.4	16.3	9.9
Base (weighted)	297	241	227	598	207	64	341	1974
11- to 16-year-olds								
Emotional disorders	1.1	2.5	6.3	3.7	2.1	8.0	6.3	3.9
Conduct disorders	4.9	4.0	6.6	6.2	9.6	6.4	16.5	8.2
Hyperkinetic disorder	1.3	1.2	1.6	1.6	3.7	5.2	4.4	2.4
Less common disorders	2.4	1.7	2.7	0.8	1.7	-	1.5	1.5
Any disorder	7.3	8.8	13.1	9.6	13.4	17.5	21.3	12.5
Base (weighted)	272	268	199	587	239	64	394	2023
All Boys								
Emotional disorders	1.1	1.5	4.5	2.6	2.4	4.7	5.6	3.1
Conduct disorders	4.2	4.0	6.9	5.6	10.0	9.4	14.1	7.5
Hyperkinetic disorder	1.2	1.3	2.0	2.1	3.4	5.2	4.8	2.6
Less common disorders	1.8	1.9	2.7	1.2	2.0	-	2.1	1.8
Any disorder	6.3	7.7	12.1	8.8	13.4	15.4	19.0	11.2
Base (weighted)	569	509	426	1185	445	128	735	3997
GIRLS								
5- to 10-year-olds								
Emotional disorders	0.3	2.7	1.7	2.2	3.0	1.7	6.0	2.6
Conduct disorders	0.8	2.4	1.9	2.6	3.9	1.9	5.7	2.8
Hyperkinetic disorder	-	0.5	-	0.4	-	-	1.4	0.4
Less common disorders	0.9	-	0.9	0.2	0.5	-	0.3	0.4
Any disorder	1.6	4.1	3.9	4.4	6.7	3.5	11.1	5.2
Base (weighted)	273	222	233	586	202	59	298	1873
11- to 16-year-olds								
Emotional disorders	2.7	7.3	5.3	3.6	12.0	4.2	8.8	6.0
Conduct disorders	0.3	4.9	2.9	4.2	7.5	2.1	9.8	5.0
Hyperkinetic disorder	0.4	0.4	0.4	0.2	1.1	-	0.3	0.4
Less common disorders	-	1.2	1.0	0.2	1.8	2.2	1.4	0.8
Any disorder	3.4	10.0	7.8	6.9	17.4	8.4	17.8	10.2
Base (weighted)	262	241	221	551	183	51	383	1892

Table 4.10 (contd)**Prevalence of mental disorders by educational qualifications of parent, age and sex, 2004**

All children

Great Britain

	Educational level (interviewed parent)							
	Degree level	Teaching/ HND/ Nursing level	A-Level (or equivalent)	GCSE grades A–C (or equivalent)	GCSE grades D–F (or equivalent)	Other qualification	No qualification	All
Percentage of children with each disorder								
All Girls								
Emotional disorders	1.5	5.1	3.5	2.9	7.3	2.9	7.6	4.3
Conduct disorders	0.5	3.7	2.4	3.4	5.6	2.0	8.0	3.9
Hyperkinetic disorder	0.2	0.5	0.2	0.3	0.5	-	0.8	0.4
Less common disorders	0.4	0.6	0.9	0.2	1.1	1.0	0.9	0.6
Any disorder	2.5	7.2	5.8	5.6	11.8	5.8	14.9	7.7
Base (weighted)	536	463	454	1137	385	110	681	3764
ALL								
5- to 10-year-olds								
Emotional disorders	0.7	1.5	2.3	1.8	2.9	1.6	5.4	2.4
Conduct disorders	2.3	3.2	4.5	3.8	7.2	7.4	8.8	4.9
Hyperkinetic disorder	0.6	0.9	1.2	1.5	1.5	2.6	3.5	1.6
Less common disorders	1.0	1.1	1.8	0.9	1.5	-	1.6	1.2
Any disorder	3.5	5.3	7.5	6.2	10.0	8.6	13.9	7.6
Base (weighted)	570	463	461	1184	409	122	639	3847
11- to 16-year-olds								
Emotional disorders	1.9	4.8	5.8	3.7	6.4	6.3	7.5	4.9
Conduct disorders	2.6	4.6	4.7	5.2	8.7	4.5	13.2	6.6
Hyperkinetic disorder	0.8	0.9	1.0	0.9	2.6	2.9	2.4	1.4
Less common disorders	1.2	1.4	1.8	0.5	1.7	1.0	1.5	1.2
Any disorder	5.4	9.4	10.3	8.3	15.1	13.5	19.6	11.4
Base (weighted)	534	509	420	1138	421	115	777	3915
All children								
Emotional disorders	1.3	3.2	4.0	2.7	4.7	3.9	6.6	3.7
Conduct disorders	2.4	3.9	4.6	4.5	8.0	6.0	11.2	5.8
Hyperkinetic disorder	0.7	0.9	1.1	1.2	2.1	2.8	2.9	1.5
Less common disorders	1.1	1.3	1.8	0.7	1.6	0.5	1.5	1.2
Any disorder	4.4	7.4	8.9	7.2	12.6	11.0	17.0	9.5
Base (weighted)	1104	972	881	2322	830	238	1415	7762

Table 4.11**Prevalence of mental disorders by family's employment, age and sex, 2004**

All children

Great Britain

Family's employment				
	Both parents working (inc. lone parents)	One parent working	Neither parent working (inc. lone parents)	All
Percentage of children with each disorder				
BOYS				
5- to 10-year-olds				
Emotional disorders	1.3	1.2	7.0	2.2
Conduct disorders	5.1	6.5	14.6	6.9
Hyperkinetic disorder	2.3	1.7	5.9	2.8
Less common disorders	1.7	2.1	3.7	2.1
Any disorder	8.1	8.2	20.5	10.1
Base (weighted)	1267	389	326	1982
11- to 16-year-olds				
Emotional disorders	2.8	3.4	11.0	4.1
Conduct disorders	5.9	9.6	17.5	8.2
Hyperkinetic disorder	2.0	1.7	5.3	2.5
Less common disorders	1.8	0.7	2.0	1.6
Any disorder	10.1	12.9	25.2	12.8
Base (weighted)	1433	305	302	2039
All Boys				
Emotional disorders	2.1	2.2	8.9	3.2
Conduct disorders	5.5	7.9	16.0	7.6
Hyperkinetic disorder	2.2	1.7	5.6	2.6
Less common disorders	1.7	1.5	2.9	1.9
Any disorder	9.2	10.3	22.7	11.5
Base (weighted)	2700	693	628	4021
GIRLS				
5- to 10-year-olds				
Emotional disorders	1.6	3.3	5.5	2.6
Conduct disorders	1.3	3.0	8.4	2.8
Hyperkinetic disorder	0.2	0.6	1.0	0.4
Less common disorders	0.3	0.5	0.6	0.4
Any disorder	3.1	5.9	12.0	5.2
Base (weighted)	1165	400	313	1877
11- to 16-year-olds				
Emotional disorders	5.2	6.5	10.7	6.2
Conduct disorders	3.3	5.7	12.8	5.1
Hyperkinetic disorder	0.2	0.6	0.8	0.4
Less common disorders	0.5	0.9	3.3	0.9
Any disorder	7.9	11.5	20.8	10.4
Base (weighted)	1318	307	277	1902

Table 4.11 (contd)**Prevalence of mental disorders by family's employment, age and sex, 2004**

All children

Great Britain

		Family's employment		
	Both parents working (inc. lone parents)	One parent working	Neither parent working (inc. lone parents)	All
Percentage of children with each disorder				
All Girls				
Emotional disorders	3.5	4.7	7.9	4.4
Conduct disorders	2.4	4.2	10.5	4.0
Hyperkinetic disorder	0.2	0.6	0.9	0.4
Less common disorders	0.4	0.7	1.9	0.7
Any disorder	5.7	8.3	16.1	7.8
Base (weighted)	2483	707	589	3779
ALL				
5- to 10-year-olds				
Emotional disorders	1.4	2.3	6.3	2.4
Conduct disorders	3.3	4.7	11.6	4.9
Hyperkinetic disorder	1.3	1.1	3.5	1.6
Less common disorders	1.0	1.3	2.2	1.3
Any disorder	5.7	7.1	16.3	7.7
Base (weighted)	2432	789	639	3859
11- to 16-year-olds				
Emotional disorders	3.9	5.0	10.9	5.1
Conduct disorders	4.7	7.7	15.2	6.7
Hyperkinetic disorder	1.2	1.2	3.1	1.4
Less common disorders	1.1	0.8	2.6	1.3
Any disorder	9.1	12.2	23.1	11.6
Base (weighted)	2751	612	578	3940
All children				
Emotional disorders	2.8	3.4	8.5	3.8
Conduct disorders	4.0	6.0	13.3	5.8
Hyperkinetic disorder	1.2	1.1	3.3	1.5
Less common disorders	1.1	1.1	2.4	1.3
Any disorder	7.5	9.3	19.5	9.7
Base (weighted)	5183	1400	1217	7800

Table 4.12

Prevalence of mental disorders by household income, age and sex, 2004

All children

Great Britain

Gross weekly household income									
	Under £100	£100– £199	£200– £299	£300– £399	£400– £499	£500– £599	£600– £770	Over £770	All
Percentage of children with each disorder									
BOYS									
5- to 10-year-olds									
Emotional disorders	1.7	3.7	5.2	0.5	2.4	0.6	1.6	1.0	2.1
Conduct disorders	11.5	8.0	13.3	5.8	8.2	3.6	2.5	3.9	6.4
Hyperkinetic disorder	9.9	2.0	4.0	2.0	4.2	3.4	0.9	1.6	2.6
Less common disorders	-	-	2.1	2.8	2.6	4.6	1.6	1.3	1.9
Any disorder	16.8	9.0	15.6	9.3	11.9	9.2	5.7	6.2	9.3
Base (weighted)	56	220	243	213	196	162	243	487	1820
11- to 16-year-olds									
Emotional disorders	11.4	6.7	6.6	6.4	3.5	2.7	1.7	1.5	3.9
Conduct disorders	13.2	13.7	15.1	13.8	4.8	7.1	3.2	3.8	8.1
Hyperkinetic disorder	3.5	4.2	4.9	4.3	0.8	1.9	1.2	1.2	2.4
Less common disorders	6.2	1.3	2.3	2.5	1.2	1.2	0.8	1.9	1.7
Any disorder	21.1	18.5	20.2	20.7	8.9	11.8	6.3	7.2	12.5
Base (weighted)	33	230	223	202	262	184	240	474	1849
All Boys									
Emotional disorders	5.3	5.2	5.9	3.3	3.0	1.7	1.6	1.3	3.0
Conduct disorders	12.2	10.9	14.2	9.7	6.3	5.5	2.9	3.8	7.2
Hyperkinetic disorder	7.5	3.1	4.4	3.2	2.2	2.6	1.1	1.4	2.5
Less common disorders	2.3	0.7	2.2	2.7	1.8	2.8	1.2	1.6	1.8
Any disorder	18.4	13.9	17.8	14.8	10.2	10.6	6.0	6.7	10.9
Base (weighted)	89	450	466	416	459	346	483	961	3668
GIRLS									
5- to 10-year-olds									
Emotional disorders	2.9	3.8	4.8	1.2	3.3	3.2	1.7	0.7	2.5
Conduct disorders	2.9	6.1	5.6	1.9	1.0	2.1	-	1.6	2.6
Hyperkinetic disorder	2.8	0.4	1.3	-	-	0.8	-	-	0.4
Less common disorders	-	0.4	0.4	0.6	0.5	-	0.4	0.6	0.4
Any disorder	5.6	8.5	9.7	3.5	4.4	4.6	2.2	2.5	4.9
Base (weighted)	38	260	231	179	203	153	248	411	1724
11- to 16-year-olds									
Emotional disorders	12.9	8.5	8.3	9.2	6.2	4.6	3.0	3.7	5.9
Conduct disorders	13.7	13.5	6.8	7.6	3.1	5.1	2.6	1.6	5.2
Hyperkinetic disorder	-	0.7	0.4	-	-	2.5	-	0.2	0.4
Less common disorders	-	2.6	1.2	1.5	0.5	-	0.4	0.5	0.9
Any disorder	21.1	19.6	13.2	15.5	9.3	9.6	5.2	5.1	10.2
Base (weighted)	39	176	245	197	197	162	257	456	1728

Table 4.12 (contd)**Prevalence of mental disorders by household income, age and sex, 2004**

All children

Great Britain

	Gross weekly household income								
	Under £100	£100– £199	£200– £299	£300– £399	£400– £499	£500– £599	£600– £770	Over £770	All
Percentage of children with each disorder									
All Girls									
Emotional disorders	7.9	5.7	6.6	5.4	4.8	3.9	2.4	2.2	4.2
Conduct disorders	8.3	9.1	6.2	4.9	2.1	3.7	1.3	1.6	3.9
Hyperkinetic disorder	1.4	0.5	0.8	-	-	1.6	-	0.1	0.4
Less common disorders	-	1.3	0.8	1.1	0.5	-	0.4	0.5	0.6
Any disorder	13.4	13.0	11.5	9.8	6.8	7.1	3.7	3.9	7.5
Base (weighted)	77	437	476	376	400	315	505	866	3452
ALL									
5- to 10-year-olds									
Emotional disorders	2.2	3.8	5.0	0.8	2.9	1.9	1.6	0.9	2.3
Conduct disorders	8.0	7.0	9.5	4.0	4.6	2.9	1.3	2.8	4.5
Hyperkinetic disorder	7.0	1.1	2.7	1.1	2.1	2.1	0.4	0.9	1.5
Less common disorders	-	0.2	1.3	1.8	1.5	2.4	1.0	0.9	1.2
Any disorder	12.3	8.8	12.7	6.7	8.1	7.0	3.9	4.5	7.2
Base (weighted)	94	480	475	392	399	315	491	897	3544
11- to 16-year-olds									
Emotional disorders	12.2	7.5	7.5	7.7	4.7	3.6	2.4	2.6	4.9
Conduct disorders	13.5	13.6	10.7	10.8	4.1	6.2	2.9	2.7	6.7
Hyperkinetic disorder	1.6	2.7	2.5	2.2	0.5	2.1	0.6	0.7	1.4
Less common disorders	2.8	1.9	1.8	2.0	0.9	0.6	0.6	1.2	1.3
Any disorder	21.1	19.0	16.5	18.1	9.1	10.8	5.7	6.1	11.4
Base (weighted)	72	406	467	399	459	346	497	930	3576
All children									
Emotional disorders	6.5	5.5	6.2	4.3	3.8	2.8	2.0	1.7	3.6
Conduct disorders	10.4	10.0	10.1	7.4	4.3	4.6	2.1	2.8	5.6
Hyperkinetic disorder	4.7	1.8	2.6	1.7	1.2	2.1	0.5	0.8	1.5
Less common disorders	1.2	1.0	1.5	1.9	1.2	1.5	0.8	1.1	1.2
Any disorder	16.1	13.4	14.6	12.4	8.6	9.0	4.8	5.3	9.3
Base (weighted)	166	887	942	791	858	661	987	1827	7120

Table 4.13**Prevalence of mental disorders by receipt of disability benefits, age and sex, 2004**

All children

Great Britain

Receipt of disability benefits						
	Carers Allowance	Disability Living/ Attendance Allowance	Incapacity Allowance	Any disability benefit	No disability benefit	All
Percentage of children with each disorder						
BOYS						
5- to 10-year-olds						
Emotional disorders	8.8	7.7	5.3	6.8	1.7	2.2
Conduct disorders	19.2	18.4	8.8	16.7	5.9	6.9
Hyperkinetic disorder	9.4	9.9	3.0	8.5	2.1	2.7
Less common disorders	20.0	18.4	-	13.8	1.0	2.2
Any disorder	36.6	38.1	13.8	31.8	7.9	10.2
Base (weighted)	56	141	37	189	1821	2010
11- to 16-year-olds						
Emotional disorders	18.2	12.7	10.2	12.1	3.3	4.0
Conduct disorders	31.0	20.6	15.2	18.0	7.2	8.1
Hyperkinetic disorder	10.2	5.3	-	4.9	2.2	2.4
Less common disorders	7.6	7.8	-	5.9	1.2	1.6
Any disorder	44.1	31.6	22.3	29.3	11.1	12.6
Base (weighted)	54	120	42	175	1926	2101
All Boys						
Emotional disorders	13.4	10.0	7.9	9.3	2.5	3.1
Conduct disorders	25.0	19.4	12.2	17.3	6.5	7.5
Hyperkinetic disorder	9.8	7.8	1.4	6.8	2.2	2.6
Less common disorders	14.0	13.5	-	10.0	1.1	1.9
Any disorder	40.3	35.1	18.3	30.6	9.6	11.4
Base (weighted)	110	261	79	365	3747	4111
GIRLS						
5- to 10-year-olds						
Emotional disorders	8.4	3.8	4.5	5.0	2.3	2.5
Conduct disorders	6.1	9.7	4.9	8.8	2.3	2.8
Hyperkinetic disorder	3.9	2.4	-	2.2	0.2	0.4
Less common disorders	1.9	1.1	-	0.7	0.4	0.4
Any disorder	10.5	10.8	6.8	10.6	4.7	5.1
Base (weighted)	52	90	42	147	1769	1916
11- to 16-year-olds						
Emotional disorders	10.2	11.0	10.8	12.0	5.6	6.1
Conduct disorders	13.8	9.8	2.9	8.7	4.7	5.1
Hyperkinetic disorder	1.6	4.6	-	3.2	0.1	0.4
Less common disorders	3.3	4.7	2.7	4.5	0.8	1.1
Any disorder	24.0	24.2	13.8	22.5	9.3	10.3
Base (weighted)	60	110	40	159	1790	1950

Table 4.13 (contd)**Prevalence of mental disorders by receipt of disability benefits, age and sex, 2004**

All children

Great Britain

	Receipt of disability benefits					
	Carers Allowance	Disability Living/ Attendance Allowance	Incapacity Allowance	Any disability benefit ¹	No disability benefit	All children
Percentage of children with each disorder						
All Girls						
Emotional disorders	9.3	7.8	7.6	8.7	4.0	4.3
Conduct disorders	10.2	9.8	3.9	8.7	3.5	3.9
Hyperkinetic disorder	2.7	3.6	-	2.7	0.2	0.4
Less common disorders	2.6	3.1	1.3	2.6	0.6	0.8
Any disorder	17.7	18.2	10.2	16.8	7.0	7.8
Base (weighted)	112	200	81	307	3559	3866
ALL						
5- to 10-year-olds						
Emotional disorders	8.6	6.2	4.9	6.0	2.0	2.4
Conduct disorders	12.9	15.0	6.8	13.2	4.1	4.9
Hyperkinetic disorder	6.7	7.0	1.4	5.7	1.2	1.6
Less common disorders	11.3	11.7	-	8.0	0.7	1.3
Any disorder	24.0	27.4	10.1	22.5	6.3	7.7
Base (weighted)	108	231	79	336	3589	3926
11- to 16-year-olds						
Emotional disorders	14.0	11.9	10.5	12.1	4.4	5.0
Conduct disorders	22.0	15.4	9.3	13.5	6.0	6.6
Hyperkinetic disorder	5.7	4.9	-	4.1	1.2	1.4
Less common disorders	5.3	6.3	1.3	5.2	1.0	1.4
Any disorder	33.5	28.0	18.2	26.1	10.2	11.5
Base (weighted)	114	230	82	335	3716	4051
All children						
Emotional disorders	11.4	9.0	7.7	9.0	3.2	3.7
Conduct disorders	17.6	15.2	8.0	13.4	5.1	5.8
Hyperkinetic disorder	6.2	6.0	0.7	4.9	1.2	1.5
Less common disorders	8.2	9.0	0.7	6.6	0.9	1.3
Any disorder	28.9	27.7	14.2	24.3	8.3	9.6
Base (weighted)	222	461	161	671	7306	7977

1. The 'Any disability benefit' category includes a small number of households receiving Severe Disablement Allowance not shown in the table.

Table 4.14

Prevalence of mental disorders by socio-economic classification, age and sex, 2004

All children

Great Britain

Socio-economic classification ¹										
	Higher managerial	Higher professions	Lower managerial /professions	Intermediate occupations	Small Employers and own account	Lower supervisory and technical	Semi-routine	Routine occupations	Never worked/ long-term unemployed	All
Percentage of children with each disorder										
BOYS										
5- to 10-year-olds										
Emotional disorders	1.2	2.3	0.8	0.5	1.2	2.3	3.2	4.3	3.7	2.1
Conduct disorders	2.1	4.1	4.3	5.4	8.5	6.8	10.1	7.9	14.2	6.7
Hyperkinetic disorder	1.4	0.6	1.5	4.0	2.1	2.4	3.9	4.8	5.9	2.8
Less common disorders	2.6	0.5	1.1	2.9	1.7	0.7	2.0	2.7	5.9	1.9
Any disorder	6.5	5.0	6.0	9.6	8.9	8.7	13.7	14.1	21.1	9.9
Base (weighted)	160	172	374	182	243	129	348	297	53	1960
11- to 16-year-olds										
Emotional disorders	2.7	3.4	3.4	5.5	2.1	1.6	4.5	5.1	14.0	4.0
Conduct disorders	4.5	3.2	3.6	12.8	4.2	6.4	11.7	16.5	11.9	8.3
Hyperkinetic disorder	0.8	0.6	1.0	5.4	2.2	0.8	2.5	5.2	3.8	2.4
Less common disorders	2.0	1.4	1.0	3.8	0.9	1.4	1.2	1.7	3.4	1.6
Any disorder	8.5	6.7	7.9	19.7	8.3	9.1	15.1	22.0	20.0	12.7
Base (weighted)	150	177	412	167	255	138	354	304	53	2010
All Boys										
Emotional disorders	2.0	2.8	2.2	2.9	1.6	1.9	3.8	4.7	8.8	3.1
Conduct disorders	3.3	3.7	3.9	8.9	6.3	6.6	10.9	12.3	13.1	7.5
Hyperkinetic disorder	1.1	0.6	1.2	4.7	2.1	1.6	3.2	5.0	4.8	2.6
Less common disorders	2.3	1.0	1.1	3.3	1.3	1.1	1.6	2.2	4.7	1.7
Any disorder	7.4	5.9	7.0	14.5	8.6	8.9	14.4	18.1	20.5	11.3
Base (weighted)	310	350	787	349	499	267	702	601	106	3969
GIRLS										
5- to 10-year-olds										
Emotional disorders	1.7	1.1	1.5	3.7	1.5	3.8	3.2	3.6	4.2	2.6
Conduct disorders	2.0	1.3	1.4	1.2	2.6	4.0	3.1	4.9	7.2	2.8
Hyperkinetic disorder	1.0	-	0.3	-	-	-	-	1.4	1.4	0.4
Less common disorders	1.7	-	0.6	0.6	-	-	-	0.4	1.4	0.4
Any disorder	3.6	2.4	3.0	4.9	4.0	7.0	5.5	8.6	9.8	5.1
Base (weighted)	119	166	366	173	249	128	291	294	71	1858
11- to 16-year-olds										
Emotional disorders	4.1	2.5	5.4	4.3	3.0	7.4	9.2	8.7	8.6	6.0
Conduct disorders	1.5	0.6	3.3	8.3	2.1	3.7	7.7	8.5	11.2	5.0
Hyperkinetic disorder	-	0.7	-	1.1	0.8	0.9	-	0.4	-	0.4
Less common disorders	-	0.7	0.5	0.5	0.4	0.8	2.0	1.3	-	0.8
Any disorder	5.5	3.2	8.1	11.3	5.0	10.2	16.4	14.7	15.8	10.1
Base (weighted)	153	152	388	180	245	110	304	285	60	1878

1. This is the National Statistics socio-economic classification (NS-SEC).

Table 4.14 (contd)**Prevalence of mental disorders by socio-economic classification, age and sex, 2004**

All children

Great Britain

	Socio-economic classification ¹									
	Higher managerial	Higher professions	Lower managerial /professions	Intermediate occupations	Small Employers and own account	Lower supervisory and technical	Semi- routine	Routine occupations	Never worked/ long-term unemployed	All
Percentage of children with each disorder										
All Girls										
Emotional disorders	3.0	1.8	3.5	4.0	2.2	5.5	6.3	6.1	6.2	4.3
Conduct disorders	1.7	1.0	2.4	4.8	2.4	3.9	5.4	6.7	9.0	3.9
Hyperkinetic disorder	0.4	0.3	0.1	0.6	0.4	0.4	-	0.9	0.8	0.4
Less common disorders	0.7	0.3	0.6	0.5	0.2	0.4	1.0	0.8	0.7	0.6
Any disorder	4.7	2.8	5.6	8.2	4.5	8.5	11.1	11.6	12.5	7.6
Base (weighted)	271	318	754	354	493	239	596	579	131	3736
ALL										
5- to 10-year-olds										
Emotional disorders	1.4	1.7	1.2	2.1	1.3	3.1	3.2	3.9	4.0	2.3
Conduct disorders	2.0	2.7	2.9	3.4	5.5	5.4	6.9	6.4	10.2	4.8
Hyperkinetic disorder	1.2	0.3	0.9	2.1	1.1	1.2	2.1	3.1	3.3	1.6
Less common disorders	2.2	0.3	0.9	1.8	0.9	0.4	1.1	1.5	3.3	1.2
Any disorder	5.2	3.7	4.5	7.3	6.4	7.9	10.0	11.4	14.6	7.5
Base (weighted)	279	339	740	356	492	257	640	590	124	3817
11- to 16-year-olds										
Emotional disorders	3.4	3.0	4.4	4.9	2.5	4.1	6.6	6.9	11.1	4.9
Conduct disorders	3.0	2.0	3.5	10.5	3.2	5.2	9.8	12.6	11.5	6.7
Hyperkinetic disorder	0.4	0.6	0.5	3.2	1.5	0.9	1.3	2.9	1.8	1.4
Less common disorders	1.0	1.1	0.8	2.1	0.7	1.1	1.5	1.5	1.6	1.2
Any disorder	7.0	5.1	8.0	15.3	6.7	9.6	15.7	18.5	17.8	11.4
Base (weighted)	302	329	800	347	500	248	658	589	113	3888
All children										
Emotional disorders	2.5	2.3	2.8	3.5	1.9	3.6	5.0	5.4	7.4	3.6
Conduct disorders	2.5	2.4	3.2	6.9	4.4	5.3	8.4	9.5	10.8	5.8
Hyperkinetic disorder	0.8	0.5	0.7	2.6	1.3	1.0	1.7	3.0	2.6	1.5
Less common disorders	1.6	0.7	0.8	1.9	0.8	0.7	1.3	1.5	2.5	1.2
Any disorder	6.1	4.4	6.3	11.3	6.6	8.7	12.9	14.9	16.1	9.5
Base (weighted)	581	668	1541	703	992	506	1298	1180	237	7705

1. This is the National Statistics Socio-economic classification (NS-SEC).

Table 4.15
Prevalence of mental disorders by tenure, age and sex, 2004

All children				Great Britain
				Tenure
	Owners	Social sector tenants	Private renters	All
<i>Percentage of children with each disorder</i>				
BOYS				
5- to 10-year-olds				
Emotional disorders	1.4	4.0	4.3	2.2
Conduct disorders	5.0	11.8	9.4	6.9
Hyperkinetic disorder	2.3	3.5	4.5	2.7
Less common disorders	2.1	2.2	3.1	2.2
Any disorder	8.1	15.0	14.4	10.2
<i>Base (weighted)</i>	<i>1396</i>	<i>452</i>	<i>160</i>	<i>2009</i>
11- to 16-year-olds				
Emotional disorders	2.6	7.5	8.6	4.0
Conduct disorders	5.6	16.7	8.5	8.1
Hyperkinetic disorder	1.6	4.0	6.3	2.4
Less common disorders	1.4	1.9	2.8	1.6
Any disorder	9.2	22.6	19.1	12.6
<i>Base (weighted)</i>	<i>1516</i>	<i>433</i>	<i>151</i>	<i>2100</i>
All Boys				
Emotional disorders	2.0	5.7	6.4	3.1
Conduct disorders	5.3	14.2	9.0	7.5
Hyperkinetic disorder	1.9	3.7	5.4	2.6
Less common disorders	1.7	2.1	3.0	1.9
Any disorder	8.7	18.7	16.7	11.4
<i>Base (weighted)</i>	<i>2912</i>	<i>885</i>	<i>312</i>	<i>4108</i>
GIRLS				
5- to 10-year-olds				
Emotional disorders	1.8	4.8	2.0	2.5
Conduct disorders	1.3	7.0	3.5	2.8
Hyperkinetic disorder	0.1	1.0	1.3	0.4
Less common disorders	0.5	0.5	-	0.4
Any disorder	3.3	10.6	5.2	5.1
<i>Base (weighted)</i>	<i>1321</i>	<i>435</i>	<i>159</i>	<i>1914</i>
11- to 16-year-olds				
Emotional disorders	4.6	9.1	13.1	6.1
Conduct disorders	3.1	11.7	5.9	5.1
Hyperkinetic disorder	0.2	0.8	0.7	0.4
Less common disorders	0.8	1.2	4.2	1.1
Any disorder	7.1	18.8	18.9	10.3
<i>Base (weighted)</i>	<i>1413</i>	<i>409</i>	<i>128</i>	<i>1950</i>

Table 4.15 (contd)
Prevalence of mental disorders by tenure, age and sex, 2004

All children	Great Britain			
	Tenure			
	Owners	Social sector tenants	Private renters	All
Percentage of children with each disorder				
All Girls				
Emotional disorders	3.3	6.9	7.0	4.3
Conduct disorders	2.2	9.3	4.6	3.9
Hyperkinetic disorder	0.1	0.9	1.1	0.4
Less common disorders	0.6	0.8	1.9	0.8
Any disorder	5.3	14.6	11.3	7.8
Base (weighted)	2734	844	287	3864
ALL				
5- to 10-year-olds				
Emotional disorders	1.6	4.4	3.2	2.4
Conduct disorders	3.2	9.5	6.5	4.9
Hyperkinetic disorder	1.2	2.3	2.9	1.6
Less common disorders	1.3	1.4	1.6	1.3
Any disorder	5.8	12.9	9.8	7.7
Base (weighted)	2718	887	319	3923
11- to 16-year-olds				
Emotional disorders	3.5	8.3	10.7	5.0
Conduct disorders	4.4	14.3	7.3	6.6
Hyperkinetic disorder	0.9	2.4	3.8	1.4
Less common disorders	1.1	1.5	3.4	1.4
Any disorder	8.2	20.7	19.0	11.5
Base (weighted)	2928	842	279	4049
All children				
Emotional disorders	2.6	6.3	6.7	3.7
Conduct disorders	3.8	11.8	6.9	5.8
Hyperkinetic disorder	1.1	2.4	3.3	1.5
Less common disorders	1.2	1.4	2.4	1.3
Any disorder	7.0	16.7	14.1	9.6
Base (weighted)	5646	1729	598	7973

Table 4.16

Prevalence of mental disorders by accommodation type, age and sex, 2004

All children					Great Britain
Accommodation type					
	Detached	Semi-detached	Terraced house	Flat/ maisonette	All
<i>Percentage of children with each disorder</i>					
BOYS					
5- to 10-year-olds					
Emotional disorders	1.2	2.5	1.9	5.1	2.2
Conduct disorders	4.9	6.4	9.1	6.7	6.9
Hyperkinetic disorder	2.0	3.3	2.9	1.9	2.7
Less common disorders	1.9	2.3	2.7	0.7	2.2
Any disorder	7.2	10.0	12.8	10.3	10.2
<i>Base (weighted)</i>	<i>493</i>	<i>735</i>	<i>616</i>	<i>161</i>	<i>2010</i>
11- to 16-year-olds					
Emotional disorders	3.3	3.6	4.9	6.1	4.0
Conduct disorders	3.2	9.2	11.4	8.4	8.1
Hyperkinetic disorder	1.2	2.8	2.9	3.5	2.4
Less common disorders	2.0	1.3	1.4	2.5	1.6
Any disorder	8.2	13.1	16.0	15.1	12.6
<i>Base (weighted)</i>	<i>594</i>	<i>780</i>	<i>590</i>	<i>132</i>	<i>2101</i>
All Boys					
Emotional disorders	2.3	3.1	3.4	5.5	3.1
Conduct disorders	4.0	7.9	10.2	7.5	7.5
Hyperkinetic disorder	1.6	3.1	2.9	2.6	2.6
Less common disorders	1.9	1.8	2.1	1.5	1.9
Any disorder	7.7	11.6	14.4	12.5	11.4
<i>Base (weighted)</i>	<i>1086</i>	<i>1514</i>	<i>1207</i>	<i>293</i>	<i>4111</i>
GIRLS					
5- to 10-year-olds					
Emotional disorders	1.2	2.6	3.0	4.2	2.5
Conduct disorders	0.7	3.3	3.4	4.3	2.8
Hyperkinetic disorder	0.2	0.3	0.3	1.5	0.4
Less common disorders	0.5	0.3	0.3	1.5	0.4
Any disorder	1.9	5.8	6.0	8.4	5.1
<i>Base (weighted)</i>	<i>453</i>	<i>712</i>	<i>612</i>	<i>134</i>	<i>1916</i>
11- to 16-year-olds					
Emotional disorders	2.4	6.8	8.5	6.6	6.1
Conduct disorders	2.1	4.6	7.6	9.1	5.1
Hyperkinetic disorder	0.2	0.2	0.5	1.1	0.4
Less common disorders	0.6	1.3	1.3	0.8	1.1
Any disorder	4.5	10.6	14.4	14.5	10.3
<i>Base (weighted)</i>	<i>511</i>	<i>738</i>	<i>590</i>	<i>106</i>	<i>1950</i>

The total includes a small number of children living in 'other' types of accommodation.

Table 4.16 (contd)**Prevalence of mental disorders by accommodation type, age and sex, 2004**

All children					Great Britain
Accommodation type					
	Detached	Semi-detached	Terraced house	Flat/ maisonette	All
<i>Percentage of children with each disorder</i>					
All Girls					
Emotional disorders	1.9	4.7	5.7	5.3	4.3
Conduct disorders	1.4	4.0	5.4	6.4	3.9
Hyperkinetic disorder	0.2	0.3	0.4	1.3	0.4
Less common disorders	0.6	0.8	0.8	1.2	0.8
Any disorder	3.3	8.2	10.1	11.1	7.8
<i>Base (weighted)</i>	<i>964</i>	<i>1450</i>	<i>1203</i>	<i>241</i>	<i>3866</i>
ALL					
5- to 10-year-olds					
Emotional disorders	1.2	2.6	2.4	4.7	2.4
Conduct disorders	2.9	4.9	6.3	5.6	4.9
Hyperkinetic disorder	1.1	1.8	1.6	1.7	1.6
Less common disorders	1.2	1.4	1.5	1.0	1.3
Any disorder	4.7	7.9	9.4	9.4	7.7
<i>Base (weighted)</i>	<i>946</i>	<i>1447</i>	<i>1229</i>	<i>295</i>	<i>3926</i>
11- to 16-year-olds					
Emotional disorders	2.9	5.1	6.7	6.3	5.0
Conduct disorders	2.7	7.0	9.5	8.7	6.6
Hyperkinetic disorder	0.8	1.6	1.7	2.4	1.4
Less common disorders	1.3	1.3	1.3	1.7	1.4
Any disorder	6.5	11.9	15.2	14.8	11.5
<i>Base (weighted)</i>	<i>1105</i>	<i>1518</i>	<i>1181</i>	<i>238</i>	<i>4051</i>
All children					
Emotional disorders	2.1	3.9	4.5	5.4	3.7
Conduct disorders	2.8	6.0	7.8	7.0	5.8
Hyperkinetic disorder	0.9	1.7	1.7	2.0	1.5
Less common disorders	1.3	1.3	1.4	1.4	1.3
Any disorder	5.6	10.0	12.2	11.8	9.6
<i>Base (weighted)</i>	<i>2051</i>	<i>2965</i>	<i>2410</i>	<i>533</i>	<i>7977</i>

The total includes a small number of children living in 'other' types of accommodation.

Table 4.17**Prevalence of mental disorders by country, 1999 and 2004**

All children aged 5–15

Great Britain

	England		Scotland	
	1999	2004	1999	2004
<i>Percentage of children with each disorder</i>				
Children aged 5–10				
Emotional disorders	3.3	2.4	4.3	2.9
Conduct disorders	4.7	5.0	3.6	4.8
Hyperkinetic disorder	1.5	1.7	1.0	1.0
Any emotional, conduct or hyperkinetic disorder	7.9	6.9	7.4	6.6
Any disorder	8.3	8.1	7.7	6.6
<i>Base (weighted)</i>	<i>5070</i>	<i>3387</i>	<i>481</i>	<i>332</i>
Children aged 11–15				
Emotional disorders	5.5	5.5	4.8	2.0
Conduct disorders	6.3	7.3	5.8	6.4
Hyperkinetic disorder	1.5	1.3	1.3	2.3
Any emotional, conduct or hyperkinetic disorder	10.9	11.6	9.2	9.6
Any disorder	11.3	12.3	9.4	10.3
<i>Base (weighted)</i>	<i>3948</i>	<i>2977</i>	<i>411</i>	<i>287</i>
Boys				
Emotional disorders	4.2	3.2	3.4	2.2
Conduct disorders	7.5	8.1	6.7	6.6
Hyperkinetic disorder	2.5	2.7	2.0	2.1
Any emotional, conduct or hyperkinetic disorder	11.2	10.6	8.8	8.8
Any disorder	11.8	12.1	9.0	9.2
<i>Base (weighted)</i>	<i>4494</i>	<i>3278</i>	<i>461</i>	<i>318</i>
Girls				
Emotional disorders	4.3	4.5	5.8	2.9
Conduct disorders	3.3	4.0	2.5	4.4
Hyperkinetic disorder	0.5	0.3	0.2	1.0
Any emotional, conduct or hyperkinetic disorder	7.2	7.5	7.6	7.1
Any disorder	7.5	7.8	8.0	7.4
<i>Base (weighted)</i>	<i>4524</i>	<i>3086</i>	<i>432</i>	<i>300</i>
All children				
Emotional disorders	4.3	3.9	4.6	2.5
Conduct disorders	5.4	6.1	4.6	5.5
Hyperkinetic disorder	1.5	1.5	1.1	1.6
Any emotional, conduct or hyperkinetic disorder	9.2	9.1	8.2	8.0
Any disorder ¹	9.6	10.1	8.5	8.3
<i>Base (weighted)</i>	<i>9018</i>	<i>6364</i>	<i>892</i>	<i>618</i>

The shaded boxes indicate figures where the difference between the 1999 and 2004 prevalence is statistically significant at the 95% confidence level.
 1. Includes less common disorders not shown in the table.

Table 4.18
Prevalence of mental disorders by region, age and sex, 2004

All children	Region				England
	London Inner	London Outer	Other Met England	Non-Met England	All England
<i>Percentage of children with each disorder</i>					
BOYS					
5- to 10-year-olds					
Emotional disorders	1.3	1.3	2.3	2.4	2.2
Conduct disorders	4.4	2.9	6.4	8.7	7.1
Hyperkinetic disorder	2.9	0.7	2.9	3.4	2.9
Less common disorders	1.3	1.4	2.4	3.0	2.5
Any disorder	8.1	5.5	10.2	11.9	10.5
<i>Base (weighted)</i>	<i>85</i>	<i>175</i>	<i>621</i>	<i>856</i>	<i>1736</i>
11- to 16-year-olds					
Emotional disorders	4.9	5.0	3.2	5.1	4.5
Conduct disorders	7.8	10.0	8.0	8.9	8.6
Hyperkinetic disorder	2.6	4.6	1.0	2.8	2.3
Less common disorders	1.2	3.6	1.5	1.8	1.8
Any disorder	13.6	16.7	11.5	14.2	13.4
<i>Base (weighted)</i>	<i>91</i>	<i>154</i>	<i>637</i>	<i>934</i>	<i>1816</i>
All Boys					
Emotional disorders	3.1	3.0	2.8	3.8	3.4
Conduct disorders	6.2	6.2	7.2	8.8	7.9
Hyperkinetic disorder	2.7	2.5	2.0	3.1	2.6
Less common disorders	1.3	2.4	1.9	2.4	2.2
Any disorder	11.0	10.7	10.9	13.1	12.0
<i>Base (weighted)</i>	<i>175</i>	<i>329</i>	<i>1258</i>	<i>1790</i>	<i>3552</i>
GIRLS					
5- to 10-year-olds					
Emotional disorders	2.9	2.5	2.6	2.8	2.7
Conduct disorders	1.7	0.9	2.5	3.7	2.9
Hyperkinetic disorder	-	-	0.2	0.7	0.4
Less common disorders	-	0.9	0.9	0.1	0.5
Any disorder	4.6	4.3	5.2	6.1	5.5
<i>Base (weighted)</i>	<i>84</i>	<i>161</i>	<i>589</i>	<i>818</i>	<i>1652</i>
11- to 16-year-olds					
Emotional disorders	3.5	6.5	7.2	6.6	6.7
Conduct disorders	3.7	2.7	6.6	4.8	5.2
Hyperkinetic disorder	1.9	-	0.3	0.2	0.3
Less common disorders	-	1.5	1.3	0.9	1.1
Any disorder	7.1	10.7	12.1	10.2	10.8
<i>Base (weighted)</i>	<i>62</i>	<i>172</i>	<i>606</i>	<i>850</i>	<i>1689</i>

Table 4.18 (contd)
Prevalence of mental disorders by region, age and sex, 2004

All children	Region				England
	London Inner	London Outer	Other Met England	Non-Met England	All England
<i>Percentage of children with each disorder</i>					
All Girls					
Emotional disorders	3.2	4.6	4.9	4.7	4.7
Conduct disorders	2.6	1.8	4.6	4.3	4.1
Hyperkinetic disorder	0.8	-	0.3	0.4	0.3
Less common disorders	-	1.2	1.1	0.5	0.8
Any disorder	5.7	7.6	8.7	8.2	8.2
<i>Base (weighted)</i>	<i>146</i>	<i>332</i>	<i>1194</i>	<i>1668</i>	<i>3341</i>
ALL					
5- to 10-year-olds					
Emotional disorders	2.1	1.9	2.5	2.6	2.4
Conduct disorders	3.1	1.9	4.5	6.2	5.0
Hyperkinetic disorder	1.4	0.4	1.6	2.0	1.7
Less common disorders	0.7	1.1	1.6	1.6	1.5
Any disorder	6.4	4.9	7.8	9.1	8.1
<i>Base (weighted)</i>	<i>169</i>	<i>335</i>	<i>1210</i>	<i>1674</i>	<i>3387</i>
11- to 16-year-olds					
Emotional disorders	4.3	5.8	5.2	5.9	5.5
Conduct disorders	6.2	6.2	7.3	7.0	7.0
Hyperkinetic disorder	2.3	2.2	0.7	1.6	1.4
Less common disorders	0.7	2.5	1.4	1.4	1.4
Any disorder	11.0	13.6	11.8	12.3	12.2
<i>Base (weighted)</i>	<i>153</i>	<i>325</i>	<i>1243</i>	<i>1784</i>	<i>3505</i>
All children					
Emotional disorders	3.1	3.8	3.8	4.3	4.0
Conduct disorders	4.5	4.0	5.9	6.6	6.0
Hyperkinetic disorder	1.8	1.3	1.1	1.8	1.5
Less common disorders	0.7	1.8	1.5	1.5	1.5
Any disorder	8.6	9.2	9.8	10.7	10.2
<i>Base (weighted)</i>	<i>321</i>	<i>661</i>	<i>2453</i>	<i>3458</i>	<i>6893</i>

Table 4.19

Prevalence of mental disorders by ACORN classification, age and sex, 2004

Great Britain						
ACORN classification						
	Wealthy Achievers	Urban prosperity	Comfortably off	Moderate Means	Hard pressed	All
<i>Percentage of children with each disorder</i>						
BOYS						
5- to 10-year-olds						
Emotional disorders	0.8	2.5	2.3	1.6	3.5	2.1
Conduct disorders	3.8	3.1	6.6	9.4	9.8	6.9
Hyperkinetic disorder	1.4	0.7	2.8	3.6	4.3	2.8
Less common disorders	1.1	2.8	2.2	3.0	2.4	2.2
Any disorder	5.5	7.3	9.3	13.3	14.4	10.1
<i>Base (weighted)</i>	<i>488</i>	<i>177</i>	<i>502</i>	<i>355</i>	<i>475</i>	<i>1998</i>
11- to 16-year-olds						
Emotional disorders	2.8	2.1	3.0	5.3	6.2	4.0
Conduct disorders	3.3	7.1	6.9	10.1	13.7	8.1
Hyperkinetic disorder	2.2	4.6	1.2	2.4	3.5	2.5
Less common disorders	1.7	0.8	1.7	1.5	1.6	1.6
Any disorder	8.3	11.0	10.3	15.1	19.0	12.7
<i>Base (weighted)</i>	<i>552</i>	<i>147</i>	<i>538</i>	<i>353</i>	<i>495</i>	<i>2085</i>
All Boys						
Emotional disorders	1.9	2.3	2.7	3.5	4.9	3.1
Conduct disorders	3.6	4.9	6.7	9.8	11.8	7.5
Hyperkinetic disorder	1.8	2.5	2.0	3.0	3.9	2.6
Less common disorders	1.4	1.9	2.0	2.3	2.0	1.9
Any disorder	7.0	9.0	9.8	14.2	16.8	11.5
<i>Base (weighted)</i>	<i>1041</i>	<i>324</i>	<i>1040</i>	<i>708</i>	<i>970</i>	<i>4083</i>
GIRLS						
5- to 10-year-olds						
Emotional disorders	1.4	2.2	2.1	2.4	3.7	2.4
Conduct disorders	0.9	1.3	1.8	2.6	6.3	2.8
Hyperkinetic disorder	0.4	-	0.5	-	0.7	0.4
Less common disorders	0.5	-	0.5	0.6	0.4	0.4
Any disorder	2.5	3.5	3.9	5.6	8.6	5.0
<i>Base (weighted)</i>	<i>462</i>	<i>151</i>	<i>481</i>	<i>327</i>	<i>477</i>	<i>1898</i>
11- to 16-year-olds						
Emotional disorders	4.5	3.6	5.9	7.8	8.0	6.2
Conduct disorders	1.8	4.6	4.0	6.1	9.8	5.1
Hyperkinetic disorder	0.2	-	0.3	0.7	0.5	0.4
Less common disorders	1.1	-	1.4	0.9	1.1	1.0
Any disorder	6.5	8.1	8.7	12.2	16.4	10.4
<i>Base (weighted)</i>	<i>517</i>	<i>144</i>	<i>526</i>	<i>315</i>	<i>434</i>	<i>1936</i>

Table 4.19 (contd)**Prevalence of mental disorders by ACORN classification, age and sex, 2004**

Great Britain						
ACORN classification						
	Wealthy Achievers	Urban prosperity	Comfortably off	Moderate Means	Hard pressed	All
<i>Percentage of children with each disorder</i>						
All Girls						
Emotional disorders	3.0	2.9	4.1	5.1	5.8	4.3
Conduct disorders	1.4	2.9	2.9	4.3	7.9	4.0
Hyperkinetic disorder	0.3	-	0.4	0.3	0.6	0.4
Less common disorders	0.8	-	0.9	0.8	0.7	0.7
Any disorder	4.6	5.7	6.4	8.8	12.3	7.7
<i>Base (weighted)</i>	<i>978</i>	<i>296</i>	<i>1007</i>	<i>641</i>	<i>911</i>	<i>3834</i>
ALL						
5- to 10-year-olds						
Emotional disorders	1.1	2.4	2.2	2.0	3.6	2.3
Conduct disorders	2.4	2.3	4.2	6.2	8.0	4.9
Hyperkinetic disorder	0.9	0.4	1.7	1.9	2.5	1.6
Less common disorders	0.8	1.5	1.4	1.8	1.4	1.3
Any disorder	4.1	5.5	6.7	9.6	11.5	7.6
<i>Base (weighted)</i>	<i>950</i>	<i>328</i>	<i>983</i>	<i>682</i>	<i>953</i>	<i>3896</i>
11- to 16-year-olds						
Emotional disorders	3.6	2.8	4.4	6.5	7.1	5.1
Conduct disorders	2.6	5.8	5.5	8.3	11.9	6.7
Hyperkinetic disorder	1.2	2.3	0.8	1.6	2.1	1.4
Less common disorders	1.4	0.4	1.6	1.3	1.4	1.3
Any disorder	7.4	9.6	9.5	13.7	17.8	11.6
<i>Base (weighted)</i>	<i>1069</i>	<i>292</i>	<i>1064</i>	<i>668</i>	<i>929</i>	<i>4021</i>
All children						
Emotional disorders	2.4	2.6	3.4	4.2	5.3	3.7
Conduct disorders	2.5	4.0	4.9	7.2	9.9	5.8
Hyperkinetic disorder	1.1	1.3	1.2	1.7	2.3	1.5
Less common disorders	1.1	1.0	1.5	1.6	1.4	1.3
Any disorder	5.8	7.4	8.2	11.7	14.6	9.6
<i>Base (weighted)</i>	<i>2019</i>	<i>619</i>	<i>2047</i>	<i>1350</i>	<i>1881</i>	<i>7916</i>

Table 4.20**Odds Ratios for socio-demographic correlates of mental disorders, 2004**

All children							Great Britain	
Variable	Emotional disorders		Conduct disorders		Hyperkinetic disorders		Any disorder ¹	
	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.
Age	NS							
5–10	1.00		1.00				1.00	
11–15	2.28***	(1.71–3.03)	1.62***	(1.29–2.03)			1.73***	(1.45–2.07)
Sex								
Female	1.00		1.00		1.00		1.00	
Male	0.70**	(0.54–0.90)	1.91***	(1.52–2.40)	6.10***	(3.39–10.99)	1.52***	(1.28–1.80)
Ethnic group	NS							
White			1.00				1.00	
Black Caribbean			0.36				0.58	
Black African			0.01				0.11*	(0.02–0.79)
Indian			0.13*	(0.02–0.96)			0.21**	(0.07–0.67)
Pakistani			0.37*	(0.15–0.95)			0.47*	(0.24–0.92)
Bangladeshi			0.31				0.38	
Mixed			1.01				1.08	
Other			0.31				0.36	
Family type	NS							
Married	1.00		1.00				1.00	
Cohabiting	1.50		1.09				1.20	
Lone parent – single	1.71*	(1.03–2.86)	1.34				1.23	
Lone parent–previously married	2.48***	(1.68–3.68)	1.59**	(1.14–2.22)			1.75***	(1.35–2.26)
Reconstituted families	NS							
No stepchildren			1.00				1.00	
Stepchildren present			1.92***	(1.37–2.69)			1.52**	(1.16–2.00)
Family's employment								
Neither parent working	1.00		1.00		1.00		1.00	
One parent working	0.85	0.68*	(0.46–1.00)		0.47		0.74	
Both parents working	0.56**	(0.39–0.81)	0.51***	(0.38–0.70)	0.47*	(0.26–0.85)	0.61***	(0.48–0.79)
Weekly household income								
More than £600	NS		1.00		1.00		1.00	
Between £400–£600			1.27		2.12*	(1.10–4.05)	1.3*	(1.0–1.69)
Less than £400			1.79**	(1.24–2.60)	1.88		1.46**	(1.11–1.93)
Parent's educational qualifications	NS							
Any qualification	1.00		1.00				1.00	
No qualification	1.52**	(1.11–2.07)	1.43**	(1.10–1.84)			1.55***	(1.26–1.91)

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Variables which were not significant predictors of the disorder are denoted as 'NS'.

Confidence intervals are shown only for categories that were significantly different from the reference category (ie the category with an odds ratio of 1.00).

1. Includes less common disorders not shown in the table.

Table 4.20 (contd)

Odds Ratios for socio-demographic correlates of mental disorders

All children		Great Britain 2004							
Variable	Emotional disorders		Conduct disorders		Hyperkinetic disorders		Any disorder ¹		
	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	
ACORN Group	NS				NS				
Wealthy achievers			1.00				1.00		
Urban prosperity			1.14				1.10		
Comfortably off			1.63*	(1.10–2.42)			1.26		
Moderate means			2.13***	(1.40–3.23)			1.74***	(1.29–2.35)	
Hard pressed			2.10***	(1.41–3.13)			1.64***	(1.23–2.18)	
Country	NS				NS				
England				1.00				1.00	
Scotland				0.80				0.77	

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Variables which were not significant predictors of the disorder are denoted as 'NS'.

Confidence intervals are shown only for categories that were significantly different from the reference category (ie the category with an odds ratio of 1.00).

1. Includes less common disorders not shown in the table.

Table 4.21**Odds ratios for socio-demographic correlates of emotional disorders, 2004**

All children					Great Britain	
	Anxiety disorders		Depressive disorders		All emotional disorders	
Variable	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.	Adjusted Odds ratio	95% C.I.
Age						
5–10	1.00		1.00		1.00	
11–16	2.07***	(1.53–2.79)	6.20***	(2.89–13.3)	2.28***	(1.71–3.03)
Sex						
Female	1.00		1.00		1.00	
Male	0.75*	(0.57–0.99)	0.51*	(0.30–0.88)	0.70**	(0.54–0.90)
Family type						
Married	1.00		1.00		1.00	
Cohabiting	1.66*	(1.02–2.73)	0.97		1.50	
Lone parent – single	1.74*	(1.01–2.99)	1.75		1.71*	(1.03–2.86)
Lone parent – previously married	2.55***	(1.68–3.86)	2.83**	(1.28–6.28)	2.48***	(1.68–3.68)
Family’s employment						
Neither parent working	1.00		1.00		1.00	
One parent working	0.9		0.87		0.85	
Both parents working	0.56**	(0.38–0.83)	0.40*	(0.19–0.85)	0.56**	(0.39–0.81)
Parent’s educational qualifications			NS			
Any qualification	1.00				1.00	
No qualification	1.50*	(1.08–2.08)			1.52**	(1.11–2.07)

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Variables which were not significant predictors of the disorder are denoted as 'NS'.

Confidence intervals are shown only for categories that were significantly different from the reference category (ie the category with an odds ratio of 1.00).

1. Includes less common disorders not shown in the table.

Chapter 5

Emotional disorders

Introduction

This chapter begins by describing the types of behaviour patterns typically found among children and young people who have an emotional disorder. It goes on to describe the characteristics of these children and young people, looking at their:

- demographic characteristics;
- family situation;
- socio-economic characteristics;
- geographic distribution;
- general, physical and mental health;
- use of services;
- scholastic ability and attendance at school;
- family's social functioning;
- their own social functioning; and
- lifestyle behaviours.

As Chapter 4 noted, there was little change between 1999 and 2004 in the prevalence rates of emotional disorders among children and young people, either overall or within different subgroups. It is therefore possible to combine the two sets of data so as to increase the sample base. This allows us to analyse the larger subcategories of emotional disorders:

- Separation anxiety.
- Specific phobia.
- Social phobia.
- Generalised anxiety disorder.
- Depression.

The remaining subgroups (Panic, Agoraphobia, Post-traumatic Stress disorder, Obsessive Compulsive Disorder and Other anxiety disorders) are too small for separate analysis and are not shown as separate categories in the tables. However, they are included in the 'Any emotional disorder' total.

As far as possible, the same questions and classifications were used in both the 1999 and the 2004 surveys. However, some changes were necessary to improve the questions or to cover new topics. In these cases, data are presented for 2004 only and hence the bases in some subgroups are very small. We have not commented on the characteristics of these very small groups.

Within each topic, the text generally follows the same pattern: first, children with any form of emotional disorder are compared with those who have no such disorder; then, any variations from the overall pattern within the subcategories of emotional disorders are reported. The shaded boxes summarise

the main features of the group as a whole followed by those for each subgroup including any characteristics on which they differ from the overall pattern. The commentary is descriptive, the aim being to provide a profile of children who have different types of emotional disorder. It therefore takes no account of the inter-relationships between the characteristics. The analysis at the end of Chapter 4 described the factors which had the largest independent effects on prevalence and this gives an indication of the key variables.

Typical behaviour patterns

A description of typical symptoms displayed by children with different types of emotional disorders is given below. As noted in Chapter 2, many children display the symptoms listed to some degree. To count as a disorder symptoms 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

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

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

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.

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 usual 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.

Demographic, socio-economic and area characteristics

Demographic characteristics

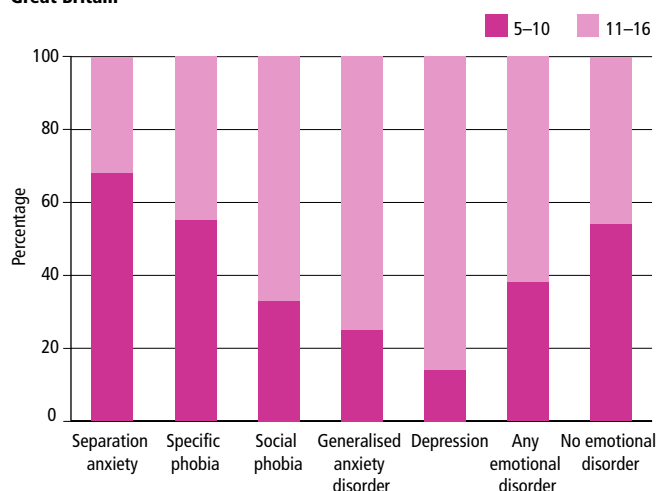
Children with an emotional disorder were more likely to be girls and more likely to be aged 11–16 than those with no such disorder (54 per cent compared with 49 per cent and 62 per cent compared with 46 per cent). Within the emotional disorder subgroups, the generalised anxiety category contained a particularly high proportion of girls compared with children with no emotional disorder (59 per cent). The preponderance of older children was evident in most subgroups. However, as might be expected, those with separation anxiety tended to be young: 68 per cent were aged 5–10. There were no ethnic variations between children who had and those who had no emotional disorders. (Figure 5.1 and Table 5.1)

Family characteristics

Children with emotional disorders were twice as likely as those with no such disorder to live with a widowed, divorced or separated lone parent (31 per cent compared with 15 per cent). Conversely, they were much less likely to live in a married couple household (51 per cent compared with 69 per cent).

Figure 5.1
Age by type of emotional disorder, 1999 and 2004 combined

Great Britain

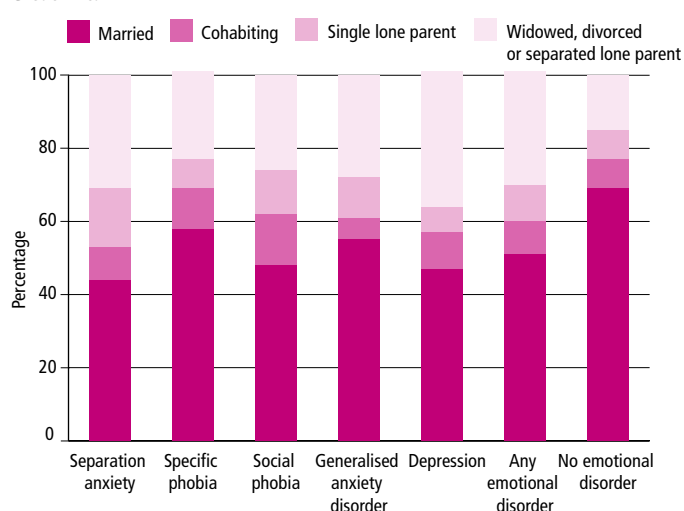


This pattern was evident across all types of disorder. Among children with separation anxiety, the proportion living with a single lone parent was also relatively high, 16 per cent compared with 8 per cent among children with no emotional disorder. (Figure 5.2 and Table 5.2)

Children with an emotional disorder tended to have more siblings than other children: 37 per cent of the former lived in households with three or more other children compared with 32 per cent of the latter. However, only those with generalised anxiety disorder were more likely to live in a family containing stepchildren, 19 per cent compared with 11 per cent among children with no emotional disorder. (Table 5.2)

Figure 5.2
Family type by type of emotional disorder, 1999 and 2004 combined

Great Britain



Parental education and socio-economic characteristics

Children with an emotional disorder were more likely than other children to have parents with no educational qualifications and to live in low-income families.

Over a third (35 per cent) of children with an emotional disorder had parents who had no educational qualifications compared with only a fifth (20 per cent) of those with no such disorder. The same variation occurred in all the subgroups.

(Table 5.3)

Children with an emotional disorder were twice as likely as other children to live in households in which neither parent was working (30 per cent compared with 14 per cent). Conversely, only a half (51 per cent) lived in households with both parents working compared with two-thirds (68 per cent) of children with no such disorder. Likewise, with respect to the socio-economic classification of the household reference person: 48 per cent of the children with an emotional disorder had a parent in the semi-routine or routine occupational group compared with 38 per cent of other children.

(Table 5.3)

Housing and income

The economic disadvantages of children with an emotional disorder are also reflected in housing and income differentials. Only a half (49 per cent) lived in owned accommodation compared with over two-thirds (70 per cent) of other children. Similarly, over a half (54 per cent) of children with an emotional disorder lived in households with gross incomes under £300 per week whereas only a third (33 per cent) of other children were in this position.

One-fifth of children with an emotional disorder lived in households in which someone received a disability benefit (20 per cent compared with 8 per cent for other children).

(Table 5.4)

Area characteristics

The tendency for children with an emotional disorder to live in less affluent circumstances than other children was also evident from the type of area in which they lived. One third (34 per cent) lived in areas classified (by ACORN) as 'Hard pressed' compared with less than a quarter (23 per cent) of children with no emotional disorder.

(Table 5.5)

The trend for children with emotional disorders to live in less affluent households prevailed in all subgroups. In general, differences between the subgroups were not statistically significant. However, there was a fairly consistent pattern for children with separation anxiety to live in the poorest economic

circumstances across a range of measures. Thus, 62 per cent lived in households with gross incomes of less than £300 per week, 34 per cent had neither parent working and 45 per cent

lived in areas classified as 'Hard pressed'. This is mainly because a relatively high proportion of these children lived in one parent families. (Tables 5.3 – 5.5)

Among children with emotional disorders:

- 54 per cent were girls (*compared with 49 per cent for children with no emotional disorder*)
- 62 per cent were aged 11–16 (*46 per cent*)
- 31 per cent lived with a widowed, divorced or separated lone parent (*15 per cent*)
- 51 per cent lived in a married couple family (*69 per cent*)
- 37 per cent lived in households containing 3 or more children (*32 per cent*)
- 35 per cent had parents with no educational qualifications (*20 per cent*)
- 49 per cent lived in owned accommodation (*70 per cent*)
- 54 per cent lived in households with gross incomes under £300 per week (*33 per cent*)
- 20 per cent lived in households in which someone received a disability benefit (*8 per cent*)
- 34 per cent lived in areas classified as 'Hard pressed' (*23 per cent*)

Among children with separation anxiety:

- 49 per cent were girls
- 32 per cent were aged 11–16
- 31 per cent lived with a widowed, divorced or separated lone parent and 16 per cent lived with a single lone parent
- 62 per cent lived in households with gross incomes under £300 per week

Among children with specific phobias:

- 52 per cent were girls
- 45 per cent were aged 11–16
- 24 per cent lived with a widowed, divorced or separated lone parent
- 49 per cent lived in households with gross incomes under £300 per week

Among children with social phobias:

- 47 per cent were girls
- 67 per cent were aged 11–16
- 26 per cent lived with a widowed, divorced or separated lone parent and 14 per cent lived in a cohabiting couple family
- 45 per cent had a parent with no educational qualifications
- 44 per cent lived in households with gross incomes under £300 per week

Among children with generalised anxiety disorders:

- 59 per cent were girls
- 75 per cent were aged 11–16
- 28 per cent lived with a widowed, divorced or separated lone parent
- 19 per cent lived in a family containing stepchildren
- 51 per cent lived in households with gross incomes under £300 per week

Among children with depression:

- 57 per cent were girls
- 86 per cent were aged 11–16
- 37 per cent lived with a widowed, divorced or separated lone parent
- 57 per cent lived in households with gross incomes under £300 per week

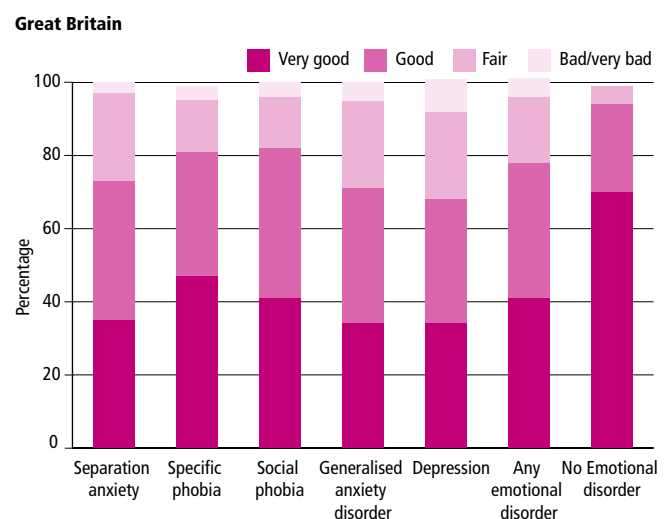
Child's general, physical and mental health

General 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).

(Figure 5.3 and Table 5.6)

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



Physical and developmental problems

Parents of children with an emotional disorder were also more likely than other parents to report that their child had a specific complaint (72 per cent and 53 per cent). The largest differences were for: asthma (23 per cent and 14 per cent), stomach or digestive problems (14 per cent and 5 per cent) and migraine or severe headaches (12 per cent and 4 per cent). (Table 5.7)

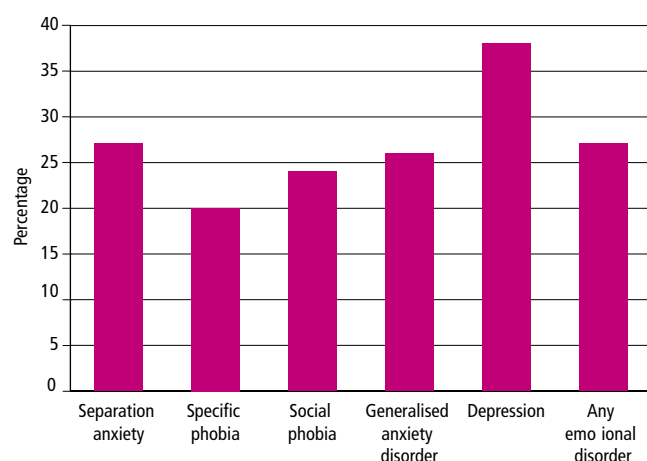
The poorer general health of children with emotional disorders was evident in all subgroups as was their greater propensity to report specific complaints. There were, however, no differences between the subgroups nor any consistent pattern of variation across the complaints.

Mental disorders

A substantial minority (27 per cent) of children with an emotional disorder also suffered from another of the main types of clinically recognisable mental disorder, most commonly conduct disorder (23 per cent). In most subgroups, children with emotional disorders who were also diagnosed with a conduct disorder generally had oppositional defiant disorder. However, among those with depression and a conduct disorder, the majority had some other form of conduct disorder (26 per cent). (Figure 5.4 and Table 5.8)

Fig re 5.4
Proportion of children with an emotional disorder who had another type of mental disorder, 1999 and 2004 combined

Great Britain



Parents were asked whether their child had any emotional problems, behavioural problems or hyperactivity. As would be expected, the parents of children with an emotional disorder were much more likely than other parents to report such problems (40 per cent compared with 9 per cent) but still less than a third (29 per cent) considered that their child had emotional problems. Almost as many, 23 per cent, mentioned behavioural problems – the same proportion as were clinically assessed as having a conduct disorder as well. Ten per cent considered that their child was hyperactive but only 4 per cent were clinically assessed as such. The low reporting rate for emotional problems among the parents of the children classified as having such disorders probably occurs because the symptoms have less impact on other family members and are less readily observable than behavioural problems and hyperkinesis. And, of course, parents do not classify symptoms in the same way as professionals. (Table 5.9)

Medication

The survey data suggests that there is no evidence that psychotropic drugs are being prescribed inappropriately for children with emotional disorders. First, the use of such medication is by no means widespread and rarely involves young children. Only seven per cent of the children with an emotional disorder were taking any form of medication at the time of interview and this includes 3 per cent who were taking Methylphenidate, all of whom had another type of disorder, usually hyperkinesis. Nearly three-quarters of all children on medication were aged 10 or over. Second, only one child with an emotional disorder was taking a tricyclic antidepressant whose effectiveness has not been proved for this group. And third, the Committee on the Safety of Medicines recommends that the only antidepressant that should be taken by children under 18 with depression is Fluoxetine. In fact, only three children with emotional disorders were taking this, all of whom had depression and only four children were taking other SSRI (selective serotonin re-uptake inhibitors) antidepressants (Citalopram/Cimpramil), of whom two had depression. (Table 5.10)

Among the parents of children with emotional disorders:

- 23 per cent reported that the child's general health was fair or bad (*compared with 5 per cent for children with no emotional disorder*)
- 72 per cent reported that the child had a specific physical or developmental problem (*53 per cent*)
- 23 per cent reported that the child suffered from asthma, 14 per cent reported stomach and digestive problems and 12 per cent reported migraine or severe headaches (*14 per cent, 5 per cent and 4 per cent*)
- 40 per cent reported that the child had mental health problems (*9 per cent*)
- 29 per cent reported that the child had emotional problems, 23 per cent reported behavioural problems and 10 per cent reported hyperactivity (*3 per cent, 5 per cent and 3 per cent*)
- 27 per cent of the children had another main type of clinically recognisable disorder (*5 per cent*)

Among the parents of children with separation anxiety:

- 27 per cent reported that the child's general health was fair or bad
- 80 per cent reported that the child had a physical or developmental problem
- 44 per cent reported that the child had mental health problems
- 27 per cent of the children had another main type of clinically recognisable disorder

Among the parents of children with specific phobias:

- 18 per cent reported that the child's general health was fair or bad
- 72 per cent reported that the child had a physical or developmental problem
- 29 per cent reported that the child had mental health problems
- 20 per cent of the children had another main type of clinically diagnosed disorder

Among the parents of children with social phobias:

- 18 per cent reported that the child's general health was fair or bad
- 73 per cent reported that the child had a physical or developmental problem
- 40 per cent reported that the child had mental health problems
- 24 per cent of the children had another main type of clinically recognisable disorder

Among the parents of children with generalised anxiety disorders:

- 29 per cent reported that the child's general health was fair or bad
- 73 per cent reported that the child had a physical or developmental problem
- 54 per cent reported that the child had mental health problems including 39 per cent who considered that the child had emotional problems
- 26 per cent of the children had another main type of clinically recognisable disorder

Among the parents of children with depression:

- 32 per cent reported that the child's general health was fair or bad
- 73 per cent reported that the child had a physical or developmental problem
- 53 per cent reported that the child had mental health problems including 40 per cent who considered that the child had emotional problems
- 38 per cent of the children had another main type of clinically recognisable disorder including 33 per cent who had a conduct disorder

Use of services

Parents were asked whether, in the last year, they had had contact with a range of specialist and non-professional services because they were worried about their child's emotions, behaviour or concentration. These questions were new for 2004. In the previous survey, the questioning covered different services and was directed only at those for whom significant problems had been reported in the interview. The questions in the 2004 survey were asked about all children.

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. The corresponding proportions for children with no disorder were 26 per cent and 21 per cent. (Table 5.11)

Teachers were the most commonly used source, contacted by nearly a half (47 per cent) of the parents of children with an emotional disorder. Next were family members and friends (34 per cent) and primary health care professionals, such as GPs and practice nurses, (29 per cent). About a quarter (24 per cent) had contacted, or been referred to, a mental health service, usually a specialist in children's mental health. This group includes a small number, 2 per cent, who used a specialist in adult mental health. (Table 5.11)

Among the parents of children with emotional disorders:

- 73 per cent had sought help or advice in the last year because of worries about their child's mental health (compared with 26 per cent for children with no emotional disorder)
- 64 per cent had contacted a professional service (21 per cent)
- The most commonly used services were: teachers (47 per cent), family members or friends (34 per cent), primary health care (29 per cent) and mental health specialists (24 per cent)

Parents who had mentioned a problem with their child's emotions, attention or behaviour during the course of the interview and who had not seen a specialist were asked whether there was anything that had stopped them seeking such help. They were shown a card listing various obstacles that they might have encountered. Fewer than a third (30 per cent) had had any of the problems prompted and there were no differences between those whose children had a clinically diagnosed emotional disorder and other parents in this respect. Overall, the most common obstacles mentioned were a belief that a specialist would not be able to help (8 per cent), lack of awareness of the services available (7 per cent) and difficulty getting a referral (5 per cent). The latter two problems were also mentioned by those who were actually seeing a specialist (12 per cent and 10 per cent overall). (Tables not shown)

As these questions were based on 2004 data only, the bases for many of the subcategories of emotional disorder are small and summary boxes for types of emotional disorder have therefore not been presented.

Scholastic ability and attendance at school

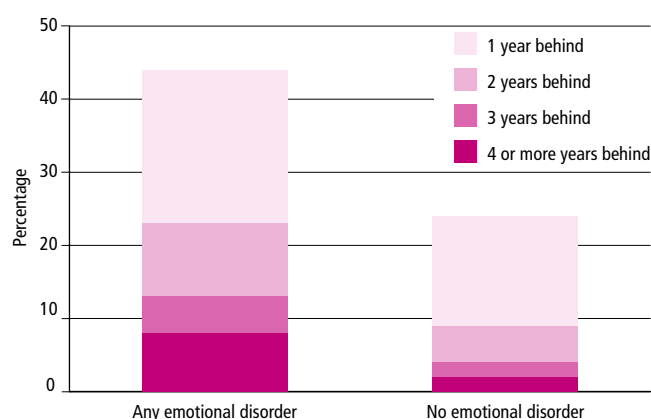
Teachers were asked to rate the child's abilities in reading, mathematics and spelling compared with an average child of the same age and to estimate at what age the child was in terms of their scholastic ability. They were also asked to say whether the child had officially recognised special educational needs.

Basic skills

Children with emotional disorders were more likely than other children to be rated as having difficulty on each of the three skills assessed: 40 per cent had difficulty with reading, 45 per cent with mathematics and 46 per cent with spelling. For children with no emotional disorder, the proportions were 23 per cent, 24 per cent and 30 per cent. Likewise, with respect to

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



overall scholastic ability, as measured by subtracting the child's actual age from their functioning age: 44 per cent of those with an emotional disorder were behind in their overall intellectual development and 13 per cent were more than 2 years behind compared with 24 per cent and 4 per cent of other children. (Figure 5.5 and Table 5.12)

Looking at specific emotional disorders, differences on basic skills were generally not statistically significant and there was no difference between any of the groups on overall ability.

(Table 5.12)

Special educational needs

Teachers reported that one in six children (17 per cent) had officially recognised needs, the same proportion as reported by the Department for Education and Skills for England (January 2004). Children with an emotional disorder were twice as likely as other children to be in this position (35 per cent compared with 16 per cent). Among the former, children with separation anxiety were most likely to have special educational needs (51 per cent) (Table 5.13)

Nearly a half (47 per cent) of all children with special needs had a written statement but there was no difference between those with, and those with no emotional disorder in this respect. (Based on 2004 data, Table not shown)

Absence from school

The majority of children had had some time away from school in the previous term but those with an emotional disorder were more likely to have been absent than other children (81 per cent compared with 68 per cent). The former were also away for longer periods – 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.

(Table 5.14)

It was noted earlier, that children with emotional disorders had poorer general health than other children and at least some of these absences will have been health related. In 2004, teachers were asked specifically about unauthorised absences. Children with emotional disorders were more than twice as likely as other children to have had these (21 per cent compared with 9 per cent). (Table not shown)²

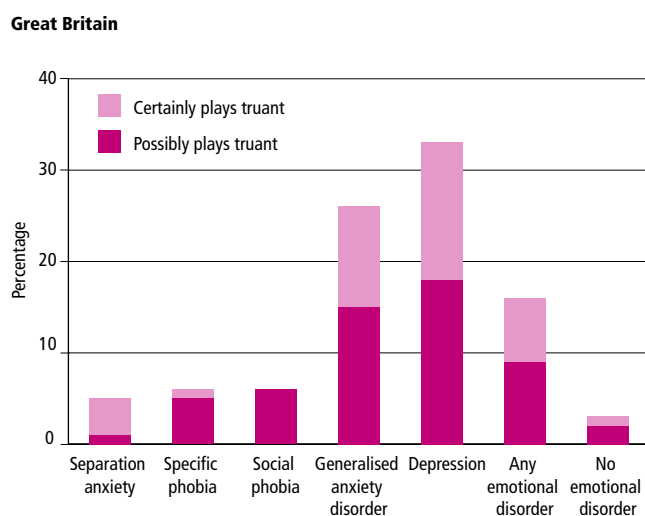
Further evidence that some of the time away from school was unofficial comes from information on truancy. Teachers reported that one in six children (16 per cent) with an emotional disorder certainly or possibly played truant. For other children the proportion was only 3 per cent. (Table 5.14)

Children with generalised anxiety disorder and those with depression had the most days away from school – a quarter (25 per cent and 26 per cent) had had more than 15 days absence in the previous term. At least some of this time off was probably unauthorised – these groups were much more likely than other children to be considered definite or possible truants (26 per cent and 33 per cent).

(Figure 5.6 and Table 5.14)

In 2004, parents were asked about exclusions from school and other absences. Looking first at the latter, the parents' reports

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



follow the same pattern as those of the teachers: over a half (54 per cent) of children with an emotional disorder had missed school for reasons other than exclusion in the previous term compared with a third (33 per cent) of other children.

(Table 5.15)

We would not expect the parents' data to match the teachers' reports because the latter were asked about all absences (including exclusions and trancies of which the parent might not be aware) and the figures in Tables 5.14 and 5.15 relate to different populations.

Among both groups of children, the most common reason for absence was illness, mentioned by three-quarters (78 per cent) of the parents of children who had been absent in the previous term. However, among the parents of those with an emotional disorder who had been absent, 15 per cent said that the child had refused to attend school or had a school phobia compared with only 2 per cent of other parents. One tenth (10 per cent) of the children who had been absent from school had received some form of educational provision and there were no differences between children with and those with no emotional disorder in this respect.

(Table 5.15)

Turning to exclusions from school, children with an emotional disorder were more likely than other children to have been excluded (12 per cent compared with 4 per cent) and 5 per cent had been excluded on three or more occasions. However, two-thirds of those excluded had another disorder, mainly conduct disorder. Among all excluded children, the majority of exclusions were fixed term but those with an emotional disorder were the more likely to have had some form of help following their exclusion (36 per cent compared with 14 per cent). (Tables not shown).

(Table 5.16)

Among children with emotional disorders:

- 44 per cent were behind in their overall intellectual development (*compared with 24 per cent for children with no emotional disorder*)
- 35 per cent had officially recognised special educational needs (*16 per cent*)
- 43 per cent had more than 5 days away from school in the previous term and 17 per cent had had more than 15 days absence (*21 per cent and 4 per cent*)
- 16 per cent were considered by teachers to be definite or possible truants (*3 per cent*)
- 12 per cent had been excluded from school and 30 per cent had changed schools apart from normal transitions (*4 per cent and 19 per cent*)

2. The bases are too small to show a detailed breakdown.

Among children with separation anxiety:

- 44 per cent were behind in their overall intellectual development
- 51 per cent had officially recognised special educational needs
- 44 per cent had had more than 5 days away from school in the previous term and 14 per cent had had more than 15 days absence
- 5 per cent were considered by teachers to be definite or possible truants

Among children with specific phobias:

- 34 per cent were behind in their overall intellectual development
- 32 per cent had officially recognised special educational needs
- 36 per cent had had more than 5 days away from school in the previous term and 12 per cent had had more than 15 days absence
- 6 per cent were considered by teachers to be definite or possible truants

Among children with generalised anxiety disorders:

- 41 per cent were behind in their overall intellectual development
- 31 per cent had officially recognised special educational needs
- 56 per cent had had more than 5 days away from school in the previous term and 25 per cent had had more than 15 days absence
- 26 per cent were considered by teachers to be definite or possible truants

Among children with depression:

- 46 per cent were behind in their overall intellectual development
- 27 per cent had officially recognised special educational needs
- 65 per cent had had more than 5 days away from school in the previous term and 26 per cent had had more than 15 days absence
- 33 per cent were considered by teachers to be definite or possible truants

(Figures for children with social phobias are not shown because of the small base)

Another indicator of interrupted schooling is given by the number of times a child has changed school apart from the normal transitions between primary, junior and secondary school. Again, this was more common among those with an emotional disorder – 30 per cent had changed schools compared with 19 per cent of other children. This variation was not attributable to the higher rate of exclusions among those with an emotional disorder since none of these children had changed schools following their exclusion. (Table 5.17)

Social functioning of the family

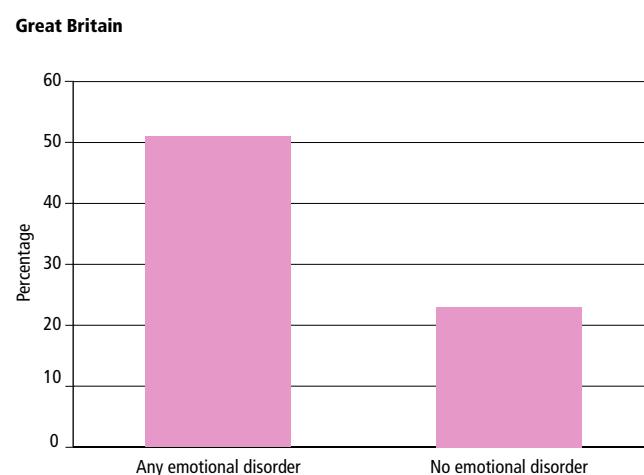
This section looks at various aspects of parental health, attitudes and behaviour which provide indicators of the social functioning of the family.

Mental health of parent

The parent who was interviewed about the child's behaviour, usually the mother, was asked about her own mental health using the General Health Questionnaire (GHQ-12 –see Chapter 2 for details). Scores range from 0 (no psychological distress) to 12 (severe psychological distress). A score of 3 is generally taken as the threshold with scores at this level or higher being considered indicative of an emotional disorder.

Overall, about one quarter of parents scored at or over the threshold which is similar to the proportion usually found in general population surveys. However, parents of children with an emotional disorder were more than twice as likely to have a score of 3 or more (51 per cent compared with 23 per cent among other parents). Almost one in five had very high scores of 9–12 (18 per cent compared with 4 per cent). This pattern occurred in all the disorder subgroups, the proportion scoring at or over the threshold ranging from 44 per cent among the

Figure 5.7
Proportion of children whose parent scored 3 or more on the GHQ-12, 1999 and 2004 combined



parents of children with a specific phobia to 61 per cent among the parents of those with depression.

(Figure 5.7 and Table 5.18)

Family functioning

Family functioning was measured using the FAD-GFS scale in which parents rated 12 statements about family relationships (see Chapter 2 for details). For this survey, families which scored over 2.00 on this scale were considered to have unhealthy family functioning.

One-third (33 per cent) of families containing children with an emotional disorder were assessed as having unhealthy functioning on this measure. Among other families, the proportion was 18 per cent. The functioning scores were relatively high for families with children in all the disorder subgroups except for those in which the child had a social phobia.

(Table 5.19)

Stressful life events

It has been suggested (Goodyer, 1990) that moderately or highly undesirable life events can cause the onset of emotional and behavioural symptoms in children of school age. Parents were asked whether their child had experienced any of 10 potentially stressful events. The list in the 2004 survey was slightly different to that used in 1999 so the data are presented for 2004 only.

Children with emotional disorders were more likely than other children to have experienced each of the 10 events listed. Over a half (55 per cent) had experienced their parents' separation and over a quarter (28 per cent) had a parent who had had a serious mental illness. For other children the proportions were 30 per cent and 7 per cent. Looking at the number of stressful life events, children with an emotional disorder were more than twice as likely as other children to have had two or more stressful events (59 per cent compared with 25 per cent)

(Tables 5.20 and 5.21)

Child's social functioning

A large part of the interview was concerned with various types of problems that children experienced. For 2004, new questions were introduced to examine the child's strengths, the rationale being that these might provide protection against the onset and course of mental disorder as well as providing parents with the opportunity to describe their child's good points. The section goes on to discuss other features of social functioning which might also affect the child's resilience: their relationships with friends, their social aptitudes and various measures of social capital.

Most of the findings presented in this section are based on new questions in the 2004 survey. The bases for the disorder subgroups are quite small and the commentary and summary boxes therefore focus on the differences between children with any emotional disorder and other children.

Strengths

Both parents and young people were asked to rate the child on a series of items covering various qualities (see Chapter 2 for details). Scores on the adult scale ranged from 0–48 and those on the children's scale ranged from 0–38. Table 5.22 shows the scores on each scale grouped into quartiles. Looking first at the parent's assessment, children with an emotional disorder were more than twice as likely as other children to have scores in the lowest quartile, 58 per cent compared with 24 per cent. The children's scale did not include all the items on the parent's scale and was asked only of young people aged 11–16 so the

Among children with emotional disorders:

- 51 per cent of parents had an emotional disorder (compared with 23 per cent for the parents of children with no emotional disorder)
- 33 per cent lived in families with unhealthy functioning (18 per cent)
- 59 per cent had had two or more stressful life events (25 per cent)

Among children with separation anxiety:

- 56 per cent of parents had an emotional disorder
- 37 per cent lived in families with unhealthy functioning
- 47 per cent had had two or more stressful life events

Among children with specific phobias:

- 44 per cent of parents had an emotional disorder
- 29 per cent lived in families with unhealthy functioning
- 49 per cent had had two or more stressful life events

Among children with social phobias:

- 50 per cent of parents had an emotional disorder
- 23 per cent lived in families with unhealthy functioning (Stressful life event figures omitted because of small base)

Among children with generalised anxiety disorders:

- 59 per cent of parents had an emotional disorder
- 36 per cent lived in families with unhealthy functioning
- 63 per cent had had two or more stressful life events

Among children with depression:

- 61 per cent of parents had an emotional disorder
- 43 per cent lived in families with unhealthy functioning
- 67 per cent had had two or more stressful life events

scores are not directly comparable. However, the proportions scoring in the lowest quartile showed the same pattern as for the parent's assessment but the differential was much smaller, 34 per cent of young people with an emotional disorder were in this quartile compared with 23 per cent of other young people. (Table 5.22)

Social aptitude

The social aptitude scale consisted of 10 questions addressed to parents designed to measure the child's ability to empathise with others (see Chapter 2 for details). Scores ranged from 0–40 and were grouped into quartiles. Those with an emotional disorder were again twice as likely as other children to have a score in the lowest quartile (48 per cent compared with 24 per cent) (Table 5.23)

Social capital

'Social capital' is a multi-faceted concept which has been defined as 'networks together with shared norms, values and understandings that facilitate co-operation within and among groups' (Cote and Healey, 2001). It is believed that high levels of social capital have a positive effect on health. The aspects of social capital covered in this report are:

- relationships with friends;
- social support;
- views about the neighbourhood;
- help provided to others; and
- participation in clubs and groups.

Many of the questions are taken from the children and young person modules included in the 2003 Home Office Citizenship Survey. The questions on friends were asked of all parents. The remaining topics were asked of young people aged 11 or over only because previous research has shown that younger children were not able to cope with some of the more complex questioning. The analysis of these questions is not presented for the subcategories of emotional disorders because of the small bases.

Relationships with friends

Questions on friendships were asked of the interviewed parent and covered:

- the child's ability to make and keep friends;
- number of friends;
- common interests and shared activities;
- emotional support; and
- parent's approval of child's friends.

On the first three measures, children with an emotional disorder were four times as likely as those with no disorder to

have a negative assessment. For example, among the former, 35 per cent found it harder than average to make friends, 22 per cent found it harder to keep friends, and 11 per cent did not engage in shared activities. For other children, the proportions were 9 per cent, 5 per cent and 3 per cent. Similarly, 20 per cent of children with an emotional disorder had fewer than two friends compared with only 5 per cent of other children. The ratio was smaller in relation to whether the child could talk things over with a friend if they were worried: 29 per cent of the children with an emotional disorder had no such confidante compared with 21 per cent of other children. (Table 5.24)

The parents of children with an emotional disorder were less likely to give their full approval to their child's friends: 35 per cent said that they did not approve at all or only approved a little compared with 15 per cent of other parents. Likewise, the former were more likely to say that many or all of their child's friends got into trouble, 7 per cent compared with 1 per cent. (Table 5.24)

Social support

This scale, completed by young people aged 11–16, was designed to assess the extent of the network of family and friends to whom they felt close. Scores ranged from 0 to 20 and were grouped into rough quartiles. Those with an emotional disorder were one and a half times as likely as other young people to have a score in the lowest quartile (42 per cent compared with 27 per cent). (Table 5.25)

Views about the neighbourhood

Young people with an emotional disorder were more likely than other young people to express negative views about their neighbourhood. For example, 23 per cent did not enjoy living there, 18 per cent felt unsafe walking alone in the daytime, 37 per cent felt that few or none of their neighbours could be trusted and 62 per cent thought it unlikely that a lost bag would be returned. The proportions among other young people were much lower: 7 per cent, 6 per cent, 17 per cent and 42 per cent. (Table 5.26)

It may be that the nature of the young people's disorders coloured their attitudes, leading them to be, for example, more despondent about their surroundings or more fearful about safety. However, we noted earlier that a relatively high proportion of children with emotional disorders lived in areas classified (by ACORN) as 'Hard pressed' so it may be that their views partly reflect the type of neighbourhood in which they lived. Further analysis showed, however, that the variation persisted within each type of area. (Table not shown)

Help provided to others

Young people were asked separately about types of help that they provided to relatives and non-relatives. Almost all young people gave help to relatives but those with an emotional disorder were more likely than others to give help to non-relatives (52 per cent compared with 39 per cent). The former were more likely to give most of the different types of help specified. Of particular interest are the proportions who looked after a sick relative – 42 per cent compared with 33 per cent. As was discussed earlier, children with an emotional disorder were the more likely to have had a parent with a mental disorder and it may be that some of the young people were providing care for them. Among those who gave help, 76 per cent provided help to relatives at least once a week and there was no difference between those with and those with no emotional disorder in this respect. However, among those helping non-relatives, young people with an emotional disorder provided help more frequently – 51 per cent helped at least once a week compared with 37 per cent of other young people. (Table 5.27)

There were no differences between young people with and those with no emotional disorder in the proportions who received payment for helping non-relatives – overall 63 per cent were sometimes or always paid. Thus, the greater propensity of young people with a disorder to help others is not due to the poorer financial situations of their families. (Table not shown). There were also no differences in the proportion doing regular paid work (that is, at least once a month) – 22 per cent overall. (Table 5.28)

Participation in groups, clubs and organisations

Young people with an emotional disorder were less likely than other young people to have taken part in a group, club or organisation in the last year: 68 per cent compared with 79 per cent had taken part in a school-based group and 55 per cent compared with 67 per cent had taken part in a group outside school. Membership of sports groups and teams was the most common group activity, both inside and outside school. There was a marked variation in participation rates in sports groups between young people with and those with no emotional disorder: 35 per cent compared with 52 per cent for school-based groups and 20 per cent versus 38 per cent for other groups. One reason for this could be the poorer general health of children with disorders. The proportions mentioning barriers to participation showed the opposite pattern with 74 per cent of young people with a disorder mentioning a barrier, in particular, not wanting to participate, 28 per cent. For other young people these proportions were 58 per cent and 15 per cent. There was, however, little variation in the proportions

who had given unpaid help to a group, club or organisation, which is consistent with findings on the provision of help to individuals. (Tables 5.29 and 5.31)

Among children with emotional disorders:

- 35 per cent found it harder than average to make friends (compared with 9 per cent for children with no emotional disorder)
- 35 per cent of parents did not fully approve of their child's friends (15 per cent)
- 23 per cent did not enjoy living in their neighbourhood (7 per cent)
- 97 per cent gave help to relatives and 52 per cent helped non-relatives (93 per cent and 39 per cent)
- 42 per cent looked after a sick relative (33 per cent)
- 68 per cent had taken part in a school-based group and 55 per cent had taken part in a group outside school in the last year (79 per cent and 67 per cent)

Smoking, drinking and drug use

Questions on smoking, drinking and drug use were included in both the 1999 and 2004 surveys. They were addressed to children aged 11–16 and were based on questions used in the national surveys of smoking, drinking and drug use among schoolchildren. A comparison of the data from the 1999 Children's Mental Health Survey with the 1999 Schools Survey showed that children interviewed at home systematically under-reported their smoking, drinking and drug use compared with those interviewed in school. Tables presented in this report should not therefore be taken as true estimates of prevalence. Their main value is in enabling comparisons to be made between children with a disorder and other children. Percentages are shown separately for young people aged 11–13 and those aged 14–16 and so the bases are not large enough to show figures for the subcategories of emotional disorder.

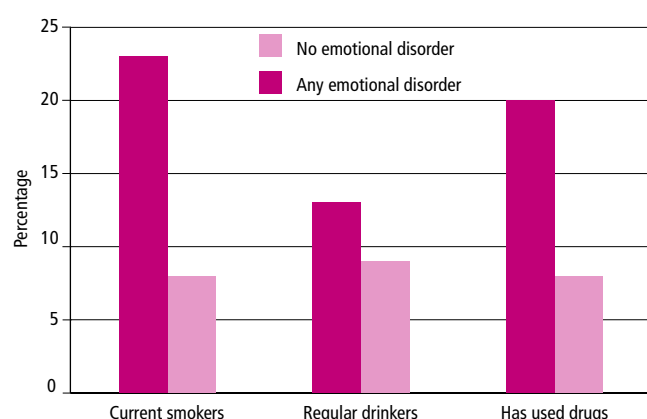
Young people with an emotional disorder were more likely to smoke, drink and take drugs than other children. The largest differences were for smoking and drug use where they were apparent among both age groups. Among all young people with an emotional disorder, 23 per cent were smokers and most of these (19 per cent) were classified as 'regular smokers' (smokes at least one cigarette a week). For other young people, the proportions were 8 per cent and 5 per cent. Likewise for drug use: 20 per cent of young people with an emotional disorder had used drugs, mainly cannabis, compared with 8 per cent of other young people. Drinking behaviour showed the same pattern but the difference was not so large

and occurred only among the older age group: 23 per cent of young people aged 14–16 who had an emotional disorder were classified as ‘regular drinkers’ (drinking at least once a week) compared with 17 per cent of other young people.

(Figure 5.8 and Tables 5.32–5.34)

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

Great Britain 1999 & 2004 combined



In the 2004 survey, young people were asked about the social context of the last occasions on which they had smoked, drunk alcohol and taken drugs. Table 5.35 shows the results for the last drinking occasion which had the largest the base size. There were no differences between young people with an emotional disorder and other young people in terms of where and with whom they had last had a drink. Overall, young people were most likely to have drunk with friends (53 per cent) or family (44 per cent), in a small group of 3–6 people (45 per cent). The child’s own home was the most popular venue (42 per cent), followed by someone else’s home (28 per cent).

(Table 5.35)

The patterns for smoking and drug use were slightly different in that young people generally engaged in these behaviours with friends and rarely with family and the most common venue was outside in a public place. Again, however, there were no differences between young people with, and those with no, emotional disorder on these measures. (Tables not shown because the base sizes for the groups with no emotional disorder were small).

Among children aged 11–16 with emotional disorders:

- 19 per cent were regular smokers (*compared with 5 per cent for children with no emotional disorder*)
- 13 per cent were regular drinkers (*9 per cent*)
- 20 per cent had taken drugs at some time (*8 per cent*)

Self-harm

All parents were asked whether the child had ever tried to hurt, harm or kill themselves and the same question was asked of older children aged 11–16 (see Chapter 2 for details). Looking first at parents’ reports for children of all ages, those whose child had an emotional disorder were much more likely to say that the child had tried to harm themselves, 14 per cent compared with 2 per cent. Young people aged 11–16 were more likely to report instances of self-harm than their parents but, among both groups, the rates were much higher for those with an emotional disorder, 28 per cent and 6 per cent based on self-reports and 19 per cent and 2 per cent based on parents’ reports.

(Table 5.36)

Results from the six-month follow-up survey

Samples of the parents of children interviewed in the 1999 and 2004 surveys were sent a self-completion questionnaire six months after the interview in order to establish whether there had been any change in their symptoms (see Chapter 3).

The average levels of total and emotional symptoms among the children with emotional disorders did fall slightly over the six months following the survey. However, as Figures 5.9 and 5.10 show, the gap between children with and those with no emotional disorder only narrowed a little as a result. The symptoms of emotional disorders were typically persistent, at least in the short term. By contrast, the impact of these symptoms fell by about a half over the six months, as shown in Figure 5.11. At first glance, it seems surprising that impact halved although the level of symptoms was fairly steady. The most likely explanation is that the impact of symptoms depends not just on the symptoms themselves but on everything else in the child’s life. Changes at home or at school may make symptoms easier or harder to live with.

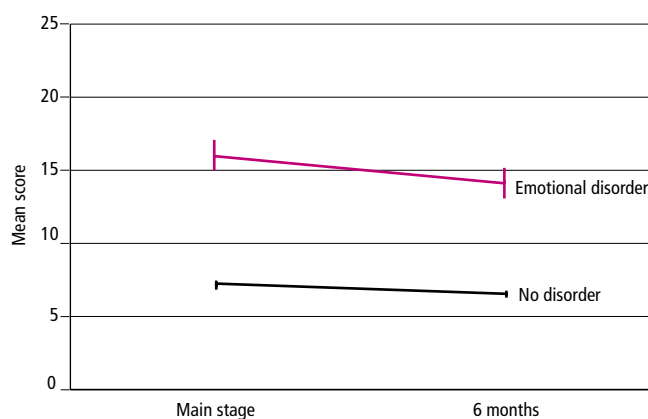
(Figures 5.9–5.11)

Since a diagnosis of an emotional disorder is only made when a child experiences both emotional symptoms and resultant impact, children can move in and out of having a diagnosable disorder according to whether or not their symptoms have a substantial impact at any given time. Some of the children who had a diagnosis of an emotional disorder at the time of the main survey would not have warranted a diagnosis six months

later because their symptoms were not having a substantial impact. Conversely, some children who did not quite warrant a diagnosis at the time of the main survey would have met the criteria six months later because their symptoms were then having a substantial impact. The frontier between normality and disorder is somewhat arbitrary, so it not surprising that some children cross and re-cross the boundary as a result of the ups and downs of life (not to mention the imprecision of the diagnostic process itself).

Figure 5.9
Total symptoms¹ at main interview and at six-month follow-up by whether child had an emotional disorder at main interview, 1999 and 2004 combined

Great Britain



1. Total symptoms is the 'total difficulties score' on the parent-reported SDQ, reflecting the sum of the subscale scores for emotional symptoms, conduct problems, hyperactivity and peer problems.

Figure 5.10
Emotional symptoms at main interview and at six-month follow-up by whether child had an emotional disorder at main interview, 1999 and 2004 combined

Great Britain

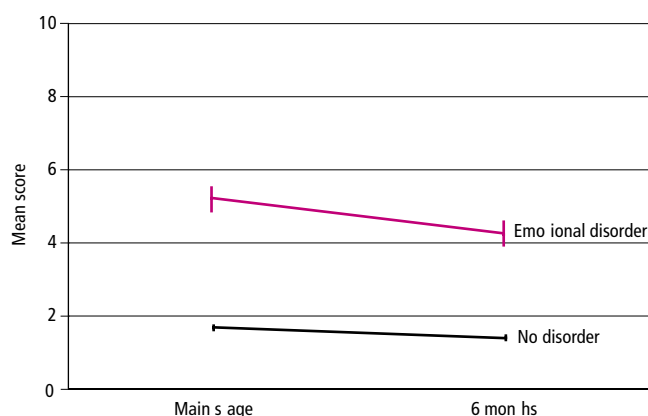
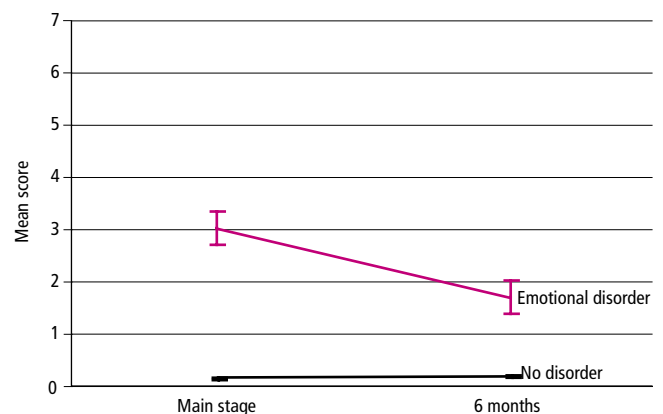


Figure 5.11
Impact of symptoms at main interview and at six-month follow-up by whether child had an emotional disorder at main interview, 1999 and 2004 combined

Great Britain



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Table 5.1**Age, sex and ethnicity of child by type of emotional disorder, 1999 and 2004 combined**

All children								Great Britain
	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	%
Sex								
Boys	51	48	54	41	43	46	51	51
Girls	49	52	47	59	57	54	49	49
Age								
5–10	68	55	33	25	14	38	54	53
11–16	32	45	67	75	86	62	46	47
Ethnicity								
White	91	91	93	92	90	90	89	89
Black ²	4	3	2	1	2	3	3	3
Indian	-	1	-	1	4	1	2	2
Pakistani/ Bangladeshi	3	3	3	4	2	3	3	3
Other	3	2	2	3	2	3	3	3
<i>Base (weighted)</i>	<i>115</i>	<i>164</i>	<i>57</i>	<i>121</i>	<i>161</i>	<i>732</i>	<i>17683</i>	<i>18415</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. Includes people of mixed black and white origin.

Table 5.2

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

All children	Great Britain						
	Type of emotional disorder						
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder
	%	%	%	%	%	%	%
Family type							
Married	44	58	48	55	47	51	69
Cohabiting	9	11	14	6	10	9	8
Lone parent – single	16	8	12	11	7	10	8
Lone parent – widowed, divorced or separated	31	24	26	28	37	31	15
Number of children in household							
1	28	21	20	23	25	26	23
2	38	41	47	37	36	38	45
3	23	26	17	24	23	24	22
4	3	10	8	10	11	9	7
5 or more	8	2	7	6	4	4	3
<i>Base (weighted 1999 and 2004 data)</i>	<i>115</i>	<i>164</i>	<i>57</i>	<i>121</i>	<i>161</i>	<i>732</i>	<i>17683</i>
If stepchildren in family							
Yes	12	9	(5)	19	14	12	11
No	88	91	(95)	81	86	88	89
<i>Base (weighted 2004 data)²</i>	<i>33</i>	<i>61</i>	<i>23</i>	<i>57</i>	<i>65</i>	<i>282</i>	<i>7695</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. The 1999 data had a different classification for whether or not a family contained stepchildren.

Table 5.3

Parent's education and socio-economic characteristics by type of emotional disorder, 1999 and 2004 combined

All children

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	%
Parent's highest educational qualification								
Degree level	6	6	3	5	7	6	13	13
Teaching/HND/Nursing	8	7	6	9	10	9	11	11
A /AS level or equivalent	7	10	9	10	9	10	11	11
GCSE Grades A–C or equivalent	25	26	21	23	21	24	30	30
GCSE Grades D–F or equivalent	14	15	11	11	14	13	11	11
Other qualification	3	2	5	3	2	3	3	3
No qualification	38	34	45	39	36	35	20	21
Parents' employment status								
Both working/lone parent working	49	53	45	58	47	51	68	67
One parent working	17	23	29	13	18	19	19	19
Neither working/lone parent not working	34	24	26	29	35	30	14	15
<i>Base (weighted 1999 and 2004 data)</i>	<i>114</i>	<i>163</i>	<i>56</i>	<i>119</i>	<i>159</i>	<i>716</i>	<i>17340</i>	<i>18056</i>
Family's socio-economic classification²								
Large employers and higher managerial	3	3	(-)	3	1	1	2	2
Higher professional	-	-	(-)	1	3	1	3	3
Lower managerial and professional	9	13	(9)	7	16	12	21	20
Intermediate occupations	20	29	(8)	13	13	18	19	19
Small employers and own account	3	6	(13)	2	3	5	7	7
Lower supervisory and technical	-	2	-	-	3	2	1	1
Semi-routine	33	24	(26)	40	30	30	26	26
Routine occupations	17	17	(26)	22	19	18	12	13
Never worked/ long-term unemployed	15	5	(14)	9	10	8	5	5
FT student/inadequate description	-	2	(5)	3	3	5	4	4
<i>Base (weighted 2004 data)³</i>	<i>33</i>	<i>61</i>	<i>23</i>	<i>57</i>	<i>65</i>	<i>282</i>	<i>7695</i>	<i>7977</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. This is the National Statistics socio-economic classification (NS-SEC).

3. The 1999 data had a different social classification

Table 5.4

Housing and income by type of emotional disorder, 1999 and 2004 combined

All children

Great Britain

	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
	%	%	%	%	%	%	%	%
Type of accommodation								
Detached	10	20	16	11	18	16	25	25
Semi-detached	39	35	37	38	35	36	38	38
Terraced house	37	33	41	40	38	38	30	30
Flat/maisonette	13	12	6	11	8	10	6	7
Tenure								
Owners	41	50	45	46	50	49	70	69
Social sector tenants	49	38	46	41	38	41	23	24
Private renters	10	11	9	12	12	10	7	7
<i>Base (weighted 1999 and 2004 data)</i>	<i>115</i>	<i>164</i>	<i>57</i>	<i>121</i>	<i>161</i>	<i>731</i>	<i>17673</i>	<i>18404</i>
Gross weekly household income								
Under £100	12	2	5	6	7	7	4	4
£100–£199	32	25	29	22	26	26	15	16
£200–£299	18	22	10	23	24	21	14	14
£300–£399	10	10	24	17	12	12	12	12
£400–£499	7	10	10	8	9	9	11	11
£500–£599	5	10	6	6	4	6	10	10
£600–£770	5	11	6	7	6	7	13	13
Over £770	11	12	11	10	12	11	21	20
<i>Base (weighted 1999 and 2004 data)</i>	<i>106</i>	<i>146</i>	<i>54</i>	<i>112</i>	<i>144</i>	<i>657</i>	<i>16239</i>	<i>16896</i>
Receipt of disability benefits								
Carers allowance	6	13	(8)	10	7	9	3	3
Severe Disablement allowance	12	17	(4)	15	15	14	5	6
Disability living/attendance allowance			(4)	3	3	1	0	0
Incapacity allowance	3	3	(5)	8	8	4	2	2
Any disability allowance	15	27	(17)	27	22	20	8	8
No disability allowance	85	73	(83)	73	78	80	92	92
<i>Base (weighted 2004 data)²</i>	<i>33</i>	<i>61</i>	<i>23</i>	<i>57</i>	<i>65</i>	<i>282</i>	<i>7695</i>	<i>7977</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. The 1999 data covered different types of disability benefit.

Table 5.5

Region, country and area type by type of emotional disorder, 1999 and 2004 combined

All children

Great Britain

	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
	%	%	%	%	%	%	%	%
Region and country								
London inner	4	3	2	10	4	5	5	5
London outer	7	6	9	6	9	7	7	7
Other met England	35	29	30	30	31	31	31	31
Non-met England	40	47	49	42	45	45	45	44
England	86	85	89	88	90	89	86	86
Scotland	12	12	8	6	6	8	9	8
Wales	2	3	3	6	4	3	5	5
<i>Base (weighted 1999 and 2004 data)</i>	<i>115</i>	<i>164</i>	<i>57</i>	<i>121</i>	<i>161</i>	<i>732</i>	<i>17683</i>	<i>18415</i>
Area type (ACORN classification)								
Wealthy achievers	14	24	(4)	16	25	17	26	26
Urban prosperity	3	5	(13)	2	1	5	8	8
Comfortably off	24	28	(25)	28	23	24	26	26
Moderate means	14	16	(21)	24	19	20	17	17
Hard pressed	45	27	(37)	31	31	34	23	24
<i>Base (weighted 2004 data)²</i>	<i>32</i>	<i>59</i>	<i>23</i>	<i>57</i>	<i>65</i>	<i>278</i>	<i>7639</i>	<i>7916</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. The 1999 data had a different ACORN classification.

Table 5.6

Child's general health by type of emotional disorder, 1999 and 2004 combined

All children

Great Britain

	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
	%	%	%	%	%	%	%	%
Child's general health								
Very good	35	47	41	34	34	41	70	69
Good	38	34	41	37	34	37	24	24
Fair	24	14	14	24	24	18	5	6
Bad	3	4	4	5	6	4	0	1
Very bad	-	-	-	-	2	1	0	0
<i>Base (weighted)</i>	<i>114</i>	<i>162</i>	<i>57</i>	<i>118</i>	<i>159</i>	<i>724</i>	<i>17448</i>	<i>18172</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.7

Co-occurrence of physical and developmental problems with emotional disorders, 1999 and 2004 combined

All children

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any Emotional disorder ¹	No Emotional disorder	
Percentage of children with each type of physical complaint								
Asthma	29	24	21	28	22	23	14	15
Eczema	14	18	16	14	17	15	13	13
Hay fever	12	13	14	19	21	14	10	11
Eyesight problems	20	16	16	15	11	16	10	10
Stomach or digestive problems	17	13	9	15	15	14	5	6
Non-food allergy	4	8	7	9	9	8	6	6
Migraine/severe headache	13	8	14	13	21	12	4	5
Bed wetting	21	12	12	8	5	10	4	5
Glue ear/otitis media/grommits	6	7	7	4	5	5	4	4
Hearing problems	4	8	2	5	4	5	4	4
Speech or language problems	17	12	14	8	4	11	4	4
Food allergy	6	7	4	1	3	6	3	4
Difficulty with co-ordination	9	11	5	3	4	7	2	2
Stiffness or deformity of foot	3	6	5	5	6	5	2	2
Heart problems	4	2		3	1	2	1	1
Soiling pants	3	5	2	2	2	3	1	1
Muscle disease or weakness	2	4	3	3	4	3	1	1
Kidney/urinary tract problems	2	3	2	4	2	3	1	1
Obesity	4	2	4	4	2	3	1	1
Congenital abnormality	2	1	2	-	1	1	1	1
Epilepsy	3	2	-	3	2	2	1	1
Any blood disorder	1	2	-	1	1	1	0	0
Diabetes	2	1	-	-	1	1	0	0
Cerebral Palsy	1	-	-	-	-	0	0	0
Cancer	1	-	-	-	1	1	0	0
Any physical or developmental problem ²	80	72	73	73	73	72	53	54
No problem	20	28	27	27	27	28	47	46
Base (weighted)	114	162	57	118	159	724	17448	18172

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. Some physical complaints are not listed in the table above because of their rarity (less than 25 cases): ME (10) Spina bifida (6) Cystic fibrosis (11) Missing digits (20). They are included in the 'Any physical or developmental problem' category.

Table 5.8**Co-occurrence of other mental disorders with emotional disorders, 1999 and 2004 combined**

All children	Great Britain							
	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
<i>Percentage of children with each type of disorder</i>								
Other mental disorders								
Conduct disorders:								
Oppositional defiant disorder	15	12	12	18	8	12	2	3
Other conduct disorders	9	4	4	5	26	11	2	2
All conduct disorders	24	16	16	23	33	23	4	5
Hyperkinetic disorders	8	4	7	5	4	4	1	1
Less common disorders	2	3	3	5	8	5	1	1
Any other disorder	27	20	24	26	38	27	5	6
No (other) disorders	73	80	76	74	62	73	95	94
<i>Base (weighted)</i>	<i>115</i>	<i>164</i>	<i>57</i>	<i>121</i>	<i>161</i>	<i>732</i>	<i>17683</i>	<i>18415</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.9**Parent's view of child's mental health by type of emotional disorder, 1999 and 2004 combined**

All children	Great Britain							
	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
<i>Percentage of children with each type of problem</i>								
Parent's view of child's mental health								
Emotional problems	29	21	32	39	40	29	3	5
Behavioural problems	23	18	23	23	33	23	5	6
Hyperactivity	19	9	7	10	9	10	3	4
Any of the above	44	29	40	54	53	40	9	10
<i>Base (weighted)</i>	<i>114</i>	<i>163</i>	<i>57</i>	<i>119</i>	<i>159</i>	<i>725</i>	<i>17449</i>	<i>18174</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.10**Whether child is taking any medication by whether has an emotional disorder, 2004**

All children	Great Britain		
	Any emotional disorder	No emotional disorder	All
<i>Percentage of children taking each type of medication</i>			
Methylphenidate, Equasym, Ritalin	3	1	1
Dexamphetamine, Dexedrine	-	0	0
Imipramine, Tofranil	-	0	0
Clonidine, Catepres, Dixarit	1	-	0
Fluoxetine, Prozac	1	0	0
Sertraline, Lustral	0	0	0
Fluvoxamine, Faverin	0	-	0
Citalopram, Cimpramil	1	0	0
Amitryptaline, Lentizol, Triptafen	0	0	0
Sulpirade, Dolmatil, Sulparex, Sulpitil	-	0	0
Risperidone, Riperadal	1	0	0
Haloperidol, Dozic, Haldol, Serenace	0	-	0
Any medication	7	1	1
No medication	93	99	99
<i>Base (weighted)</i>	<i>280</i>	<i>7581</i>	<i>7862</i>

Table 5.11

Help sought in last year for child's mental health problems by type of emotional disorder, 2004

All children

Great Britain

	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
Percentage of children using each service/source								
Specialist services								
Child/adult mental health specialist (eg psychiatrist)	27	20	(31)	27	27	24	3	3
Child physical health specialist (eg paediatrician)	6	11	(-)	7	3	8	2	2
Social services (eg social worker)	8	8	(9)	9	12	10	1	2
Education services (eg educational psychologist)	26	12	(23)	17	24	18	3	4
Front line services								
Primary health care (eg GP or practice nurse)	29	17	(26)	31	40	29	5	6
Teachers	52	36	(36)	52	53	47	17	18
All professional services	67	53	(52)	72	72	64	21	22
Informal sources								
Family member/friends	43	28	(42)	45	46	34	11	12
Internet	8	3	(14)	5	7	5	1	1
Telephone help line	12	3	(5)	5	6	4	0	1
Self-help group	6	6	-	-	2	3	0	0
Other type of help	12	3	(9)	7	11	8	1	2
All sources	76	63	(76)	85	77	73	26	28
No help sought	24	37	(24)	15	23	27	74	72
Base (weighted)	33	61	22	56	64	277	7508	7784

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.12**Teacher's rating of child's basic skills by type of emotional disorder, 1999 and 2004 combined**

Children whose teacher completed a questionnaire

Great Britain

	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
	%	%	%	%	%	%	%	%
Reading								
Above average	15	23	24	23	26	23	37	37
Average	29	41	26	41	42	37	40	40
Some difficulty	33	23	37	26	24	25	17	17
Marked difficulty	23	13	13	9	9	15	6	6
Mathematics								
Above average	10	21	14	21	22	18	32	31
Average	35	44	38	36	35	37	44	44
Some difficulty	36	24	29	34	31	29	18	19
Marked difficulty	20	12	19	9	12	16	6	6
Spelling								
Above average	9	17	19	18	20	16	29	28
Average	32	42	26	37	43	38	41	41
Some difficulty	33	22	21	29	23	26	21	21
Marked difficulty	27	19	35	16	14	20	9	9
<i>Base (weighted)</i>	<i>82</i>	<i>131</i>	<i>37</i>	<i>89</i>	<i>114</i>	<i>541</i>	<i>13633</i>	<i>14174</i>
Overall scholastic ability²								
4 or more years behind	9	6	9	8	7	8	2	2
3 years behind	5	3	-	3	5	5	2	2
2 years behind	6	7	17	9	12	10	5	5
1 year behind	24	18	21	21	22	21	15	15
Equivalent	36	39	29	37	29	33	36	35
1 or more years ahead	20	27	24	22	25	23	41	40
<i>Base (weighted)</i>	<i>76</i>	<i>129</i>	<i>34</i>	<i>81</i>	<i>103</i>	<i>503</i>	<i>12751</i>	<i>13254</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. Functioning age-actual age.

Table 5.13**Whether child has special educational needs by type of emotional disorder, 1999 and 2004 combined**

Children whose teacher completed a questionnaire

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	
Whether child has officially recognised special educational needs								
Yes	51	32	34	31	27	35	16	17
No	49	68	66	69	73	65	84	83
<i>Base (weighted)</i>	<i>81</i>	<i>132</i>	<i>37</i>	<i>89</i>	<i>116</i>	<i>541</i>	<i>13403</i>	<i>13944</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. Functioning age-actual age.

Table 5.14**Absence from school and truancy (teacher's report) by type of emotional disorder, 1999 and 2004 combined**

Children whose teacher completed a questionnaire

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	
Number of days absent in last term								
0	24	30	(4)	14	5	19	32	32
1–5	33	35	(50)	31	31	37	46	46
6–10	20	17	(20)	26	24	19	13	13
11–15	10	7	(9)	5	15	7	4	4
16 or more	14	12	(17)	25	26	17	4	5
Any days absent	77	70	(96)	86	95	81	68	68
<i>Base (weighted)</i>	<i>64</i>	<i>105</i>	<i>23</i>	<i>56</i>	<i>68</i>	<i>387</i>	<i>9998</i>	<i>10385</i>
Any unauthorised days absent								
Yes	(4)	20	(0)	25	44	21	9	9
No	(96)	80	(100)	75	56	79	91	91
<i>Base (weighted) 2004 data²</i>	<i>22</i>	<i>37</i>	<i>9</i>	<i>30</i>	<i>33</i>	<i>157</i>	<i>4533</i>	<i>4689</i>
Whether plays truant								
Not true	95	93	94	75	67	84	97	97
Somewhat true	1	5	6	15	18	9	2	2
Certainly true	4	1	-	11	16	7	1	1
<i>Base (weighted)</i>	<i>83</i>	<i>133</i>	<i>36</i>	<i>89</i>	<i>116</i>	<i>545</i>	<i>13720</i>	<i>14265</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. This question was not asked in 1999.

Table 5.15

Absence from school (parent's report) by whether has an emotional disorder, 2004

All children	Great Britain		
	Any emotional disorder	No emotional disorder	All
	%	%	%
Whether missed school in last term¹			
Yes	54	33	34
No	46	67	66
<i>Base (weighted): all children</i>	<i>263</i>	<i>7358</i>	<i>7621</i>
Reasons for absence			
Short-term illness	64	79	78
Long-term illness	9	2	2
Refused to attend	10	2	2
Has a school phobia	5	0	1
Other	23	20	21
<i>Base (weighted): those who missed school</i>	<i>141</i>	<i>2458</i>	<i>2599</i>
Whether child received any educational provision			
Yes	8	10	10
No	92	90	90
<i>Base (weighted): those who missed school (excluding short-term illness)</i>	<i>61</i>	<i>591</i>	<i>652</i>

1. Excluding exclusions.

Table 5.16

Exclusion from school (parent's report) by whether has an emotional disorder, 2004

All children	Great Britain		
	Any emotional disorder	No emotional disorder	All
	%	%	%
Number of times child has been excluded from school			
None	88	96	96
Once	4	2	2
Twice	2	1	1
Three or more times	5	1	1
<i>Base (weighted)</i>	<i>274</i>	<i>7496</i>	<i>7770</i>

Table 5.17**Number of times child has changed schools by whether has an emotional disorder, 2004**

All children	Great Britain		
	Any emotional disorder	No emotional disorder	All
	%	%	%
Number of times child has changed school¹			
None	70	81	81
Once	22	14	14
Twice	3	3	3
Three or more times	5	2	2
<i>Base (weighted)</i>	<i>274</i>	<i>7502</i>	<i>7776</i>

1. Apart from normal transitions.

Table 5.18**Parent's GHQ-12 score by type of emotional disorder, 1999 and 2004 combined**

All children	Great Britain							
	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
	%	%	%	%	%	%	%	%
Parent's GHQ-12 ²								
0-2	44	56	50	41	39	49	77	76
3-5	17	20	16	23	19	18	13	13
6-8	19	13	14	14	15	15	6	7
9-12	21	11	20	22	26	18	4	4
3 or more	56	44	50	59	61	51	23	24
Base (weighted)	114	162	56	118	159	714	17269	17983

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. For this survey, scores of 3 or more were taken to indicate a severe emotional problem.

Table 5.19**Family functioning score by type of emotional disorder, 1999 and 2004 combined**

All children

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	%
Family functioning score²								
Up to 1.50	27	33	31	22	18	27	36	36
1.51 – 2.00	37	38	46	41	33	26	15	16
2.51 or more	11	7	7	7	10	7	2	2
Unhealthy functioning (2.01 or more)	37	29	23	36	43	33	18	18
<i>Base (weighted)</i>	<i>114</i>	<i>162</i>	<i>55</i>	<i>117</i>	<i>154</i>	<i>704</i>	<i>17204</i>	<i>17908</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

2. For this survey, scores over 2.0 were taken to indicate unhealthy family functioning.

Table 5.20

Stressful life events by type of emotional disorder, 2004

All children

Great Britain

	Type of emotional disorder							
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	All
Percentage reporting each event								
Stressful life events								
Since child was born, parent had a separation due to marital difficulties or broken off steady relationship	53	43	54	56	62	55	30	31
Since child was born, parent had a major financial crisis such as losing the equivalent of three months income	17	22	13	26	36	25	13	13
Since child was born, parent had a problem with the police involving a court appearance	15	11	10	18	16	14	6	6
Since child was born, parent has had serious physical illness	3	16	17	12	16	13	7	8
Since child was born, parent has had serious mental illness	24	21	27	42	27	28	7	8
At any stage in child's life, a parent, brother or sister died	11	2	19	3	4	7	3	4
At any stage in child's life, a close friend died	11	10	4	15	13	13	6	6
At some stage in the child's life, s/he had a serious illness which required a stay in hospital	18	25	21	17	19	20	13	13
At any stage in child's life, s/he had been in a serious accident or badly hurt in an accident	18	10	7	6	9	11	5	5
In the past year child has broken off a steady relationship with a boy or girl friend (aged 13 or above)/ a close friendship has ended (any age)	18	8	28	23	26	17	6	7
Base (weighted)	33	61	22	56	64	274	7496	7770

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.21

Number of stressful life events by type of emotional disorder, 2004

All children

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	%
Number of stressful life events								
0	17	22	(13)	16	9	16	43	42
1	36	29	(24)	21	23	25	33	32
2	21	22	(32)	23	28	24	14	15
3	15	19	(19)	23	20	19	7	7
4	3	6	(3)	10	12	9	2	3
5 or more	9	3	(8)	8	8	7	1	1
Two or more events	47	49	(63)	63	67	59	25	26
<i>Base (weighted)</i>	<i>33</i>	<i>61</i>	<i>22</i>	<i>56</i>	<i>64</i>	<i>274</i>	<i>7496</i>	<i>7770</i>

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.22

Child's strengths (parent's and child's assessment) by whether has an emotional disorder, 2004

Great Britain

	Any emotional disorder	No emotional disorder	All
	%	%	%
ALL CHILDREN			
Strength score – parent assessment			
0–36	58	24	25
37–40	19	25	25
41–43	15	25	25
44–48	8	26	25
<i>Base (weighted)</i>	<i>268</i>	<i>7303</i>	<i>7571</i>
CHILDREN AGED 11–16			
Strength score – child assessment			
0–23	34	23	23
24–27	25	27	27
28–30	24	23	23
31–38	17	28	27
<i>Base (weighted)</i>	<i>147</i>	<i>3191</i>	<i>3338</i>

Table 5.23

Social aptitude (parent's assessment) by whether has an emotional disorder, 2004

All children	Great Britain		
	Any emotional disorder	No emotional disorder	All
	%	%	%
Social aptitude score			
0–20	48	24	25
21–24	22	28	27
25–28	14	23	22
29–40	16	26	25
<i>Base (weighted)</i>	<i>265</i>	<i>7218</i>	<i>7483</i>

Table 5.24
Friendships by type of emotional disorder, 2004

All children

Great Britain

	Type of emotional disorder							All
	Separation anxiety	Specific phobia	Social phobia	Generalised anxiety disorder	Depression	Any emotional disorder ¹	No emotional disorder	
	%	%	%	%	%	%	%	%
What is child like at making friends?								
Finds it harder than average	37	28	(61)	41	33	35	9	10
About average	32	40	(26)	20	23	31	36	36
Easier than average	31	32	(13)	38	45	34	55	54
What is child like at keeping friends?								
Finds it harder than average	20	12	(30)	31	23	22	5	5
About average	49	45	(30)	38	36	42	35	35
Easier than average	31	43	(40)	31	41	36	60	59
Number of friends								
0	6	5	(17)	12	8	6	1	2
1	21	6	(17)	14	13	14	4	4
2–4	37	48	(46)	37	42	45	43	43
5–9	26	37	(19)	30	29	29	40	39
10 or more	10	5	(-)	7	8	6	12	11
<i>Base (weighted): all children</i>	33	61	(23)	56	64	280	7560	7840
Do child and friends have things in common								
No	3	3	(6)	2	5	4	1	1
A little	19	23	(24)	40	19	29	21	21
A lot	78	74	(70)	58	76	66	78	78
Do child and friends do things together								
No	13	18	(26)	6	8	11	3	4
A little	15	27	(30)	28	25	27	21	21
A lot	72	55	(44)	66	67	61	76	75
If worried, can child talk to friends								
No	49	28	(34)	23	15	29	21	21
Perhaps	38	37	(15)	33	33	33	42	42
Definitely	13	35	(51)	44	53	38	37	37
Whether friends get into trouble								
Not at all	54	67	(55)	60	55	57	68	67
A few are like that	40	32	(29)	35	31	36	31	31
Many are like that	6	-	(5)	6	11	5	1	1
All are like that	-	2	(11)	-	3	2	0	0
Whether parent approves of child's friends								
No	-	3	(6)	4	8	5	2	2
A little	28	14	(30)	36	34	30	14	14
A lot	72	83	(65)	60	58	65	85	84
<i>Base (weighted): those who had friends</i>	31	57	19	50	58	261	7309	7570

1. The 'Any emotional disorder category' includes children with other types of emotional disorder.

Table 5.25

Child's sources of emotional support by whether has an emotional disorder, 2004

Children aged 11–16			Great Britain
	Any emotional disorder	No emotional disorder	All
	%	%	%
Social support score			
0–17	42	27	28
18	19	16	16
19	23	20	20
20	17	36	35
<i>Base (weighted)</i>	<i>148</i>	<i>3182</i>	<i>3331</i>

Table 5.26

Views about the neighbourhood by whether has an emotional disorder, 2004

Children aged 11–16			Great Britain
	Any emotional disorder	No emotional disorder	All
	%	%	%
Whether enjoys living in the neighbourhood			
A lot	39	65	64
A little	38	29	29
No	23	7	7
How safe child feels walking alone in the neighbourhood during the daytime			
Very safe	46	62	61
Fairly safe	36	32	32
A bit unsafe	11	5	5
Very unsafe	7	1	1
Never goes out alone	1	1	1
Whether ever goes to the local shops or park alone			
Yes	79	80	80
No	21	20	20
How many people in the neighbourhood can be trusted			
Many	23	38	38
Some	40	45	44
A few	27	16	16
None	10	1	2
Likelihood of someone returning a lost bag			
Very likely	7	12	12
Quite likely	30	46	45
Not very likely	39	30	30
Not at all likely	23	12	13
<i>Base (weighted)</i>	<i>144</i>	<i>3175</i>	<i>3319</i>

Table 5.27

Help provided to others by whether has an emotional disorder, 2004

Children aged 11–16

Great Britain

	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All
	<i>Percentage giving each type of help to relatives</i>			<i>Percentage giving each type of help to non-relatives</i>		
Type of help						
Doing shopping for someone	41	36	37	14	9	9
Cooking or helping to prepare family meals	58	52	52	10	5	6
Cleaning, hoovering or gardening	76	69	69	17	10	11
Washing or ironing clothes	51	35	36	6	2	2
Decorating or repairs	23	21	21	5	5	5
Baby sitting or caring for children	48	38	39	30	19	19
Writing letters or filling in forms	15	10	10	1	4	4
Taking care of someone who is sick	42	33	34	12	9	9
Helping out in a family business	13	11	11
Anything else	6	9	9	4	3	3
None of the above	3	7	7	48	61	60
<i>Base (weighted): all aged 11 or over</i>	<i>149</i>	<i>3209</i>	<i>3358</i>	<i>149</i>	<i>3209</i>	<i>3358</i>
Frequency of providing help						
Every day	19	17	17	10	6	6
At least once a week	57	59	59	41	31	32
At least once a month	14	17	17	33	38	38
Less often	9	6	6	15	25	24
<i>Base (weighted): those who helped</i>	<i>145</i>	<i>2989</i>	<i>3134</i>	<i>78</i>	<i>1264</i>	<i>1342</i>

Table 5.28**Whether child does any paid work by whether has an emotional disorder, 2004**

Children aged 11–16		Great Britain	
	Any emotional disorder	No emotional disorder	All
	%	%	%
Whether child does any paid work at least once a month			
Yes	19	22	22
No	81	78	78
<i>Base(weighted): all children aged 11 or over</i>	<i>150</i>	<i>3209</i>	<i>3359</i>
<i>Percentage doing each type of work</i>			
Type of paid work			
Family business	10	10	10
Newspaper round delivery	20	25	25
Shop or restaurant	24	27	27
Building, decorating or gardening	-	2	2
Household chores	31	18	18
Other	22	23	23
<i>Base (weighted): those doing paid work</i>	<i>29</i>	<i>742</i>	<i>740</i>

Table 5.29**Participation in groups, clubs and organisations by whether has an emotional disorder, 2004**

Children aged 11–16

Great Britain

	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All
	<i>Percentage participating in clubs at school</i>			<i>Percentage participating in clubs outside school</i>		
Type of group/club/ organisation						
Sports	35	52	51	20	38	37
Art, drama, dance or music	31	32	32	20	17	18
Youth	11	11	11	21	21	21
Computers	13	14	14	3	3	3
Political	-	2	2	-	1	1
Debating	3	4	4	1	0	1
Religious	4	3	3	6	4	5
Local community or neighbourhood	3	2	2	4	2	2
Voluntary groups helping people	5	4	4	4	2	2
Safety, First Aid	6	4	4	2	3	3
Environmental	5	5	5	1	2	2
Animal (welfare)	1	1	1	1	1	1
Human rights	1	1	1	1	0	0
School holiday playschemes	7	9	9	4	7	7
After-school clubs	18	28	28
School student councils	12	11	11
Student Union	-	1	1
Extra teaching or special lessons	10	9	9
Other	6	9	9
None of the above	32	21	22	45	33	33
<i>Base (weighted)</i>	<i>142</i>	<i>3147</i>	<i>3288</i>	<i>142</i>	<i>3149</i>	<i>3290</i>

Table 5.30**Unpaid help given to groups, clubs and organisations by whether has an emotional disorder, 2004**

Children aged 11–16

Great Britain

	Any emotional disorder	No emotional disorder	All
	<i>Percentage mentioning each type of help</i>		
Unpaid help given to groups, clubs and organisations in last 12 months			
Collected or raised money	25	33	33
Took part in a sponsored activity	27	32	32
Was part of a committee	6	6	6
Helped to organise or run an event	23	19	19
Other help	12	9	9
None of the above	46	42	42
<i>Base (weighted)</i>	<i>149</i>	<i>3209</i>	<i>3358</i>

Table 5.31

Barriers to participation in groups, clubs and organisations by whether has an emotional disorder, 2004

Children aged 11–16		Great Britain	
	Any emotional disorder	No emotional disorder	All
<i>Percentage mentioning each barrier</i>			
Barriers to participation			
Difficulty getting to clubs	11	6	6
No good groups or clubs locally	19	16	16
Cannot afford to join	4	2	2
Would not feel safe travelling to club	7	2	2
No clubs of interest	13	14	14
Too busy	12	15	15
Do not want to participate	28	15	16
Do not have time after homework	14	12	12
Not allowed	8	2	2
Other barrier	6	3	3
None of the above	26	42	42
<i>Base (weighted)</i>	<i>142</i>	<i>3150</i>	<i>3291</i>

Table 5.32

Smoking behaviour by whether has an emotional disorder, 1999 and 2004 combined

Children aged 11–16		Great Britain							
11- to 13-year-olds			14- to 16-year-olds			All aged 11–16			
	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All
	%	%	%	%	%	%	%	%	%
Smoking behaviour									
Regular smoker	6	1	1	33	11	13	19	5	6
Occasional smoker	3	1	1	4	5	5	3	3	3
All smokers	8	2	2	37	17	18	23	8	9
Used to smoke	5	3	3	11	9	9	8	5	5
Tried smoking once	22	16	16	25	28	28	24	21	21
Never smoked	64	79	78	27	46	45	45	65	64
<i>Base (weighted)</i>	<i>192</i>	<i>4208</i>	<i>4400</i>	<i>194</i>	<i>3075</i>	<i>3269</i>	<i>387</i>	<i>7283</i>	<i>7670</i>

Table 5.33

Drinking behaviour by whether has an emotional disorder, 1999 and 2004 combined

Children aged 11–16

Great Britain

	11- to 13-year-olds			14- to 16-year-olds			All aged 11–16		
	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All
	%	%	%	%	%	%	%	%	%
Drinking behaviour									
Almost every day	1	0	0	1	1	1	1	0	0
About twice a week	1	1	1	8	6	6	4	3	3
About once a week	1	2	2	15	10	10	8	5	6
All regular drinkers	3	3	3	23	17	17	13	9	9
About once a fortnight	4	3	3	13	12	12	9	7	7
About once a month	7	5	5	16	16	16	12	9	10
Only a few times a year	28	20	21	24	29	29	26	24	24
Never drinks alcohol	4	2	2	1	2	2	3	2	2
Never had a drink	54	67	67	23	24	24	39	49	49
<i>Base (weighted)</i>	<i>192</i>	<i>4205</i>	<i>4397</i>	<i>195</i>	<i>3075</i>	<i>3270</i>	<i>387</i>	<i>7282</i>	<i>7669</i>

Table 5.34

Drug use by whether has an emotional disorder, 1999 and 2004 combined

Children aged 11–16

Great Britain

	11- to 13-year-olds			14- to 16-year-olds			All aged 11–16		
	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All	Any emotional disorder	No emotional disorder	All
	%	%	%	%	%	%	%	%	%
Ever used:									
Cannabis	4	1	1	28	14	15	16	7	7
Inhalants	1	0	0	2	1	1	1	1	1
Ecstasy	1	0	0	1	1	1	1	0	0
Amphetamines	1	0	0	4	1	1	3	1	1
LSD	1	0	0	1	0	0	1	0	0
Tranquilisers	-	0	0	1	0	0	1	0	0
Cocaine	-	0	0	-	1	1	-	0	0
Heroin	-	0	0	1	-	0	0	0	0
Any drugs	8	2	3	31	16	16	20	8	9
<i>Base (weighted)</i>	<i>192</i>	<i>4203</i>	<i>4395</i>	<i>194</i>	<i>3074</i>	<i>3268</i>	<i>387</i>	<i>7278</i>	<i>7665</i>

Table 5.35

Social context of last drinking occasion by whether has an emotional disorder, 2004

Children aged 11–16 who had had an alcoholic drink in the last 6 months

Great Britain

	Any emotional disorder	No emotional disorder	All
	%	%	%
Where had last drink			
Own home	43	43	42
Other's home	28	28	28
Public house	8	8	8
Restaurant	7	3	3
Nightclub/other club	6	5	5
Outside in public place	3	8	7
Other venue	6	6	6
Number of other people in group			
Alone	2	3	3
1	20	14	14
2–5	44	45	45
6–10	20	19	19
More than 10	14	19	18
<i>Base (weighted)¹</i>	<i>86</i>	<i>1375</i>	<i>1461</i>
Who was with respondent²			
Boyfriend/girlfriend	10	7	7
Other friend(s)	54	53	53
Family	48	44	44
Other	4	3	3
<i>Base (weighted)¹</i>	<i>84</i>	<i>1328</i>	<i>1411</i>

1. The bases are those who had engaged in the behaviour with others.

2. Percentages may sum to more than 100 because some children were accompanied by more than one group.

Table 5.36

eliberate self-harm by whether has an emotional disorder, 1999 and 2004 combined

	Great Britain		
	Any emotional disorder	No emotional disorder	All
<i>Percentage who have tried to harm, hurt or kill themselves</i>			
All children			
Parent's report	14	2	2
<i>Base (weighted)</i>	<i>595</i>	<i>17060</i>	<i>17655</i>
Children aged 11–16			
Parent's report	19	2	3
<i>Base (weighted)</i>	<i>367</i>	<i>7872</i>	<i>8239</i>
Child's report	28	6	7
<i>Base (weighted)</i>	<i>324</i>	<i>7080</i>	<i>7404</i>

Chapter 6

Conduct disorders

Introduction

This chapter follows the same structure as Chapter 5. First, we describe the types of behaviour patterns typically found among children and young people who have a conduct disorder. We then go on to describe the characteristics of these children and young people, looking at their:

- demographic characteristics;
- family situation;
- socio-economic characteristics;
- geographic distribution;
- general, physical and mental health;
- use of services;
- scholastic ability and attendance at school;
- family's social functioning;
- own social functioning; and
- lifestyle behaviours.

There was no change between 1999 and 2004 in the prevalence of conduct disorders among children and young people, either overall or within different subgroups. It is therefore possible to combine the two sets of data so as to increase the sample base. This allows us to analyse the larger subcategories of conduct disorders:

- Oppositional defiant disorder.
- Socialised conduct disorder.
- Unsocialised conduct disorder.

The numbers of children with other types of conduct disorder are too small for separate analysis and are not shown as separate categories in the tables. However, they are included in the 'Any conduct disorder' total.

As far as possible, the same questions and classifications were used in both the 1999 and the 2004 surveys. However, some changes were necessary to improve the questions or to cover new topics. In these cases, data are presented for 2004 only and hence the bases in some subgroups are very small. We have not commented on the characteristics of these very small groups.

Within each topic, the text generally follows the same pattern: first, children with any form of conduct disorder are compared with those who have no such disorder; then, any variations from the overall pattern within the subcategories of conduct disorders are reported. The shaded boxes summarise the main features of the group as a whole followed by those for each subgroup including any characteristics on which they differ from the overall pattern. The commentary is descriptive, the

aim being to provide a profile of children who have different types of conduct disorder. It therefore takes no account of the inter-relationships between the characteristics. The analysis at the end of Chapter 4 described the factors which had the largest independent effects on prevalence and this gives an indication of the key variables.

Typical behaviour patterns

This section describes typical symptoms displayed by children with different types of conduct disorder. The symptoms listed are found, to some extent, in most children. To count as a disorder they have to be sufficiently severe to cause distress to the child or an impairment in his/her 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

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 stroppy, 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

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

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.

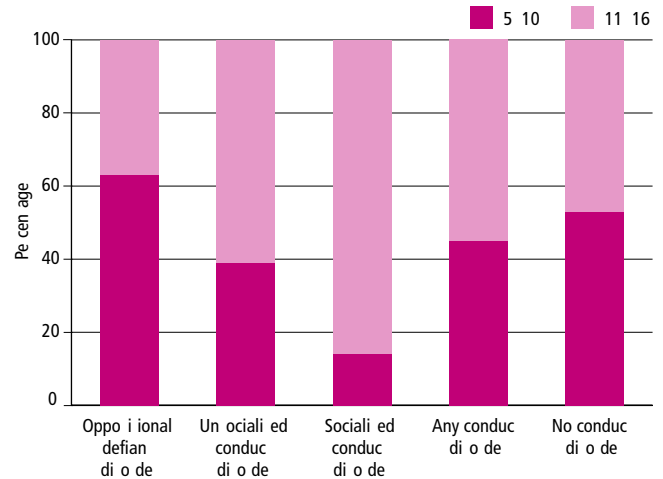
Demographic, socio-economic and area characteristics

Demographic characteristics

Children with a conduct disorder were more likely to be boys and more likely to be older than children with no such disorder. About two-thirds (69 per cent) of children with a conduct disorder were boys and over a half (55 per cent) were aged 11–16 compared with about a half (50 per cent and 47 per cent) of other children. Boys predominated in all the subgroups of conduct disorder but there were considerable age variations within these groups: the proportion aged 11–16 ranged from 37 per cent among children with oppositional defiant disorder to 61 per cent among those with unsocialised conduct disorder to 86 per cent among those with socialised conduct disorder. The only ethnic variation was that children with unsocialised conduct disorder were more likely to be white than children

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

Great Britain



with no conduct disorder (96 per cent compared with 89 per cent).

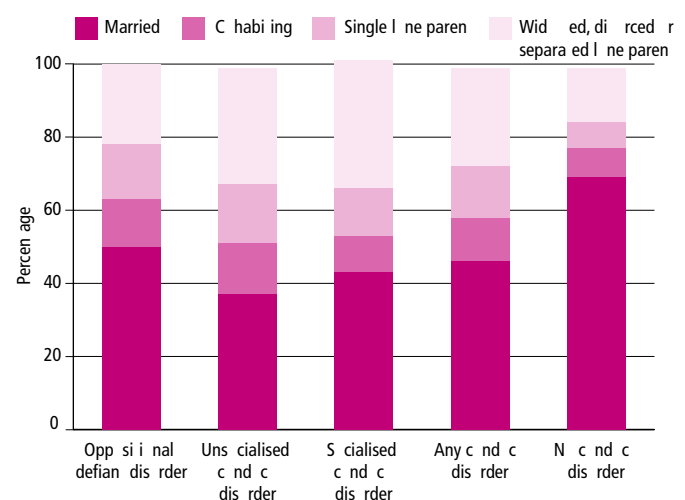
(Figure 6.1 and Table 6.1)

Family characteristics

Fewer than a half (46 per cent) of children with conduct disorders lived with married parents compared with about two-thirds (69 per cent) of children with no such disorder. Among the former, higher proportions lived with cohabiting parents (12 per cent compared with 8 per cent), single lone parents (14 per cent compared with 7 per cent) or previously married lone parents (27 per cent compared with 15 per cent). Among children with unsocialised and socialised conduct disorders,

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

Great Britain



about a third lived with a previously married lone parent (32 per cent and 35 per cent). For those with oppositional defiant disorder, the proportion was about a fifth (22 per cent).

(Figure 6.2 and Table 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. These patterns were evident in all the subgroups but 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 also almost twice as likely as other children to live in households containing stepchildren (18 per cent compared with 10 per cent). This proportion was relatively high among children with unsocialised and those with socialised conduct disorders (18 per cent and 22 per cent). The difference between those with oppositional defiant disorder and those with no conduct disorder was not quite statistically significant.

(Table 6.2)

Parental education and socio-economic characteristics

Children with conduct disorders, like those with emotional disorders, were more likely than other children to have parents with no educational qualifications and to live in low-income families. Those with unsocialised conduct disorder seemed to live in the most economically disadvantaged circumstances, as indicated by a range of measures.

Children with a conduct disorder were twice as likely as those with no such disorder to have parents who had no educational qualifications (39 per cent compared with 20 per cent). The same variation occurred in all the subgroups but was most pronounced among those with unsocialised conduct disorder of whom well over a half (57 per cent) had parents with no educational qualifications.

(Table 6.3)

A third of children with conduct disorders lived in households in which neither parent was working (34 per cent compared with 14 per cent of other children). Conversely, only a half (49 per cent) lived in households in which both parents worked compared with two thirds (68 per cent) of children with no such disorder. Similarly, with respect to the socio-economic classification of the household reference person: 51 per cent of the children with a conduct disorder had a parent in the semi-routine or routine occupational group compared with 38 per cent of other children. Again, the differences were evident in all the subgroups but were particularly marked among children with unsocialised conduct disorder: 49 per cent lived in

households in which neither parent was working and 70 per cent had a parent in the semi-routine or routine group.

(Table 6.3)

Housing and income

A half (50 per cent) of children with conduct disorders lived in social rented sector accommodation compared with less than a quarter (23 per cent) of those with no such disorder.

Conversely, only 41 per cent compared with 71 per cent lived in owned accommodation. The income measure showed the same kind of differential. Nearly three fifths (58 per cent) of children with a conduct disorder lived in households with a gross weekly income of less than £300 compared with a third (33 per cent) of other children. These housing and income variations occurred in all three subgroups.

(Table 6.4)

Table 6.4 also shows the disability benefits received by households containing children with a conduct disorder. One-fifth (20 per cent) were receiving a disability benefit, including 15 per cent who were receiving severe disablement allowance. Households with children who had unsocialised conduct disorders were particularly likely to receive a disability benefit, 31 per cent, and the proportion was also relatively high among children with oppositional defiant disorder, 17 per cent. However, households in which the child had socialised conduct disorder were no more likely to receive a disability benefit than households in which the child had no conduct disorder.

(Table 6.4)

Area characteristics

There were no differences between countries or between metropolitan and other areas within England in the distribution of children with and those with no conduct disorder. There were, however, marked differences in the types of area in which they lived. Households containing children with conduct disorders were almost twice as likely as other households to live in areas classified as 'Hard pressed', 41 per cent compared with 23 per cent. This proportion was relatively high in all the subgroups but, again, was particularly high, 61 per cent, among those with unsocialised conduct disorder.

(Table 6.5)

Among children with conduct disorders:

- 69 per cent were boys (*compared with 50 per cent for children with no conduct disorder*)
- 55 per cent were aged 11–16 (*47 per cent*)
- 92 per cent were white (*89 per cent*)
- 27 per cent lived with a widowed, divorced or separated lone parent (*15 per cent*)
- 46 per cent lived in a married couple family (*69 per cent*)
- 17 per cent lived in households containing 4 or more children (*10 per cent*)
- 18 per cent lived in households containing stepchildren (*10 per cent*)
- 39 per cent had parents with no educational qualifications (*20 per cent*)
- 41 per cent lived in owned accommodation (*71 per cent*)
- 58 per cent lived in households with gross incomes under £300 per week (*33 per cent*)
- 20 per cent lived in households in which someone received a disability benefit (*8 per cent*)
- 41 per cent lived in areas classified as 'Hard pressed' (*23 per cent*)

Among children with oppositional defiant disorder:

- 69 per cent were boys
- 37 per cent were aged 11–16
- 91 per cent were white
- 22 per cent lived with a widowed, divorced or separated lone parent
- 14 per cent lived in households containing 4 or more children
- 16 per cent lived in households containing stepchildren
- 53 per cent lived in households with gross incomes under £300 per week

Among children with unsocialised conduct disorder:

- 71 per cent were boys
- 61 per cent were aged 11–16
- 96 per cent were white
- 32 per cent lived with a widowed, divorced or separated lone parent
- 26 per cent lived in households containing 4 or more children
- 18 per cent lived in households containing stepchildren
- 66 per cent lived in households with gross incomes under £300 per week

Among children with socialised conduct disorder:

- 70 per cent were boys
- 86 per cent were aged 11–16
- 90 per cent were white
- 35 per cent lived with a widowed, divorced or separated lone parent
- 19 per cent lived in households containing 4 or more children
- 22 per cent lived in households containing stepchildren
- 61 per cent lived in households with gross incomes under £300 per week

Child's general, physical and mental health**General health**

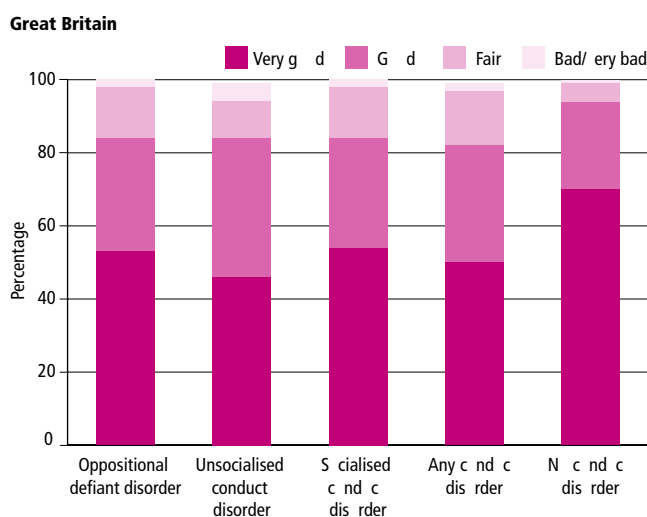
The parents of children with a conduct disorder were more than three times as likely as other parents to say that their child's general health was fair or bad (17 per cent compared with 5 per cent) and less likely to say that it was very good (50 per cent compared with 70 per cent).

(Figure 6.3 and Table 6.6)

Physical and developmental problems

About two-thirds (65 per cent) of children with conduct disorders had some type of physical or developmental problem as well. Among other children the proportion was just over a half (53 per cent). Among both groups, there was no difference in the proportions reporting some of the more common complaints, for example, eczema and hay fever. The parents of children with conduct disorders were, however, the more likely to report bed wetting (12 per cent and 4 per cent), speech or

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



language problems (11 per cent and 3 per cent), co-ordination difficulties (7 per cent and 2 per cent) asthma (19 per cent and 15 per cent) and eyesight problems (14 per cent and 10 per cent). (Table 6.7)

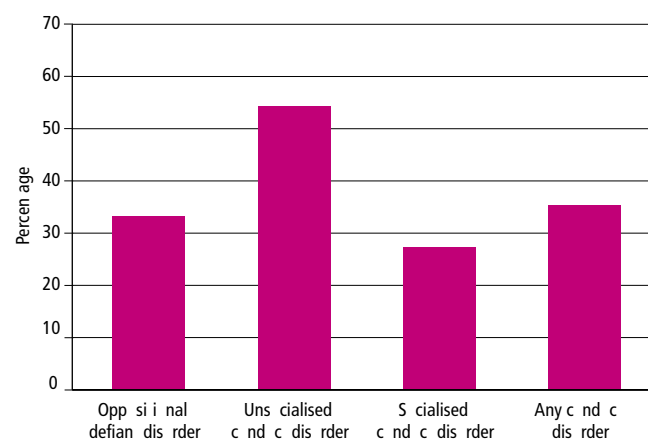
The poorer general and physical health of children with conduct disorders compared with other children was evident in the three subgroups of conduct disorders and there was very little variation between them.

Mental disorders

About one-third (35 per cent) of children with conduct disorders had another clinically recognisable disorder as well: 19 per cent had an emotional disorder, including 15 per cent with anxiety disorders; 17 per cent had a hyperkinetic disorder; and 3 per cent had one of the less common disorders. However, there were marked differences between the subgroups in both the extent and the nature of their co-morbidity. Those with unsocialised conduct disorder were the most likely to have another mental disorder (54 per cent), usually hyperkinesia (34 per cent). About one-fifth (22 per cent) of this group had an emotional disorder, 17 per cent having an anxiety disorder and 12 per cent having depression. Among children with oppositional defiant disorder, one-third (33 per cent) had multiple disorders, evenly split between hyperkinesia (18 per cent) and emotional disorders (18 per cent), usually anxiety disorders (17 per cent). In the third subgroup, children with socialised conduct disorder, 27 per cent had another disorder: 11 per cent had a hyperkinetic disorder and 18 per cent had an emotional disorder, evenly divided between anxiety and depressive disorders. (Figure 6.4 and Table 6.8)

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

Great Britain



Parents were asked whether their child had any emotional problems, behavioural problems or hyperactivity. Just under two-thirds (64 per cent) of the parents whose children were clinically assessed as having a conduct disorder reported these kinds of problems: 55 per cent reported behavioural problems, 27 per cent emotional problems and 23 per cent hyperactivity. Since these proportions sum to well over 64 per cent, it is clear that many parents reported more than one type of problem – which is consistent with the co-morbidity observed in the clinical classification. As discussed above, children with unsocialised conduct disorders were most likely to suffer from multiple disorders and their parents were most likely to report some kind of problem (78 per cent). While the majority mentioned behavioural problems (72 per cent), high proportions mentioned hyperactivity (39 per cent) and emotional problems (37 per cent). As was the case with the clinical assessments, the parental reports also indicate multiple types of disorder among these children. (Table 6.9)

Medication

Medication would not often be prescribed for behavioural problems per se. Nine per cent of children with a conduct disorder were taking some form of medication, mainly Methylphenidate (7 per cent), which is usually prescribed for hyperactivity. Further investigation showed that all but two of the children with conduct disorders who were taking medication had another disorder as well, usually hyperkinesia. One of the two exceptions was taking citalopram (an anti-depressant) and was reported to have had depressed mood with deliberate self-harm but did not fulfil diagnostic criteria for emotional disorder at the time of assessment. The other child was taking imipramine and had symptoms of overactivity at home following brain injury, but the onset was too late to diagnose hyperkinetic disorder. (Table 6.10)

Among the parents of children with conduct disorders:

- 17 per cent reported that the child's general health was fair or bad (compared with 5 per cent for children with no conduct disorder)
- 65 per cent reported that the child had a specific physical or developmental problem (53 per cent)
- 64 per cent reported that the child had mental health problems (7 per cent)
- 27 per cent reported that the child had emotional problems, 55 per cent reported behavioural problems and 23 per cent reported hyperactivity (3 per cent, 3 per cent and 3 per cent)
- 35 per cent of the children had another main type of clinically recognisable disorder (4 per cent)

Among the parents of children with oppositional defiant disorder:

- 16 per cent reported that the child's general health was fair or bad
- 66 per cent reported that the child had a specific physical or developmental problem
- 59 per cent reported that the child had mental health problems
- 24 per cent reported that the child had emotional problems, 50 per cent reported behavioural problems and 23 per cent reported hyperactivity
- 33 per cent of the children had another main type of clinically recognisable disorder

Among the parents of children with unsocialised conduct disorder:

- 16 per cent reported that the child's general health was fair or bad
- 66 per cent reported that the child had a specific physical or developmental problem
- 78 per cent reported that the child had mental health problems
- 37 per cent reported that the child had emotional problems, 72 per cent reported behavioural problems and 39 per cent reported hyperactivity
- 54 per cent of the children had another main type of clinically recognisable disorder

Among the parents of children with socialised conduct disorder:

- 16 per cent reported that the child's general health was fair or bad
- 60 per cent reported that the child had a specific physical or developmental problem
- 66 per cent reported that the child had mental health problems
- 27 per cent reported that the child had emotional problems, 57 per cent reported behavioural problems and 15 per cent reported hyperactivity
- 27 per cent of the children had another main type of clinically recognisable disorder

Use of services

In the previous survey, the questioning about service use was directed only at those for whom significant problems had been reported in the interview. The questions in the 2004 survey were asked about all children. Parents were asked whether, in the last year, they had had contact with a range of specialist

and non-professional services because they were worried about their child's emotions, behaviour or concentration.

Over three-quarters (81 per cent) of parents of children with a conduct disorder had sought some form of advice or help in the previous 12 months because of concerns about their child's mental health or behaviour. The majority of these (76 per cent overall) had approached a professional source, most commonly a teacher (60 per cent). Substantial minorities had contacted, or been referred to, a specialist, 28 per cent had contacted a mental health specialist and 24 per cent a special educational service such as an educational psychologist. A third (32 per cent) had approached their GP or a practice nurse and a similar proportion (34 per cent) had talked to family members or friends. Children with unsocialised or socialised conduct disorders were more likely than those with oppositional defiant disorder to have sought help with their child's health or behavioural problems, 90 per cent and 87 per cent compared with 74 per cent. This difference was evident for both professional and informal sources. It may reflect the younger age profile of children with oppositional defiant disorder but further analysis showed that the variation was present for both children aged 5–10 and these aged 11–16. (Table 6.11).

Parents who had mentioned a problem with their child's emotions, attention or behaviour during the course of the interview and who had not seen a specialist were asked whether there was anything that had stopped them seeking such help. Fewer than a half (45 per cent) of the parents of children with conduct disorders mentioned any of the barriers prompted by the interviewer. The most common obstacles mentioned were lack of awareness of the service available (14 per cent), difficulty in getting a referral (14 per cent) and a belief that a specialist would be of no help (10 per cent). Similar barriers were mentioned by parents of children with emotional disorders although, again, the numbers with problems were quite small. (Table not shown)

Among the parents of children with conduct disorders:

- 81 per cent had sought help or advice in the last year because of worries about their child's mental health (*compared with 25 per cent for children with no conduct disorder*)
- 76 per cent had contacted a professional service (*19 per cent*)
- The most commonly used services were: teachers (60 per cent), family members or friends (34 per cent), primary health care (32 per cent) and mental health specialists (28 per cent).

Among the parents of children with oppositional defiant disorder:

- 74 per cent had sought help or advice in the last year because of worries about their child's mental health
- 69 per cent had contacted a professional service

Among the parents of children with unsocialised conduct disorder:

- 90 per cent had sought help or advice in the last year because of worries about their child's mental health
- 85 per cent had contacted a professional service

Among the parents of children with socialised conduct disorder:

- 87 per cent had sought help or advice in the last year because of worries about their child's mental health
- 81 per cent had contacted a professional service

Scholastic ability and attendance at school

Teachers were asked to rate the child's abilities in reading, mathematics and spelling compared with an average child of the same age and to estimate the child's age in terms of their scholastic ability. They were also asked to say whether the child had officially recognised special educational needs.

Basic skills

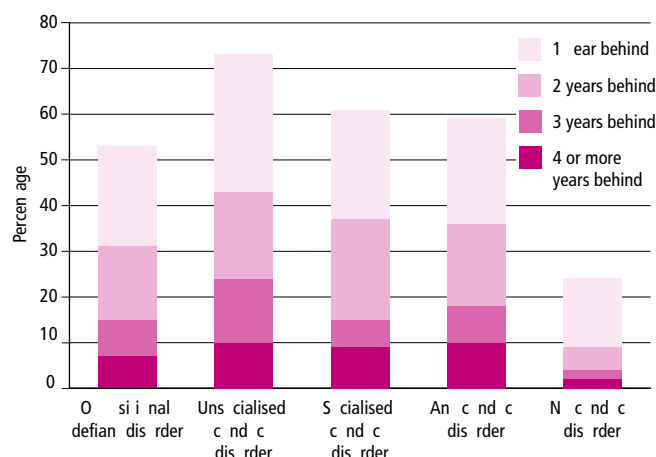
Over a half (56 per cent – 57 per cent) of children with conduct disorders had difficulty with reading and mathematics and nearly two-thirds (64 per cent) had problems with spelling. Among those with no such disorder these proportions were around a quarter (21 per cent, 23 per cent and 29 per cent). The difficulties of children with conduct disorders are reflected in the teacher's assessment of their overall functioning in relation to what would be expected of a child of that age: 59 per cent were rated as being behind in their overall intellectual development and 36 per cent were 2 or more years behind. For other children, these proportions were 24 per cent and 9 per cent. Children with unsocialised conduct disorders were more likely to be behind than those with oppositional defiant disorder (73 per cent compared with 53 per cent). Those with socialised conduct disorders were in between with 61 per cent being behind. (Figure 6.5 and Table 6.12).

Special educational needs

About a half (52 per cent) of children with conduct disorders were considered by their teachers to have special educational needs. This figure is over three times the proportion among other children, 15 per cent. The proportion with special educational needs ranged from 62 per cent among those with

Figure 6.5
Proportion of children who were behind in their overall scholastic ability by type of conduct disorder, 1999 and 2004 combined

Great Britain



unsocialised conduct disorder to 37 per cent among those with socialised conduct disorder. (Table 6.13)

Among the children who had special needs, those with conduct disorders were more likely than other children to have a written statement. (60 per cent compared with 44 per cent.) (Based on 2004 data, Table not shown)

Absence from school

Teachers reported that two thirds of all children had missed school for some reason in the previous term. However, those with a conduct disorder were more likely to have done so than other children (79 per cent compared with 68 per cent). The former were also away for longer periods – 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. In both groups, the majority of absences were authorised but 28 per cent of children with conduct disorders had had unauthorised absences compared with 8 per cent of other children. Truancy is one of the diagnostic criteria for conduct disorder and teachers reported that nearly one quarter (22 per cent) of children with such disorders had possibly or certainly played truant. The corresponding proportion for other children was just 3 per cent.

(Figure 6.6 and Table 6.14)

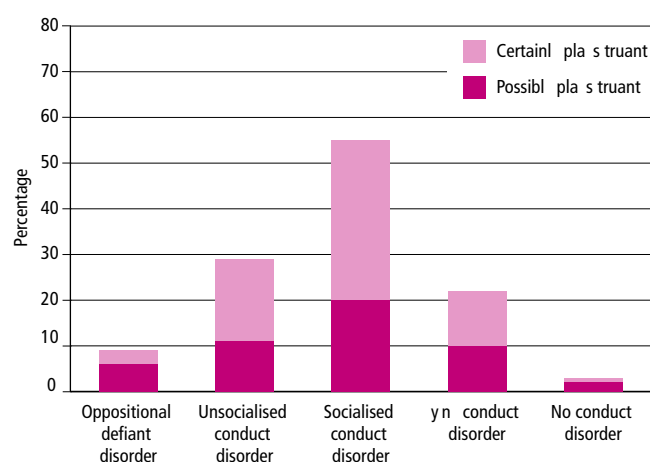
Absenteeism and truancy rates were relatively high in all the subgroups with conduct disorders but particularly among those with socialised conduct disorder. In this group: 87 per cent had been absent in the previous term; 55 per cent had had an

unauthorised absence; and 55 per cent were considered by their teachers to be definite or possible truants.

(Figure 6.6 and Table 6.14)

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

Great Britain



The teachers' questions were asked in both the 1999 and 2004 surveys and the figures quoted above are based on combined data from these studies. In 2004, parents were also asked about their child's absences from school and about any occasions on which they had been excluded. As with the teachers' reports, the parents of children with conduct disorders were more likely than other parents to report absences. Among the former, 41 per cent said that their child had missed school for reasons other than exclusion in the previous term compared with 34 per cent of the latter. Among the children who had been absent, 16 per cent of those with a conduct disorder had missed school because they refused to attend or had a school phobia. For other children this proportion was 2 per cent. One-tenth (10 per cent) of the children who had been absent from school had received some form of educational provision and there were no differences between children with and those with no conduct disorder in this respect. (The absence figures based on the parents' reports are lower than those based on the teachers' reports because the latter include exclusions and trancies; they also relate to a different population.)

(Table 6.15)

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. 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). For children with no conduct disorder, these proportions were 2 per cent and 1 per cent. (Table 6.16)

Overall, 8 per cent of exclusions had been permanent and 14 per cent of children had received some educational provision after exclusion. There were no differences between children with conduct disorders and other children who had been excluded in these respects. (Tables not shown)

Children with conduct disorders were also more likely than other children to have changed schools other than at the usual transition stages, although the differences were much less marked than for exclusions and there were no differences between the three subgroups. Nearly a third (30 per cent) of children with conduct disorders had changed schools compared with just under a fifth (18 per cent) of other children. This variation was not attributable to the higher rate of exclusions among those with a conduct disorder since only 3 per cent of children had changed schools following their exclusion and there was no difference between those with and those with no conduct disorder in this respect.

(Table 6.17)

Among children with conduct disorders:

- 59 per cent were behind in their overall intellectual development (*compared with 24 per cent for children with no conduct disorder*)
- 52 per cent had officially recognised special educational needs (*15 per cent*)
- 42 per cent had more than 5 days away from school in the previous term and 14 per cent had had more than 15 days absence (*21 per cent and 4 per cent*)
- 22 per cent were considered by teachers to be definite or possible truants (*3 per cent*)
- 33 per cent had been excluded from school and 30 per cent had changed schools apart from normal transitions (*2 per cent and 19 per cent*)

Among children with oppositional defiant disorder:

- 53 per cent were behind in their overall intellectual development
- 53 per cent had officially recognised special educational needs
- 33 per cent had more than 5 days away from school in the previous term and 9 per cent had had more than 15 days absence
- 9 per cent were considered by teachers to be definite or possible truants
- 22 per cent had been excluded from school

Among children with unsocialised conduct disorder:

- 73 per cent were behind in their overall intellectual development
- 62 per cent had officially recognised special educational needs
- 45 per cent had more than 5 days away from school in the previous term and 19 per cent had had more than 15 days absence
- 29 per cent were considered by teachers to be definite or possible truants
- 46 per cent had been excluded from school

Among children with socialised conduct disorder:

- 61 per cent were behind in their overall intellectual development
- 37 per cent had officially recognised special educational needs
- 62 per cent had more than 5 days away from school in the previous term and 26 per cent had had more than 15 days absence
- 55 per cent were considered by teachers to be definite or possible truants
- 48 per cent had been excluded from school

Social functioning of the family

This section looks at various aspects of parental health, attitudes and behaviour which provide indicators of the social functioning of the family.

Mental health of parent

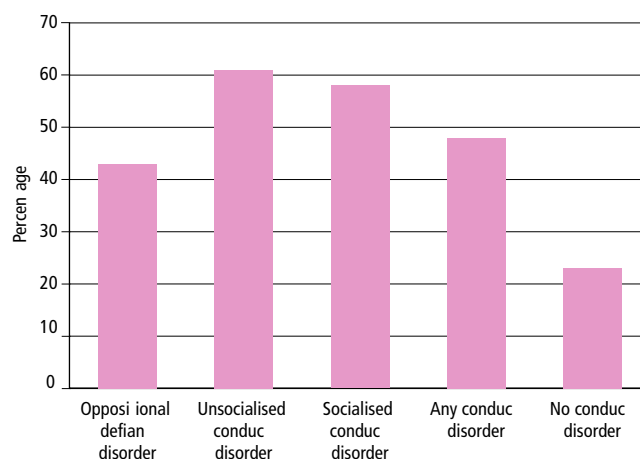
The parent who was interviewed about the child's behaviour, usually the mother, was asked about her own mental health using the General Health Questionnaire (GHQ-12 –see Chapter 2 for details). Scores range from 0 (no psychological distress) to 12 (severe psychological distress). A score of 3 is generally taken as the threshold with scores at this level or higher being considered indicative of an emotional disorder.

Nearly a half (48 per cent) of the parents of children with conduct disorders had scores of 3 or more, twice the proportion among other parents (23 per cent). Among the parents of children with unsocialised or socialised conduct disorders, the proportion was as high as three-fifths (61 per cent and 58 per cent).

(Figure 6.7 and Table 6.18)

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

Great Britain



Family functioning

Family functioning was measured using the FAD-GFS scale in which parents rated 12 statements about family relationships (see Chapter 2 for details). For this survey, families which scored over 2.00 on this scale were considered to have unhealthy functioning.

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. This pattern was evident in all three subgroups, the proportion living in families scoring above 2.00 ranging from 36 per cent among those with oppositional defiant disorder to 56 per cent among those with socialised conduct disorder. (Table 6.19)

Stressful life events

Parents were asked whether their child had experienced any of 10 potentially stressful events. The list in the 2004 survey was slightly different to that used in 1999 so the data are presented for 2004 only.

For all but two events, the proportions of children who had experienced the event were higher among those with conduct disorders than among other children. For both groups, the separation of parents was the most common life event. This was reported by over a half (54 per cent) of children with conduct disorders but by 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). Overall, children with conduct disorders were twice as likely as other children to have experienced two or more stressful life events (50 per cent compared with 25 per cent)

(Tables 6.20 and 6.21)

The proportions reporting two or more events were relatively high in all three subgroups with conduct disorder, 45 per cent among those with oppositional defiant disorder, 55 per cent among those with socialised conduct disorder and 60 per cent among those with unsocialised conduct disorder. In the last group, a fifth of parents (21 per cent) had been in trouble with the police and a quarter (24 per cent) had had a serious mental illness.

(Tables 6.20 and 6.21)

Among children with conduct disorders:

- 48 per cent of parents had an emotional disorder (*compared with 23 per cent for the parents of children with no conduct disorder*)
- 42 per cent lived in families with unhealthy functioning (17 per cent)
- 50 per cent had had two or more stressful life events (25 per cent)

Among children with oppositional defiant disorder:

- 43 per cent of parents had an emotional disorder
- 36 per cent lived in families with unhealthy functioning
- 45 per cent had had two or more stressful life events

Among children with unsocialised conduct disorder:

- 61 per cent of parents had an emotional disorder
- 46 per cent lived in families with unhealthy functioning
- 60 per cent had had two or more stressful life events

Among children with socialised conduct disorders:

- 58 per cent of parents had an emotional disorder
- 56 per cent lived in families with unhealthy functioning
- 55 per cent had had two or more stressful life events

Child's social functioning

In 2004, new questions were introduced to examine the child's strengths, the rationale being that these might provide protection against the onset and course of mental disorder as well as providing parents with the opportunity to describe their child's good points rather than focussing exclusively on their problems. The section also covers other features of social functioning which might affect the child's resilience: their relationships with friends, their social aptitudes and various measures of social capital.

Strengths

Both parents and young people were asked to rate the child on a series of items covering various qualities (see Chapter 2 for details). Scores on the adult scale ranged from 0-48 and those on the children's scale ranged from 0-38. Table 6.22 shows the scores on each scale grouped into quartiles. Looking first at the parent's assessment, three-quarters (77 per cent) of children with conduct disorders had scores in the bottom quartile compared with 23 per cent of other children. The same pattern occurred in all three subcategories of conduct disorder but children with unsocialised or socialised conduct disorder were more likely than those with oppositional defiant disorder to fall into the bottom quartile, 88 per cent and 85 per cent compared with 68 per cent.

(Table 6.22)

The children's own assessments of their strengths showed the same pattern of variation as those of the parents but the differences were not so large. On this measure, nearly a half (46 per cent) of children with conduct disorders had scores in the bottom quartile compared with 22 per cent of other children. The children's scale did not include all the items on the parent's scale and was asked only of young people aged 11-16 so the scores are not directly comparable.

(Table 6.22)

Social aptitudes

The social aptitude scale consisted of 10 questions addressed to parents designed to measure the child's ability to empathise with others (see Chapter 2 for details). Scores ranged from 0-40 and were grouped into quartiles. About two-thirds (69 per cent) of children with conduct disorders had scores in the bottom quartile compared with 22 per cent of other children. Children with unsocialised conduct disorder again had particularly low scores, 82 per cent were in the bottom quartile compared with 64 per cent of those with oppositional defiant or socialised conduct disorders.

(Table 6.23)

Social capital

'Social capital' is a multi-faceted concept which has been defined as 'networks together with shared norms, values and understandings that facilitate co-operation within and among groups' (Cote and Healey, 2001). It is believed that high levels of social capital have a positive effect on health. The aspects of social capital covered in this report are:

- relationships with friends;
- social support;
- views about the neighbourhood;
- help provided to others; and
- participation in clubs and groups.

Many of the questions are taken from the children and young

person modules included in the 2003 Home Office Citizenship Survey. The questions on friends were asked of all parents. The remaining topics were asked of young people aged 11 or over only because previous research has shown that younger children were not able to cope with some of the more complex questioning. The analysis of these questions is not presented for the subcategories of conduct disorders because of the small bases.

Relationships with friends

Questions on friendships were asked of the interviewed parent and covered:

- the child's ability to make and keep friends;
- number of friends;
- common interests and shared activities;
- emotional support; and
- parent's approval of child's friends.

On all these measures children with conduct disorders performed less well than other children. For example, among the former, 24 per cent found it harder than average to make friends and 33 per cent found it harder to keep friends. The proportions for children with no conduct disorder were 9 per cent and 4 per cent. Likewise, 35 per cent compared with 20 per cent did not have a friend whom they could talk to if they were worried. The variations in the proportions who shared interests or activities with friends and in the number of friends were similar. (Table 6.24)

As might be expected, children with unsocialised conduct disorders who tended to have solitary behaviour patterns, fared particularly badly on these measures. Thus about a half had difficulty making and keeping friends (47 per cent and 54 per cent) and a similar proportion had no-one to talk to if they were worried (50 per cent). Those with socialised conduct disorders, on the other hand, were similar in many respects to children with no conduct disorder, although they did have more difficulty in keeping friends – 17 per cent compared with 4 per cent found this harder than average. (Table 6.24)

The parents of children with conduct disorders were much more likely than other parents to disapprove of their child's friends, 10 per cent compared with 1 per cent. Similarly, the former were more likely to say that many or all of their child's friends got into trouble, 15 per cent compared with 1 per cent. This last proportion rose to 35 per cent among those with unsocialised conduct disorder. Children with oppositional defiant disorder tend to be rated more positively than the other subgroups at these questions: only 4 per cent of parents disapproved of their friends and 8 per cent thought that many or all of their child's friends got into trouble. Further analysis

showed that this variation was not attributable to their younger age profile. (Table 6.24)

Social support

Young people aged 11–16 were asked about the number of family members and friends to whom they felt close. A scale was constructed from the responses with scores ranging from 0 to 20 which were grouped into rough quartiles. Those with a conduct disorder were twice as likely as other young people to have a score in the lowest quartile (54 per cent compared with 27 per cent). (Table 6.25)

Views about the neighbourhood

Young people aged 11–16 who had conduct disorders were less positive about their neighbourhood than other children. For example, 21 per cent (compared with 7 per cent) did not enjoy living there, 32 per cent (compared with 18 per cent) thought that few or no people could be trusted and 65 per cent (compared with 42 per cent) thought that it was unlikely that a lost bag would be returned. As was shown earlier, children with conduct disorders tended to live in poorer areas than other children. However, the differences in their views persisted within different types of area. (Table not shown) There were no differences, however, between children with and those with no conduct disorder in opinions about safety while walking alone during the daytime or in visiting local shops or the park alone. (Table 6.26)

Help provided to others

Young people were asked separately about types of help that they provided to relatives and non-relatives. In the previous chapter, it was noted that children with an emotional disorder were more likely than other children to give help to family members and other relatives. The reverse was the case for those with a conduct disorder, 84 per cent gave help compared with 94 per cent. There were no differences, however, in the extent to which the two groups provided help to non-relatives, or in the frequency with which either form of help was given. (Table 6.27)

Likewise, there were no differences in the proportions who were paid for the help they gave (Table not shown) or in the proportions who did some form of paid work at least once a month. (Table 6.28)

Participation in groups, clubs and organisations

Young people with conduct disorders were much less likely than those with no such disorder to take part in school-based groups, clubs or organisations, 56 per cent compared with 79 per cent. Looking at the more common types of group, 38 per

cent of children with conduct disorders attended sports groups compared with 52 per cent of other children. For art, drama and music clubs, the proportions were 15 per cent and 33 per cent. However, there were no differences in the proportions involved in computer clubs and youth clubs. (Table 6.29)

The same pattern prevailed in relation to groups, clubs or organisations outside school: 55 per cent of children with a conduct disorder attended such groups compared with 67 per cent of other children. Again there were large differences in participation rates for sport clubs (24 per cent and 38 per cent) and arts, drama and music clubs (9 per cent and 18 per cent) but no differences with regard to youth clubs. (Table 6.29)

Children with conduct disorders were also the less likely to have given unpaid help in the last 12 months to a group, club or organisation, 39 per cent compared with 59 per cent. (Table 6.30)

There were no differences between children with conduct disorders and those with no such disorder in the proportions mentioning any type of barrier to participation, but the former were a little less likely to mention lack of time, either because of homework (5 per cent and 12 per cent) or simply that they were too busy (8 per cent and 15 per cent). Common reasons for non-participation among both groups were that the child thought that there were no suitable groups available locally or that they had no desire to participate (16 per cent overall for both). (Table 6.31)

Among children with conduct disorders:

- 24 per cent found it harder than average to make friends (compared with 9 per cent for children with no conduct disorder)
- 46 per cent of parents did not fully approve of their child's friends (14 per cent)
- 21 per cent did not enjoy living in the neighbourhood (7 per cent)
- 84 per cent had given help to relatives and 43 per cent had helped non-relatives (94 per cent and 40 per cent)
- 56 per cent had taken part in a school-based group and 55 per cent had taken part in a group outside school in the last year (79 per cent and 67 per cent)

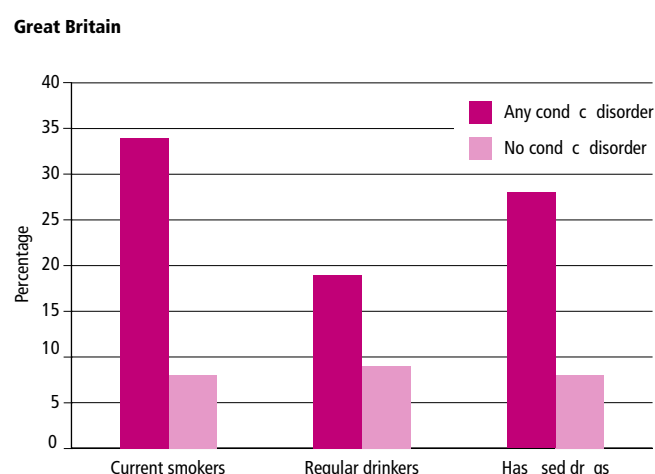
Smoking, drinking and drug use

Questions on smoking, drinking and drug use were included in both the 1999 and 2004 surveys. They were addressed to children aged 11–16 and were based on questions used in the national surveys of smoking, drinking and drug use among schoolchildren. A comparison of the data from the 1999

Children's Mental Health Survey with the 1999 Schools Survey showed that children interviewed at home systematically under-reported their smoking, drinking and drug use compared with those interviewed in school. The rates presented in this report should not therefore be taken as true estimates of prevalence. Their main value is in enabling comparisons to be made between children with a disorder and other children. As these behaviours vary with age, percentages are shown separately for young people aged 11–13 and those aged 14–16.

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. Thus, looking at smoking behaviour among young people with a conduct disorder and those with no such disorder, 34 per cent compared with 8 per cent were smokers and 30 per cent compared with 5 per cent were regular smokers (smoking at least one cigarette a week). The differences were evident even in the younger age group, 11–13: 13 per cent of those with a conduct disorder smoked compared with only 2 per cent of other children. Among older children, aged 14–16, over a half (54 per cent) of those with a conduct disorder smoked compared with 16 per cent of other young people. (Figure 6.8 and Table 6.32)

Figure 6.8
Smoking, drinking and drug use by whether has a conduct disorder: children aged 11–16, 1999 and 2004 combined



Drinking behaviour showed the same pattern but the differences were less marked and largely confined to the older age group. Among those aged 14–16, young people with conduct disorders were twice as likely as those with no such disorder to be regular drinkers (drinking once a week or more often), 32 per cent compared with 16 per cent. Even in the younger age group, however, there were differences in

exposure: nearly a half (46 per cent) of those with a conduct disorder had had an alcoholic drink at some time compared with only a third (33 per cent) of other young people.

(Figure 6.8 and Table 6.33)

Turning to drug use, 28 per cent of young people with a conduct disorder had taken drugs at some time compared with only 8 per cent of other young people. As with smoking, the differences were large even in the youngest age group: 13 per cent of 11- to 13-year-olds with a conduct disorder had taken drugs compared with 2 per cent of other young people. Among 14- to 16-year-olds, the difference was very marked, 43 per cent compared with 15 per cent. Cannabis was the most commonly used drug, taken by 23 per cent of young people with a conduct disorder and 6 per cent of other young people. Among the former, 5 per cent had taken amphetamines and 4 per cent had taken inhalants. These substances had been taken by less than 1 per cent of other young people.

(Figure 6.8 and Table 6.34)

In the 2004 survey, young people were asked about the social context of the last occasions on which they had smoked, drunk alcohol and taken drugs. The only statistically significant variations were in the situations on the last drinking occasion. Young people with conduct disorders were much more likely than other young people to have drunk alcohol outside in a public place (25 per cent compared with 6 per cent) and less likely to have drunk at home (31 per cent compared with 43 per cent). There were no differences between young people with a conduct disorder and those with no such disorder in the size of the group with whom they had been drinking but the former were more likely to have been accompanied by a boyfriend or girlfriend (15 per cent compared with 6 per cent) or other friends (64 per cent compared with 52 per cent) and less likely to have been with family members (32 per cent compared with 45 per cent).

(Table 6.35)

Among children aged 11–16 with conduct disorders:

- 30 per cent were regular smokers (*compared with 5 per cent for children with no conduct disorder*)
- 19 per cent were regular drinkers (*9 per cent*)
- 28 per cent had taken drugs at some time (*8 per cent*)

Self-harm

All parents were asked whether the child had ever tried to hurt, harm or kill themselves and the same question were asked of older children aged 11–16 (see Chapter 2 for details). Looking first at parents' reports for children of all ages, those whose child had a conduct disorder were much more likely to say that the child had tried to harm themselves, 16 per cent compared with 2 per cent. The variations for young people aged 11–16

showed a similar pattern, 18 per cent and 2 per cent based on parents' reports and 21 per cent and 6 per cent based on self-reports.

(Table 6.36)

Results from the six-month follow-up survey

Samples of the parents of children interviewed in the 1999 and 2004 surveys were sent a self-completion questionnaire six months after the interview in order to establish whether there had been any change in their symptoms (see Chapter 3).

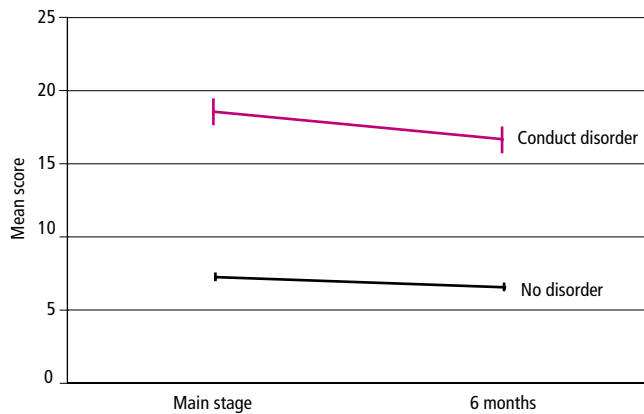
The average levels of total and behavioural symptoms among the children with conduct disorders did fall slightly over the six months following the survey. However, as Figures 6.9 and 6.10 show, the gap between children with and those with no conduct disorder only narrowed a little as a result. The symptoms of conduct disorders were typically persistent, at least in the short term. By contrast, the impact of these symptoms fell by about a third over the six months, as shown in Figure 6.11. At first glance, it seems surprising that impact dropped by a third although the level of symptoms was fairly steady. The most likely explanation is that the impact of symptoms depends not just on the symptoms themselves but on everything else in the child's life. Changes at home or at school may make symptoms easier or harder to live with.

(Figures 6.9–6.11)

Since a diagnosis of a conduct disorder is only made when a child experiences both conduct symptoms and resultant impact, children can move in and out of having a diagnosable disorder according to whether or not their symptoms have a substantial impact at any given time. Some of the children who had a diagnosis of a conduct disorder at the time of the main survey would not have warranted a diagnosis six months later because their symptoms were not having a substantial impact. Conversely, some children who did not quite warrant a diagnosis at the time of the main survey would have met the criteria six months later because their symptoms were then having a substantial impact. The frontier between normality and disorder is somewhat arbitrary, so it not surprising that some children cross and re-cross the boundary as a result of the ups and downs of life (not to mention the imprecision of the diagnostic process itself).

Figure 6.9
Total symptoms¹ at main interview and at six-month follow-up by whether child had a conduct disorder at main interview, 1999 and 2004 combined

Great Britain



¹ Total symptoms is the 'total difficulties score' on the parent-reported SDQ, reflecting the sum of the subscale scores for emotional symptoms, conduct problems, hyperactivity and peer problems.

Figure 6.10
Conduct symptoms at main interview and at six-month follow-up by whether child had a conduct disorder at main interview, 1999 and 2004 combined

Great Britain

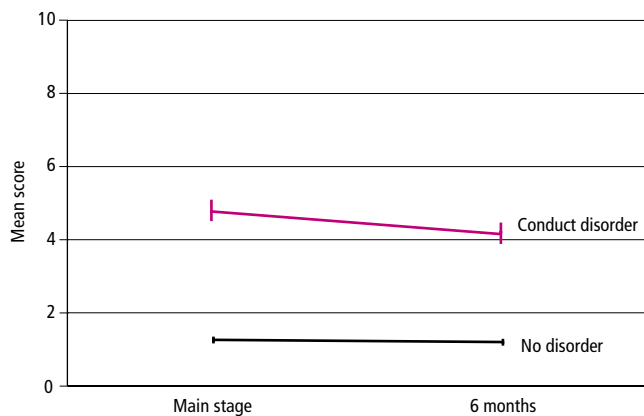
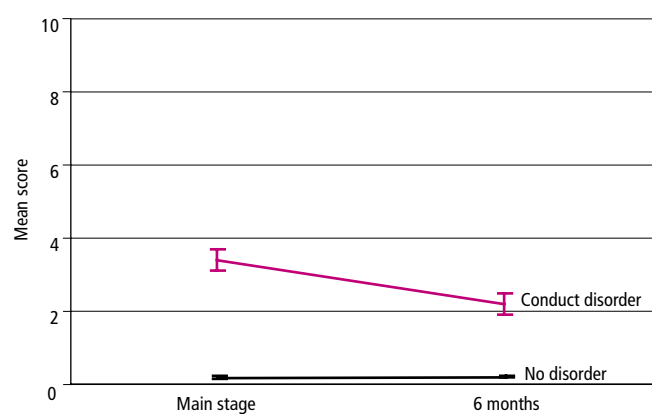


Figure 6.11
Impact of symptoms at main interview and at six-month follow-up by whether child had a conduct disorder at main interview, 1999 and 2004 combined

Great Britain



References

Goddard E and Higgins V (1999) *Smoking, drinking and drug use among young teenagers in 1998 (Volume I: England)*, TSO: London.

Home Office (December 2004) *2003 Home Office Citizenship Survey*, Home Office Research, Development and Statistics Directorate.

Table 6.1**Sex, age and ethnicity of child by type of conduct disorder, 1999 and 2004 combined**

All children

Great Britain

	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
Sex						
Boys	69	71	70	69	50	51
Girls	31	29	30	31	50	49
Age						
5–10	63	39	14	45	53	53
11–16	37	61	86	55	47	47
Ethnicity						
White	91	96	90	92	89	89
Black ²	4	3	6	4	3	3
Indian	1	1	1	1	2	2
Pakistani/ Bangladeshi	2	-	1	2	3	3
Other	2	-	2	2	3	3
<i>Base (weighted)</i>	<i>481</i>	<i>102</i>	<i>184</i>	<i>902</i>	<i>17502</i>	<i>18403</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. Includes people of mixed black and white origin.

Table 6.2**Family characteristics by type of conduct disorder, 1999 and 2004 combined**

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Family type						
Married	50	37	43	46	69	68
Cohabiting	13	14	10	12	8	8
Lone parent – single	15	16	13	14	7	8
Lone parent – widowed, divorced or separated	22	32	35	27	15	16
Number of children in household						
1	20	24	24	22	23	23
2	41	31	37	38	45	45
3	26	20	20	23	22	22
4	9	19	13	12	7	7
5 or more	5	7	6	5	3	3
<i>Base (weighted 1999 and 2004 data)</i>	<i>481</i>	<i>102</i>	<i>184</i>	<i>902</i>	<i>17514</i>	<i>18415</i>
If stepchildren in family						
Yes	16	18	22	18	10	11
No	84	82	78	82	90	89
<i>Base (weighted 2004 data)²</i>	<i>215</i>	<i>57</i>	<i>90</i>	<i>407</i>	<i>7570</i>	<i>7977</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. The 1999 data had a different classification for whether or not a family contained stepchildren.

Table 6.3

Parent's education and socio-economic characteristics by type of conduct disorder, 1999 and 2004 combined

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Parent's highest educational qualification						
Degree level	7	1	6	6	13	13
Teaching/HND/Nursing	7	7	5	7	11	11
A /AS level or equivalent	9	6	8	8	11	11
GCSE Grades A–C or equivalent	25	18	22	23	30	30
GCSE Grades D–F or equivalent	15	12	11	13	11	11
Other qualification	4	-	6	4	3	3
No qualification	34	57	43	39	20	21
Parent's employment status						
Both working/lone parent working	54	33	51	49	68	67
One parent working	18	18	15	17	19	19
Neither working/lone parent not working	28	49	34	34	14	15
<i>Base (weighted 1999 and 2004 data)</i>	<i>478</i>	<i>102</i>	<i>183</i>	<i>894</i>	<i>17217</i>	<i>18111</i>
Family's socio-economic classification						
Large employers and higher managerial	2	-	-	1	2	2
Higher professional	2	-	2	2	3	3
Lower managerial and professional	11	4	13	11	21	20
Intermediate occupations	19	11	18	17	19	19
Small employers and own account	8	2	2	6	7	7
Lower supervisory and technical	1	3	2	1	1	1
Semi-routine	33	46	32	33	26	26
Routine occupations	15	24	23	18	12	12
Never worked/ long-term unemployed	8	12	6	9	5	5
FT student/inadequate description	3	-	1	3	4	4
<i>Base (weighted 2004 data)²</i>	<i>215</i>	<i>57</i>	<i>90</i>	<i>407</i>	<i>7570</i>	<i>7977</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. The 1999 data had a different social classification.

3. This is the National Statistics Socio-economic Classification (NS-SEC).

Table 6.4

Housing and income by type of conduct disorder, 1999 and 2004 combined

All children

Great Britain

	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
Type of accommodation						
Detached	13	8	8	11	26	25
Semi-detached	38	39	39	39	38	38
Terraced house	42	45	45	42	30	30
Flat/maisonette	8	8	8	8	7	7
Tenure						
Owners	46	30	36	41	71	69
Social sector tenants	45	56	58	50	23	24
Private renters	9	14	6	9	7	7
<i>Base (weighted 1999 and 2004 data)</i>	<i>481</i>	<i>102</i>	<i>184</i>	<i>902</i>	<i>17503</i>	<i>18404</i>
Gross weekly household income						
Under £100	8	7	6	7	4	4
£100–£199	26	32	35	30	15	16
£200–£299	19	27	20	21	14	14
£300–£399	14	10	14	13	12	12
£400–£499	11	6	7	8	11	11
£500–£599	6	8	5	6	10	10
£600–£770	5	7	6	5	13	13
Over £770	11	3	8	9	21	20
<i>Base (weighted 1999 and 2004 data)</i>	<i>443</i>	<i>90</i>	<i>169</i>	<i>821</i>	<i>16075</i>	<i>16896</i>
Receipt of disability benefits						
Carers allowance	6	20	3	9	2	3
Severe Disablement allowance	14	18	7	15	5	6
Disability living/attendance allowance	2	3	1	2	0	0
Incapacity allowance	1	5	4	3	2	2
Any disability allowance	17	31	10	20	8	8
No disability allowance	83	69	90	80	92	92
<i>Base (weighted 2004 data)²</i>	<i>215</i>	<i>57</i>	<i>90</i>	<i>407</i>	<i>7570</i>	<i>7977</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. The 1999 data covered different types of disability benefit.

Table 6.5

Region, country and area type by type of conduct disorder, 1999 and 2004 combined

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Region and country						
London Inner	4	3	5	4	5	5
London Outer	6	2	7	5	7	7
Other met England	33	28	33	32	31	31
Non-met England	47	54	43	48	44	44
England	90	87	89	89	86	86
Scotland	6	9	8	8	9	8
Wales	4	4	4	4	5	5
<i>Base (weighted 1999 and 2004 data)</i>	<i>481</i>	<i>102</i>	<i>184</i>	<i>902</i>	<i>17513</i>	<i>18415</i>
Area type (ACORN classification)						
Wealthy achievers	10	10	12	11	26	26
Urban prosperity	6	2	6	5	8	8
Comfortably off	26	7	18	22	26	26
Moderate means	22	21	19	21	17	17
Hard pressed	36	61	45	41	23	24
<i>Base (weighted 2004 data)²</i>	<i>214</i>	<i>57</i>	<i>90</i>	<i>406</i>	<i>7510</i>	<i>7917</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. The 1999 data had a different ACORN classification.

Table 6.6

Child's general health by type of conduct disorder, 1999 and 2004 combined

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Child's general health						
Very good	53	46	54	50	70	69
Good	31	38	30	32	24	24
Fair	14	10	14	15	5	6
Bad	2	5	2	2	0	1
Very bad	0	1	-	0	0	0
<i>Base (weighted)</i>	<i>479</i>	<i>102</i>	<i>183</i>	<i>897</i>	<i>17276</i>	<i>18172</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.7**Co-occurrence of physical and developmental problems with conduct disorders, 1999 and 2004 combined**

All children

Great Britain

Type of conduct disorder						
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
Percentage of children with each type of physical complaint						
Asthma	19	21	15	19	15	15
Eczema	13	11	11	13	13	13
Hay fever	12	11	14	12	10	11
Eyesight problems	13	19	14	14	10	10
Stomach or digestive problems	8	7	7	7	6	6
Non-food allergy	5	9	9	6	6	6
Migraine/severe headache	5	9	10	8	5	5
Bed wetting	14	11	7	12	4	5
Glue ear/otitis media/grommits	6	5	2	5	4	4
Hearing problems	8	6	3	6	4	4
Speech or language problems	13	7	3	11	3	4
Food allergy	6	4	3	6	3	4
Difficulty with co-ordination	9	7	1	7	2	2
Stiffness or deformity of foot	4	4	5	4	2	2
Heart problems	2	2	0	2	1	1
Soiling pants	4	3	2	4	1	1
Muscle disease or weakness	2	2	3	2	1	1
Kidney/urinary tract problems	2	1	2	2	1	1
Obesity	2	2	1	2	1	1
Congenital abnormality	0	-	-	0	1	1
Epilepsy	2	1	0	3	1	1
Any blood disorder	1	-	1	1	0	0
Diabetes	0	1	2	1	0	0
Cerebral Palsy	1	-	-	1	0	0
Cancer	-	1	-	0	0	0
Any physical or developmental problem²	66	66	60	65	53	54
No problem	34	34	40	35	47	46
<i>Base (weighted)</i>	<i>479</i>	<i>102</i>	<i>183</i>	<i>897</i>	<i>17276</i>	<i>18172</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. Some physical complaints are not listed in the table above because of their rarity (less than 25 cases): ME (10), Spina bifida (6), Cystic fibrosis (11), Missing digits (20) They are included in the 'Any physical or developmental problem' category.

Table 6.8

Co-occurrence of other mental disorders with conduct disorders, 1999 and 2004 combined

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
<i>Percentage of children with each type of disorder</i>						
Other mental disorders						
Emotional disorders:						
Anxiety disorders	17	17	10	15	3	4
Depression	3	12	11	6	1	1
All emotional disorders	18	22	18	19	3	4
Hyperkinetic disorders	18	34	11	17	1	1
Less common disorders	1	3	0	3	1	1
Any other disorder	33	54	27	35	4	6
No (other) disorders	67	46	73	65	96	94
<i>Base (weighted)</i>	<i>481</i>	<i>102</i>	<i>184</i>	<i>902</i>	<i>17513</i>	<i>18415</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.9

Parent's view of child's mental health by type of conduct disorder, 1999 and 2004 combined

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
<i>Percentage of children with each type of problem</i>						
Parent's view of child's mental health						
Emotional problems	24	37	27	27	3	5
Behavioural problems	50	72	57	55	3	6
Hyperactivity	23	39	15	23	3	4
Any of the above	59	78	66	64	7	10
<i>Base (weighted)</i>	<i>479</i>	<i>102</i>	<i>183</i>	<i>897</i>	<i>17277</i>	<i>18174</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.10**Whether child is taking any medication by whether has a conduct disorder, 2004**

All children	Great Britain		
	Any conduct disorder	No conduct disorder	All
<i>Percentage of children taking each type of medication</i>			
Methylphenidate, Equasym, Ritalin	7	0	1
Dexamphetamine, Dexedrine	1	-	0
Imipramine, Tofranil	0	0	0
Clonidine, Catepres, Dixarit	0	0	0
Fluoxetine, Prozac	-	0	0
Sertraline, Lustral	0	0	0
Fluvoxamine, Faverin	-	0	0
Citalopram, Cimpramil	1	0	0
Amitryptaline, Lentizol, Triptafen	-	0	0
Sulpirade, Dolmatil, Sulparex, Sulpitil	-	0	0
Risperidone, Riperadal	1	0	0
Haloperidol, Dozic, Haldol, Serenace	0	-	0
Any medication	9	1	1
No medication	91	99	99
<i>Base (weighted)</i>	<i>404</i>	<i>7458</i>	<i>7862</i>

Table 6.11**Help sought in last year for child's mental health problems by type of conduct disorder, 2004**

All children	Great Britain					
	Type of conduct disorder					
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
Percentage of children using each service/source						
Specialist services						
Child/adult mental health specialist (eg psychiatrist)	26	43	19	28	2	3
Child physical health specialist (eg paediatrician)	5	6	2	7	2	2
Social services (eg social worker)	10	32	15	16	1	2
Education services (eg educational psychologist)	23	30	19	24	3	4
Front line services						
Primary health care (eg GP or practice nurse)	30	34	34	32	5	6
Teachers	54	63	64	60	16	18
All professional services	69	85	81	76	19	22
Informal sources						
Family member/friends	29	44	47	34	11	12
Internet	6	5	5	6	1	1
Telephone help line	2	10	5	4	0	1
Self-help group	5	-	1	3	0	0
Other type of help	7	10	6	7	1	2
All sources	74	90	87	81	25	28
No help sought	26	10	13	19	75	72
Base (weighted)	213	57	89	402	7383	7784

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.12**Teacher's rating of child's basic skills by type of conduct disorder, 199 and 2004 combined**

All children

Great Britain

	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
Reading						
Above average	14	6	13	13	38	37
Average	30	29	38	31	41	40
Some difficulty	33	38	37	34	16	17
Marked difficulty	23	27	13	22	5	6
Mathematics						
Above average	15	6	11	13	32	31
Average	30	29	38	30	45	44
Some difficulty	34	42	38	36	18	19
Marked difficulty	21	23	13	21	5	6
Spelling						
Above average	12	4	10	10	29	28
Average	26	24	31	27	42	41
Some difficulty	32	41	45	36	21	21
Marked difficulty	30	31	13	28	8	9
<i>Base (weighted)</i>	<i>408</i>	<i>77</i>	<i>126</i>	<i>708</i>	<i>13466</i>	<i>14174</i>
Overall scholastic ability²						
4 or more years behind	7	10	9	10	2	2
3 years behind	8	14	6	8	2	2
2 years behind	16	19	22	18	5	5
1 year behind	22	30	24	23	15	15
Equivalent	30	22	24	27	36	35
1 or more years ahead	16	5	15	15	41	40
<i>Base (weighted)</i>	<i>375</i>	<i>64</i>	<i>111</i>	<i>638</i>	<i>12616</i>	<i>13254</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. Functioning age-actual age.

Table 6.13**Whether child has special educational needs by type of conduct disorder, 1999 and 2004 combined**

All children

Great Britain

	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
If child has officially recognised special educational needs						
Yes	53	62	37	52	15	17
No	47	38	63	48	85	83
<i>Base (weighted)</i>	<i>404</i>	<i>76</i>	<i>125</i>	<i>701</i>	<i>13242</i>	<i>13943</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.14**Absence from school and truancy (teacher's report) by type of conduct disorder, 1999 and 2004 combined**

All children

Great Britain

	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
Number of days absent in last term						
0	26	19	13	21	32	32
1–5	42	36	26	38	46	46
6–10	18	19	18	18	13	13
11–15	6	7	18	10	4	4
16 or more	9	19	26	14	4	5
Any days absent	74	81	87	79	68	68
<i>Base (weighted)</i>	<i>282</i>	<i>57</i>	<i>89</i>	<i>495</i>	<i>9890</i>	<i>10385</i>
Any unauthorised days absent						
Yes	18	26	55	28	8	9
No	82	74	45	72	92	91
<i>Base (weighted 2004 data)²</i>	<i>127</i>	<i>29</i>	<i>47</i>	<i>222</i>	<i>4467</i>	<i>4689</i>
Whether plays truant						
Not true	91	71	44	78	98	97
Somewhat true	6	11	20	10	2	2
Certainly true	3	18	35	12	1	1
<i>Base (weighted)</i>	<i>410</i>	<i>77</i>	<i>125</i>	<i>712</i>	<i>13553</i>	<i>14265</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. This question was not asked in 1999.

Table 6.15

Absence from school (parent's report) by whether has a conduct disorder, 2004

All children	Great Britain		
	Any conduct disorder	No conduct disorder	All
	%	%	%
Whether missed school in last term¹			
Yes	41	34	34
No	59	66	66
<i>Base (weighted): all children</i>	<i>377</i>	<i>7244</i>	<i>7621</i>
Reasons for absence			
Short-term illness	67	79	78
Long-term illness	5	2	2
Refused to attend	13	1	2
Has a school phobia	3	0	0
Other	25	20	20
<i>Base (weighted): those who missed school</i>	<i>155</i>	<i>2445</i>	<i>2599</i>
Whether child received any educational provision			
Yes	9	10	10
No	91	90	90
<i>Base (weighted): those who missed school (excluding short-term illness)</i>	<i>65</i>	<i>587</i>	<i>652</i>

1. Excluding exclusions.

Table 6.16

Exclusions from school (parent's report) by type of conduct disorder, 2004

All children	Great Britain					
	Type of conduct disorder					
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Number of times child has been excluded from school						
None	78	54	52	67	98	96
Once	7	19	20	12	1	2
Twice	6	3	8	7	0	1
Three or more times	8	24	20	15	0	1
<i>Base (weighted)</i>	<i>212</i>	<i>57</i>	<i>88</i>	<i>398</i>	<i>7372</i>	<i>7770</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.17**Number of times child has changed schools by whether has a conduct disorder, 2004**

All children	Great Britain		
	Any conduct disorder	No conduct disorder	All
	%	%	%
Number of times child has changed school¹			
None	70	82	81
Once	19	14	14
Twice	4	3	3
Three or more times	7	2	2
<i>Base (weighted)</i>	<i>401</i>	<i>7376</i>	<i>7776</i>

1. Apart from normal transitions.

Table 6.18**Parent's GHQ-12 score by type of conduct disorder, 1999 and 2004 combined**

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Parent's GHQ-12²						
0-2	57	39	42	52	77	76
3-5	20	24	21	20	13	13
6-8	13	18	14	14	6	7
9-12	10	19	22	14	4	4
3 or more	43	61	58	48	23	24
<i>Base (weighted)</i>	<i>474</i>	<i>101</i>	<i>182</i>	<i>886</i>	<i>17097</i>	<i>17983</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. For this survey, scores of 3 or more were taken to indicate a severe emotional problem.

Table 6.19**Family functioning score by type of conduct disorder, 1999 and 2004 combined**

All children

Great Britain

	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
Family functioning score²						
Up to 1.50	22	18	12	18	37	36
1.51–2.00	42	36	32	40	46	46
2.01–2.50	28	23	41	30	15	16
2.51 or more	8	22	15	12	2	3
Unhealthy functioning (2.01 or more)	36	46	56	42	17	18
<i>Base (weighted)</i>	<i>472</i>	<i>101</i>	<i>180</i>	<i>878</i>	<i>17030</i>	<i>17908</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

2. For this survey, scores over 2.0 were taken to indicate unhealthy family functioning.

Table 6.20**Stressful life events by type of conduct disorder, 2004**

All children

Great Britain

	Type of conduct disorder					
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
Percentage reporting each event						
Stressful life events						
Since child was born, parent had a separation due to marital difficulties or broken off steady relationship	52	57	62	54	30	31
Since child was born, parent had a major financial crisis such as losing the equivalent of three months income	21	30	25	22	13	13
Since child was born, parent had a problem with the police involving a court appearance	12	21	14	15	5	6
Since child was born, parent has had serious physical illness	9	15	14	11	7	8
Since child was born, parent has had serious mental illness	18	24	14	17	7	8
At any stage in child's life, a parent, brother or sister died	6	3	5	6	3	4
At any stage in child's life, a close friend died	9	13	15	11	6	6
At some stage in the child's life, s/he had a serious illness which required a stay in hospital	20	22	18	21	13	13
At any stage in child's life, s/he had been in a serious accident or badly hurt in an accident	9	13	6	10	5	5
In the past year child has broken off a steady relationship with a boy or girl friend (aged 13 or above)/ a close friendship has ended (any age)	12	16	17	13	6	7
Base (weighted)	213	56	89	401	7369	7770

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.21**Number of stressful life events by type of conduct disorder, 1999 and 2004 combined**

All children						Great Britain
	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
Number of stressful life events						
0	18	24	16	18	43	42
1	36	16	29	32	32	32
2	20	21	21	20	15	15
3	17	17	20	18	7	7
4	5	10	11	7	2	3
5 or more	3	12	3	5	1	1
Two or more events	45	60	55	50	25	26
<i>Base (weighted)</i>	<i>213</i>	<i>56</i>	<i>89</i>	<i>401</i>	<i>7369</i>	<i>7770</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.22**Child's strengths (parent's and child's assessment) by type of conduct disorder, 2004**

All children						Great Britain
	Type of conduct disorder					All
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	
	%	%	%	%	%	%
ALL CHILDREN						
Strength score – parent assessment						
0–36	68	88	85	77	23	25
37–40	17	5	8	13	25	25
41–43	7	3	5	6	26	25
44–48	7	4	1	5	26	25
<i>Base (weighted)</i>	<i>205</i>	<i>54</i>	<i>87</i>	<i>386</i>	<i>7185</i>	<i>7571</i>
CHILDREN AGED 11–16						
Strength score – child assessment						
0–23	41	(42)	53	46	22	23
24–27	24	(34)	32	28	27	27
28–30	26	(15)	6	16	23	23
31–38	10	(9)	9	10	28	27
<i>Base (weighted)</i>	<i>68</i>	<i>20</i>	<i>63</i>	<i>162</i>	<i>3176</i>	<i>3338</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.23**Social aptitude (parent's assessment) by type of conduct disorder, 2004**

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
Social aptitude score						
0–20	64	82	64	69	22	25
21–24	19	12	22	17	28	27
25–28	10	3	7	8	23	22
29–40	7	2	7	6	26	25
<i>Base (weighted)</i>	<i>202</i>	<i>55</i>	<i>87</i>	<i>385</i>	<i>7098</i>	<i>7483</i>

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.24
Friendships by type of conduct disorder, 2004

All children	Type of conduct disorder					Great Britain
	Oppositional defiant disorder	Unsocialised conduct disorder	Socialised conduct disorder	Any conduct disorder ¹	No conduct disorder	All
	%	%	%	%	%	%
What is child like at making friends?						
Finds it harder than average	23	47	6	24	9	10
About average	36	27	42	36	36	36
Easier than average	41	26	53	40	55	54
What is child like at keeping friends?						
Finds it harder than average	31	54	17	33	4	5
About average	38	30	43	37	35	35
Easier than average	31	16	40	30	61	59
Number of friends						
None	7	10	-	8	1	2
1	12	24	4	12	4	4
2–4	44	42	43	43	43	43
5–9	25	24	42	28	40	39
10 or more	12	-	11	9	12	11
<i>Base (weighted): all children</i>	212	57	88	401	7439	7840
Do child and friends have things in common						
No	6	6	2	5	1	1
A little	30	43	29	32	20	21
A lot	64	51	69	63	79	78
Do child and friends do things together						
No	9	13	2	7	3	4
A little	29	37	19	28	21	21
A lot	62	51	79	65	76	75
If worried, can child talk to friends						
No	41	50	17	35	20	21
Perhaps	30	28	35	33	42	42
Definitely	28	22	48	32	38	37
Whether friends get into trouble						
Not at all	40	28	23	34	69	67
A few are like that	52	36	58	51	30	31
Many are like that	7	24	12	11	1	1
All are like that	1	11	6	4	0	0
Whether parent approves of child's friends						
No	4	21	17	10	1	2
A little	32	42	41	36	13	14
A lot	64	37	42	54	86	84
<i>Base (weighted): those who had friends</i>	195	49	86	362	7208	7570

1. The 'Any conduct disorder category' includes children with other types of conduct disorder.

Table 6.25**Child's sources of emotional support by whether has a conduct disorder, 2004**

Children aged 11–16		Great Britain	
	Any conduct disorder	No conduct disorder	All
	%	%	%
Social support score			
0–17	54	27	28
18	16	16	16
19	15	21	20
20	16	36	35
Base (weighted)	162	3168	3330

Table 6.26**Views about the neighbourhood by whether has a conduct disorder, 2004**

Children aged 11–16		Great Britain	
	Any conduct disorder	No conduct disorder	All
	%	%	%
Whether enjoys living in the neighbourhood			
A lot	44	65	64
A little	35	29	29
No	21	7	7
How safe child feels walking alone in the neighbourhood during the daytime			
Very safe	62	61	61
Fairly safe	26	32	32
A bit unsafe	8	5	5
Very unsafe	4	1	1
Never goes out alone	1	1	1
Whether ever goes to the local shops or park alone			
Yes	82	80	80
No	18	20	20
How many people in the neighbourhood can be trusted			
Many	20	39	38
Some	48	44	44
A few	26	16	16
None	6	2	2
Likelihood of someone returning a lost bag			
Very likely	10	12	12
Quite likely	26	46	45
Not very likely	38	30	30
Not at all likely	27	12	13
Base (weighted)	162	3169	3331

Table 6.27**Help provided to others by whether has a conduct disorder, 2004**

Children aged 11–16

Great Britain

	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All
	<i>Percentage giving each type of help to relatives</i>			<i>Percentage giving each type of help to non-relatives</i>		
Type of help						
Doing shopping for someone	34	37	37	12	9	9
Cooking or helping to prepare family meals	48	52	52	7	6	6
Cleaning, hoovering or gardening	60	69	69	16	10	11
Washing or ironing clothes	35	36	36	2	2	2
Decorating or repairs	18	21	21	5	5	5
Baby sitting or caring for children	35	39	39	24	19	19
Writing letters or filling in forms	9	10	10	2	4	4
Taking care of someone who is sick	29	34	34	9	9	9
Helping out in a family business	10	11	11
Anything else	6	9	9	4	3	3
None of the above	16	6	7	57	60	60
<i>Base (weighted): all aged 11 or over</i>	<i>163</i>	<i>3195</i>	<i>3358</i>	<i>163</i>	<i>3195</i>	<i>3358</i>
Frequency of providing help						
Every day	15	18	17	7	6	6
At least once a week	58	59	59	30	32	32
At least once a month	20	17	17	36	38	38
Less often	6	6	6	27	24	24
<i>Base (weighted): those who helped</i>	<i>138</i>	<i>2996</i>	<i>3134</i>	<i>71</i>	<i>1270</i>	<i>1341</i>

Table 6.28**Whether child does any paid work by whether has a conduct disorder, 2004**

Children aged 11–16			Great Britain
	Any conduct disorder	No conduct disorder	All
	%	%	%
Whether child does any paid work at least once a month			
Yes	23	22	22
No	77	78	78
<i>Base(weighted): all children aged 11 or over</i>	<i>163</i>	<i>3195</i>	<i>3359</i>
<i>Percentage doing each type of work</i>			
Type of paid work			
Family business	10	10	10
Newspaper round delivery	13	26	25
Shop or restaurant	27	27	27
Building, decorating or gardening	5	2	2
Household chores	21	18	18
Other	29	23	23
<i>Base (weighted): those doing paid work</i>	<i>37</i>	<i>703</i>	<i>740</i>

Table 6.29**Participation in groups, clubs and organisations by whether has a conduct disorder, 2004**

Children aged 11–16

Great Britain

	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All
	<i>Percentage participating in clubs at school</i>			<i>Percentage participating in clubs outside school</i>		
Type of group/club/ organisation						
Sports	38	52	51	24	38	37
Art, drama, dance or music	15	33	32	9	18	18
Youth	10	11	11	24	21	21
Computers	14	14	14	3	3	3
Political	1	2	2	1	1	1
Debating	1	4	4	-	0	0
Religious	1	3	3	2	5	5
Local community or neighbourhood	-	2	2	3	2	2
Voluntary groups helping people	4	4	4	1	3	2
Safety, First Aid	3	4	4	1	3	3
Environmental	3	5	5	3	2	2
Animal (welfare)	1	1	1	1	1	1
Human rights	1	1	1	-	0	0
School holiday playschemes	7	9	9	6	7	7
After-school clubs	18	28	28
School student councils	5	11	11
Student Union	-	1	1
Extra teaching or special lessons	7	9	9
Other	7	9	9
None of the above	44	21	22	45	33	33
<i>Base (weighted)</i>	<i>151</i>	<i>3138</i>	<i>3288</i>	<i>151</i>	<i>3139</i>	<i>3290</i>

Table 6.30**Unpaid help given to groups, clubs and organisations by whether has a conduct disorder, 2004**

Children aged 11–16

Great Britain

	Any conduct disorder	No conduct disorder	All
	<i>Percentage mentioning each type of help</i>		
Unpaid help given to groups, clubs and organisations in the last 12 months			
Collected or raised money	21	34	33
Took part in a sponsored activity	18	32	32
Was part of a committee	1	7	6
Helped to organise or run an event	13	20	19
Other help	6	9	9
None of the above	61	41	42
<i>Base (weighted)</i>	<i>163</i>	<i>3195</i>	<i>3358</i>

Table 6.31

Barriers to participation in groups, clubs and organisations by whether has a conduct disorder, 2004

Children aged 11–16		Great Britain	
	Any conduct disorder	No conduct disorder	All
<i>Percentage mentioning each barrier</i>			
Barriers to participation			
Difficulty getting to clubs	9	6	6
No good groups or clubs locally	17	16	16
Cannot afford to join	4	2	2
Would not feel safe travelling to club	3	2	2
No clubs of interest	13	14	14
Too busy	8	15	15
Do not want to participate	22	15	16
Do not have time after homework	5	12	12
Not allowed	2	2	2
Other barrier	4	3	3
None of the above	42	42	42
<i>Base (weighted)</i>	<i>151</i>	<i>3140</i>	<i>3291</i>

Table 6.32

Smoking behaviour by whether has a conduct disorder, 1999 and 2004 combined

Children aged 11–16		Great Britain							
11- to 13-year-olds			14- to 16-year-olds			All aged 11–16			
Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All	
	%	%	%	%	%	%	%	%	
Smoking behaviour									
Regular smoker	10	1	1	50	10	13	30	5	6
Occasional smoker	3	1	1	4	5	5	3	3	3
All smokers	13	2	2	54	16	18	34	8	9
Used to smoke	7	3	3	13	9	9	10	5	5
Tried smoking once	34	15	16	17	29	28	25	21	21
Never smoked	46	80	79	17	47	45	31	66	64
<i>Base (weighted)</i>	<i>193</i>	<i>4208</i>	<i>4400</i>	<i>193</i>	<i>3077</i>	<i>3269</i>	<i>385</i>	<i>7285</i>	<i>7670</i>

Table 6.33

Drinking behaviour by whether has a conduct disorder, 1999 and 2004 combined

Children aged 11–16

Great Britain

	11- to 13-year-olds			14- to 16-year-olds			All aged 11–16		
	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All
	%	%	%	%	%	%	%	%	%
Drinking behaviour									
Almost every day	2	0	0	2	0	1	2	0	0
About twice a week	3	1	1	17	6	6	10	3	3
About once a week	1	2	2	14	10	10	7	5	6
All regular drinkers	6	3	3	32	16	17	19	9	9
About once a fortnight	4	3	3	11	12	12	8	7	7
About once a month	6	5	5	16	16	16	11	10	10
Only a few times a year	26	20	21	24	29	29	25	24	24
Never drinks alcohol	4	2	2	1	2	2	2	2	2
Never had a drink	54	67	67	16	25	24	35	49	49
<i>Base (weighted)</i>	<i>193</i>	<i>4205</i>	<i>4397</i>	<i>193</i>	<i>3078</i>	<i>3270</i>	<i>386</i>	<i>7282</i>	<i>7669</i>

Table 6.34

Drug use by whether has a conduct disorder, 1999 and 2004 combined

Children aged 11–16

Great Britain

	11- to 13-year-olds			14- to 16-year-olds			All aged 11–16		
	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All
	%	%	%	%	%	%	%	%	%
Ever used:									
Cannabis	7	1	2	40	14	15	23	6	7
Inhalants	2	0	0	6	1	1	4	0	1
Ecstasy	2	0	0	3	1	1	2	0	0
Amphetamines	2	0	0	8	1	1	5	1	1
LSD	-	0	0	4	0	1	2	0	0
Tranquilisers	-	0	0	2	0	0	1	0	0
Cocaine	-	0	0	3	1	1	1	0	0
Heroin	1	0	0	1	-	0	1	0	0
Any drugs	13	2	3	43	15	16	28	8	9
<i>Base (weighted)</i>	<i>191</i>	<i>4204</i>	<i>4395</i>	<i>191</i>	<i>3077</i>	<i>3268</i>	<i>383</i>	<i>7281</i>	<i>7665</i>

Table 6.35

Social context of last smoking, drinking and drug taking occasions by whether has a conduct disorder, 2004

Children aged 11–16 who had engaged in each behaviour

Great Britain

	Last smoking occasion			Last drinking occasion			Last occasion took cannabis		
	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All	Any conduct disorder	No conduct disorder	All
	%	%	%	%	%	%	%	%	%
Where had last drink									
Own home	37	30	32	31	43	42	4	11	10
Other's home	8	10	9	21	29	28	33	40	39
Public house	-	3	2	10	7	8	2	0	1
Restaurant	-	-	-	3	3	3	-	-	-
Nightclub/other club	2	3	3	4	5	5	-	2	2
Outside in public place	44	39	40	25	6	7	49	38	40
Other venue	8	15	14	5	6	6	11	8	9
Number of other people in group									
Alone	20	21	21	7	3	3	-	2	2
1	29	26	27	19	14	14	16	15	15
2–5	27	33	31	36	46	45	51	55	54
6–10	19	8	11	19	19	19	20	15	16
More than 10	5	12	11	18	19	18	13	13	13
<i>Base (weighted)¹</i>	<i>59</i>	<i>178</i>	<i>237</i>	<i>98</i>	<i>1362</i>	<i>1461</i>	<i>45</i>	<i>213</i>	<i>258</i>
Who was with respondent²									
Boyfriend/girlfriend	10	12	11	15	6	7	2	8	7
Other friend(s)	80	81	81	64	52	53	90	91	91
Family	14	10	11	32	45	44	2	5	4
Other	6	3	4	2	3	3	8	4	5
<i>Base (weighted)³</i>	<i>47</i>	<i>139</i>	<i>186</i>	<i>91</i>	<i>1321</i>	<i>1411</i>	<i>44</i>	<i>207</i>	<i>252</i>

1. The bases are: regular smokers; those who had had an alcoholic drink in the last 6 months; those who had used cannabis in the last year.

2. Percentages may sum to more than 100 because some children were accompanied by more than one group.

3. The bases are those who had engaged in the behaviour with others.

Table 6.36**eliberate self-harm by whether has a conduct disorder, 1999 and 2004 combined**

	Great Britain		
	Any conduct disorder	No conduct disorder	All
<i>Percentage who have tried to harm, hurt or kill themselves</i>			
All children			
Parent's report	16	2	2
<i>Base (weighted)</i>	<i>805</i>	<i>16851</i>	<i>17655</i>
Children aged 11–16			
Parent's report	18	2	3
<i>Base (weighted)</i>	<i>438</i>	<i>7800</i>	<i>8239</i>
Child's report	21	6	7
<i>Base (weighted)</i>	<i>355</i>	<i>7050</i>	<i>7404</i>

Chapter 7

Hyperkinetic disorders

Introduction

This chapter begins with a description of the typical behaviour patterns displayed by children and young people who have a hyperkinetic disorder. This is followed by an overview of their characteristics looking at their:

- demographic characteristics;
- family situation;
- socio-economic characteristics;
- geographic distribution;
- general, physical and mental health;
- use of services;
- scholastic ability and attendance at school;
- family's social functioning;
- own social functioning; and
- lifestyle behaviours.

As noted in Chapter 4, there was no change in the prevalence of hyperkinetic disorders between 1999 and 2004. The two datasets have therefore been combined, so as to increase the sample base.

In 1999 hyperkinetic disorders were subdivided into two categories: *hyperkinesis* and *other hyperkinetic disorders*. As there were very few cases in the latter category in 2004, all types of hyperkinetic disorder were classified into a single category of *hyperkinetic disorders*. This type of disorder is sometimes referred to as Attention Deficit Hyperactivity Disorder (ADHD), which is the name for a broader (and therefore commoner but milder) disorder defined by the American Psychiatric Association.

The tables compare the children with any form of hyperkinetic disorder with those who have no such disorder. The commentary is descriptive, the aim being to provide a profile of children who have a hyperkinetic disorder. It therefore takes no account of the inter-relationships between the characteristics. The analysis at the end of Chapter 4 described the factors which had the largest independent effects on prevalence and this gives an indication of the key variables.

Typical behaviour patterns

This section describes the typical behavioural symptoms displayed by children with hyperkinetic disorders. The symptoms described below can be observed, to some degree, in most children but for a child to be diagnosed as having a hyperkinetic disorder the symptoms have to be sufficiently severe so as to cause the child distress or impairment in his/her social functioning. As an illustration of the possible impact of

such a disorder on the child's life and that of his/her family, the description of symptoms is followed by a case vignette of a fictitious child.¹

Hyperkinetic disorders

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.

Demographic, socio-economic and area characteristics

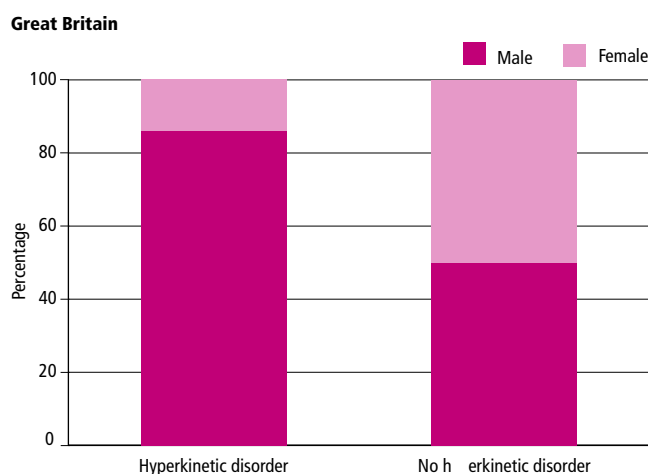
Demographic characteristics

Children with hyperkinetic disorders were predominantly boys, 86 per cent compared with 50 per cent of those with no such disorder. Almost all were white, 97 per cent compared with 89 per cent of other children. There were no differences in the age profile of children with a hyperkinetic disorder and those with no such disorder.

(Figure 7.1 and Table 7.1)

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

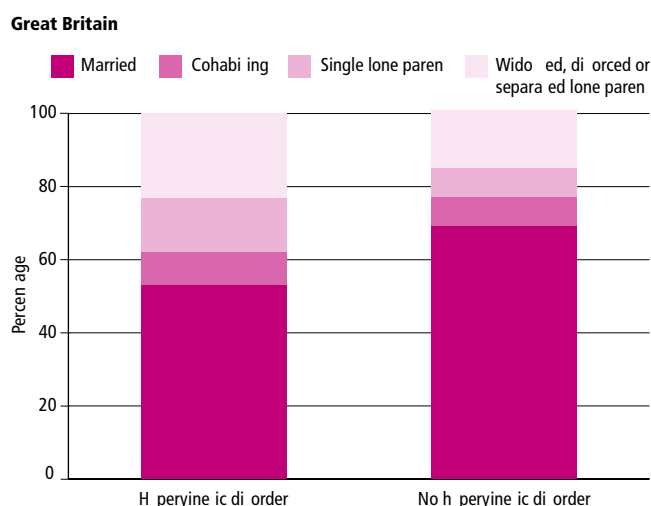
Figure 7.1
Sex by whether has a hyperkinetic disorder, 1999 and 2004 combined



Family characteristics

Children with hyperkinetic disorders were more likely than other children to live with single or previously married lone parents (15 and 23 per cent compared with 8 and 16 per cent). Conversely, just over half (53 per cent) of children with hyperkinetic disorders lived with parents who were married compared with about two-thirds (69 per cent) of children with no such disorder. (Figure 7.2 and Table 7.2)

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



Unlike children with emotional and conduct disorders who tended to live in relatively large families, there were no differences between children with and those with no hyperkinetic disorder in relation to the number of children in the household and whether or not there were stepchildren in the family. (Table 7.2)

Parental education and socio-economic characteristics

Children with hyperkinetic disorders were more likely than other children to live in low income households and to have parents who had no educational qualifications.

Over a third (36 per cent) of children with hyperkinetic disorders had parents with no educational qualifications compared with a fifth (21 per cent) of those with no such disorder. (Table 7.3)

Children with hyperkinetic disorders were more than twice as likely as children with no such disorder to live in a household in which neither parent was working (31 per cent compared with 14 per cent). Similarly, children with hyperkinetic disorders were twice as likely as other children to have parents in the routine occupational group (25 per cent compared with 12 per cent). (Table 7.3)

Housing and income

More than half (54 per cent) of children with hyperkinetic disorders lived in rented property compared with less than a third (31 per cent) of other children. Most of these lived in the social rented sector (41 per cent compared with 24 per cent of other children). (Table 7.4)

About a half (52 per cent) of children with hyperkinetic disorders lived in households with a gross weekly income of less than £300 compared with a third (34 per cent) of other children. Conversely, children with hyperkinetic disorders were much less likely than other children to live in households with a gross weekly income of over £600 (17 per cent compared with 33 per cent). (Table 7.4)

Over a quarter of children with hyperkinetic disorders were living in households in which someone received a disability benefit (27 per cent compared with 8 per cent of other children). (Table 7.4)

Area characteristics

There were no significant differences between countries in the distribution of children with and those with no hyperkinetic disorder. The only regional differences were that the former were more likely than other children to live in a non-metropolitan areas of England (53 per cent compared with 44 per cent). (Table 7.5)

Households containing children with hyperkinetic disorders were more likely than other households to live in areas classified as 'Hard Pressed' (36 per cent compared with 24 per cent) and less likely to live in areas classified as 'Wealthy Achievers' (18 per cent compared with 26 per cent). (Table 7.5)

Among children with hyperkinetic disorders:

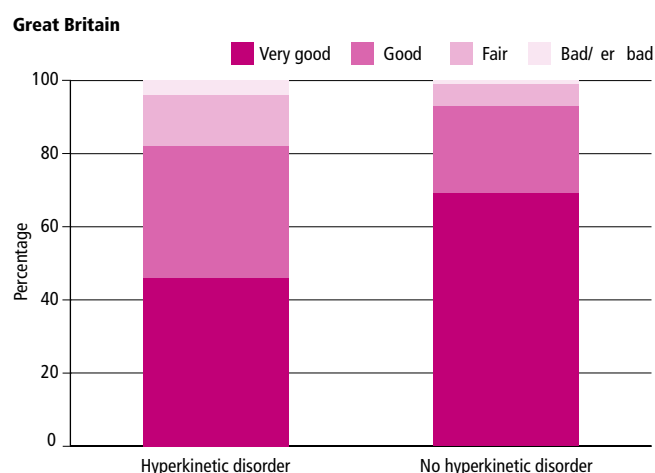
- 86 per cent were boys (*compared with 50 per cent for children with no hyperkinetic disorder*)
- 55 per cent were aged 5–10 (*53 per cent*)
- 97 per cent were white (*89 per cent*)
- 23 per cent lived with a widowed, divorced or separated lone parent (*16 per cent*)
- 15 per cent lived with a single lone parent (*8 per cent*)
- 53 per cent lived in a married couple family (*69 per cent*)
- 36 per cent had parents with no educational qualifications (*21 per cent*)
- 46 per cent lived in owned accommodation (*69 per cent*)
- 52 per cent lived in households with gross incomes under £300 per week (*34 per cent*)
- 27 per cent lived in households in which someone received a disability benefit (*8 per cent*)
- 36 per cent lived in areas classified as 'Hard pressed' (*24 per cent*)

Child's general, physical and mental health**General 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).

(Figure 7.3 and Table 7.6)

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

**Physical or developmental problems**

Just over two-thirds (70 per cent) of children with hyperkinetic disorders had a specific physical or developmental problem compared with just over a half (54 per cent) of other children. The largest differences were for difficulty with co-ordination (14 per cent compared with 2 per cent), bed wetting (17 per cent compared with 4 per cent) and speech or language difficulties (15 per cent compared with 4 per cent). (Table 7.7)

Mental disorders

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. (Table 7.8)

The parents of those with hyperkinetic disorders mentioned a range of mental health problems among their children. Two-thirds (66 per cent) reported that their child had behavioural problems, over a half (56 per cent) said that their child was hyperactive and nearly a third (29 per cent) mentioned emotional problems. (Table 7.9)

Medication

About 2 in 5 (43 per cent) children with a hyperkinetic disorder were taking some kind of medication. The majority of these children were taking Methylphenidate (41 per cent) while the others were taking other medications that are recognised for use with hyperkinetic disorders (3 per cent Risperidone, 2 per cent Dexamphetamine, 1 per cent Clonidine and 1 per cent Amitriptyline). There have been some concerns about the over-prescription of stimulant medication. However, while we would expect the majority of children with a hyperkinetic disorder to respond to stimulant medication, less than half the children with this disorder were taking such medication. Moreover, we did not find children taking stimulant medication who did not have evidence of pervasive hyperactivity. This suggests that, despite a large increase in the numbers of children prescribed stimulant medication in recent years, concerns about over-prescription are unfounded, and that there is still a large proportion of children with hyperkinetic disorders who are not gaining access to an evidence-based treatment. (Table 7.10)

Among the parents of children with hyperkinetic disorders:

- 18 per cent reported that the child's general health was fair or bad (*compared with 7 per cent for children with no hyperkinetic disorder*)
- 70 per cent reported that the child had a specific physical complaint (*54 per cent*)
- 77 per cent reported that the child had mental health or developmental problems (*9 per cent*)
- 29 per cent reported that the child had emotional problems, 66 per cent reported behavioural problems and 56 per cent reported hyperactivity (*4 per cent, 5 per cent and 3 per cent*)
- 66 per cent of the children had another main type of clinically recognisable disorder (*8 per cent*)

Use of services

Parents were asked if they had had contact with any services in the past year because they were concerned about their child's emotions, behaviour or concentration. In the 1999 survey these questions were asked only of children who had been identified as having some significant problem in the interview whereas, in the 2004 survey, the questions were asked of all children. Data is presented for the 2004 survey only.

Almost all (95 per cent) parents of children with hyperkinetic disorders had sought some form of help in the previous 12 months because of concerns about their child's mental health.

Most (93 per cent) had accessed some professional service. The most commonly used source of professional help were teachers (70 per cent) but parents also sought help from, or were referred to, other professional sources such as mental health services (52 per cent), primary health care (46 per cent) and specialist education services, such as educational psychologists (37 per cent).

The parents of children with hyperkinetic disorders had also sought advice from informal sources such as family and friends (35 per cent), self help groups (7 per cent) and the internet (11 per cent). (Table 7.11)

Parents of children with hyperkinetic disorders who had not accessed any services were asked if there was anything that prevented them from doing so. They were shown a list of potential obstacles to service use and asked to identify any that they had encountered. Almost a half (49 per cent) had

Among the parents of children with hyperkinetic disorders:

- 95 per cent had sought help or advice in the last year because of worries about their child's mental health (*compared with 27 per cent for children with no hyperkinetic disorder*)
- 93 per cent had contacted a professional service (*21 per cent*)
- The most commonly used services were: Teachers (70 per cent), mental health services (52 per cent), primary health care (46 per cent), specialist educational services (37 per cent) and family members or friends (35 per cent)

experienced one or more of the obstacles listed. The most common were that parents found it difficult to get a referral (23 per cent), that they often did not know such services existed (15 per cent) or did not believe that the specialist help would be of any use (10 per cent). (Table not shown)

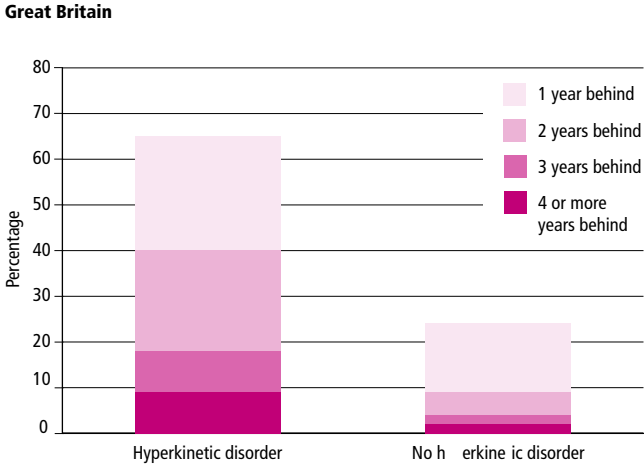
Scholastic ability and attendance at school

Teachers were asked to rate the child's abilities in reading, mathematics and spelling compared with an average child of the same age and to estimate the child's age in terms of scholastic ability. They were also asked whether or not the child had officially recognised special educational needs.

Basic skills

Almost two-thirds (64 per cent and 63 per cent) of children with hyperkinetic disorders had difficulties with reading and mathematics while three-quarters (75 per cent) had difficulties with spelling. The corresponding figures for children with no such disorder were 23 per cent, 25 per cent and 30 per cent. These difficulties were also reflected in the teacher's assessment of the child's overall scholastic ability. About two-thirds (65 per cent) of children with hyperkinetic disorders were rated as being behind on their overall intellectual development compared with about a quarter (24 per cent) of children with no such disorder. Teachers' ratings indicated that 18 per cent of children with hyperkinetic disorders were three or more years behind in their schooling (compared with 4 per cent of other children). (Figure 7.4 and Table 7.12)

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



Special educational needs

Almost three-quarters (71 per cent) of children with hyperkinetic disorders had officially recognised special educational needs (compared with 16 per cent of other children). (Table 7.13)

Over a half (56 per cent) of those with recognised needs had a written statement of special educational needs but there was no difference between the two groups in this respect. (Table not shown)

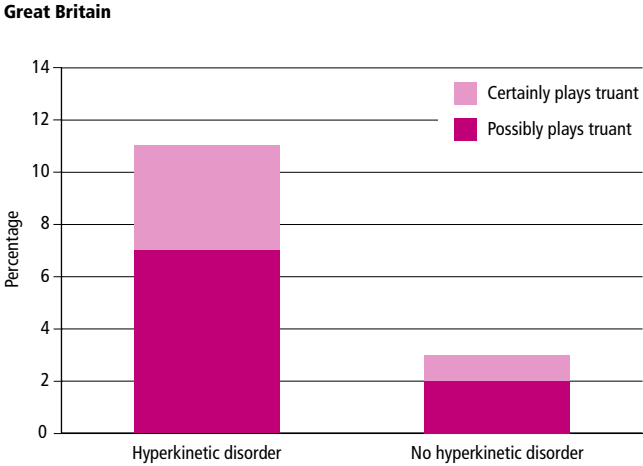
Absence from school

Unlike children with emotional and conduct disorders, children with hyperkinetic disorders were no more likely to have been absent from school than other children. They were, however, more likely than other children to have been absent for long periods: 11 per cent had missed more than fifteen days, compared with 5 per cent of other children. (Table 7.14)

There were no differences between children with hyperkinetic disorders and other children in relation to the proportions who had had an unauthorised absence from school for any reason but teachers were more likely to consider that the former definitely or possibly played truant (11 per cent compared with 3 per cent of other children). (Figure 7.5 and Table 7.14)

In the 2004 survey, parents were asked about absence and exclusions from school. As with the teachers' reports, there were no differences between children with a hyperkinetic disorder and other children in terms of the proportions who had been absent but there were differences in relation to the

Figure 7.5
Proportion of children whose teacher thought that they played truant by whether has a hyperkinetic disorder, 1999 and 2004 combined



reasons: 15 per cent of children with a hyperkinetic disorder refused to attend school compared with 2 per cent of other children. (Table 7.15)

Overall, 10 per cent of children had received some form of educational provision when they were absent from school but there were no differences in this respect between children with hyperkinetic disorders and those with no such disorder. (Table 7.15)

Nearly one-third (29 per cent) of children with hyperkinetic disorders had been excluded from school and 12 per cent had been excluded three or more times. Among other children, these proportions were very low, 4 per cent and 1 per cent. (Table 7.16)

As previously mentioned, 62 per cent of children with hyperkinetic disorders also had a clinically recognisable conduct disorder. Further investigation showed that over four-fifths (84 per cent) of the children with a hyperkinetic disorder who had been excluded from school also had a conduct disorder. Among those children who had a hyperkinetic disorder but no conduct disorder, only 14 per cent had ever been excluded from school. (Table not shown)

Children with a hyperkinetic disorder were also more likely than other children to have changed schools other than at the usual transition stages (35 per cent compared with 19 per cent). This variation was not attributable to the higher rate of exclusions among those with a hyperkinetic disorder since hardly any of these children had changed schools following their exclusion. (Table 7.17)

Among children with hyperkinetic disorders:

- 65 per cent were behind in their overall scholastic ability (*compared with 24 per cent of children with no hyperkinetic disorder*)
- 71 per cent had officially recognised special educational needs (*16 per cent*)
- 11 per cent had had more than 15 days away from school in the previous term (*5 per cent*)
- 11 per cent were considered by teachers to be definite or possible truants (*3 per cent*)
- 29 per cent had been excluded from school and 35 per cent had changed schools apart from the normal transitions (*4 per cent and 19 per cent*)

Social functioning of the family

This section looks at various aspects of parental health, attitudes and behaviour which provide indicators of the social functioning of the family.

Mental health of parent

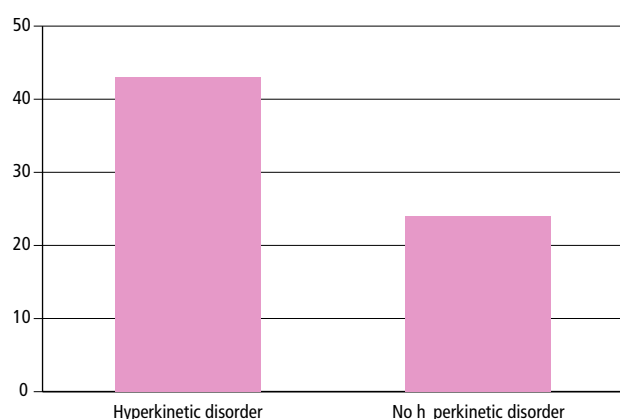
The parent who was interviewed about the child, usually the mother, was asked about her own mental health using the General Health Questionnaire (GHQ-12 – see Chapter 2 for details). Scores range from 0 (no psychological distress) to 12 (severe psychological distress). A score of 3 is generally taken as the threshold, with scores at this level or higher being considered suggestive of an emotional disorder.

Over two-fifths (43 per cent) of parents of children with hyperkinetic disorders had scores of 3 or more on the GHQ-12 (compared with 24 per cent of other parents) and 10 per cent had a score of 9 or more (compared with 4 per cent).

(Figure 7.6 and Table 7.18)

Figure 7.6
Proportion of children whose parent scored 3 or more on the GHQ-12, 1999 and 2004 combined

Great Britain

**Family functioning**

Family functioning was measured using the FAD-GFS scale in which parents rated 12 statements about family relationships (see Chapter 2 for details). For this survey, families that scored over 2.00 on this scale were considered to have unhealthy functioning.

Children with hyperkinetic disorders were twice as likely as other children to live in families classified as having unhealthy functioning (36 per cent compared with 18 per cent).

(Table 7.19)

Stressful life events

Parents were asked whether their child had experienced any of 10 potentially stressful events. The list in the 2004 survey differed slightly to that used in the 1999 survey so data are presented for 2004 only.

For 6 out of the 10 events the proportions of children who had experienced the event were higher among children with hyperkinetic disorders than other children. The separation of a parent was the most common stressful life event for both groups of children. Almost half (49 per cent) of children with a hyperkinetic disorder had experienced this compared with just under a third (31 per cent) of other children. Children with hyperkinetic disorders were also more likely to have had a serious illness which required a stay in hospital (23 per cent compared with 13 per cent), to have parents who had had a major financial crisis (21 per cent compared with 13 per cent), had experienced a problem with the police involving a court appearance (18 per cent compared with 6 per cent) or had had a serious mental illness (17 per cent compared with 8 per cent). Overall, children with hyperkinetic disorders were almost twice as likely as other children to have experienced two or more stressful life events (47 per cent compared with 26 per cent).

(Table 7.20 and Table 7.21)

Among children with hyperkinetic disorders:

- 43 per cent of parents had an emotional disorder (*compared with 24 per cent of children with no hyperkinetic disorder*)
- 36 per cent lived in families with unhealthy functioning (*18 per cent*)
- 47 per cent had two or more stressful life events (*26 per cent*)

Child's social functioning

This section covers features of social functioning which might affect the child's resilience against the onset and course of mental disorder. These include their strengths, relationships with friends, social aptitudes and various measures of social capital. The questions on strengths were introduced in the 2004 survey as an added measure of resilience and to give parents the opportunity to describe their child's good points. For all scales, a low score indicates negative social functioning on that measure.

Strengths

Parents were asked to rate their child and young people aged 11–16 were asked to rate themselves on a series of items covering various qualities (see Chapter 2 for details). Scores on the adult's scale ranged from 0–48 and those on the children's scale ranged from 0–38. [Table 7.22](#) shows the scores on each scale grouped into quartiles.

Looking first at the adult's assessment, 84 per cent of children with hyperkinetic disorders had scores in the lowest quartile compared with 25 per cent of children with no such disorder. Conversely, none of the children with hyperkinetic disorders had a score in the highest quartile compared with 26 per cent of other children. [\(Table 7.22\)](#)

The young people's own assessment of their strengths showed a similar pattern of variation as the parents' assessments although there was less difference between the groups. Nearly half (48 per cent) of children with hyperkinetic disorders had a score of 23 or less on this measure compared with about a quarter (23 per cent) of other children. [\(Table 7.22\)](#)

Social aptitudes

Parents were asked to rate their children on 10 questions designed to measure the child's ability to empathise with others. Scores ranged from 0–40 and were grouped into quartiles. Over four-fifths (83 per cent) of children with hyperkinetic disorders had scores in the lowest quartile compared with 24 per cent of other children. Conversely, only 2 per cent of the former had scores in the highest quartile compared with 26 per cent of other children. [\(Table 7.23\)](#)

Social capital

'Social capital' is a multi-faceted concept which has been defined as 'networks together with shared norms, values and understandings that facilitate co-operation within and among groups' (Cote and Healey, 2001). It is believed that high levels of social capital have a positive effect on health. The aspects of social capital covered in this report are:

- relationships with friends;
- social support;
- views about neighbourhood;
- help provided to others; and
- participation in clubs and groups.

Many of the questions are taken from the children and young person modules included in the 2003 Home Office Citizenship Survey. The questions on friends were asked of all parents. The remaining topics were asked of young people aged 11 or over only because previous research has shown that younger children are not able to cope with some of the more complex questioning.

Relationships with friends

Questions on friendships were asked of parents and covered:

- the child's ability to make and keep friends;
- number of friends;
- common interests and shared activities;
- emotional support; and
- parent's approval of child's friends.

Children with hyperkinetic disorders performed less well than other children on all the above measures. For example, 32 per cent found it harder than average to make friends and 44 per cent found it harder to keep friends (compared with 10 per cent and 5 per cent for other children). Likewise, 10 per cent had no friends and 50 per cent had no friend they could confide in if they were worried. The proportions for children with no hyperkinetic disorder were 2 per cent and 21 per cent. [\(Table 7.24\)](#)

The parents of children with hyperkinetic disorders were more likely than other parents to express some reservations about their child's friends (43 per cent compared with 16 per cent). The former were also more likely to say that many or all of their child's friends got into trouble (19 per cent compared with 1 per cent). [\(Table 7.24\)](#)

Social support

As a measure of social support, young people aged 11–16 were asked about the number of family members and friends to whom they felt close. Scores ranged from 0–20 and were grouped into rough quartiles. Young people with a hyperkinetic disorder were almost twice as likely as other children to have a social support score in the lowest quartile (54 per cent compared with 28 per cent).

Views about the neighbourhood

Unlike young people with emotional and conduct disorders, those with hyperkinetic disorders were, in general, no more

likely than other young people to have negative views about their neighbourhood. The only difference was that the former were more likely to think that nobody in their neighbourhood could be trusted (8 per cent compared with 2 per cent).

(Table 7.26)

Help provided to others

There were no differences between young people with a hyperkinetic disorder and other young people in relation to the amount or frequency of help given to relatives and non-relatives and very few differences in the proportions giving specific forms of help.

(Table 7.27)

There were also no differences between the two groups in the proportions who were paid for the help they gave (Table not shown) or in the proportions that did some paid work at least once a month.

(Table 7.28)

Participation in groups, clubs and organisations

Young people with hyperkinetic disorders were less likely than other young people to participate in school-based groups, clubs and organisations (59 per cent compared with 78 per cent) but there were no differences between the two groups in the proportions who participated in such clubs outside of school.

(Table 7.29)

Among children with hyperkinetic disorders:

- 32 per cent found it harder than average to make friends and 44 per cent found it harder than average to keep friends (*compared with 10 per cent and 5 per cent for children with no hyperkinetic disorder*)
- 43 per cent of parents did not fully approve of their child's friends (*16 per cent*)
- 59 per cent had taken part in a school-based group in the last year (*78 per cent*)

Smoking, drinking and drug use

Questions on smoking, drinking and drug use were addressed to children aged 11–16 and were based on questions used in the national surveys of smoking, drinking and drug use among schoolchildren. A comparison of the data from the 1999 Children's Mental Health Survey with the 1999 Schools Survey showed that children interviewed at home systematically under-reported their smoking, drinking and drug use compared with those interviewed in school. The rates presented in this report should not therefore be taken as true estimates of prevalence. Their main value is in enabling comparisons to be made between children with a disorder and other children. As

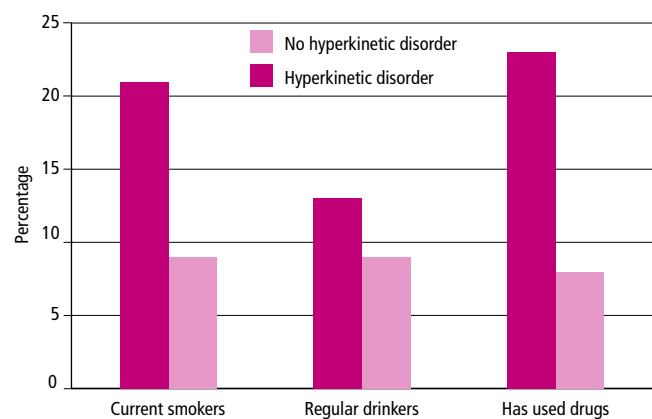
these behaviours vary with age, percentages are shown separately for young people aged 11–13 and those aged 14–16.

Young people with hyperkinetic disorders were more likely than other young people to smoke and take drugs. Unlike young people with emotional and conduct disorders, however, those with hyperkinetic disorders were no more likely than other young people to drink alcohol.

(Figure 7.7 and Tables 7.30–7.32)

Figure 7.7
Smoking, drinking and drug use by whether has a hyperkinetic disorder: children aged 11–16, 1999 and 2004 combined

Great Britain



Among all young people with a hyperkinetic disorder, 21 per cent were smokers and most of these (15 per cent) were classified as 'regular smokers' (smokes at least one cigarette per week). For other young people the proportions were 9 per cent and 6 per cent. This pattern of variation was also evident among the younger age group, 11–13: 8 per cent of those with a hyperkinetic disorder smoked compared with only 2 per cent of other children. Among the older group, aged 14–16, 41 per cent of those with a hyperkinetic disorder smoked, compared with 18 per cent of other young people.

(Figure 7.7 and Table 7.30)

Drug use showed a similar pattern to smoking behaviour, although the differences were more pronounced for the older age group: 45 per cent of young people aged 14–16 who had a hyperkinetic disorder had used drugs compared with 16 per cent of other young people. Among the younger age group, 11–13, 8 per cent of those with hyperkinetic disorders had used drugs compared with 3 per cent of those with no such disorder. Cannabis was the most commonly used drug, taken by 18 per cent of young people with a hyperkinetic disorder

and 7 per cent of other young people. Among the former, 4 per cent had taken amphetamines and 3 per cent had taken inhalants. These substances were taken by only 1 per cent of other young people. (Figure 7.7 and Table 7.32)

All but one of the children with a hyperkinetic disorder who were regular smokers also had a conduct disorder. Among those children who had a hyperkinetic disorder but no conduct disorder the percentages of regular smokers were very similar to those among children with no such disorder. However, there were no differences between children who had both a conduct and hyperkinetic disorder and other children with hyperkinetic disorders in terms of the percentages who were regular drinkers or who had taken drugs.

In the 2004 survey, young people were asked about the social context of the last time they had smoked, drank alcohol and taken drugs but there were too few cases of young people with hyperkinetic disorders to analyse the data.

Among children aged 11–16 with hyperkinetic disorders:

- 15 per cent were regular smokers (compared with 6 per cent for children with no hyperkinetic disorder)
- 13 per cent were regular drinkers (9 per cent)
- 23 per cent had taken drugs at some time (8 per cent)

Self-harm

Both parents and children were asked if the child had ever tried to hurt, harm or kill themselves. Looking first at parents' reports for children of all ages, those who had a child with a hyperkinetic disorder were much more likely to say that their child had tried to harm themselves (14 per cent compared with 2 per cent). The variations for children aged 11–16 showed a similar pattern, 18 per cent and 7 per cent based on self-reports and 14 per cent and 3 per cent based on parents' reports. (Table 7.33)

Among children with a hyperkinetic disorder whose parents had reported that they had tried to harm themselves, over three-quarters also had a conduct disorder.

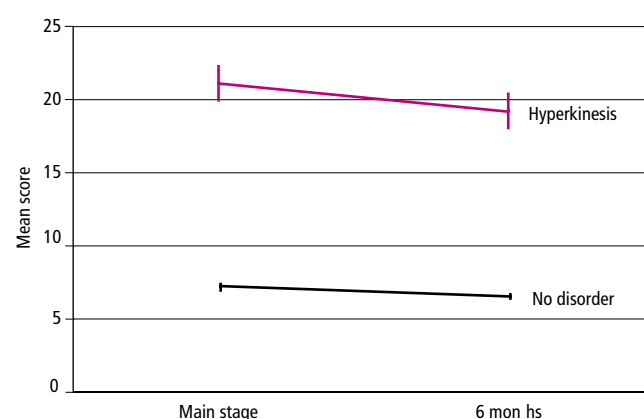
Results from the six-month follow-up survey

Samples of the parents of children interviewed in the 1999 and 2004 surveys were sent a self-completion questionnaire six months after the interview in order to establish whether there had been any change in their symptoms (see Chapter 3).

The average levels of total and hyperactive symptoms among the children with hyperkinetic disorders did fall slightly over the six months following the survey. However, as Figures 7.8 and 7.9 show, the gap between children with and those with no hyperkinetic disorder only narrowed a little as a result. The symptoms of hyperkinetic disorder were typically persistent, at least in the short term. The impact of these symptoms changed rather more, falling by about a quarter over the six months, as shown in Figure 7.10. It is important to remember that the impact of symptoms depends not just on the symptoms themselves but on everything else in the child's life. Changes at home or at school may make hyperkinetic symptoms easier or harder to live with.

Figure 7.8
Total symptoms¹ at main interview and at six-month follow-up by whether child had a hyperkinetic disorder at main interview, 1999 and 2004 combined

Great Britain



¹ Total symptoms is the 'total difficulties score' on the parent-reported SDQ, reflecting the sum of the subscale scores for emotional symptoms, conduct problems, hyperactivity and peer problems.

Figure 7.9
Hyperactivity symptoms at main interview and at six-month follow-up by whether child had a hyperkinetic disorder at main interview, 1999 and 2004 combined

Great Britain

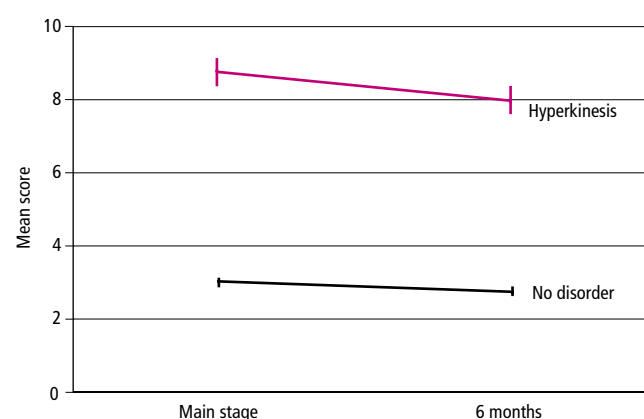
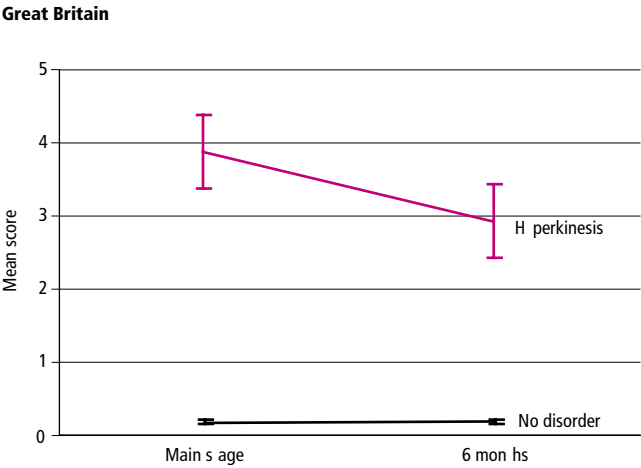


Figure 7.10
Impact of symptoms at main interview and at six-month follow-up by whether child had a hyperkinetic disorder at main interview, 1999 and 2004 combined



(Figures 7.8–7.10)

References

Goddard E and Higgins V (1999) *Smoking, drinking and drug use among young teenagers in 1998 , Volume 1: England*, TSO: London.

Home Office (December 2004) *2003 Home Office Citizenship Survey*, Home Office Research, Development and Statistics Directorate.

Table 7.1**Sex, age and ethnicity of child by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Sex			
Boys	86	50	51
Girls	14	50	49
Age			
5–10	55	53	53
11–16	45	47	47
Ethnicity			
White	97	89	89
Black ¹	1	3	3
Indian	-	2	2
Pakistani/ Bangladeshi	-	3	3
Other	2	3	3
<i>Base (weighted)</i>	<i>246</i>	<i>18157</i>	<i>18403</i>

1. Includes people of mixed black and white origin.

Table 7.2**Family characteristics by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Family type			
Married	53	69	68
Cohabiting	9	8	8
Lone parent – single	15	8	8
Lone parent – widowed, divorced or separated	23	16	16
Number of children in household			
1	28	23	23
2	42	45	45
3	21	22	22
4	6	7	7
5 or more	3	3	3
<i>Base (weighted 1999 and 2004 data)</i>	<i>246</i>	<i>18169</i>	<i>18415</i>
If stepchildren in family			
Yes	15	11	11
No	85	89	89
<i>Base (weighted 2004 data)¹</i>	<i>108</i>	<i>7869</i>	<i>7977</i>

1. The 1999 data had a different classification for whether or not a family contained stepchildren.

Table 7.3**Parent's education and socio-economic characteristics by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Parent's highest educational qualification			
Degree level	7	13	13
Teaching/HND/Nursing	6	11	11
A /AS level or equivalent	9	11	11
GCSE Grades A–C or equivalent	21	30	30
GCSE Grades D–F or equivalent	16	11	11
Other qualification	6	3	3
No qualification	36	21	21
Parents' employment status			
Both working/lone parent working	52	67	67
One parent working	18	19	19
Neither working/lone parent not working	31	14	15
<i>Base (weighted 1999 and 2004 data)</i>	<i>245</i>	<i>17866</i>	<i>18111</i>
Family's socio-economic classification¹			
Large employers and higher managerial	4	2	2
Higher professional	3	3	3
Lower managerial and professional	8	21	20
Intermediate occupations	19	19	19
Small employers and own account	5	7	7
Lower supervisory and technical	1	1	1
Semi-routine	26	26	26
Routine occupations	25	12	13
Never worked/ long-term unemployed	8	5	5
FT student/inadequate description	2	4	4
<i>Base (weighted 2004 data)²</i>	<i>108</i>	<i>7869</i>	<i>7977</i>

1. This is the National Statistics Socio-economic Classification (NS-SEC).

2. The 1999 data had a different social classification.

Table 7.4**Housing and income by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Type of accommodation			
Detached	16	25	25
Semi-detached	38	38	38
Terraced house	38	30	30
Flat/maisonette	9	7	7
Tenure			
Owners	46	69	69
Social sector tenants	41	24	24
Private renters	13	7	7
<i>Base (weighted 1999 and 2004 data)</i>	<i>246</i>	<i>18158</i>	<i>18404</i>
Gross weekly household income			
Under £100	8	4	4
£100–£199	25	16	16
£200–£299	19	14	14
£300–£399	12	12	12
£400–£499	8	11	11
£500–£599	10	10	10
£600–£770	7	13	13
Over £770	10	20	20
<i>Base (weighted 1999 and 2004 data)</i>	<i>226</i>	<i>16670</i>	<i>16896</i>
Receipt of disability benefits			
Carers allowance	11	3	3
Severe Disablement allowance	23	6	6
Disability living/attendance allowance	3	0	0
Incapacity allowance	1	2	2
Any disability allowance	27	8	8
No disability allowance	73	92	92
<i>Base (weighted 2004 data)¹</i>	<i>108</i>	<i>7869</i>	<i>7977</i>

1. The 1999 data covered different types of disability benefit.

Table 7.5**Region, country and area type by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Region and country			
London Inner	6	5	5
London Outer	5	7	7
Other met England	24	31	31
Non-met England	53	44	44
England	88	86	86
Scotland	7	9	8
Wales	5	5	5
<i>Base (weighted 1999 and 2004 data)</i>	<i>246</i>	<i>18169</i>	<i>18415</i>
Area type (ACORN classification)			
Wealthy achievers	18	26	26
Urban prosperity	7	8	8
Comfortably off	21	26	26
Moderate means	19	17	17
Hard pressed	36	24	24
<i>Base (weighted 2004 data)¹</i>	<i>108</i>	<i>7809</i>	<i>7916</i>

1. The 1999 data had a different ACORN classification.

Table 7.6**Child's general health by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Child's general health			
Very good	46	69	69
Good	36	24	24
Fair	14	6	6
Bad	4	1	1
Very bad	0	0	0
<i>Base (weighted)</i>	<i>246</i>	<i>17926</i>	<i>18172</i>

Table 7.7

Co-occurrence of physical and developmental problems with hyperkinetic disorders, 1999 and 2004 combined

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
<i>Percentage of children with each type of complaint</i>			
Asthma	23	15	15
Eczema	14	13	13
Hay fever	12	11	11
Eyesight problems	15	10	10
Stomach or digestive problems	7	6	6
Non-food allergy	7	6	6
Migraine/severe headache	5	5	5
Bed wetting	17	4	5
Glue ear/otitis media/grommits	7	4	4
Hearing problems	7	4	4
Speech or language problems	15	4	4
Food allergy	8	3	4
Difficulty with co-ordination	14	2	2
Stiffness or deformity of foot	5	2	2
Heart problems	2	1	1
Soiling pants	6	1	1
Muscle disease or weakness	4	1	1
Kidney/urinary tract problems	2	1	1
Obesity	2	1	1
Congenital abnormality	2	1	1
Epilepsy	1	1	1
Any blood disorder	0	0	0
Diabetes	1	0	0
Cerebral Palsy	1	0	0
Cancer	0	-	0
Any physical or developmental problems¹	70	54	54
No problem	30	46	46
<i>Base (weighted)</i>	<i>246</i>	<i>17926</i>	<i>18172</i>

1. Some physical complaints are not listed in the table above because of their rarity (less than 25 cases): ME (10), Spina bifida (6), Cystic fibrosis (11), Missing digits (23). They are included in the 'Any physical or developmental problem' category.

Table 7.8**Co-occurrence of other mental disorders with hyperkinetic disorders, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
<i>Percentage of children with each type of disorder</i>			
Other mental disorders			
Emotional disorders:			
Anxiety disorders	10	3	4
Depression	2	1	1
All emotional disorders	12	4	4
Conduct disorders:			
Oppositional defiant disorder	34	2	3
Other conduct disorders	28	2	2
All conduct disorders	62	4	5
Less common disorders	2	1	1
Any other disorder	66	8	9
No (other) disorders	34	92	91
<i>Base (weighted)</i>	<i>246</i>	<i>18169</i>	<i>18415</i>

Table 7.9**Parent's view of child's mental health by whether child has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
<i>Percentage of children with each type of problem</i>			
Parent's view of child's mental health			
Emotional problems	29	4	5
Behavioural problems	66	5	6
Hyperactivity	56	3	4
Any of the above	77	9	10
<i>Base (weighted)</i>	<i>246</i>	<i>17927</i>	<i>18174</i>

Table 7.10**Whether child is taking any medication by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
<i>Percentage of children taking each type of medication</i>			
Methylphenidate, Equasym, Ritalin	41	0	1
Dexamphetamine, Dexedrine	2	-	0
Imipramine, Tofranil	-	0	0
Clonidine, Catepres, Dixarit	1	0	0
Fluoxetine, Prozac	-	0	0
Sertraline, Lustral	-	0	0
Fluvoxamine, Faverin	-	0	0
Citalopram, Cimpramil	-	0	0
Amitryptaline, Lentizol, Triptafen	1	0	0
Sulpirade, Dolmatil, Sulparex, Sulpitil	-	0	0
Risperidone, Riperadal	3	0	0
Haloperidol, Dozic, Haldol, Serenace	-	0	0
Any medication	43	0	1
No medication	57	100	99
<i>Base (weighted)</i>	<i>107</i>	<i>7755</i>	<i>7862</i>

Table 7.11**Help sought in last year for child's mental health problems by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
<i>Percentage of children using each service</i>			
Specialist services			
Child/adult mental health specialist (eg psychiatrist)	52	3	3
Child physical health specialist (eg paediatrician)	15	2	2
Social services (eg social worker)	15	2	2
Education services (eg educational psychologist)	37	3	4
Front line services			
Primary health care (eg GP or practice nurse)	46	5	6
Teachers	70	17	18
All professional services	93	21	22
Informal sources			
Family member/friends	35	11	12
Internet	11	1	1
Telephone help line	6	1	1
Self-help group	7	0	0
Other type of help	4	2	2
All sources	95	27	28
No help sought	5	73	73
<i>Base (weighted)</i>	<i>107</i>	<i>7678</i>	<i>7784</i>

Table 7.12**Teacher's rating of child's basic skills by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Reading			
Above average	8	37	37
Average	28	40	40
Some difficulty	31	17	17
Marked difficulty	33	6	6
Mathematics			
Above average	11	32	31
Average	26	44	44
Some difficulty	34	19	19
Marked difficulty	29	6	6
Spelling			
Above average	5	28	28
Average	19	42	41
Some difficulty	35	21	21
Marked difficulty	40	9	9
<i>Base (weighted)</i>	<i>197</i>	<i>13977</i>	<i>14174</i>
Overall scholastic ability¹			
4 or more years behind	9	2	2
3 years behind	9	2	2
2 years behind	22	5	6
1 year behind	25	15	15
Equivalent	25	36	35
1 or more years ahead	10	40	40
<i>Base (weighted)</i>	<i>179</i>	<i>13075</i>	<i>13254</i>

1. Functioning age-actual age.

Table 7.13**Whether child has special educational needs by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
If child has officially recognised special educational needs			
Yes	71	16	17
No	29	84	83
<i>Base (weighted)</i>	<i>193</i>	<i>13750</i>	<i>13943</i>

Table 7.14**Absence from school and truancy (teacher's report) by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Number of days absent in last term			
0	29	32	32
1–5	41	46	46
6–10	14	13	13
11–15	5	4	4
16 or more	11	5	5
Any days absent	71	68	68
<i>Base (weighted)</i>	<i>131</i>	<i>10254</i>	<i>10385</i>
Any unauthorised days absent			
Yes	13	9	9
No	87	91	91
<i>Base (weighted 2004 data)¹</i>	<i>58</i>	<i>4632</i>	<i>4689</i>
Whether plays truant			
Not true	89	97	97
Somewhat true	7	2	2
Certainly true	5	1	1
<i>Base (weighted)</i>	<i>195</i>	<i>14070</i>	<i>14265</i>

1. This question was not asked in 1999.

Table 7.15**Absence from school (parent's report) by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Whether missed school in last term¹			
Yes	37	34	34
No	63	66	66
<i>Base (weighted): all children</i>	<i>103</i>	<i>7518</i>	<i>7621</i>
Reasons for absence			
Short-term illness	73	78	78
Long-term illness	2	2	2
Refused to attend	15	2	2
Has a school phobia	-	0	0
Other	18	21	20
<i>Base (weighted): those who missed school</i>	<i>38</i>	<i>2561</i>	<i>2599</i>
Whether child received any educational provision			
Yes	(7)	10	10
No	(93)	90	90
<i>Base (weighted): those who missed school (excluding short term illness)</i>	<i>13</i>	<i>639</i>	<i>652</i>

1. Excluding exclusions.

Table 7.16**Exclusions from school (parent's report) by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Number of times child has been excluded from school			
None	71	97	96
Once	13	2	2
Twice	4	1	1
Three or more times	12	1	1
<i>Base (weighted)</i>	<i>107</i>	<i>7664</i>	<i>7770</i>

Table 7.17**Number of times child has changed schools by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Number of times child has changed school¹			
None	64	81	81
Once	23	14	14
Twice	8	3	3
Three or more times	4	2	2
<i>Base (weighted)</i>	<i>107</i>	<i>7670</i>	<i>7776</i>

1. Apart from normal transitions.

Table 7.18**Parent's GHQ-12 score by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Parent's GHQ-12¹			
0–2	57	76	76
3–5	19	13	13
6–8	14	7	7
9–12	10	4	4
3 or more	43	24	24
<i>Base (weighted)</i>	<i>244</i>	<i>17738</i>	<i>17983</i>

1 For this survey, scores of 3 or more were taken to indicate a severe emotional problem.

Table 7.19**Family functioning score by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Family functioning score¹			
Up to 1.50	22	36	36
1.51–2.00	43	46	46
2.01–2.50	27	16	16
2.51 or more	9	2	2
Unhealthy functioning (2.01 or more)	36	18	18
<i>Base (weighted)</i>	<i>243</i>	<i>17665</i>	<i>17908</i>

1. For this survey, scores over 2.0 were taken to suggest unhealthy family functioning.

Table 7.20**Stressful life events by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
<i>Percentage reporting each event</i>			
Stressful life events			
Since child was born, parent had a separation due to marital difficulties or broken off steady relationship	49	31	31
Since child was born, parent had a major financial crisis such as losing the equivalent of three months income	21	13	13
Since child was born, parent had a problem with the police involving a court appearance	18	6	6
Since child was born, parent has had serious physical illness	8	8	8
Since child was born, parent has had serious mental illness	17	8	8
At any stage in child's life, a parent, brother or sister died	4	3	4
At any stage in child's life, a close friend died	6	6	6
At some stage in the child's life, s/he had a serious illness which required a stay in hospital	23	13	13
At any stage in child's life, s/he had been in a serious accident or badly hurt in an accident	9	5	5
In the past year child has broken off a steady relationship with a boy or girl friend (aged 13 or above)/ a close friendship has ended (any age)	14	7	7
<i>Base (weighted)</i>	<i>107</i>	<i>7663</i>	<i>7770</i>

Table 7.21**Number of stressful life events by whether has a hyperkinetic disorder, 1999 and 2004 combined**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Number of stressful life events			
0	22	42	42
1	31	32	32
2	19	15	15
3	17	7	7
4	6	2	3
5 or more	5	1	1
Two or more events	47	26	26
<i>Base (weighted)</i>	<i>107</i>	<i>7663</i>	<i>7770</i>

Table 7.22**Child's strengths (parent's and child's assessment) by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
ALL CHILDREN			
Strength score – parent assessment			
0–36	84	25	25
37–40	14	25	25
41–43	2	25	25
44–48	-	26	25
<i>Base (weighted)</i>	<i>103</i>	<i>7468</i>	<i>7571</i>
CHILDREN AGED 11–16			
Strength score – child assessment			
0–23	48	23	23
24–27	20	27	27
28–30	20	23	23
31–38	12	27	27
<i>Base (weighted)</i>	<i>34</i>	<i>3304</i>	<i>3338</i>

Table 7.23**Social aptitude (parent's assessment) by whether has a hyperkinetic disorder, 2004**

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Social aptitude score			
0–20	83	24	25
21–24	11	28	27
25–28	5	23	22
29–40	2	26	25
<i>Base (weighted)</i>	<i>104</i>	<i>7378</i>	<i>7483</i>

Table 7.24

Friendships by whether has a hyperkinetic disorder, 2004

All children	Great Britain		
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
What is child like at making friends?			
Finds it harder than average	32	10	10
About average	31	36	36
Easier than average	36	55	54
What is child like at keeping friends?			
Finds it harder than average	44	5	5
About average	32	35	35
Easier than average	24	60	59
Number of friends			
None	10	2	2
1	15	4	4
2–4	47	43	43
5–9	19	40	39
10 or more	9	12	11
<i>Base (weighted): all children</i>	<i>108</i>	<i>7732</i>	<i>7840</i>
Do child and friends have things in common			
No	7	1	1
A little	32	21	21
A lot	61	78	78
Do child and friends do things together			
No	6	3	4
A little	34	21	21
A lot	60	75	75
If worried, can child talk to friends			
No	50	21	21
Perhaps	30	42	42
Definitely	20	38	37
Whether friends get into trouble			
Not at all	31	68	67
A few are like that	50	31	31
Many are like that	14	1	1
All are like that	5	0	0
Whether parent approves of child's friends			
No	6	2	2
A little	37	14	14
A lot	57	84	84
<i>Base (weighted): those who had friends</i>	<i>93</i>	<i>7477</i>	<i>7570</i>

Table 7.25**Child's sources of emotional support by whether has a hyperkinetic disorder, 2004**

Children aged 11–16		Great Britain	
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Social support score			
0–17	54	28	28
18	21	16	16
19	3	20	20
20	21	35	35
<i>Base (weighted)</i>	32	3298	3330

Table 7.26**Views about the neighbourhood by whether has a hyperkinetic disorder, 2004**

Children aged 11–16		Great Britain	
	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Whether enjoys living in the neighbourhood			
A lot	50	64	64
A little	37	29	29
No	13	7	7
How safe child feels walking alone in the neighbourhood during the daytime			
Very safe	66	61	61
Fairly safe	26	32	32
A bit unsafe	6	5	5
Very unsafe	-	1	1
Never goes out alone	2	1	1
Whether ever goes to the local shops or park alone			
Yes	89	80	80
No	11	20	20
How many people in the neighbourhood can be trusted			
Many	25	38	38
Some	51	44	44
A few	15	16	16
None	8	2	2
Likelihood of someone returning a lost bag			
Very likely	14	12	12
Quite likely	49	45	45
Not very likely	19	30	30
Not at all likely	17	13	13
<i>Base (weighted)</i>	34	3297	3331

Table 7.27**Help provided to others by whether has a hyperkinetic disorder, 2004**

Children aged 11–16

Great Britain

	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All
	<i>Percentage giving each type of help to relatives</i>			<i>Percentage giving each type of help to non-relatives</i>		
Type of help						
Doing shopping for someone	41	36	37	18	9	9
Cooking or helping to prepare family meals	46	52	52	6	6	6
Cleaning, hoovering or gardening	66	69	69	29	10	11
Washing or ironing clothes	29	36	36	3	2	2
Decorating or repairs	22	21	21	8	5	5
Baby sitting or caring for children	25	39	39	17	19	19
Writing letters or filling in forms	11	10	10	-	4	4
Taking care of someone who is sick	35	34	34	-	9	9
Helping out in a family business	10	11	11
Anything else	14	8	9	8	3	3
None of the above	12	7	7	58	60	60
<i>Base (weighted): all aged 11 or over</i>	<i>34</i>	<i>3324</i>	<i>3358</i>	<i>34</i>	<i>3324</i>	<i>3358</i>
Frequency of providing help						
Every day	26	17	17	(14)	6	6
At least once a week	48	59	59	(21)	32	32
At least once a month	13	17	17	(52)	38	38
Less often	10	6	6	(13)	24	24
<i>Base (weighted): those who helped</i>	<i>30</i>	<i>3103</i>	<i>3133</i>	<i>14</i>	<i>1327</i>	<i>1341</i>

Table 7.28**Whether child does any paid work by whether has a hyperkinetic disorder, 2004**

Children aged 11–16

Great Britain

	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%
Whether child does any paid work at least once a month			
Yes	18	22	22
No	82	78	78
<i>Base (weighted)</i>	<i>34</i>	<i>3325</i>	<i>3359</i>

Table 7.29**Participation in groups, clubs and organisations by whether has a hyperkinetic disorder, 2004**

Children aged 11–16

Great Britain

	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All
	<i>Percentage participating in clubs at school</i>			<i>Percentage participating in clubs outside school</i>		
Type of group/club/ organisation						
Sports	35	51	51	33	37	37
Art, drama, dance or music	17	32	32	8	18	18
Youth	18	11	11	34	21	21
Computers	28	13	14	12	3	3
Political	3	2	2	3	1	1
Debating	3	4	4	3	0	0
Religious	..	3	3	..	5	5
Local community or neighbourhood	..	2	2	..	2	2
Voluntary groups helping people	6	4	4	3	2	2
Safety, First Aid	3	4	4	..	3	3
Environmental	12	5	5	3	2	2
Animal (welfare)	..	1	1	..	1	1
Human rights	..	1	1	..	0	0
School holiday playschemes	12	9	9	3	7	7
After-school clubs	23	28	28
School student councils	6	11	11
Student Union	3	1	1
Extra teaching or special lessons	3	9	9
Other	3	9	9
None of the above	41	22	22	39	33	33
<i>Base (weighted)</i>	33	3255	3288	33	3257	3290

Table 7.30**Smoking behaviour by whether has a hyperkinetic disorder, 1999 and 2004 combined**

Children aged 11–16

Great Britain

	11- to 13-year-olds			14- to 16-year-olds			All aged 11–16		
	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%	%	%	%	%	%	%
Smoking behaviour									
Regular smoker	4	1	1	32	13	13	15	6	6
Occasional smoker	4	1	1	9	5	5	6	3	3
All smokers	8	2	2	41	18	18	21	9	9
Used to smoke	10	3	3	22	9	9	15	5	5
Tried smoking once	37	16	16	13	28	28	28	21	21
Never smoked	45	79	78	23	45	45	36	65	64
<i>Base (weighted)</i>	<i>50</i>	<i>4350</i>	<i>4400</i>	<i>34</i>	<i>3235</i>	<i>3269</i>	<i>84</i>	<i>7586</i>	<i>7670</i>

Table 7.31**Drinking behaviour by whether has a hyperkinetic disorder, 1999 and 2004 combined**

Children aged 11–16

Great Britain

	11- to 13-year-olds			14- to 16-year-olds			All aged 11–16		
	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All
	%	%	%	%	%	%	%	%	%
Drinking behaviour									
Almost every day	2	0	0	-	1	1	1	0	0
About twice a week	2	1	1	13	6	6	6	3	3
About once a week	-	2	2	15	10	10	6	6	6
All regular drinkers	4	3	3	28	17	17	13	9	9
About once a fortnight	2	3	3	10	12	12	5	7	7
About once a month	8	5	5	9	16	16	8	10	10
Only a few times a year	25	20	21	32	29	29	28	24	24
Never drinks alcohol	4	2	2	-	2	2	2	2	2
Never had a drink	57	67	67	21	24	24	43	49	49
<i>Base (weighted)</i>	<i>51</i>	<i>4346</i>	<i>4397</i>	<i>33</i>	<i>3237</i>	<i>3270</i>	<i>84</i>	<i>7585</i>	<i>7669</i>

Table 7.32
rug use by whether has a hyperkinetic disorder, 1999 and 2004 combined

Children aged 11–16									Great Britain
11- to 13-year-olds			14- to 16-year-olds			All aged 11–16			
Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All	Hyperkinetic disorder	No hyperkinetic disorder	All	
%	%	%	%	%	%	%	%	%	
Ever used:									
Cannabis	4	1	1	39	15	15	18	7	7
Inhalants	-	0	0	8	1	1	3	1	1
Ecstasy	-	0	0	-	1	1	-	0	0
Amphetamines	-	0	0	9	1	1	4	1	1
LSD	-	0	0	-	0	0	-	0	0
Tranquilisers	-	0	0	-	0	0	-	0	0
Cocaine	-	0	0	-	1	1	-	0	0
Heroin	-	0	0	-	0	0	-	0	0
Any drugs	8	3	3	45	16	16	23	8	9
<i>Base (weighted)</i>	<i>50</i>	<i>4345</i>	<i>4395</i>	<i>34</i>	<i>3234</i>	<i>3268</i>	<i>83</i>	<i>7581</i>	<i>7665</i>

Table 7.33
eliberate self-harm by whether has a hyperkinetic disorder, 1999 and 2004 combined

Hyperkinetic disorder			No hyperkinetic disorder	All
Percentage who have tried to harm, hurt or kill themselves				
All children				
Parent's report	14		2	2
<i>Base (weighted)</i>	<i>223</i>		<i>17432</i>	<i>17655</i>
Children aged 11–16				
Parent's report	14		3	3
<i>Base (weighted)</i>	<i>100</i>		<i>8138</i>	<i>8238</i>
Child's report	18		7	7
<i>Base (weighted)</i>	<i>79</i>		<i>7325</i>	<i>7404</i>

Chapter 8

Autistic spectrum disorder and other less common disorders

Introduction

This chapter focuses on less common disorders – autistic spectrum disorder, tics, eating disorders and selective mutism. As in previous chapters, we describe the types of behaviour patterns typically found among children and young people with these disorders. We then go on to describe the characteristics of children and young people with autistic spectrum disorder, looking at their:

- demographic characteristics;
- family situation;
- socio-economic characteristics;
- geographic distribution;
- general, physical and mental health;
- use of services;
- scholastic ability and attendance at school;
- family's social functioning;
- own social functioning; and
- lifestyle behaviours.

The tables compare children with autistic spectrum disorder with those who have no such disorder. Where possible, data from the 1999 and 2004 surveys have been combined to increase the sample base. The numbers of children with tics (33), eating disorders (24) and selective mutism (3) are too small for analysis, even when data from two survey years are combined.

Typical behaviour patterns

This section describes typical symptoms displayed by children with these less common disorders. The symptoms listed are found, to some extent, in most children. To count as a disorder they have to be sufficiently severe to cause distress to the child or impair his/her 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

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.

Eating disorders

Children with eating disorders are excessively concerned with their eating habits, weight and shape. For example, they may perceive themselves as being too fat even though they are thin, they may be ashamed of, or feel guilty about eating or engage in binge eating followed by fasting. Measures to control eating may involve excessive dieting, hiding food, vomiting, taking pills to aid weight loss.

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

She will eat all the chocolate in the house. This might be a whole packet of chocolate biscuits, and any chocolate cake she can find, and one or more bars of chocolate. It really depends what is around – we try to keep as little chocolate in the house as possible or hide it. But sometimes she finds our hidden chocolate and that goes all at once.

She has got more concerned about her appearance lately. I think she's getting interested in boys. She's lost a lot of weight and is now painfully thin, but she still insists that she is fat. She says she isn't hungry, but I'm sure that's not true, because of the times when she eats loads of chocolate and biscuits. She once got hold of some diuretics that her grandmother was on, but we found out and she hasn't got any more since.

Tic disorders including Tourette's syndrome

This disorder covers motor and vocal tics. The former include: eye blinking, squinting, eye rolling, nose twitching, head nodding, screwing up face, shoulder shrugging, jerking of arm or leg. Vocal tics include: throat clearing, excessive sniffing, coughing, squeaking, sucking noises, word repetition.

He went through a time when his hand kept on coming up to his head – if there was anyone about, he'd pretend that he was smoothing his hair into place. When he went through a phase of squinting his eyes, we took him for an eye test and they gave him glasses because he was a bit short sighted. The squinting did get better after that. About a year ago, he made barking noises as if he were a dog. Fortunately, those have stopped now. The sniffing is a bit worse in the summer when there is pollen about, so I have wondered if it is hay fever – but it happens at other times of the year too.

At present he blinks a lot and keeps on wrinkling up his nose – the bigger tics are not there at the moment. He also sniffs all the time, and has been through phases of barking, coughing and squeaking. He's usually at his worst after coming back from school – he'll sit down in front of the TV and he has lots of tics. When he knows people are watching him, he has less. They come in bouts, being bad for several weeks, and then having good periods when he hardly has any. They began when he was 7, initially with a lot of eye blinking, but then with various other motor tics coming in too. The sounds didn't start until he was about 10. They make it very hard for him to keep and make friends. This is the main problem – we are used to it at home and try not to let it interfere with his life. We try going out, but it is hard sometimes with people staring. The doctor prescribed him some medicine, and it did reduce the number of tics – but

the side effects included weight gain and some drowsiness. So he doesn't take anything regularly now – medicine is just for when he has a particularly nasty upsurge of tics.

Selective mutism

This disorder is characterised by a failure to speak in certain circumstances although the child is able to converse normally in other situations.

She has always been a shy child, but the main thing is that she won't speak when she is at school. She has been at school for over a year now, and she still won't talk to the teacher or to her classmates. That doesn't stop her doing her work in class, or playing chase with her friends during break. At home, she chats away happily to us, but she'll go completely silent if we have a visitor.

As explained in earlier in this chapter, the numbers of children with tics, eating disorders and selective mutism are too small for analysis and therefore no data have been shown for these groups. The following sections focus on children with autistic spectrum disorder.

Demographic, socio-economic and area characteristics

Demographic and family characteristics

Children with autistic spectrum disorder were predominantly boys, 82 per cent. There were no differences between autistic and other children in their age and ethnic profiles or in any of the measures of family size or composition.

(Tables 8.1 and 8.2)

Parental education and socio-economic characteristics

Unlike children with the more common disorders discussed in previous chapters, 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. The same proportions, 21 per cent, had parents with no qualifications. Likewise, autistic children were no more likely than other children to have a parent in a routine or semi-routine occupational group. 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, as discussed in the following section.

(Table 8.3)

Housing and income

Housing and income followed the same pattern as education. Autistic children were no less likely than other children to live in owned accommodation and they were 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. (Table 8.4)

Over a half (56 per cent) of families containing autistic children were receiving a disability benefit; 54 per cent received Severe Disablement Allowance and 23 per cent received Carers Allowance. Whilst we do not know for certain that the benefits were awarded on behalf of the child, this would have been the case for the majority. The proportion of these families receiving such benefits is much higher than for the families of children with conduct or emotional disorder (20 per cent in each case). This reflects the particularly heavy burden of caring for autistic children partly because of their behaviour patterns but also, as is discussed later in the chapter, because they often have learning and physical disabilities as well. (Table 8.4)

Area characteristics

There were no differences between families containing autistic children and other families with respect to the country and region in which they lived or in the type of area. Again, this is consistent with the other measures of affluence described above. Children with other types of disorder tended to live in poorer areas than other children but there was no such relationship for autistic children. (Table 8.5)

Among children with autistic spectrum disorder:

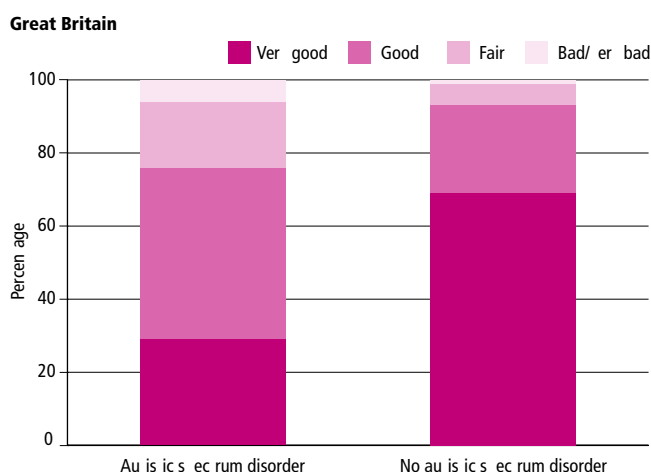
- 82 per cent were boys (*compared with 50 per cent for children with no autistic spectrum disorder*)
- 62 per cent were aged 5–10 (*53 per cent*)
- 92 per cent were white (*89 per cent*)
- 66 per cent lived in a married couple family (*68 per cent*)
- 46 per cent had parents with qualifications above GCSE level (*35 per cent*)
- 30 per cent lived in households in which neither parent worked (*14 per cent*)
- 56 per cent lived in households in which someone received a disability benefit (*8 per cent*)

Child's general, physical and mental health

General 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

Figure 8.1
Child's general health by whether they had autistic spectrum disorder, 1999 and 2004 combined



7 per cent). Conversely, less than one-third of the former described their child's health as very good compared with about two-thirds of the latter (29 per cent compared with 69 per cent) (Figure 8.1 and Table 8.6)

Physical and developmental problems

Consistent with their reported poor general health, the great majority of autistic children had a physical or developmental problem (89 per cent compared with 54 per cent of other children). The most common complaints were: speech or language problems (67 per cent), difficulty with co-ordination (47 per cent), bed wetting (29 per cent) and eyesight problems (23 per cent). These were reported for 10 per cent or fewer of other children. Autistic children were also much more likely than other children to have stomach and digestive problems (19 per cent), epilepsy (19 per cent) and to soil their pants (19 per cent). These problems were very rare among other children. (Table 8.7)

Mental disorders

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 19 per cent had an additional diagnosis of conduct disorder, often made on the basis of severely challenging behaviour. (Table 8.8)

The parents of autistic children reported multiple types of mental health problem: 71 per cent reported behavioural problems, 51 per cent emotional problems and 42 per cent hyperactivity. Overall, about three-quarters (78 per cent) of parents reported some form of mental health problem. (Table 8.9)

Medication

Thirteen per cent of children with autistic spectrum disorder were taking some form of medication. Overactivity and inattention are common symptoms of autism and all those on medication were taking drugs that were likely to have been prescribed for hyperkinesia: Methylphenidate (12 per cent), Clonidine (1 per cent) and Risperidone (1 per cent). (Table 8.10)

Among the parents of children with autistic spectrum disorder:

- 24 per cent reported that the child's general health was fair or bad (*compared with 7 per cent for children with no autistic spectrum disorder*)
- 89 per cent reported that the child had a specific physical or developmental problem (*54 per cent*)
- 78 per cent reported that the child had mental health problems (*10 per cent*)
- 51 per cent reported that the child had emotional problems, 71 per cent reported behavioural problems and 42 per cent reported hyperactivity (*4 per cent, 6 per cent and 3 per cent*)
- 30 per cent of the children had another main type of clinically recognisable disorder (*9 per cent*)

Use of services

Nine out of ten parents (89 per cent) of children with autistic spectrum disorder had sought help in the previous 12 months for their child's mental health problem and almost all of these had approached, or been referred to a professional source for advice (86 per cent). As with other groups, teachers were the most commonly used source (69 per cent) followed by specialist educational services, such as educational psychologists (51 per cent), mental health specialists (43 per cent) and child physical health specialists, such as paediatricians (36 per cent). About a quarter (22 per cent) had asked family members or friends for help or advice. (Table 8.11)

Scholastic ability and attendance at school

Teachers were asked to rate the child's abilities in reading, mathematics and spelling compared with an average child of the same age and to estimate the child's age in terms of their scholastic ability. They were also asked to say whether the child had officially recognised special educational needs.

Basic skills

In general, autistic children had much lower levels of educational attainment than other children and they had more difficulty with basic skills than children with other types of

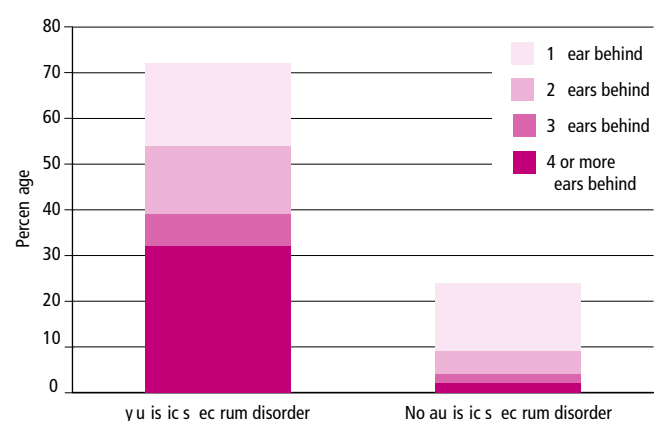
Among the parents of children with autistic spectrum disorder:

- 89 per cent had sought help or advice in the last year because of worries about their child's mental health (*compared with 27 per cent for children with no conduct disorder*)
- 86 per cent had contacted a professional service (*22 per cent*)
- The most commonly used services were: teachers (69 per cent), specialist educational services (51 per cent), mental health specialists (43 per cent) and child physical health specialists (36 per cent)

disorder. About a half were reported as having marked difficulty with reading and mathematics (48 per cent compared with 6 per cent of other children) and over a half were behind with spelling (58 per cent compared with 9 per cent). Overall, they were three times as likely as other children to be behind in their overall intellectual development (72 per cent compared with 24 per cent). Two-fifths (39 per cent) were more than two years behind. (Figure 8.2 and Table 8.12)

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



Special educational needs

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) and the majority of these had a written statement of their needs (84 per cent compared with 45 per cent). (Table 8.13)

Absence from school

The lower level of educational attainment among autistic children was not attributable to poor attendance at school. As Tables 8.14 and 8.15 show, they were no more likely than other children to have missed school nor was their truancy rate any higher. There is, however, evidence of interrupted schooling. Over a quarter (27 per cent) had been excluded from school at some point and most of these (23 per cent overall) had been excluded on more than one occasion. Just over a half of the autistic children who had been excluded also had a conduct disorder. Exclusion was very rare among other children (4 per cent). Similarly, a half (50 per cent) of autistic children had changed schools other than at normal transition stages, including 17 per cent who had experienced more than one change. None of these changes followed exclusion from school. Among other children, 19 per cent had changed schools and only 5 per cent had changed more than once.

(Tables 8.14–8.17)

Among children with autistic spectrum disorder:

- 72 per cent were behind in their overall intellectual development (*compared with 24 per cent for children with no autistic spectrum disorder*)
- 97 per cent had officially recognised special educational needs (*16 per cent*)
- 27 per cent had been excluded from school and 50 per cent had changed schools apart from normal transitions (*4 per cent and 19 per cent*)

Social functioning of the family

This section looks at various aspects of parental health, attitudes and behaviour which provide indicators of the social functioning of the family.

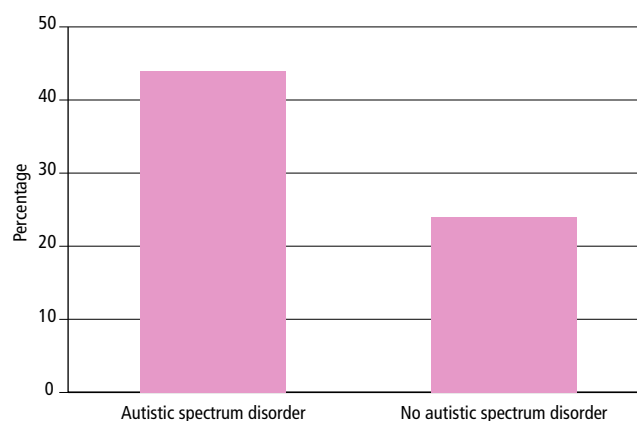
Mental health of parent

The parent who was interviewed about the child's behaviour, usually the mother, was asked about her own mental health using the General Health Questionnaire (GHQ-12 – see Chapter 2 for details). Scores range from 0 (no psychological distress) to 12 (severe psychological distress). A score of 3 is generally taken as the threshold with scores at this level or higher being considered indicative of an emotional disorder.

The parents of autistic children were almost twice as likely as other parents to have scores at or above the threshold (44 per cent compared with 24 per cent). (Figure 8.3 and Table 8.18)

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

Great Britain



Family functioning

Family functioning was measured using the FAD-GFS scale in which parents rated 12 statements about family relationships (see Chapter 2 for details). For this survey, families which scored over 2.00 on this scale were considered to have unhealthy functioning.

Family functioning scores showed the same pattern as parental mental health. Autistic children were twice as likely as other children to live in families classified as having unhealthy functioning on this scale (37 per cent compared with 18 per cent).

(Table 8.19)

Stressful life events

Autistic children were more likely than other children to have experienced two or more stressful life events (42 per cent compared with 26 per cent). There was also a general pattern across several events for the proportions experiencing the event to be higher among autistic children but none of the differences was large enough to be statistically significant. Since autism is present from infancy onwards, there is no reason to believe that exposure to stressful life events in childhood cause the autism. The link in this study may be a coincidence or, more likely, autism may trigger life events by placing extra stress on the family. (Tables 8.20 and 8.21)

Among children with autistic spectrum disorder:

- 44 per cent of parents had an emotional disorder (*compared with 24 per cent for the parents of children with no autistic spectrum disorder*)
- 37 per cent lived in families with unhealthy functioning (*18 per cent*)

Child's social functioning

This section covers features of the child's social functioning which might provide protection against the onset and course of mental disorder: their strengths, their relationships with friends and their social aptitudes. In previous chapters, this section has also described various measures of social capital, such as children's views about their neighbourhood and the extent to which they participated in group activities. These questions were addressed to children aged 11–16 who were interviewed in the 2004 survey. However, it was often not possible to conduct an interview with an autistic child. Of the 28 children with autistic spectrum disorder who were potentially eligible for the questions, interviews were achieved with only 10 and some of these did not provide full information. Data have therefore not been presented for these topics or for the child's assessment of their strengths.

Strengths

Parents were asked to rate the child on 24 items covering various qualities (see Chapter 2 for details). The scores ranged from 0–48 and were divided into quartiles. Almost all of the children with autistic spectrum disorder fell into the bottom quartile (96 per cent compared with 25 per cent of other children). (Table 8.22)

Social aptitudes

The social aptitude scale consisted of 10 questions addressed to parents designed to measure the child's ability to empathise with others (see Chapter 2 for details). Scores ranged from 0–40 and were grouped into quartiles. The results showed the same pattern as the strengths scores with almost all children with autistic spectrum disorder falling into the bottom quartile (96 per cent compared with 24 per cent of other children). (Table 8.23)

Friendships

As discussed at the beginning of the chapter, impaired social interaction is a common feature of autistic spectrum disorder and the responses to the questions on friendships illustrate this problem. Thus, well 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. Among those who had friends, autistic children were less likely to share interests and activities with friends and a high proportion, 59 per cent did not have a friend to whom they could talk if they were worried. However, there were no differences between autistic and other children in the likelihood of their parents disapproving of their friends. (Table 8.24)

Smoking, drinking and drug use

Questions about smoking, drinking and drug use were asked of 11- to 16-year-olds who were interviewed in the 1999 and 2004 surveys. The information was collected by self-completion. As with the social capital questions, the number of children with autistic spectrum disorder who were able to complete the questionnaire was too small for analysis.

Self-harm

All parents were asked whether their child had ever tried to hurt, harm or kill themselves (see Chapter 2 for details). A quarter (25 per cent) of parents of autistic children reported such instances of self-harm. Among other parents, the proportion was 2 per cent. Again, there were too few interviews with autistic children aged 11–16 for the equivalent analysis based on the child's report. (Table 8.25)

Results from the six-month follow-up survey

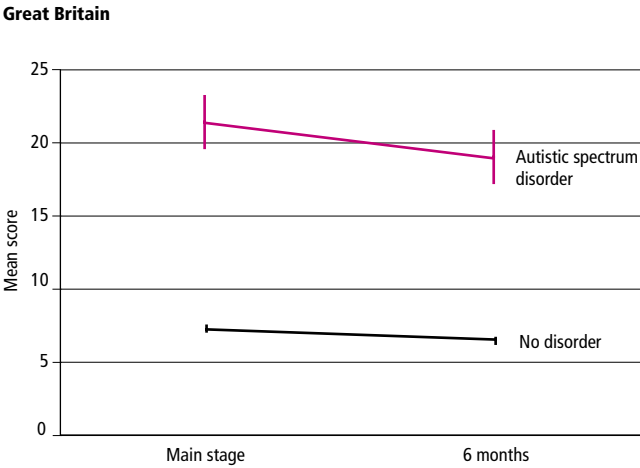
Samples of the parents of children interviewed in the 1999 and 2004 surveys were sent a self-completion questionnaire six months after the interview in order to establish whether there had been any change in their symptoms (see Chapter 3).

The average levels of total symptoms and problems with peer relationships among the children with autistic spectrum disorders did fall slightly over the 6 months following the survey. However, as Figures 8.4 and 8.5 show, the gap between children with and those with no autistic spectrum disorders only narrowed a little as a result. Nor did the impact of symptoms change much (Figure 8.6). Both the symptoms and the impact of autistic spectrum disorders were typically very persistent, at least in the short term. (Figures 8.4–8.6)

Among children with autistic spectrum disorder:

- 71 per cent found it harder than average to make friends (*compared with 10 per cent for children with no autistic spectrum disorder*)
- 42 per cent had no friends (*1 per cent*)

Figure 8.4
Total symptoms¹ at main interview and at six-month follow-up by whether child had autistic spectrum disorder at main interview, 1999 and 2004 combined



1. Total symptoms is the 'total difficulties score' on the parent-reported SDQ, reflecting the sum of the subscale scores for emotional symptoms, conduct problems, hyperactivity and peer problems.

Figure 8.5
Peer problems at main interview and at six-month follow-up by whether child had an autistic spectrum disorder at main interview, 1999 and 2004 combined



Figure 8.6
Impact of symptoms at main interview and at six-month follow-up by whether child had an autistic spectrum disorder at main interview, 1999 and 2004 combined

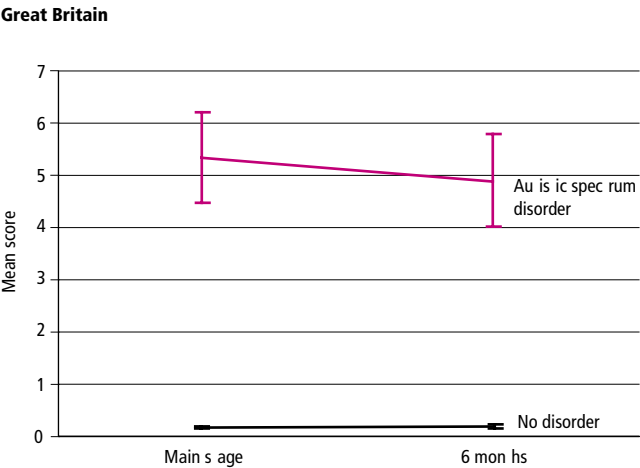


Table 8.1**Sex, age and ethnicity of child by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Sex			
Boys	82	50	51
Girls	18	50	49
Age			
5–10	62	53	53
11–16	38	47	47
Ethnicity			
White	92	89	89
Black ¹	3	3	3
Indian	1	2	2
Pakistani/ Bangladeshi	1	3	3
Other	3	3	3
<i>Base (weighted)</i>	<i>98</i>	<i>18306</i>	<i>18403</i>

1. Includes people of mixed black and white origin.

Table 8.2**Family characteristics by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Family type			
Married	66	68	68
Cohabiting	6	8	8
Lone parent – single	8	8	8
Lone parent – widowed, divorced or separated	19	16	16
Number of children in household			
1	21	23	23
2	48	45	45
3	22	22	22
4	9	7	7
5 or more	1	3	3
<i>Base (weighted 1999 and 2004 data)</i>	<i>98</i>	<i>18318</i>	<i>18415</i>
If stepchildren in family			
Yes	14	11	11
No	86	89	89
<i>Base (weighted 2004 data)¹</i>	<i>66</i>	<i>7911</i>	<i>7977</i>

1. The 1999 data had a different classification for whether or not a family contained stepchildren.

Table 8.3**Parent's education and socio-economic characteristics by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Parent's highest educational qualification			
Degree level	19	13	13
Teaching/HND/Nursing	10	11	11
A /AS level or equivalent	17	11	11
GCSE Grades A–C or equivalent	18	30	30
GCSE Grades D–F or equivalent	14	11	11
Other qualification	1	3	3
No qualification	21	21	21
Parent's employment status			
Both working/lone parent working	47	67	67
One parent working	23	19	19
Neither working/lone parent not working	30	14	15
<i>Base (weighted 1999 and 2004 data)</i>	<i>91</i>	<i>18020</i>	<i>18111</i>
Family's socio-economic classification¹			
Large employers and higher managerial	2	2	2
Higher professional	2	3	3
Lower managerial and professional	19	20	20
Intermediate occupations	10	19	19
Small employers and own account	4	7	7
Lower supervisory and technical	-	1	1
Semi-routine	20	26	26
Routine occupations	14	12	12
Never worked/ long-term unemployed	7	5	5
FT student/inadequate description	21	4	4
<i>Base (weighted 2004 data)²</i>	<i>66</i>	<i>7911</i>	<i>7977</i>

1. This is the National Statistics Socio-economic Classification (NS-SEC).

2. The 1999 data had a different social classification.

Table 8.4**Housing and income by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Type of accommodation			
Detached	26	25	25
Semi-detached	38	38	38
Terraced house	30	30	30
Flat/maisonette	5	7	7
Tenure			
Owners	63	69	69
Social sector tenants	26	24	24
Private renters	11	7	7
<i>Base (weighted 1999 and 2004 data)</i>	<i>98</i>	<i>18307</i>	<i>18404</i>
Gross weekly household income			
Under £100	1	4	4
£100–£199	8	16	16
£200–£299	22	14	14
£300–£399	18	12	12
£400–£499	12	11	11
£500–£599	10	10	10
£600–£770	7	13	13
Over £770	22	20	20
<i>Base (weighted 1999 and 2004 data)</i>	<i>79</i>	<i>16817</i>	<i>16896</i>
Receipt of disability benefits			
Carers allowance	23	3	3
Severe Disablement allowance	54	5	6
Disability living/attendance allowance	-	0	0
Incapacity allowance	-	2	2
Any disability allowance	56	8	8
No disability allowance	44	92	92
<i>Base (weighted 2004 data¹)</i>	<i>66</i>	<i>7911</i>	<i>7977</i>

1. The 1999 data covered different types of disability benefit.

Table 8.5**Region, country and area type by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Region and country			
London Inner	2	5	5
London Outer	11	7	7
Other met England	29	31	31
Non-met England	49	44	44
England	92	86	86
Scotland	6	9	8
Wales	2	5	5
<i>Base (weighted 1999 and 2004 data)</i>	<i>98</i>	<i>18318</i>	<i>18415</i>
Area type (ACORN classification)			
Wealthy achievers	20	26	26
Urban prosperity	6	8	8
Comfortably off	34	26	26
Moderate means	20	17	17
Hard pressed	19	24	24
<i>Base (weighted 2004 data)¹</i>	<i>65</i>	<i>7852</i>	<i>7917</i>

1. The 1999 data had a different ACORN classification.

Table 8.6**Child's general health by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Child's general health			
Very good	29	69	69
Good	47	24	24
Fair	18	6	6
Bad	3	1	1
Very bad	3	0	0
<i>Base (weighted)</i>	<i>98</i>	<i>18075</i>	<i>18172</i>

Table 8.7**Co-occurrence of physical and developmental problems, and autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
<i>Percentage of children with each type of physical complaint</i>			
Asthma	20	15	15
Eczema	18	13	13
Hay fever	10	11	11
Eyesight problems	23	10	10
Stomach or digestive problems	19	6	6
Non-food allergy	10	6	6
Migraine/severe headache	6	5	5
Bed wetting	29	4	5
Glue ear/otitis media/grommits	10	4	4
Hearing problems	6	4	4
Speech or language problems	67	4	4
Food allergy	18	3	4
Difficulty with co-ordination	47	2	2
Stiffness or deformity of foot	8	2	2
Heart problems	5	1	1
Soiling pants	19	1	1
Muscle disease or weakness	7	1	1
Kidney/urinary tract problems	1	1	1
Obesity	3	1	1
Congenital abnormality	6	1	1
Epilepsy	19	1	1
Any blood disorder	1	0	0
Diabetes	-	0	0
Cerebral Palsy	3	0	0
Cancer	-	0	0
Any physical or developmental problem¹	89	54	54
No problem	11	46	46
<i>Base (weighted)</i>	<i>96</i>	<i>18076</i>	<i>18172</i>

1. Some physical complaints are not listed in the table above because of their rarity (less than 25 cases): ME (10), Spina bifida (6), Cystic fibrosis (11), Missing digits (20). They are included in the 'Any physical or developmental problems' category.

Table 8.8**Co-occurrence of other mental disorders and autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
<i>Percentage of children with each type of disorder</i>			
Other mental disorders			
Emotional disorders:			
Anxiety disorders	16	3	4
Depression	1	1	1
All emotional disorders	16	4	4
Conduct disorders:			
Oppositional defiant disorder	-	3	3
Other conduct disorders	19	2	2
All conduct disorders	19	5	5
Hyperkinetic disorders	-	1	1
Less common disorders (excluding ASD)	-	0	0
Any other disorder	30	9	9
No (other) disorders	70	91	91
<i>Base (weighted)</i>	<i>98</i>	<i>18318</i>	<i>18415</i>

Table 8.9**Parent's view of child's mental health by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
<i>Percentage of children with each type of problem</i>			
Parent's view of child's mental health			
Emotional problems	51	4	5
Behavioural problems	71	6	6
Hyperactivity	42	3	4
Any of the above	78	10	10
<i>Base (weighted)</i>	<i>98</i>	<i>18076</i>	<i>18174</i>

Table 8.10**Whether child is taking any medication by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
<i>Percentage of children taking each type of medication</i>			
Methylphenidate, Equasym, Ritalin	12	1	1
Dexamphetamine, Dexedrine	-	0	0
Imipramine, Tofranil	-	0	0
Clonidine, Catepres, Dixarit	1	0	0
Fluoxetine, Prozac	-	0	0
Sertraline, Lustral	-	0	0
Fluvoxamine, Faverin	-	0	0
Citalopram, Cimpramil	-	0	0
Amitryptaline, Lentizol, Triptafen	-	0	0
Sulpirade, Dolmatil, Sulparex, Sulpitil	-	0	0
Risperidone, Riperadal	1	0	0
Haloperidol, Dozic, Haldol, Serenace	-	0	0
Any medication	13	1	1
No medication	87	99	99
<i>Base (weighted)</i>	<i>66</i>	<i>7795</i>	<i>7862</i>

Table 8.11**Help sought in last year for child's mental health problems by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
<i>Percentage of children using each service/source</i>			
Specialist services			
Child/adult mental health specialist (eg psychiatrist)	43	3	3
Child physical health specialist (eg paediatrician)	36	2	2
Social services (eg social worker)	23	2	2
Education services (eg educational psychologist)	51	4	4
Front line services			
Primary health care (eg GP or practice nurse)	33	6	6
Teachers	69	17	18
All professional services	86	22	22
Informal sources			
Family member/friends	22	12	12
Internet	10	1	1
Telephone help line	3	1	1
Self-help group	10	0	0
Other type of help	8	2	2
All sources	89	27	28
No help sought	11	73	72
<i>Base (weighted)</i>	<i>58</i>	<i>7726</i>	<i>7784</i>

Table 8.12**Teacher's rating of child's basic skills by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Reading			
Above average	16	37	37
Average	14	40	40
Some difficulty	22	17	17
Marked difficulty	48	6	6
Mathematics			
Above average	17	32	31
Average	9	44	44
Some difficulty	25	19	19
Marked difficulty	48	6	6
Spelling			
Above average	5	28	28
Average	21	41	41
Some difficulty	16	21	21
Marked difficulty	58	9	9
<i>Base (weighted)</i>	<i>75</i>	<i>14100</i>	<i>14174</i>
Overall scholastic ability¹			
4 or more years behind	32	2	2
3 years behind	7	2	2
2 years behind	15	5	5
1 year behind	18	15	15
Equivalent	11	36	35
1 or more years ahead	17	40	40
<i>Base (weighted)</i>	<i>66</i>	<i>13188</i>	<i>13254</i>

1. Functioning age-actual age.

Table 8.13**Whether child has special educational needs by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
If child has officially recognised special educational needs			
Yes	97	16	17
No	3	84	83
<i>Base (weighted)</i>	<i>75</i>	<i>13869</i>	<i>13944</i>

Table 8.14**Absence from school and truancy (teacher's report) by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Number of days absent in last term			
0	32	32	32
1–5	38	46	46
6–10	17	13	13
11–15	7	4	4
16 or more	6	5	5
Any days absent	68	68	68
<i>Base (weighted)</i>	<i>57</i>	<i>10328</i>	<i>10385</i>
Any unauthorised days absent			
Yes	13	9	9
No	87	91	91
<i>Base (weighted): 2004 data¹</i>	<i>38</i>	<i>4651</i>	<i>4689</i>
Whether plays truant			
Not true	93	97	97
Somewhat true	1	2	2
Certainly true	6	1	1
<i>Base (weighted)</i>	<i>74</i>	<i>14191</i>	<i>14265</i>

1. This question was not asked in 1999.

Table 8.15**Absence from school (parent's report) by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Whether missed school in last term¹			
Yes	37	34	34
No	63	66	66
<i>Base (weighted): all children</i>	<i>56</i>	<i>7566</i>	<i>7621</i>
Reasons for absence			
Short-term illness	(71)	78	78
Long-term illness	(10)	2	2
Refused to attend	-	2	2
Has a school phobia	(4)	0	0
Other	(23)	20	20
<i>Base (weighted): those who missed school</i>	<i>20</i>	<i>2579</i>	<i>2599</i>

1. Excluding exclusions.

Table 8.16**Exclusions from school (parent's report) by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Number of times child has been excluded from school			
None	73	96	96
Once	3	2	2
Twice	8	1	1
Three or more times	15	1	1
<i>Base (weighted)</i>	<i>57</i>	<i>7713</i>	<i>7770</i>

Table 8.17**Number of times child has changed schools by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Number of times child has changed school¹			
None	50	81	81
Once	33	14	14
Twice	3	3	3
Three or more times	14	2	2
<i>Base (weighted)</i>	<i>57</i>	<i>7719</i>	<i>7776</i>

1. Apart from normal transitions.

Table 8.18**Parent's GHQ-12 score by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Parent's GHQ-12¹			
0–2	56	76	76
3–5	15	13	13
6–8	17	7	7
9–12	12	4	4
3 or more	44	24	24
<i>Base (weighted)</i>	<i>83</i>	<i>17899</i>	<i>17983</i>

1. For this survey, scores of 3 or more were taken to indicate a severe emotional problem.

Table 8.19**Family functioning score by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Family functioning score¹			
Up to 1.50	21	36	36
1.51–2.00	42	46	46
2.01–2.50	29	16	16
2.51 or more	9	2	2
Unhealthy functioning (2.01 or more)	37	18	18
<i>Base (weighted)</i>	<i>82</i>	<i>17826</i>	<i>17908</i>

1. For this survey, scores over 20 were taken to suggest unhealthy family functioning.

Table 8.20**Stressful life events by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	Percentage reporting each event		
Stressful life events			
Since child was born, parent had a separation due to marital difficulties or broken off steady relationship	38	31	31
Since child was born, parent had a major financial crisis such as losing the equivalent of three months income	19	13	13
Since child was born, parent had a problem with the police involving a court appearance	8	6	6
Since child was born, parent has had serious physical illness	7	8	8
Since child was born, parent has had serious mental illness	15	8	8
At any stage in child's life, a parent, brother or sister died	7	3	4
At any stage in child's life, a close friend died	11	6	6
At some stage in the child's life, s/he had a serious illness which required a stay in hospital	22	13	13
At any stage in child's life, s/he had been in a serious accident or badly hurt in an accident	7	5	5
In the past year child has broken off a steady relationship with a boy or girl friend (aged 13 or above)/ a close friendship has ended (any age)	4	7	7
<i>Base (weighted)</i>	<i>57</i>	<i>7713</i>	<i>7770</i>

Table 8.21**Number of stressful life events by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Number of stressful life events			
0	34	42	42
1	24	32	32
2	20	15	15
3	16	7	7
4	2	3	3
5 or more	4	1	1
Two or more events	42	26	26
<i>Base (weighted)</i>	<i>57</i>	<i>7713</i>	<i>7770</i>

Table 8.22**Child's strengths (parent's assessment) by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Strength score – parent assessment			
0–36	96	25	25
37–40	4	25	25
41–43	-	25	25
44–48	-	25	25
<i>Base (weighted)</i>	<i>51</i>	<i>7520</i>	<i>7571</i>

Table 8.23**Social aptitude (parent's assessment) by whether has autistic spectrum disorder, 2004**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
Social aptitude score			
0–20	96	24	25
21–24	4	28	27
25–28	-	23	22
29–40	-	26	25
<i>Base (weighted)</i>	<i>56</i>	<i>7426</i>	<i>7483</i>

Table 8.24

Friendships by whether has autistic spectrum disorder, 2004

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
	%	%	%
What is child like at making friends?			
Finds it harder than average	71	10	10
About average	21	36	36
Easier than average	7	55	54
What is child like at keeping friends?			
Finds it harder than average	73	5	5
About average	21	35	35
Easier than average	6	60	59
Number of friends			
0	42	1	2
1	18	4	4
2–4	34	43	43
5–9	4	40	39
10 or more	1	12	11
<i>Base (weighted): All children</i>	<i>65</i>	<i>7775</i>	<i>7840</i>
Do child and friends have things in common			
No	9	1	1
A little	59	21	21
A lot	33	78	78
Do child and friends do things together			
No	30	3	4
A little	29	21	21
A lot	41	75	75
If worried, can child talk to friends			
No	59	21	21
Perhaps	30	42	42
Definitely	11	38	37
Whether friends get into trouble			
Not at all	67	67	67
A few are like that	21	31	31
Many are like that	5	1	1
All are like that	6	0	0
Whether parent approves of child's friends			
No	6	2	2
A little	16	14	14
A lot	78	84	84
<i>Base (weighted): those who had friends</i>	<i>36</i>	<i>7534</i>	<i>7570</i>

Table 8.25**eliberate self-harm (parent's report) by whether has autistic spectrum disorder, 1999 and 2004 combined**

All children	Great Britain		
	Autistic spectrum disorder	No autistic spectrum disorder	All
Percentage who have tried to harm, hurt or kill themselves	25	2	2
<i>Base (weighted)</i>	<i>84</i>	<i>17571</i>	<i>17655</i>

Chapter 9

Children with multiple disorders

Introduction

The previous chapters focused on each of the main broad categories of mental disorder. However, some children were diagnosed with more than one of these disorders. While this subgroup is relatively small, it is likely to include children with the most serious problems. This short chapter first examines the prevalence of co-morbidity and then explores whether children with multiple disorders have poorer health, educational and behavioural characteristics and make greater use of services than those with a single disorder.

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). (Table 9.1)

The tables in the next section compare children who had multiple disorders with those who had a single disorder. As the former include a higher proportion of children with conduct disorders (90 per cent compared with 45 per cent), who tend to have more problems than children with emotional disorders, we would expect the multiple disorder group to fare worse quite apart from the effects of their co-morbidity. However, the aim of this analysis is simply to describe key features of the subgroup rather than to determine the independent effects of factors such as the type or extent of comorbidity.

Characteristics and behaviour of children with multiple disorders

Demographic characteristics

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. Among those with a single disorder, boys were also in the majority but by a smaller margin (58 per cent). There were no differences by number of disorders with regard to age profiles. (Table 9.2)

Physical and developmental problems and general health

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. The former were the more likely to report asthma (26 per cent and 18 per cent), bed wetting (17 per cent and 10 per cent), speech or language problems (21 per cent and 10 per

cent) and difficulty with co-ordination (15 per cent and 7 per cent). (Table 9.3)

Similarly, parents whose child had multiple disorders were more likely than those whose child had a single disorder to report that the child's general health was fair or bad (26 per cent compared with 17 per cent) and much less likely to say that their child's health was very good (37 per cent compared with 50 per cent). (Table not shown)

Use of services

Almost all parents of children with multiple disorders had sought help with their child's mental health problems in the previous 12 months (96 per cent) and most had sought, or been referred to, some form of professional advice (93 per cent). Nearly three quarters (73 per cent) had approached a teacher and about a half had approached specialist mental health services (51 per cent) or GP services (46 per cent). These proportions are much higher than the corresponding figures for parents of children with a single disorder: 71 per cent had sought help of some kind and 64 per cent had sought professional advice. (Table 9.4)

There is particular interest among clinicians in the diagnostic make-up of children who present at specialist mental health clinics. Overall 3 per cent of children had attended such clinics in the previous year. This group consisted of roughly equal proportions of children with 2 or more disorders (32 per cent), children with single disorders (37 per cent) and those with no diagnosed disorder (31 per cent). Thus, while children with multiple disorders represent only 2 per cent of all children, they account for about one-third of the cases using specialist mental health services. It may seem surprising that children with no diagnosed disorder should have had contact with specialist mental health services. However, these children may have had a disorder at the time that they were referred which may have been some months before the assessment carried out for this survey. (Table not shown)

Scholastic ability

Teachers' ratings of children's progress at school showed that nearly two thirds (63 per cent) of children with multiple disorders were behind with their overall intellectual development 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. (Table 9.5)

Child's strengths and social aptitudes

Both parents and young people were asked to rate the child on a series of items covering various qualities (see Chapter 2 for details). Scores on the adult scale ranged from 0-48 and those

on the children's scale ranged from 0–38. Table 9.6 shows the scores on each scale grouped into quartiles. Looking first at the parent's assessment, 88 per cent of children with multiple disorders had scores in the bottom quartile compared with 61 per cent of those with a single disorder. There was no such difference between the young people's assessments probably because those with multiple disorders tend to have less insight into their problems. (Table 9.6)

Parents were also asked to rate their child's social aptitude using a scale of 10 questions designed to measure the child's ability to empathise with others (see Chapter 2 for details). Scores ranged from 0–40 and were grouped into quartiles. These scores showed the same pattern as the strengths scores. About three-quarters (78 per cent) of children with multiple disorders had scores in the bottom quartile compared with just over a half (56 per cent) of children with a single disorder. (Table 9.7)

Smoking, drinking and drug use

There were no differences between children with multiple and those with single disorders in terms of the proportions who were smokers, regular drinkers or who had ever taken cannabis. The apparent difference between the proportions of smokers was not statistically significant. (Table 9.8)

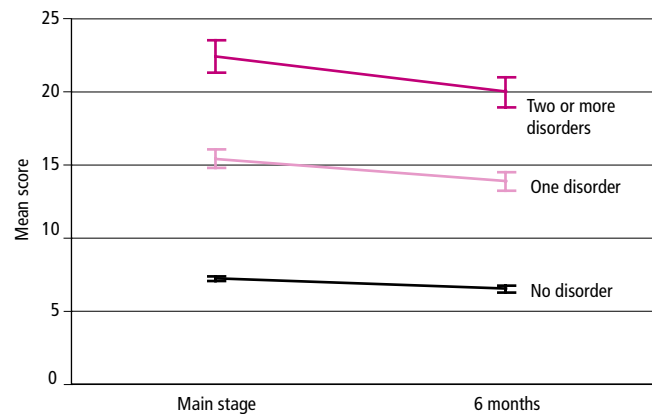
Results from the six-month follow-up survey

Samples of the parents of children interviewed in the 1999 and 2004 surveys were sent a self-completion questionnaire six months after the interview in order to establish whether there had been any change in their symptoms (see Chapter 3).

The average level of total symptoms among the children with two or more disorders did fall slightly over the six months following the survey. However, as Figure 9.1 shows, the gap between children with multiple disorders and their comparison groups only narrowed a little as a result. The impact attributable to these symptoms was less persistent, falling by around a third (Figure 9.2). At first glance, it seems surprising that impact dropped by a third although the level of symptoms was fairly steady. The most likely explanation is that the impact of symptoms depends not just on the symptoms themselves but on everything else in the child's life. Changes at home or at school may make symptoms easier or harder to live with. (Figures 9.1 and 9.2)

Figure 9.1
Total symptoms¹ at main interview and at six-month follow-up by number of disorders at main interview, 1999 and 2004 combined

Great Britain



¹ Total symptoms is the 'total difficulties score' on the parent-reported SDQ, reflecting the sum of the subscale scores for emotional symptoms, conduct problems, hyperactivity and peer problems.

Figure 9.2
Impact of symptoms at main interview and at six-month follow-up by number of disorders at main interview, 1999 and 2004 combined

Great Britain

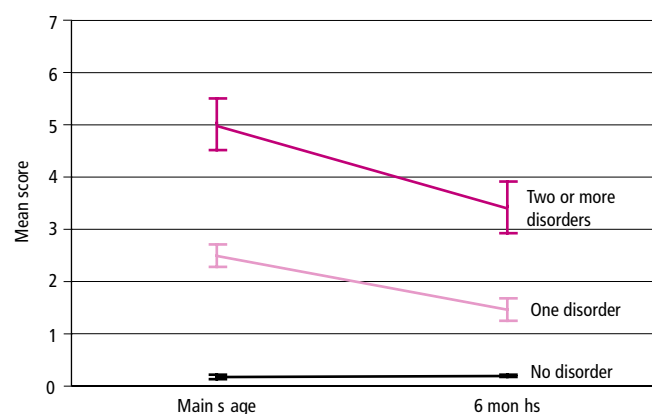


Table 9.1**Number and combinations of main disorder categories, 1999 and 2004 combined**

All children	Great Britain
	<i>Percentage of children</i>
Three or more disorders:	0.2
Emotional, conduct and hyperkinetic disorders	0.1
Emotional, conduct and less common disorders	0.1
Other combinations	0.0
Two disorders:	1.7
Emotional and conduct disorders	0.7
Conduct and hyperkinetic disorders	0.7
Emotional and less common disorders	0.1
Other combinations	0.1
One disorder:	7.1
Emotional disorder	2.9
Conduct disorder	3.2
Hyperkinetic disorder	0.5
Less common disorder	0.6
<i>Base (weighted)</i>	<i>18415</i>

Table 9.2**Sex and age by number of mental disorders, 1999 and 2004 combined**

All children	Great Britain			
	Number of mental disorders ¹			
	Two or more	One	None	All
	%	%	%	%
Sex				
Boys	72	58	50	51
Girls	28	42	50	49
Age				
5–10	45	44	54	53
11–16	55	56	46	47
Base (weighted)	349	1306	16760	18415

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

Table 9.3**Occurrence of physical or developmental problems by number of mental disorders, 1999 and 2004 combined**

All children

Great Britain

Number of men al disorders ¹				
	Two or more	One	None	All
Percentage of children with each type of physical complaint				
Asthma	26	18	14	15
Eczema	13	15	12	13
Hay fever	13	13	10	11
Eyesight problems	18	14	10	10
Stomach or digestive problems	11	10	5	6
Non-food allergy	9	6	6	6
Migraine/severe headache	11	8	4	5
Bed wetting	17	10	4	5
Glue ear/otitis media/grommits	7	5	4	4
Hearing problems	5	6	3	4
Speech or language problems	21	10	3	4
Food allergy	8	6	3	4
Difficulty with co-ordination	15	7	2	2
Stiffness or deformity of foot	5	4	2	2
Heart problems	3	2	1	1
Soiling pants	7	3	1	1
Muscle disease or weakness	3	3	1	1
Kidney/urinary tract problems	3	2	1	1
Obesity	3	2	1	1
Congenital abnormality	1	1	1	1
Epilepsy	4	2	0	1
Any blood disorder	1	0	0	0
Diabetes	1	0	0	0
Cerebral Palsy	0	1	0	0
Cancer	1	0	0	0
Any physical or developmental problem ²	76	66	53	54
No physical problem	24	34	47	46
Base (weighted)	349	1294	16531	18172

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

2. Some physical complaints are not listed in the table above because of their rarity (less than 25 cases): ME (10), Spina bifida (6), Cystic fibrosis (11), Missing digits (20) They are included in the 'Any physical or developmental problem' category.

Table 9.4**Help sought in last year for child's mental health problems by number of mental disorders, 2004**

All children				Great Britain
Number of mental disorders ¹				
	Two or more	One	None	All
<i>Percentage of children using each service/source</i>				
Specialist services				
Child/adult mental health specialist (eg psychiatrist)	51	17	1	3
Child physical health specialist (eg paediatrician)	14	8	1	2
Social services (eg social worker)	23	8	1	2
Education services (eg educational psychologist)	38	18	2	4
Front line services				
Primary health care (eg GP or practice nurse)	46	26	4	6
Teachers	73	48	14	18
All professional services	93	64	17	22
Informal sources				
Family member/friends	43	29	10	12
Internet	10	4	1	1
Telephone help line	5	4	0	1
Self-help group	7	2	0	0
Other type of help	9	5	1	2
All sources	96	71	23	28
No help sought	4	29	77	72
<i>Base (weighted)</i>	<i>158</i>	<i>542</i>	<i>7084</i>	<i>7784</i>

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

Table 9.5**Overall scholastic ability by number of mental disorders, 1999 and 2004 combined**

All children				Great Britain
Number of mental disorders ¹				
	Two or more	One	None	All
	%	%	%	%
Overall scholastic ability²				
4 or more years behind	12	9	2	2
3 years behind	8	6	2	2
2 years behind	20	12	5	6
1 year behind	23	22	14	15
Equivalent	25	30	36	35
1 or more years ahead	12	21	42	40
<i>Base (weighted)</i>	<i>238</i>	<i>933</i>	<i>12083</i>	<i>13254</i>

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

2. Functioning age-actual age.

Table 9.6**Child's strengths (parent's and child's assessment) by number of mental disorders, 2004**

All children

Great Britain

	Number of mental disorders ¹			
	Two or more	One	None	All
	%	%	%	%
ALL CHILDREN				
Strength score—parent assessment				
0–36	88	61	21	25
37–40	7	19	26	25
41–43	3	13	26	25
44–48	1	8	27	25
<i>Base (weighted)</i>	<i>150</i>	<i>523</i>	<i>6899</i>	<i>7571</i>
CHILDREN AGED 11–16				
Strength score—child assessment				
0–23	43	40	21	23
24–27	23	27	27	27
28–30	20	19	23	23
31–38	13	14	29	27
<i>Base (weighted)</i>	<i>57</i>	<i>252</i>	<i>3030</i>	<i>3338</i>

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

Table 9.7**Social aptitude (parent's assessment) by number of mental disorders, 2004**

All children

Great Britain

	Number of mental disorders ¹			
	Two or more	One	None	All
	%	%	%	%
Social aptitude score				
0–20	78	56	21	25
21–24	11	21	28	27
25–28	6	12	24	22
29–40	6	11	27	25
<i>Base (weighted)</i>	<i>152</i>	<i>519</i>	<i>6811</i>	<i>7483</i>

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

Table 9.8**Smoking, drinking and drug use by number of mental disorders, 1999 and 2004 combined**

Children aged 11–16

Great Britain

	11- o 13-year-olds				14- o 16-year-olds				All aged 11–16			
	Two or more	One	None	All	Two or more	One	None	All	Two or more	One	None	All
	%	%	%	%	%	%	%	%	%	%	%	%
All smokers	16	7	2	2	51	41	15	18	32	24	7	9
All regular drinkers	4	5	3	3	24	28	16	17	13	16	8	9
Ever used cannabis	6	5	1	1	41	30	13	15	22	18	6	7
<i>Base (weighted)</i>	<i>81</i>	<i>287</i>	<i>4029</i>	<i>4397</i>	<i>70</i>	<i>300</i>	<i>2899</i>	<i>3269</i>	<i>150</i>	<i>587</i>	<i>6928</i>	<i>7665</i>

1. Based on broad categories of emotional, conduct, hyperkinetic and less common disorders.

Chapter 10

Mental disorders in Scotland

Introduction

This chapter describes the characteristics and behaviour of children and young people with emotional and conduct disorders living in Scotland. The characteristics covered are:

- demographic characteristics;
- family situation;
- socio-economic characteristics;
- general, physical and mental health;
- scholastic ability and attendance at school;
- family's social functioning; and
- lifestyle behaviours.

The tables compare children with any form of emotional and conduct disorder with those who have no such disorders. Because of the relatively small numbers of children sampled in Scotland, it has only been possible to analyse those characteristics for which data for 1999 and 2004 could be combined. There were too few cases to show hyperkinetic and less common disorders or to show tables based only on 2004 data.

The commentary is descriptive, the aim being to provide profiles of children in Scotland who have emotional or conduct disorders. It therefore takes no account of the inter-relationships between the characteristics. The analysis at the end of Chapter 4 described the factors which had the largest independent effects on prevalence and this gives an indication of the key variables.

On the whole, the patterns of variation in Scotland were very similar to those in Great Britain as a whole. Where large differences did occur they have been noted in the text.

Descriptions of typical symptoms displayed by children with different types of emotional and conduct disorders are provided in Chapters 5 and 6 of this report.

Demographic, socio-economic and area characteristics

Demographic characteristics

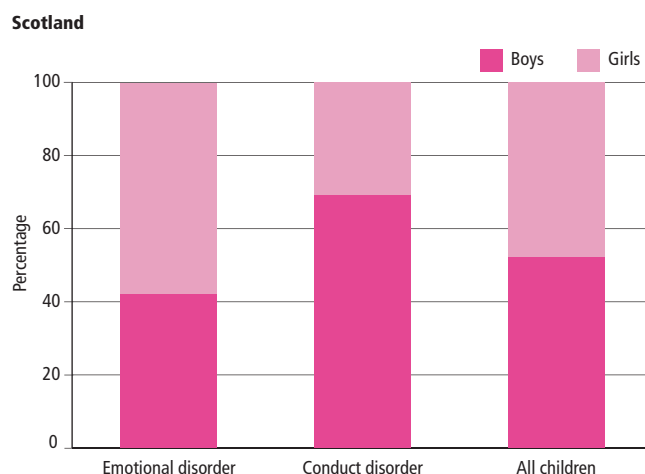
There were no differences between children with an emotional disorder and those with no such disorder in relation to their sex, age and ethnic profile. In Great Britain as a whole, children with an emotional disorder were more likely than other children to be girls. The same pattern was evident in Scotland but the difference was not large enough to reach statistical significance at the 95 per cent confidence level. (Figure 10.1 and Table 10.1)

Children with conduct disorders were predominantly boys, 69 per cent compared with 51 per cent of those with no such disorder. Otherwise, there were no differences between

children with and those with no conduct disorder with regard to the other demographic characteristics, age and ethnic group.

(Figure 10.1 and Table 10.1)

Figure 10.1
Sex by type of mental disorder, 1999 and 2004 combined

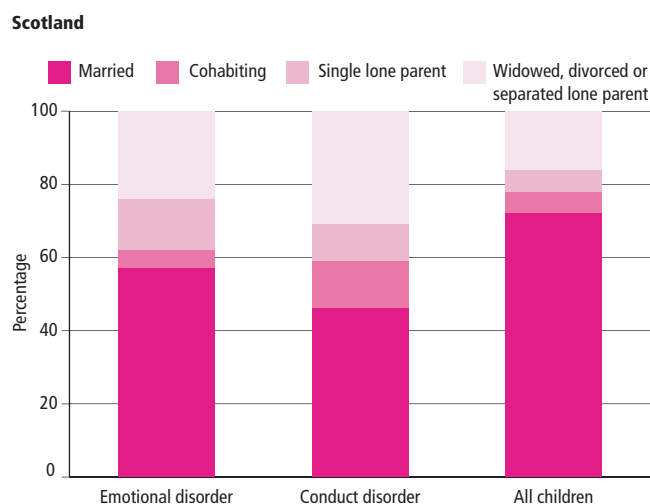


Family characteristics

Children with an emotional disorder were more likely than other children to live with a single lone parent (14 per cent compared with 6 per cent) and less likely to live with parents who were married (57 per cent compared with 73 per cent of other children). (Figure 10.2 and Table 10.2)

Almost a third (31 per cent) of children with conduct disorders lived with a previously married lone parent compared with under a fifth (15 per cent) of children with no such disorder.

Figure 10.2
Family type by type of mental disorder, 1999 and 2004 combined



The former were more likely than the latter to live with cohabiting parents (13 per cent compared with 6 per cent) and less likely to live with parents who were married (46 per cent compared with 73 per cent). (Figure 10.2 and Table 10.2)

There was no consistent pattern of variation between children with emotional or conduct disorders and other children in relation to the number of children in the household. This was different to the findings for children in Great Britain as a whole. As noted in Chapters 5 and 6 children with emotional disorders and those with conduct disorders were more likely than other children to live in large families. (Table 10.2)

Parental education and employment status

Children with emotional disorders were more than twice as likely as other children to live with parents who had no educational qualifications (52 per cent compared with 21 per cent of other children). Conversely, the former were less likely to live with parents who had been educated to degree level (4 per cent compared with 17 per cent of other children). (Table 10.3)

In Great Britain as a whole, there was a smaller differential between the parents of children with and those with no emotional disorder in the proportions who had no educational qualifications (35 per cent compared with 20 per cent).

Children with emotional disorders were about three times as likely as other children to live in households in which neither parent was working (37 per cent compared with 12 per cent). Conversely, they were much less likely than other children to live in households in which both parents were working (45 per cent compared with 70 per cent). (Table 10.3)

Like children with emotional disorders, those with conduct disorders were more likely than other children to live with parents who had no educational qualifications (42 per cent compared with 21 per cent) and less likely to have parents who had been educated to degree level (4 per cent compared with 17 per cent). Almost a half (44 per cent) of children with conduct disorders lived in households in which neither parent was working compared with just over one-tenth (12 per cent) of other children. The former were much less likely than other children to live in households in which both parents were working (38 per cent compared with 70 per cent). (Table 10.3)

Housing and Income

Housing and income followed the same pattern as education. Almost two-thirds (72 per cent) of children with emotional disorders lived in rented property compared with around one-third (32 per cent) of other children. Most of these lived in the social rented sector (64 per cent compared with 27 per cent of other children). An almost identical pattern emerged for children with conduct disorders with 69 per cent of such children living in the social rented sector compared with 27 per cent of other children. (Table 10.4)

The findings for Great Britain were similar but the concentrations of children with emotional and conduct disorders in the social rented sector were much less pronounced (41 per cent for children with emotional disorders and 50 per cent for those with conduct disorders).

Children with emotional disorders were about twice as likely as other children to have a household income of less than £200 (37 per cent compared with 18 per cent). Again, the pattern was similar for children with conduct disorders. Over a third (37 per cent) had a household income of less than £200 compared with about a sixth (17 per cent) of other children. (Table 10.4)

Among children with emotional disorders in Scotland:

- 58 per cent were girls (*compared with 48 per cent for children with no emotional disorder*)
- 51 per cent were aged 5-10 (*52 per cent*)
- 100 per cent were white (*98 per cent*)
- 14 per cent lived with a single lone parent (*6 per cent*)
- 57 per cent lived in a married couple family (*73 per cent*)
- 52 per cent had parents with no educational qualifications (*21 per cent*)
- 72 per cent lived in rented accommodation (*32 per cent*)
- 37 per cent lived in households with gross incomes under £200 per week (*18 per cent*)

Among children with conduct disorders in Scotland:

- 69 per cent were boys (*compared with 51 per cent for children with no conduct disorder*)
- 57 per cent were aged 11-16 (*48 per cent*)
- 100 per cent were white (*98 per cent*)
- 31 per cent lived with a previously married lone parent (*15 per cent*)
- 46 per cent lived in a married couple family (*73 per cent*)
- 42 per cent had parents with no educational qualifications (*21 per cent*)
- 72 per cent lived in rented accommodation (*32 per cent*)
- 37 per cent lived in households with gross incomes under £200 per week (*17 per cent*)

Child's general health and mental health

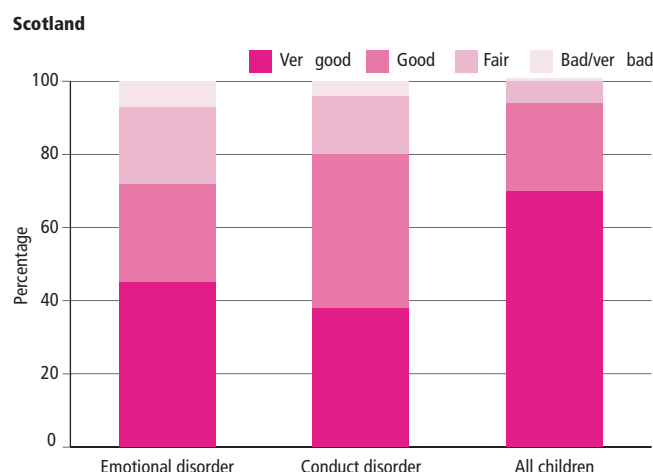
General health

The parents of children with emotional disorders were much more likely than other parents to say that their child's health was fair or bad (28 per cent compared with 5 per cent). Conversely, less than half (45 per cent) of the former described their child's health as very good, compared with almost three-quarters (71 per cent) of the latter. (Figure 10.3 and Table 10.5)

Likewise, the parents of children with conduct disorders were three times as likely as other parents to say that their child's health was fair or bad (20 per cent compared with 6 per cent) and less likely to say that their child's health was very good (38 per cent compared with 72 per cent).

(Figure 10.3 and Table 10.5)

Figure 10.3
Child's general health by type of mental disorder,
1999 and 2004 combined



Physical and developmental problems

There were no differences between children with an emotional disorder and those with no such disorder in relation to the overall proportions who had a physical or developmental problem. There were some differences, however, in relation to certain physical and developmental problems. Children with emotional disorders were more likely than other children to have bed wetting and urinary tract problems and to have difficulty with co-ordination (10, 6 and 6 per cent). The proportions for children with no emotional disorder were 3, 1 and 1 per cent.

(Table 10.6)

As with children with emotional disorders, there were no differences between children with conduct disorders and other children in relation to the occurrence of physical or developmental problems overall. Again, however, there were some differences between the groups for certain complaints. For example, children with conduct disorders were more likely than other children to have hearing, speech and muscle problems. (6, 8 and 6 per cent compared with 2, 3, and 1 per cent).

(Table 10.6)

In Great Britain as a whole those with emotional and conduct disorders were more likely than other children to report physical complaints. In the case of emotional disorders, the differential in Scotland was somewhat smaller than in Great Britain, while, for conduct disorders, the proportions in Scotland were similar to those in Great Britain. However, the Scotland data is based on a much smaller sample and the differences need to be correspondingly larger in order to reach statistical significance.

Mental disorders

A quarter (25 per cent) of children with an emotional disorder had another clinically diagnosed mental disorder: 20 per cent had a conduct disorder, 8 per cent had a hyperkinetic disorder and 3 per cent had a less common disorder.

(Table 10.7)

The parents of children with emotional disorders reported multiple types of mental health problems: 23 per cent reported emotional problems, 29 per cent reported behavioural problems and 8 per cent reported hyperactivity.

(Table 10.8)

A third (34 per cent) of children with conduct disorders had another clinically diagnosed mental disorder: 18 per cent had an emotional disorder, 17 per cent had a hyperkinetic disorder and 6 per cent had a less common disorder.

(Table 10.7)

Two-thirds of the parents of children with conduct disorders reported that their child had some form of mental health problem: 31 per cent reported emotional problems, 57 per cent reported behavioural problems and 21 per cent reported hyperactivity.

(Table 10.8)

Among the parents of children with emotional disorders:

- 28 per cent reported that the child's general health was fair or bad (*compared with 5 per cent for children with no emotional disorder*)
- 65 per cent reported that the child had a specific physical or developmental problem (*52 per cent*)
- 36 per cent reported that the child had mental health problems (*7 per cent*)
- 23 per cent reported that the child had emotional problems, 29 per cent reported behavioural problems and 8 per cent reported hyperactivity (*3 per cent, 4 per cent and 3 per cent*)
- 25 per cent of the children had another main type of clinically recognisable disorder (*4 per cent*)

Among the parents of children with conduct disorders:

- 20 per cent reported that the child's general health was fair or bad (*compared with 6 per cent for children with no conduct disorder*)
- 63 per cent reported that the child had a specific physical or developmental problem (*52 per cent*)
- 65 per cent reported that the child had mental health problems (*5 per cent*)
- 31 per cent reported that the child had emotional problems, 57 per cent reported behavioural problems and 21 per cent reported hyperactivity (*2 per cent, 3 per cent and 2 per cent*)
- 34 per cent of the children had another main type of clinically recognisable disorder (*4 per cent*)

Scholastic ability and attendance at school

Teachers were asked to rate their child's abilities in reading, mathematics and spelling compared with an average child of the same age and to estimate the child's age in terms of scholastic ability. They were also asked whether or not the child had officially recognised special educational needs.

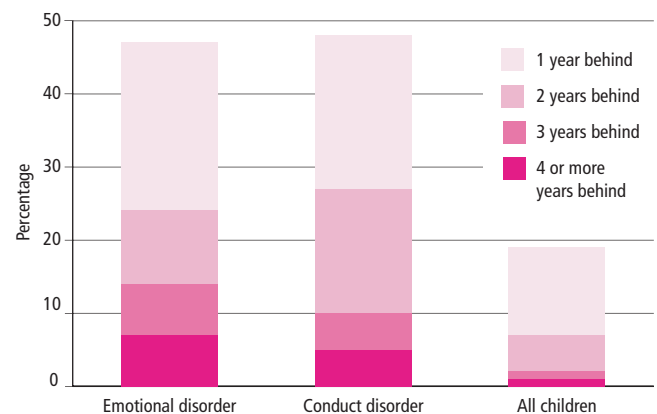
Basic skills

Children with emotional disorders had more difficulty with basic skills than other children. Around two-fifths had problems with reading (44 per cent), mathematics (37 per cent) and spelling (41 per cent). The corresponding proportions for children with no emotional disorders were 19 per cent for reading and mathematics and 25 per cent for spelling. Children with emotional disorders were more than twice as likely as other children to be behind in terms of their overall scholastic ability (47 per cent compared with 18 per cent).

(Figure 10.4 and Table 10.9)

Figure 10.4
Proportion of children who were behind in their overall scholastic ability by type of mental disorder, 1999 and 2004 combined

Scotland



There was a similar pattern for children with conduct disorders but the differential was larger. Almost a half (46 per cent) had problems with reading and mathematics and almost two-thirds (61 per cent) had problems with spelling. The proportions for children with no such disorder were 18 per cent for reading and mathematics and 24 per cent for spelling. Children with conduct disorders were about three times as likely as other children to be behind in terms of their overall scholastic ability (48 per cent compared with 18 per cent).

(Figure 10.4 and Table 10.9)

The overall proportion of children who were behind in their scholastic ability was higher among children in Great Britain as a whole but the difference between those with and those with no conduct disorder was about the same.

Special educational needs

Almost a fifth (17 per cent) of children with emotional disorders and nearly a quarter (22 per cent) of those with conduct disorders had officially recognised special educational needs compared with under a tenth (7 per cent and 6 per cent) of their comparison groups.

(Table 10.10)

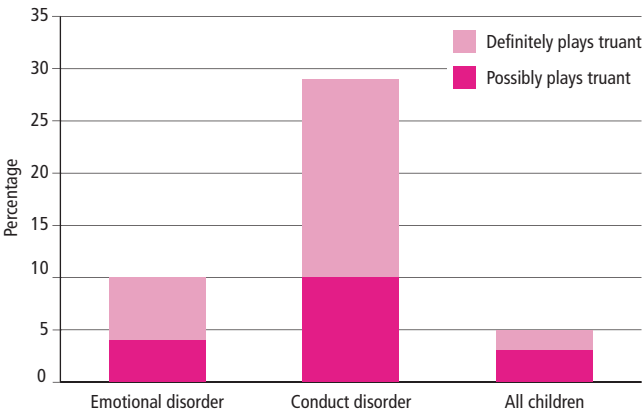
Truancy and Exclusions

Teachers reported that 10 per cent of children with emotional disorders had possibly or definitely played truant. The corresponding proportion for other children was just 3 per cent.

(Figure 10.5 and Table 10.11)

Fig re 10.5
Proportion of children whose teacher thought that they played truant by type of mental disorder, 1999 and 2004 combined

Scotland



- Among children with emotional disorders:**
- 47 per cent were behind in their overall scholastic ability (compared with 18 per cent of children with no emotional disorder)
 - 17 per cent had officially recognised special educational needs (7 per cent)
 - 10 per cent were considered by teachers to be definite or possible truants (3 per cent)
- Among children with conduct disorders:**
- 48 per cent were behind in their overall scholastic ability (compared with 18 per cent of children with no conduct disorder)
 - 22 per cent had officially recognised special educational needs (6 per cent)
 - 29 per cent were considered by teachers to be definite or possible truants (3 per cent)
 - 36 per cent had been excluded from school (2 per cent)

The findings were much more pronounced for children with conduct disorders: 29 per cent were considered to be possible or definite truants compared with 3 per cent of other children. (Figure 10.5 and Table 10.11)

Over a third (36 per cent) of children with conduct disorders had been excluded from school and almost a fifth (18 per cent) had been excluded three or more times. Among other children these proportions were very low, 2 per cent and 0 per cent. (Table 10.12)

Social functioning of the family

This section looks at various aspects of parental health, attitudes and behaviour which provide indicators of the social functioning of the family.

Mental health of parent

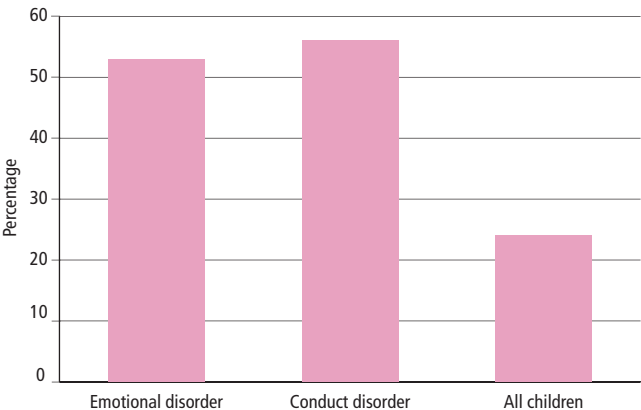
The parent who was interviewed about the child, usually the mother, was asked about her own mental health using the General Health Questionnaire (GHQ-12 – see Chapter 2 for details). Scores range from 0 (no psychological distress) to 12 (severe psychological distress). A score of 3 is generally taken as the threshold, with scores at this level or higher being considered indicative of an emotional disorder.

Over half (53 per cent) of parents of children with an emotional disorder had scores of 3 or more on the GHQ-12 (compared with 22 per cent of other parents) and 21 per cent had a score of 9 or more (compared with 4 per cent of other parents). (Figure 10.6 and Table 10.13)

The results were similar for children with conduct disorders: 56 per cent of parents had a score of 3 or more on the GHQ-12 (compared with 22 per cent of other parents) and 18 per cent had a score of 9 or more (compared with 4 per cent of other parents). (Figure 10.6 and Table 10.13)

Fig re 10.6
Proportion of children whose parent scored 3 or more on the GHQ-12, 1999 and 2004 combined

Scotland



Family functioning

Family functioning was measured using the FAD-GFS scale in which parents rated 12 statements about family relationships (see Chapter 2 for details). For this survey, families that scored over 2.00 on this scale were considered to have unhealthy functioning.

Children with emotional disorders were more than twice as likely as other children to live in families classified as having unhealthy functioning (38 per cent compared with 17 per cent). (Table 10.14)

A half (50 per cent) of children with conduct disorders lived in families classified as having unhealthy functioning (compared with 16 per cent of other children). (Table 10.14)

Stressful life events

Parents were asked whether their child had experienced any of 10 potentially stressful events.

Three-fifths (60 per cent) of children with conduct disorders had experienced two or more stressful life events compared with around a quarter (24 per cent) of other children. The former were much more likely than other children to have experienced four or more stressful life events (19 per cent compared with 3 per cent). (The number of children with emotional disorders for whom we have information about life events was too small for analysis.) (Table 10.15)

Among children with emotional disorders:

- 53 per cent of parents had an emotional disorder
(compared with 22 per cent of children with no emotional disorder)
- 38 per cent lived in families with unhealthy functioning
(17 per cent)

Among children with conduct disorders:

- 56 per cent of parents had an emotional disorder
(compared with 22 per cent of children with no conduct disorder)
- 50 per cent lived in families with unhealthy functioning
(16 per cent)
- 60 per cent had had two or more stressful life events (24 per cent)

Self-harm

Both parents and children were asked if the child had ever tried to hurt, harm or kill themselves. Table 10.16 shows the data based on parents' reports only as the sample base for the children's reports was too small for analysis.

The parents of children with an emotional disorder and those who had children with conduct disorders were more likely than other parents to say that their child had tried to harm themselves (6 per cent and 11 per cent compared with 1 per cent of their comparison groups). (Table 10.16)

Table 10.1**Age, sex and ethnicity of child by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Sex					
Boys	42	52	69	51	52
Girls	58	48	31	49	48
Age					
5–10	51	52	43	52	52
11–16	49	48	57	48	48
Ethnicity					
White	100	98	100	98	98
Black ¹	-	0	-	0	0
Indian	-	0	-	0	0
Pakistani/Bangladeshi	-	1	-	1	1
Other	-	1	-	1	1
<i>Base (weighted)</i>	<i>59</i>	<i>1505</i>	<i>68</i>	<i>1496</i>	<i>1564</i>

1. Includes people of mixed black and white origin.

Table 10.2**Family characteristics by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Family type					
Married	57	73	46	73	72
Cohabiting	5	6	13	6	6
Lone parent – single	14	6	10	6	6
Lone parent – widowed, divorced or separated	24	15	31	15	16
Number of children in household					
1	24	25	27	25	25
2	39	46	32	47	46
3	26	20	28	20	20
4	6	7	8	7	7
5 or more	5	2	4	2	2
<i>Base (weighted)</i>	<i>59</i>	<i>1505</i>	<i>68</i>	<i>1496</i>	<i>1564</i>

Table 10.3**Parent's education and employment status by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Parent's highest educational qualification					
Degree level	4	17	4	17	16
Teaching/HND/Nursing	17	15	12	15	15
A /AS level or equivalent	5	13	11	13	13
GCSE Grades A–C or equivalent	13	26	21	26	25
GCSE Grades D–F or equivalent	5	4	4	4	4
Other qualification	4	5	6	5	5
No qualification	52	21	42	21	22
Parent's employment status					
Both working/lone parent working	45	70	38	70	69
One parent working	19	18	18	18	18
Neither working/lone parent not working	37	12	44	12	13
<i>Base (weighted)</i>	<i>57</i>	<i>1495</i>	<i>68</i>	<i>1484</i>	<i>1552</i>

Table 10.4**Housing and income by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Type of accommodation					
Detached	11	29	10	29	28
Semi-detached	30	28	27	29	29
Terraced house	20	24	38	24	24
Flat/maisonette	39	18	25	19	19
Tenure					
Owners	28	68	28	68	67
Social sector tenants	64	27	69	27	28
Private renters	8	5	3	5	5
<i>Base (weighted)</i>	<i>59</i>	<i>1504</i>	<i>68</i>	<i>1495</i>	<i>1563</i>
Gross weekly household income					
Under £100	7	3	5	3	4
£100–£199	30	15	32	14	15
£200–£299	20	14	27	13	14
£300–£399	13	11	17	10	11
£400–£499	12	12	6	13	12
£500–£599	7	10	5	10	10
£600–£770	5	13	3	14	13
Over £770	5	22	5	22	21
<i>Base (weighted)</i>	<i>53</i>	<i>1387</i>	<i>59</i>	<i>1381</i>	<i>1439</i>

Table 10.5**Child's general health by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Child's general health					
Very good	45	71	38	72	70
Good	27	23	42	23	24
Fair	21	5	16	5	6
Bad	7	0	4	1	1
Very bad	-	0	-	0	0
<i>Base (weighted)</i>	<i>57</i>	<i>1498</i>	<i>68</i>	<i>1488</i>	<i>1556</i>

Table 10.6**Co-occurrence of physical and developmental problems with emotional and conduct disorders, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
<i>Percentage of children with each type of physical complaint</i>					
Asthma	16	13	16	13	13
Eczema	6	12	9	12	12
Hay fever	6	9	10	9	9
Eyesight problems	17	11	10	11	11
Stomach or digestive problems	11	5	7	5	5
Non-food allergy	8	7	3	8	7
Migraine/severe headache	10	5	6	5	5
Bed wetting	10	3	9	3	3
Glue ear/otitis media/grommits	-	2	6	2	2
Hearing problems	3	2	6	2	2
Speech or language problems	8	3	8	3	3
Food allergy	7	4	4	4	4
Difficulty with co-ordination	6	1	4	1	1
Stiffness or deformity of foot	1	1	1	1	1
Heart problems	-	1	-	1	1
Soiling pants	3	1	3	1	1
Muscle disease or weakness	-	1	6	1	1
Kidney/urinary tract problems	6	1	1	1	1
Obesity	2	0	-	1	1
Congenital abnormality	2	0	-	0	0
Epilepsy	2	0	3	0	0
Any blood disorder	2	0	1	0	0
Diabetes	2	1	1	1	1
Cerebral Palsy	-	0	1	0	0
Cancer	2	0	-	0	0
Any physical or developmental problem¹	65	52	63	52	53
No problem	35	48	37	48	47
<i>Base (weighted)</i>	<i>57</i>	<i>1498</i>	<i>68</i>	<i>1488</i>	<i>1556</i>

1. Some physical complaints are not listed in the table above because of their rarity. They are included in the 'Any physical or developmental problem' category.

Table 10.7**Co-occurrence of other mental disorders with emotional and conduct disorders, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
<i>Percentage of children with each type of disorder</i>					
Other mental disorders					
Emotional disorders:					
Anxiety disorders	13	3	3
Depression	6	0	1
All emotional disorders	18	3	4
Conduct disorders:					
Oppositional defiant disorder	11	2	2
Other conduct disorders	10	2	3
All conduct disorders	20	4	4
Hyperkinetic disorders	8	1	17	0	1
Less common disorders	3	1	6	0	1
Any other disorder	25	4	34	4	5
No (other) disorders	75	96	66	96	95
<i>Base (weighted)</i>	<i>59</i>	<i>1505</i>	<i>68</i>	<i>1496</i>	<i>1564</i>

Table 10.8**Parent's view of child's mental health by whether child has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
<i>Percentage of children with each type of problem</i>					
Parent's view of child's mental health					
Emotional problems	23	3	31	2	4
Behavioural problems	29	4	57	3	5
Hyperactivity	8	3	21	2	3
Any of the above	36	7	65	5	8
<i>Base (weighted)</i>	<i>57</i>	<i>1498</i>	<i>68</i>	<i>1488</i>	<i>1556</i>

Table 10.9**Teacher's rating of child's basic skills by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children	Scotland				
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Reading					
Above average	19	37	16	37	36
Average	37	45	38	45	45
Some difficulty	29	15	31	15	15
Marked difficulty	15	4	15	3	4
Mathematics					
Above average	17	32	11	32	31
Average	46	49	43	50	49
Some difficulty	21	15	35	14	15
Marked difficulty	16	4	11	4	5
Spelling					
Above average	19	28	11	28	27
Average	39	47	28	48	47
Some difficulty	25	19	42	18	19
Marked difficulty	16	6	19	6	6
<i>Base (weighted)</i>	<i>43</i>	<i>1218</i>	<i>55</i>	<i>1206</i>	<i>1259</i>
Overall scholastic ability¹					
4 or more years behind	7	1	5	1	1
3 years behind	7	1	5	1	1
2 years behind	10	4	17	4	5
1 year behind	23	12	21	12	12
Equivalent	31	41	40	41	41
1 or more years ahead	23	41	13	41	40
<i>Base (weighted)</i>	<i>40</i>	<i>1143</i>	<i>50</i>	<i>1132</i>	<i>1183</i>

1. Functioning age-actual age.

Table 10.10**Whether child has special educational needs by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children	Scotland				
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
If child has officially recognised special educational needs					
Yes	17	7	22	6	7
No	83	93	78	94	93
<i>Base (weighted)</i>	<i>43</i>	<i>1193</i>	<i>54</i>	<i>1182</i>	<i>1235</i>

Table 10.11**Truancy (teacher's report) by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Whether plays truant					
Not true	90	96	71	97	96
Somewhat true	4	2	10	2	3
Certainly true	6	1	19	1	2
<i>Base (weighted)</i>	<i>45</i>	<i>1238</i>	<i>58</i>	<i>1225</i>	<i>1283</i>

Table 10.12**Exclusions from school (parent's report) by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Number of times child has been excluded from school					
None	(92)	96	63	98	96
Once	(4)	2	15	2	2
Twice		0	3	0	0
Three or more times	(4)	1	18	0	1
<i>Base (weighted)</i>	<i>18</i>	<i>648</i>	<i>31</i>	<i>635</i>	<i>666</i>

Table 10.13**Parent's GHQ-12 score by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Parent's GHQ-12¹					
0-2	47	78	44	78	76
3-5	23	12	29	12	13
6-8	10	6	10	6	6
9-12	21	4	18	4	5
3 or more	53	22	56	22	24
<i>Base (weighted)</i>	<i>57</i>	<i>1494</i>	<i>68</i>	<i>1483</i>	<i>1551</i>

1. For this survey, scores of 3 or more were taken to suggest a severe emotional problem.

Table 10.14**Family functioning score by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Family functioning score¹					
Up to 1.50	27	35	11	36	35
1.51–2.00	36	48	39	48	47
2.01–2.50	25	15	39	14	15
2.51 or more	13	2	11	2	2
Unhealthy functioning (2.01 or more)	38	17	50	16	18
<i>Base (weighted)</i>	<i>57</i>	<i>1492</i>	<i>68</i>	<i>1481</i>	<i>1549</i>

1. For this survey, scores over 2.0 were taken to suggest unhealthy family functioning.

Table 10.15**Number of stressful life events by whether has an emotional or conduct disorder, 1999 and 2004 combined**

All children					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
	%	%	%	%	%
Number of stressful life events					
0	(20)	43	9	44	42
1	(42)	32	31	33	32
2	(5)	16	31	15	16
3	(4)	6	10	6	6
4	(19)	2	10	2	2
5 or more	(9)	1	9	1	2
Two or more events	(38)	25	60	24	25
<i>Base (weighted)</i>	<i>18</i>	<i>649</i>	<i>30</i>	<i>637</i>	<i>667</i>

Table 10.16**eliberate self-harm by whether has an emotional or conduct disorder, 1999 and 2004 combined**

					Scotland
	Emotional disorder	No emotional disorder	Conduct disorder	No conduct disorder	All
<i>Percentage of children who have tried to harm, hurt or kill themselves</i>					
All children					
Parent's report	6	1	11	1	2
<i>Base (weighted)</i>	<i>46</i>	<i>1469</i>	<i>61</i>	<i>1454</i>	<i>1514</i>

Appendix A

Sampling, weighting and adjustment procedures

Sampling procedures

The sampling frame

The sample was drawn from the Child Benefit Register (CBR) held by the Department for Work and Pensions' Child Benefit Centre (CBC). The principal advantage of this frame over alternatives is that the CBR lists children and their date of birth, so the sample can be identified directly. This means that response can be maximised by avoiding an initial sifting step, and survey costs can be contained by avoiding the collection of the information needed to establish the eligibility of different addresses. A second advantage of the CBR sample, compared with that of a PAF-based sift, is that it is possible to select the children with equal probabilities and so avoid weights that are required when one child is selected per household, with the consequent reduction in effective sample size.

The Department for Work and Pensions believe that Child Benefit is claimed by virtually all the eligible population in Britain, though there is some delay in claiming for new babies. The register should therefore provide almost complete coverage of children in the required age group (5–16) in Britain, although it excludes children in foster care and those living in non-private households.

Of the 8,040,445 eligible records on the CBR 98 per cent had a valid postcode sector. The remaining 2 per cent of addresses that did not have a valid postcode sector were excluded from the sample, as was a further 0.25 per cent in sectors that were considered too small to be viable (i.e. had fewer than 100 children). In addition, some children were not accessible for sampling because they were considered sensitive cases by CBC. It is assumed that these represent a random sub-sample that will not create any coverage bias.

Stratification and selection of sectors

The sampling design for the survey involved a two-stage process: the selection of 426 postal sectors and then 29 children within each sector.

The CBC provided ONS with a list of postcode sectors with counts of eligible children whose parents were in receipt of Child Benefit. These postcode sectors were linked to the current version of the Postcode Address File (PAF) to establish their validity, as mentioned above. Any sectors which contained fewer than 100 children were excluded from the sampling frame.

The frame was then stratified by government office region (GOR) and within that by socio-economic group (SEG). In England and Scotland the sectors were selected with probability proportional to the number of eligible children: 378 sectors in England and 37 sectors in Scotland. In Wales, for

financial reasons, a half sample of 11 sectors was selected. The data have been weighted to take account of any imbalance in the distribution of sectors by geographical area.

CBC were supplied with the list of 426 postal sectors and asked to select a random sample of 29 children from each area, using date of birth to establish age eligibility. Five sectors contained fewer than 29 children resulting in a shortfall of 60 families. The set sample therefore consisted of 12,294 families.

The sampling design results in a self-weighting sample in which each child should have the same probability of selection. However, there was some delay between sampling the areas and sampling the children within the areas so that the size measure used to select the children sample was inaccurate in some areas. Also, as noted above, a small number of children were withdrawn by the Agency prior to drawing the sample of children. As a result, the final sampling probabilities for the children were not exactly equal. The weighting procedure corrects for this.

Response

As discussed in Chapter 3, interviews were achieved with 76 per cent of the parents approached, representing 65 per cent of the original set sample. [Table A1](#) shows that there was considerable regional variation in response, the rate ranging from 69 per cent in London to 81 per cent in the South West. The weighting procedure described in the following section corrects for this variation.

Weighting procedures

Weighting was carried out in two stages. First, weights were applied to correct for the unequal sampling probabilities of the children which arose because of the delay between selecting the area and children samples (see above). Respondents were then weighted to represent the age/sex/region structure of the total population of children and young people aged 5–16 in Great Britain, using ONS population figures for April–June 2004. The weights were calculated separately for boys and girls aged 5–9, 10–15 and 16. [Tables A2–A4](#) show both unscaled and scaled weights. The former allow the data to be grossed to population figures. The latter scale the weights so that the number of respondents in each age/sex group matches the total number of interviews carried out in that group. The tables in the report show weighted bases using the scaled weights.

Adjustment procedures for teacher non-response

The assessments of mental disorders among children and young people by psychiatrists were based on data obtained from the parent, the child (aged 11–16), and the teacher. In

most cases, data were available from both the parent and child where appropriate, but for a substantial number of cases (17 per cent), the teacher did not provide any information.

We can assume that, given a complete set of data from both home and school, the psychiatrists would on average, make the right assessment. Therefore, if they were able to use both home and school information to assess all children in the population and we were able to average the results of this census over a large number of repeats under identical circumstances, they would arrive at the prevalence level in the population. Therefore if this complete information were available for all sampled children in the survey, the estimated prevalence level would be unbiased for the actual prevalence level, differing only through sampling error and response error.

On the other hand, if repeated censuses were taken but collecting only the home information, another average prevalence would be measured. The question is: would the prevalence level measured with the school and home information taken together be the same as with just the home information? If the measures were the same, then we would not need to carry out adjustments for the missing teacher data. If the measures were different, some adjustment factor would need to be incorporated into the reported data.

Estimating and measuring the difference in the two measures

The evidence for the need to carry out this readjustment comes from looking at the ratio of parent-based to clinical-based diagnoses in no teacher information ($t=0$) and with teacher information ($t=1$) groups. If the ratio is the same, it suggests that having the teacher report doesn't make a significant contribution. If the ratio is higher for the $t=1$ group, it suggests that clinical diagnoses underestimate prevalence in the absence of teacher reports.

Estimating and measuring the difference in the two measures

Table A5 shows the prevalence rates for the three types of disorder and for any disorder under the conditions of no teacher information ($t=0$) and with teacher ($t=1$) information. Table A6 shows the ratio of clinical-parent assessments under these two conditions. The ratios were higher when the teacher information was available for all disorders but particularly for conduct and hyperkinetic disorders. Thus, the clinical diagnoses under-estimate prevalence in the absence of teacher reports. A similar pattern was observed in 1999.

These findings fit in with clinical experience, namely, that teacher reports contribute relatively little to the diagnosis of

emotional disorders but make a substantial difference to the diagnosis of conduct and hyperkinetic disorders, though for rather different reasons. As far as conduct disorder is concerned, the key issue is that there are a lot of children who are oppositional, aggressive and antisocial at school but not at home. Psychiatrists rarely get to know about these children unless they have a teacher report. As far as hyperkinetic disorders are concerned, there are many children where the parental evidence is inconclusive and where the teacher report tips the balance, (Ford *et al* 2005).

The adjustment factors shown in Table A7 were applied to the prevalence rates of mental disorders incorporated in all the tables in Chapter 4. They were calculated on the raw number according to the following rules.

(a) Calculate revised number of children with each clinically-assessed type of mental disorder with no teacher data:

$$N(\text{clin})_{\text{revised}} = \frac{N(\text{clin})_{t=1} \times N(\text{parent})_{t=0}}{N(\text{parent})_{t=1}}$$

$N(\text{clin})_{t=1}$ = Number of children with disorder from a clinical assessment with teacher data.

$N(\text{parent})_{t=1}$ = Number of children with disorder from a parent only assessment with teacher data.

$N(\text{parent})_{t=0}$ = Number of children with disorder from a parent only assessment with no teacher data.

(b) Calculate adjustment factor:

$$\text{Adjustment factor} = \frac{N(\text{clin})_{\text{revised}} + N(\text{clin})_{t=1}}{N(\text{clin})_{t=0} + N(\text{clin})_{t=1}}$$

The adjustment factors used in the 1999 and 2004 surveys were very similar. For presenting joint estimates of prevalence the adjusted numbers from the two datasets were added together.

References

Ford T, Goodman R and Meltzer H (2003) The British Child and Adolescent Mental Health Survey 1999. The prevalence of DSM-IV disorder. *Journal of the American Academy of Child and Adolescent Psychiatry* 42, 1203–12110.

Table A1**Response by Government Office Region**

Region	Response rate	Number interviewed	Number approached
1. North East	70	328	468
2. North West and Merseyside	75	1,000	1,339
3. Yorkshire and Humberside	79	763	968
4. East Midlands	79	635	804
5. West Midlands	73	787	1,079
6. Eastern	78	783	1,005
7. London	69	881	1,268
8. South East	77	1,144	1,481
9. South West	81	723	894
10. Wales	79	212	269
11. Scotland	78	721	920
Total	76	7,977	10,495

Table A2**Boys and girls age 5–9 by Government Office Region**

Region	Boys aged 5–9				Girls aged 5–9			
	Unweighted numbers in survey	ONS population estimates	Grossed weight	Scaled weight	Unweighted numbers in survey	ONS population estimates	Grossed weight	Scaled weight
1 North East	69	74,907	1085.60	1.009	64	71,775	1121.48	1.041
2 North West and Merseyside	208	209,490	1007.16	0.936	193	200,004	1036.29	0.962
4 Yorkshire and Humberside	158	155,014	981.01	0.912	130	148,380	1141.38	1.059
5 East Midlands	113	130,619	1155.92	1.074	115	123,850	1076.96	1.000
6 West Midlands	162	169,219	1044.56	0.971	164	161,158	982.67	0.912
7 Eastern	162	173,113	1068.60	0.993	164	164,963	1005.87	0.934
8 London	193	231,854	1201.32	1.116	159	222,706	1400.67	1.300
9 South East	261	253,082	969.66	0.901	236	240,001	1016.95	0.944
10 South West	149	146,795	985.20	0.916	155	139,699	901.28	0.837
11 Wales	39	90,955	2332.17	2.167	44	86,641	1969.12	1.828
12 Scotland	143	148,019	1035.01	0.962	154	140,834	914.51	0.849
Total	1657	1783,065			1578	1700,011		

Table A3**Boys and girls age 10–15 by Government Office Region**

Region	Boys aged 10–15				Girls aged 10–15			
	Unweighted numbers in survey	ONS population estimates	Grossed weight	Scaled weight	Unweighted numbers in survey	ONS population estimates	Grossed weight	Scaled weight
1 North East	95	100,581	1058.74	0.986	79	96,135	1216.89	1.108
2 North West and Merseyside	276	281,906	1021.40	0.951	235	267,555	1138.53	1.037
4 Yorkshire and Humberside	212	203,636	960.55	0.895	201	194,894	969.62	0.883
5 East Midlands	183	171,048	934.69	0.870	171	161,650	945.32	0.861
6 West Midlands	198	219,251	1107.33	1.031	195	208,622	1069.85	0.974
7 Eastern	197	216,224	1097.58	1.022	199	207,634	1043.39	0.950
8 London	240	270,219	1125.91	1.049	231	261,054	1130.10	1.029
9 South East	297	323,000	1087.54	1.013	278	305,029	1097.23	0.999
10 South West	197	193,420	981.83	0.914	162	184,983	1141.87	1.040
11 Wales	58	120,159	2071.71	1.929	56	113,847	2032.97	1.851
12 Scotland	183	194,181	1061.01	0.988	185	185,929	1005.02	0.915
Total	2,136	2293,624			1,992	2187,331		

Table A4**Boys and girls age 16 by Government Office Region**

Region	Boys aged 16				Girls aged 16			
	Unweighted numbers in survey	ONS population estimates	Grossed weight	Scaled weight	Unweighted numbers in survey	ONS population estimates	Grossed weight	Scaled weight
1 North East	13	17,524	1,348.00	1.106	8	16,669	2083.63	1.669
2 North West and Merseyside	44	47,869	1,087.93	0.892	44	45,721	1039.11	0.832
4 Yorkshire and Humberside	32	34,001	1,062.53	0.872	30	33,113	1103.77	0.884
5 East Midlands	26	29,029	1,116.50	0.916	27	27,302	1011.19	0.810
6 West Midlands	26	36,885	1,418.65	1.164	42	35,009	833.55	0.668
7 Eastern	35	36,118	1,031.94	0.847	26	34,740	1336.15	1.070
8 London	34	44,737	1,315.79	1.079	24	42,377	1765.71	1.414
9 South East	34	54,462	1,601.82	1.314	38	51,895	1365.66	1.094
10 South West	29	33,094	1,141.17	0.936	31	31,826	1026.65	0.822
11 Wales	10	20,378	2,037.80	1.672	5	19,473	3894.60	3.119
12 Scotland	35	33,549	958.54	0.786	21	31,506	1500.29	1.201
Total	318	387,646			296	369,631		

Table A5**Prevalence of mental disorders with and without teacher data by type of assessment**

	Clinical diagnoses			Parental assessments		
	T=0	T=1	All	T=0	T=1	All
Emotional disorders	4.0	3.4	3.5	3.8	2.7	3.0
Conduct disorders	5.1	5.2	5.1	4.1	2.7	3.1
Hyperkinesis	1.7	1.3	1.4	1.1	0.6	0.7
Other	1.4	1.2	1.3	1.7	1.1	1.3
Any disorder	9.2	9.0	9.0	7.1	5.4	5.9

Table A6**Ratio of parent-based to clinical-based diagnoses by whether teacher data obtained**

	No teacher data	With teacher data
	T=0	T=1
Emotional disorders	1.05	1.26
Conduct disorders	1.25	1.89
Hyperkinesis	1.50	2.08
Other	0.85	1.07
Any disorder	1.29	1.66

Table A7**Final adjustment factors**

Disorder	Adjustment factor
Emotional disorders	1.05
Conduct disorders	1.13
Hyperkinesis	1.12
Other disorders	1.07
Any disorder	1.07

Appendix B

Statistical terms and their interpretation

Confidence interval

The percentages quoted in the text of this report represent summary information about a variable (e.g. presence of a mental disorder) based on the sample of people interviewed in this study. However, extrapolation from these sample statistics is required in order to make inferences about the distribution of that particular variable in the population. This is done by calculating confidence intervals around the statistic in question. These confidence intervals indicate the range within which the 'true' (or population) percentage is likely to lie. Where 95 per cent confidence intervals are calculated, this simply indicates that one is '95 per cent confident' that the population percentage lies within this range. (More accurately, it indicates that if repeated samples were drawn from the population, the true percentage would lie within this range in 95 per cent of the samples).

Confidence intervals are calculated on the basis of the sampling error (q.v.). The upper 95 per cent confidence intervals are calculated by adding the sampling error multiplied by 1.96 to the sample percentage or mean. The lower confidence interval is derived by subtracting the same value. Ninety-nine per cent confidence intervals can also be calculated, by replacing the value 1.96 by the value 2.58.

Sampling errors

The sampling error is a measure of the degree to which a percentage (or other summary statistic) would vary if repeatedly calculated in a series of samples. For example, if the prevalence rate of a mental disorder was calculated for a random sample of children and young people drawn from the population at large, then another sample drawn and the rate calculated again, its value would be unlikely to be identical to the first. If this process were continued, the rate would continue to vary from sample to sample. Thus, the sampling error provides a measure of this variability, and is used in the calculation of confidence intervals and statistical significance tests. In this survey a multi-stage stratified sampling design was used instead of simple random sampling. To take account of this design, sampling errors were calculated using STATA. However, this does not affect the interpretation of the sampling errors or their use in the calculation of confidence intervals.

Tables C1 – C7 in Appendix C show the sampling errors and confidence intervals for a range of variables.

Multiple logistic regression and Odds Ratios

Logistic regression analysis has been used in the analysis of the survey data to provide a measure of the effect of various sociodemographic variables on the prevalence of mental disorders among children. Unlike the cross-tabulations presented

elsewhere in the report, multiple logistic regression estimates the effect of any sociodemographic variable while controlling for the confounding effects of other variables in the analysis.

Logistic regression produces an estimate of the probability of an event occurring when an individual is in a particular sociodemographic category compared to a reference category. This effect is measured in terms of odds. For example, Table 4.15 shows that being in a family in which parents are classified as having 'no educational qualifications' increases the odds of having an emotional disorder compared to the reference category of 'any educational qualifications'. The amount by which the odds of this disorder actually increases is shown by the Adjusted Odds Ratio (OR). In this case, the OR is 1.52 indicating that being a child of parents with no educational qualifications increases the odds of having an emotional disorder by about one half, controlling for the possible confounding effects of the other variables in the statistical model, for example, age, sex, family type and family employment.

Confidence intervals around an Odds Ratio

The confidence intervals around odds ratios can be interpreted in the manner described earlier in this section. For example, Table 4.20, shows an odds ratio of 6.10 for the association between sex and hyperkinetic disorders, with a confidence interval from 3.39 to 10.99, indicating that the 'true' (i.e., population) OR is likely to lie between these two values. If the confidence interval does not include 1.00 then the OR is likely to be significant - that is, the association between the variable and the odds of a particular disorder is unlikely to be due to chance. If the interval includes 1.00, then it is possible that the 'true' OR is actually 1.00, that is, no increase in odds can be attributed to the variable.

Odds ratios and how to use them multiplicatively

The odds ratios presented in the tables show the adjusted odds due solely to membership of one particularly category – for example, being a boy rather than a girl. However, odds for more than one category can be combined by multiplying them together. This provides an estimate of the increased odds of a disorder or symptom due to being a member of more than one category at once – for example, being a boy and aged 11–15. For example, in Table 4.20 being a boy rather than a girl increases the odds of any mental disorder (OR=1.52), while being aged 11–15 (compared with 5-10 year olds) also independently increases the odds (OR=1.73). The increased odds for 11- to 15-year-old boys compared with 5- to 10-year-old girls is therefore the product of the two independent odds ratios, 2.63.

Appendix C

Sampling errors

This survey involved a multi-stage sampling design with both clustering and stratification. Clustering can lead to a substantial increase in standard error if the households or individuals within the primary sampling units (postal sectors) are relatively homogenous but the primary sampling units differ from one another. Stratification tends to reduce standard error and is of most advantage where the stratification factor is related to the characteristics of interest on the survey.

The effect of a complex sampling design on the precision of survey estimates is usually quantified by means of the design factor (deft). For any survey estimate, the deft is calculated as the ratio of the standard error allowing for the full complexity of the survey design to the standard error assuming a simple random sample. The standard error based on a simple random sample (se_{srs}) multiplied by the deft gives the standard error of a complex design (se):

$$se(p) = \text{deft} \times se_{srs}(p)$$

where:

$$se_{srs}(p) = \sqrt{p(1-p)/N}$$

The formula to measure whether the differences between the percentages is likely to be due entirely to sampling error for a complex design is:

$$se(p_1 - p_2) = \sqrt{(\text{deft}_1^2 \cdot p_1(100-p_1)/n_1 + \text{deft}_2^2 \cdot p_2(100-p_2)/n_2)}$$

where p_1 and p_2 are observed percentages for the two subsamples and n_1 and n_2 are the subsample sizes.

The 95 per cent confidence interval for the difference between two percentages is then given by:

$$(p_1 - p_2) \pm 1.96 \times se(p_1 - p_2)$$

If this confidence interval includes zero then the observed difference is considered to be a result of chance variation in the sample. If the interval does not include zero then it is unlikely (less than 5 per cent probability) that the observed differences could have occurred by chance.

Tables C1 to C7 show standard errors for selected variables for children in each of the main disorder categories. The standard errors of survey measures which are not presented in these tables, or for other subgroups, may be estimated by applying an appropriate value of deft to the standard error for a simple random sample. The choice of an appropriate value of deft will vary according to whether the basic survey measure is included in the tables. Since most deft values are relatively small (1.2 or less) the absolute effect of adjusting sampling errors to take account of the survey's complex design will be small.

Table C1**Standard errors and 95% confidence intervals for prevalence of mental disorders by sex, age and ethnicity**

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
All children	Emotional disorders	3.71	7,977	0.25	1.13	3.23	4.20
	Conduct disorders	5.77	7,977	0.32	1.16	5.13	6.40
	Hyperkinetic disorders	1.51	7,977	0.15	1.07	1.21	1.82
	Any mental disorder	9.64	7,977	0.42	1.22	8.82	10.47
Boys	Emotional disorders	3.13	4,111	0.28	1.00	2.58	3.67
	Conduct disorders	7.49	4,111	0.48	1.09	6.56	8.43
	Hyperkinetic disorders	2.58	4,111	0.28	1.08	2.03	3.14
	Any mental disorder	11.42	4,111	0.57	1.11	10.30	12.54
Girls	Emotional disorders	4.34	3,866	0.38	1.12	3.60	5.08
	Conduct disorders	3.93	3,866	0.36	1.07	3.23	4.63
	Hyperkinetic disorders	0.38	3,866	0.09	0.88	0.20	0.55
	Any mental disorder	7.75	3,866	0.50	1.12	6.77	8.73
5- to 10-year-olds	Emotional disorders	2.36	3,925	0.27	1.01	1.83	2.89
	Conduct disorders	4.88	3,925	0.38	1.03	4.14	5.62
	Hyperkinetic disorders	1.59	3,925	0.20	0.97	1.19	1.99
	Any mental disorder	7.70	3,925	0.47	1.07	6.77	8.63
11- to 16-year-olds	Emotional disorders	5.03	4,052	0.37	1.04	4.31	5.74
	Conduct disorders	6.62	4,052	0.49	1.17	5.66	7.58
	Hyperkinetic disorders	1.44	4,052	0.21	1.08	1.02	1.86
	Any mental disorder	11.53	4,052	0.62	1.20	10.30	12.75
5- to 10-year-olds: boys	Emotional disorders	2.20	2,008	0.34	1.02	1.53	2.88
	Conduct disorders	6.89	2,008	0.57	0.95	5.77	8.02
	Hyperkinetic disorders	2.74	2,008	0.38	0.98	2.00	3.48
	Any mental disorder	10.16	2,008	0.70	1.01	8.78	11.54
11- to 16-year-olds: boys	Emotional disorders	4.01	2,103	0.40	0.92	3.22	4.80
	Conduct disorders	8.07	2,103	0.72	1.13	6.67	9.48
	Hyperkinetic disorders	2.43	2,103	0.38	1.07	1.68	3.18
	Any mental disorder	12.63	2,103	0.84	1.12	10.98	14.28
5- to 10-year-olds: girls	Emotional disorders	2.53	1,917	0.40	1.09	1.74	3.31
	Conduct disorders	2.78	1,917	0.43	1.07	1.94	3.61
	Hyperkinetic disorders	0.39	1,917	0.12	0.81	0.15	0.63
	Any mental disorder	5.12	1,917	0.54	1.03	4.06	6.17
11- 16-year-olds: girls	Emotional disorders	6.12	1,949	0.61	1.10	4.92	7.32
	Conduct disorders	5.06	1,949	0.58	1.10	3.92	6.20
	Hyperkinetic disorders	0.36	1,949	0.14	0.95	0.01	0.63
	Any mental disorder	10.34	1,949	0.80	1.12	8.77	11.91

The standard errors are slight under-estimates because they take account of adjustment factors which are estimated from the same sample.

Table C1 (contd)

Standard errors and 95% confidence intervals for prevalence of mental disorders by sex, age and ethnicity

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
All 5- to 10-year-olds	Separation anxiety	0.55	3,925	0.11	0.92	0.33	0.77
	Specific phobia	0.73	3,925	0.14	1.01	0.46	1.01
	Social phobia	0.06	3,925	0.04	1.02	-0.02	0.13
	Generalised anxiety	0.25	3,925	0.08	0.97	0.09	0.41
	Depression	0.25	3,925	0.08	0.96	0.09	0.40
	Oppositional defiant disorder	3.46	3,925	0.34	1.08	2.81	4.12
	Unsocialised conduct disorder	0.60	3,925	0.13	0.98	0.35	0.86
	Socialised conduct disorder	0.29	3,925	0.09	1.00	0.11	0.47
	Autistic Spectrum Disorder	1.02	3,925	0.19	1.13	0.65	1.39
All 11- to 16-year-olds	Separation anxiety	0.32	4,052	0.01	1.06	0.13	0.51
	Specific phobia	0.88	4,052	0.16	1.08	0.56	1.19
	Social phobia	0.55	4,052	0.12	1.00	0.32	0.78
	Generalised anxiety	1.24	4,052	0.17	0.94	0.91	1.57
	Depression	1.44	4,052	0.20	1.05	1.05	1.84
	Oppositional defiant disorder	2.63	4,052	0.27	1.02	2.09	3.16
	Unsocialised conduct disorder	1.00	4,052	0.18	1.10	0.65	1.37
	Socialised conduct disorder	2.23	4,052	0.27	1.09	1.70	2.76
	Autistic Spectrum Disorder	0.76	4,052	0.15	1.05	0.47	1.06
White	Emotional disorders	3.81	6,920	0.26	1.01	3.31	4.32
	Conduct disorders	6.09	6,920	0.35	1.15	5.40	6.79
	Hyperkinetic disorders	1.67	6,920	0.17	1.07	1.33	2.02
	Any mental disorder	10.05	6,920	0.45	1.19	9.18	10.93
Black	Emotional disorders	3.26	325	1.05	1.09	1.20	5.31
	Conduct disorders	5.86	325	1.41	1.06	3.01	8.62
	Hyperkinetic disorders	0.61	325	0.43	0.99	-0.24	1.46
	Any mental disorder	9.18	325	2.03	1.28	5.20	13.15
Indian	Emotional disorders	1.44	199	0.97	1.12	-0.45	3.34
	Conduct disorders	0.63	199	0.62	1.04	-0.58	1.84
	Hyperkinetic disorders	0.00	199	0.00	–	0.00	0.00
	Any mental disorder	2.61	199	1.20	1.03	0.25	4.96
Pakistani and Bangladeshi	Emotional disorders	4.27	307	1.60	1.35	1.14	7.40
	Conduct disorders	3.98	307	1.03	0.86	1.97	5.99
	Hyperkinetic disorders	0.00	307	0.00	–	0.00	0.00
	Any mental disorder	7.81	307	1.76	1.11	4.36	11.26
Other	Emotional disorders	2.79	222	1.14	1.04	0.55	5.03
	Conduct disorders	2.86	222	1.15	1.00	0.59	5.12
	Hyperkinetic disorders	1.44	222	0.83	1.01	-0.19	3.08
	Any mental disorder	6.94	222	1.88	1.01	3.25	10.63

The standard errors are slight under-estimates because they take account of adjustment factors which are estimated from the same sample.

Table C2

Standard errors and 95% confidence intervals for prevalence of mental disorders by family and household characteristics

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
Married/cohabiting parents	Emotional disorders	2.64	6,039	0.22	1.02	2.22	3.06
	Conduct disorders	4.45	6,039	0.30	1.05	3.86	5.03
	Hyperkinetic disorders	1.21	6,039	0.15	0.99	0.92	1.50
	Any mental disorder	7.70	6,039	0.38	1.08	6.95	8.45
Single lone parent	Emotional disorders	4.92	684	0.89	1.06	3.18	6.66
	Conduct disorders	9.57	684	1.20	1.01	7.21	11.92
	Hyperkinetic disorders	2.57	684	0.64	1.02	1.31	3.83
	Any mental disorder	13.41	684	1.39	1.04	10.69	16.14
Previously married lone parent	Emotional disorders	8.21	1,254	0.88	1.10	6.49	9.93
	Conduct disorders	9.97	1,254	0.98	1.08	8.04	11.89
	Hyperkinetic disorders	2.38	1,254	0.49	1.07	1.42	3.33
	Any mental disorder	16.86	1,254	1.22	1.11	14.46	19.25
Both parents/lone parent working	Emotional disorders	2.76	5,200	0.25	1.07	2.27	3.26
	Conduct disorders	4.01	5,200	0.32	1.12	3.37	4.64
	Hyperkinetic disorders	1.22	5,200	0.18	1.13	0.86	1.57
	Any mental disorder	7.48	5,200	0.43	1.13	6.64	8.32
One parent working	Emotional disorders	3.44	1,401	0.53	1.05	2.41	4.47
	Conduct disorders	6.02	1,401	0.66	0.97	4.74	7.30
	Hyperkinetic disorders	1.14	1,401	0.27	0.89	0.62	1.66
	Any mental disorder	9.30	1,401	0.81	1.00	7.72	10.89
No parent working	Emotional disorders	8.46	1,203	0.89	1.08	6.72	10.20
	Conduct disorders	13.30	1,203	1.07	1.02	11.21	15.40
	Hyperkinetic disorders	3.33	1,203	0.56	1.02	2.24	4.42
	Any mental disorder	19.52	1,203	1.25	1.06	17.06	21.98
Owner occupiers	Emotional disorders	2.61	5,667	0.23	1.04	2.17	3.06
	Conduct disorders	3.81	5,667	0.28	1.02	3.27	4.35
	Hyperkinetic disorders	1.06	5,667	0.14	0.97	0.79	1.34
	Any mental disorder	7.02	5,667	0.36	1.03	6.30	7.73
Social sector tenants	Emotional disorders	6.30	1,718	0.66	1.01	5.01	7.59
	Conduct disorders	11.80	1,718	0.85	1.02	10.14	13.46
	Hyperkinetic disorders	2.35	1,718	0.39	1.01	1.59	3.12
	Any mental disorder	16.70	1,718	1.05	1.12	14.65	18.75
Private renters	Emotional disorders	6.67	587	1.06	1.01	4.60	8.75
	Conduct disorders	6.85	587	1.10	1.00	4.70	9.01
	Hyperkinetic disorders	3.33	587	0.82	1.06	1.72	4.95
	Any mental disorder	14.12	587	1.55	1.05	11.09	17.16

The standard errors are slight under-estimates because they take account of adjustment factors which are estimated from the same sample.

Table C3

Standard errors and 95% confidence intervals for prevalence of mental disorders by area characteristics

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
Wealthy achievers¹	Emotional disorders	2.44	2,041	0.37	1.04	1.72	3.15
	Conduct disorders	2.51	2,041	0.39	1.05	1.74	3.27
	Hyperkinetic disorders	1.07	2,041	0.23	0.96	0.61	1.53
	Any mental disorder	5.84	2,041	0.55	1.02	4.76	6.92
Urban Prosperity¹	Emotional disorders	2.59	600	0.78	1.19	1.07	4.11
	Conduct disorders	3.97	600	0.89	1.07	2.22	5.72
	Hyperkinetic disorders	1.29	600	0.53	1.11	0.25	2.33
	Any mental disorder	7.44	600	1.16	1.06	5.16	9.71
Comfortably off¹	Emotional disorders	3.37	2,057	0.44	1.06	2.52	4.23
	Conduct disorders	4.87	2,057	0.45	0.89	3.98	5.76
	Hyperkinetic disorders	1.21	2,057	0.25	0.97	0.72	1.69
	Any mental disorder	8.16	2,057	0.61	0.98	6.96	9.36
Moderate means¹	Emotional disorders	4.23	1,335	0.62	1.01	3.02	5.44
	Conduct disorders	7.20	1,335	0.79	1.06	5.65	8.76
	Hyperkinetic disorders	1.72	1,335	0.47	1.25	0.80	2.64
	Any mental disorder	11.66	1,335	1.06	1.17	9.58	13.74
Hard pressed¹	Emotional disorders	5.32	1,882	0.59	1.12	4.16	6.48
	Conduct disorders	9.93	1,882	0.73	0.99	8.50	11.36
	Hyperkinetic disorders	2.29	1,882	0.36	0.98	1.59	2.99
	Any mental disorder	14.61	1,882	0.95	1.12	12.74	16.47
England	Emotional disorders	4.02	7,044	0.28	1.14	3.48	4.56
	Conduct disorders	6.03	7,044	0.35	1.14	5.35	6.72
	Hyperkinetic disorders	1.51	7,044	0.16	1.00	1.21	1.82
	Any mental disorder	10.16	7,044	0.45	1.20	9.27	11.04
Scotland	Emotional disorders	2.88	721	0.67	1.01	1.57	4.19
	Conduct disorders	5.22	721	1.23	1.34	2.81	7.63
	Hyperkinetic disorders	1.44	721	0.49	1.01	0.48	2.41
	Any mental disorder	8.35	721	1.67	1.51	5.08	11.63

1. Acorn classification.

The standard errors are slight under-estimates because they take account of adjustment factors which are estimated from the same sample.

Table C4

Standard errors and 95% confidence intervals for key characteristics of children with emotional disorders

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
Children with emotional disorders	Parental GHQ score 3–12	51.45	293	2.88	0.97	45.78	57.13
	2 or more stressful life events	57.58	293	2.90	0.99	51.87	63.29
	Unhealthy family functioning (2.01 or more)	31.46	276	2.83	0.99	25.89	37.04
	Strengths score in lowest quartile (<37) ¹	58.11	278	2.65	0.88	52.88	63.33
	Social aptitude score in lowest quartile (<21) ¹	47.79	275	2.83	0.92	42.22	53.37
	Social support score in lowest quartile (<18) ¹	41.98	154	4.30	1.08	33.51	50.45
	Enjoys living in neighbourhood 'a lot'	38.47	155	3.93	1.00	30.72	46.21
	Participates in groups, clubs or organisations	57.13	201	3.73	1.07	49.78	64.48
	Smoker (regular or occasional)	23.57	153	3.30	0.96	17.07	30.07
	Regular drinker (once a week or more)	9.91	153	2.24	0.93	5.49	14.33
	Ever used cannabis	17.20	153	3.27	1.07	10.75	23.65

Some of the proportions are different from those shown in the main tables because they are based on 2004 data only.

1. Based on parent's report.

Table C5

Standard errors and 95% confidence intervals for key characteristics of children with conduct disorders

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
Children with conduct disorders	Parental GHQ score 3–12	46.73	420	2.50	1.00	41.81	51.65
	2 or more stressful life events	48.86	420	2.39	0.96	44.14	53.57
	Unhealthy family functioning (2.01 or more)	41.50	406	2.51	1.01	36.55	46.45
	Strengths score in lowest quartile (<37) ¹	76.69	399	2.24	1.04	72.27	81.11
	Social aptitude score in lowest quartile (<21) ¹	68.77	398	2.34	0.99	64.16	73.38
	Social support score in lowest quartile (<18) ¹	53.72	170	3.92	1.02	46.00	61.45
	Enjoys living in neighbourhood 'a lot'	43.08	171	3.88	1.02	35.43	50.73
	Participates in groups, clubs or organisations	47.41	246	3.14	0.98	41.22	53.59
	Smoker (regular or occasional)	39.83	170	3.85	1.02	32.25	47.41
	Regular drinker (once a week or more)	26.62	170	3.20	0.94	20.31	32.93
	Ever used cannabis	28.70	169	3.46	0.99	21.88	35.52

Some of the proportions are different from those shown in the main tables because they are based on 2004 data only.

1. Based on parent's report.

Table C6**Standard errors and 95% confidence intervals for key characteristics of children with hyperkinetic disorders**

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
Children with hyperkinetic disorders	Parental GHQ score 3–12	43.65	109	4.83	1.01	34.13	53.17
	2 or more stressful life events	46.68	109	4.52	0.94	37.77	55.59
	Unhealthy family functioning (2.01 or more)	34.71	106	4.40	0.95	26.05	43.37
	Strengths score in lowest quartile (<37) ¹	84.41	104	3.46	0.97	77.59	91.23
	Social aptitude score in lowest quartile (<21) ¹	82.54	105	3.72	1.00	75.20	89.88
	Social support score in lowest quartile (<18) ¹	54.38	33	8.18	0.93	38.25	70.51
	Enjoys living in neighbourhood 'a lot'	49.58	35	8.93	1.04	31.99	67.18
	Participates in groups, clubs or organisations	52.71	52	6.97	1.00	38.96	66.46
	Smoker (regular or occasional)	25.54	35	7.51	1.01	10.73	40.35
	Regular drinker (once a week or more)	11.52	35	5.31	0.97	1.06	21.98
	Ever used cannabis	13.50	35	5.70	0.97	2.26	24.73

Some of the proportions are different from those shown in the main tables because they are based on 2004 data only.

1. Based on parent's report.

Table C7**Standard errors and 95% confidence intervals for key characteristics of children with autistic spectrum disorder**

Base	Characteristic	%(p) adj	Sample size	True standard error of p	Deft	95% confidence interval	
Children with autistic spectrum disorder	Parental GHQ score 3-12	30.88	67	5.75	1.01	19.54	42.22
	2 or more stressful life events	36.30	67	5.40	0.92	25.66	46.95
	Unhealthy family functioning (2.01 or more)	39.45	54	7.30	1.08	25.06	53.84
	Strengths score in lowest quartile (<37) ¹	96.48	52	2.45	0.95	91.66	101.31
	Social aptitude score in lowest quartile (<21) ¹	96.40	58	2.46	0.99	91.55	101.25

Some of the proportions are different from those shown in the main tables because they are based on 2004 data only.

1. Based on parent's report.

Appendix D

Recent research on the Strengths and Difficulties Questionnaire

Appendix D gives a brief description of research on the Strengths and Difficulties Questionnaire (SDQ) over the past five years. The published papers are summarised below in terms of their focus on (a) psychometric properties of the SDQ, (b) comparisons of the performance of the SDQ with the Rutter Scales and the Child Behaviour Checklist (CBCL), and (c) the relationship between the SDQ and subsequent clinical assessments.

Psychometric properties of the SDQ

The first national survey of childhood mental disorders in Great Britain included SDQ data on a representative sample of 10,438, 5- to 15-year-olds. Analysis by Goodman (2001) confirmed the predicted five-factor structure: emotional, conduct, hyperactivity-inattention, peer and prosocial. Reliability was generally satisfactory, whether judged by internal consistency, cross-informant correlation, or retest stability after four to six months.

Muris *et al* (2003) examined the psychometric properties of the SDQ in a sample of Dutch young people. A sample of 562 children and young people and their parents completed the SDQ along with a number of other psychopathology measures. Factor analysis of the SDQ yielded the five factors that were consistent with the five hypothesised subscales. They concluded that the internal consistency, test-retest stability and parent-youth agreement of the various SDQ scales were acceptable and that the concurrent validity of the SDQ was good in that its scores correlated in a theoretically meaningful way with other measures of psychopathology.

Muris *et al* (2004) also looked at the psychometric properties (reliability and validity) of the self-report version of SDQ for younger children: 8- to 13-year-olds. The SDQ was administered to 1,111 non-clinical children. In a subsample, self-report SDQ scores of 439 children with and without behaviour problems were compared, and related *inter alia* to the teacher version of the SDQ. Although they found the reliability of the self-report SDQ somewhat less satisfactory in the younger children, most other psychometric properties were acceptable and comparable to those obtained in the older children. They concluded that although the self-report SDQ was designed for young people aged 11 years and above, their study suggested that the scale may provide useful information about psychopathological symptoms in children as young as 8 years old.

Woerner, Becker and Rothenberger (2004) carried out a study with the SDQ in Germany. They gathered information from parents, teachers and older children. To allow comparisons with SDQ findings in other countries, they collected data using the German parent-rated form as well as evaluating the scale in

both community and clinical samples. Parent ratings were collected for a community-based sample of 930, 6- to 16-year-olds. Statistical evaluation of psychometric properties included a factor analysis verifying the proposed scale structure, assessment of scale homogeneities, and determination of age, gender and social class effects. Based on the distributions of SDQ scores observed in this normative sample, recommended bandings identifying normal, borderline, and clinical ranges were defined for each scale. They reported exact replication of the original scale structure, satisfactory internal reliabilities, and observation of the expected associations with age and gender confirmed the equivalence of the German SDQ parent questionnaire with the English original. Differences between community-based results and clinical groups provided descriptive evidence of a dramatic impact of clinically defined psychiatric status on SDQ scores.

Koskelainen, Sourander and Vauras M (2001) examined the psychometric properties of the self-report version of the SDQ among 1,458 Finnish 13- to 17-year-olds. Their results confirmed the postulated structure of the SDQ self-report. The correlations of the items to their respective subscales ranged from moderate to high. The internal consistency was acceptable on three and somewhat lower on two of the five subscales. In addition, the factor analysis sufficiently confirmed the postulated structure of the SDQ for girls and boys, except for the conduct problem scale of boys, which was fused with emotional symptoms and with hyperactivity. The means of the SDQ self-report total difficulties scores were very similar to those found in the 1999 Great Britain survey.

A study by Malmberg, Rydell and Smedje (2003) investigated the adequacy of the Swedish adaptation of the SDQ (SDQ-Swe). They compared SDQ parent reports on 263, 5- to 15-year-old children drawn from a community sample and a clinical sample of 230 children. They found that the Swedish adaptation of the SDQ differentiated well between the community and the psychiatric samples, the latter displaying more symptoms, fewer strengths and more social impairment. ROC analyses showed satisfactory sensitivity and specificity of the principal scales of the SDQ-Swe at proposed cut-offs.

A study by Ronning *et al* (2004) used the Norwegian, self-report version of the Strengths and Difficulties Questionnaire (SDQ-S). The survey included 4,167 young people aged 11 to 16 years, attending 66 primary and secondary schools in Northern Norway. Structural analysis of the instrument, including confirmatory factor analysis, internal consistency and intra- and cross-scale correlations revealed somewhat variable psychometric properties. Norwegian cut-off points were similar to those found in other Scandinavian studies. About one-third of the subjects reported at least minor perceived difficulties,

while about 5 per cent reported definite or severe difficulties. These difficulties were strongly associated with all symptom scales. Girls reported a significantly higher level of emotional problems and better prosocial functioning. Boys reported significantly higher scores on the externalising scales and on peer problems.

Comparison of the SDQ with Rutter scales and the Child Behaviour Checklist (CBCL)

Goodman (1997) administered the Strengths and Difficulties Questionnaire (SDQ) along with Rutter questionnaires (Rutter *et al*, 1970) to parents and teachers of 403 children drawn from dental and psychiatric clinics. Scores derived from the SDQ and Rutter questionnaires were highly correlated; parent-teacher correlations for the two sets of measures were comparable or favoured the SDQ. The two sets of measures did not differ in their ability to discriminate between psychiatric and dental clinic attenders. Goodman suggests that the SDQ functions as well as the Rutter questionnaires while offering several advantages: a focus on strengths as well as difficulties, better coverage of inattention, peer relationships and prosocial behaviour, a shorter format, and a single form suitable for both parents and teachers. (Achenbach and Edelbrock, 1983).

Goodman R and Scott S (1999) asked parents to complete the SDQ and the CBCL (Achenbach and Edelbrock, 1983) on 132 children aged 4–7 and drawn from psychiatric and dental clinics. They found that scores from the SDQ and CBCL were highly correlated and equally able to discriminate psychiatric from dental cases. As judged against a semi-structured interview, the SDQ was significantly better than the CBCL at detecting inattention and hyperactivity, and at least as good at detecting internalising and externalising problems.

In a Finnish study Koskelainen, Sourander and Kaljonen, 2000, the emotional and behavioural problems of 735, 7- to 15-year-olds were assessed in a community population by the parent-, teacher- and self-reports of the SDQ and with the CBCL and the Youth Self Report. The correlation of the parental SDQ total scores and the Child Behaviour Checklist total scores was 0.75 and the correlation of the self-report SDQ total scores with the Youth Self Report total scores was 0.71.

Klasen *et al* (2000) compared the German versions of the SDQ with the CBCL. Both instruments were completed by the parents of 273 children drawn from psychiatric clinics (163) and from a community sample (110). The children from the community sample also filled in the SDQ self-report and the Youth Self Report (YSR). Scores from the parent and self-rated SDQ and CBCL/YSR were highly correlated and equally able to distinguish between the community and clinic samples, with

the SDQ showing significantly better results regarding the total scores. They were also equally able to distinguish between disorders within the clinic sample, the only significant difference being that the SDQ was better able to differentiate between children with and without hyperactivity-inattention.

Klasen *et al* (2003) reviewed the validation studies carried out on the German version of the Strengths and Difficulties Questionnaire (SDQ-Deu). They reported that it correlated well with the considerably longer German versions of the CBCL and respective teacher and self-report derivatives (TRF, YSR). Both parent-rated instruments were equally able to distinguish between a community and a clinic sample, and between subgroups with and without specified categories of disorders within a clinic sample.

Bettge *et al* (2002) were able to compare the SDQ and the CBCL in the context of a pre-test to a Health Survey for Children and Adolescents in terms of their psychometric properties, their diagnostic power, and the study participants' acceptance of the instruments. With this comparison, the question addressed was which of the two questionnaires was more reliable, valid and acceptable to the participants in describing mental health problems and psychiatric disorders in a population-based survey intended for a target age group of 6- to 17-year-olds. They concluded both instruments detected mental disorders that were established in a clinical interview with equal probability. The self-report tended to be superior to the parents' report in the age group from 11–17 years. The SDQ also had a higher acceptance rate than the CBCL.

Comparisons of the SDQ with subsequent diagnosis

In a study by Goodman *et al* (2000), SDQ predictions were compared with independent psychiatric diagnoses in a community sample of 7,984 5- to 15-year-olds from the 1999 survey in Great Britain. Multi-informant (parents, teachers, older children) SDQs identified young people with a psychiatric diagnosis with a specificity of 94.6 per cent (95 per cent CI 94.1–95.1 per cent) and a sensitivity of 63.3 per cent (59.7–66.9 per cent). The questionnaires identified over 70 per cent of individuals with conduct, hyperactivity, depressive and some anxiety disorders, but under 50 per cent of individuals with specific phobias, separation anxiety and eating disorders. Sensitivity was substantially poorer with single-informant rather than multi-informant SDQs.

Goodman, Renfrew and Mullick (2000) used a computerised algorithm to predict child psychiatric diagnoses on the basis of the symptom and impact scores derived from SDQs completed by parents, teachers and young people. The predictive

algorithm generated 'unlikely', 'possible' or 'probable' ratings for four broad categories of disorder: conduct disorders, emotional disorders, hyperactivity disorders, and any psychiatric disorder. The algorithm was applied to 101 patients attending child mental health clinics in Britain and 89 in Bangladesh. The level of chance-corrected agreement between SDQ prediction and an independent clinical diagnosis was substantial and highly significant (Kendall's tau b between 0.49 and 0.73; $p < 0.001$). A 'probable' SDQ prediction for any given disorder correctly identified 81–91 per cent of the children who definitely had that clinical diagnosis. There were more false positives than false negatives, i.e. the SDQ categories were over-inclusive.

The same computerised algorithm developed by Goodman *et al*, was used by Mathai, Anderson and Bourne (2004) to examine the level of agreement between clinical diagnoses by a community child and adolescent mental health service (CAMHS) and diagnoses generated by the SDQ. The algorithm was used at a community CAMHS in Australia to predict child psychiatric diagnoses on the basis of the symptom and impact scores derived from the SDQ completed by 130 parents, 101 teachers and 38 young people. These diagnoses were compared with those made by clinicians in a multidisciplinary community outpatient team and an independent clinician that examined the case notes and was blind to the SDQ scores. The level of agreement between SDQ generated diagnoses and clinical team diagnoses was moderate to high, ranging from 0.39 to 0.56. Correlations between the SDQ and an independent clinician ranged from 0.26 to 0.43.

Becker *et al* (2004) aimed to evaluate the German self-reported SDQ in a clinical setting. SDQ self-reports were collected from 214 in- and out-patients (81 girls and 133 boys) aged 11 to 17 years who were seen at the department of child and adolescent psychiatry of the University of Gottingen. Results obtained with the self-rated questionnaire were compared with the parent and teacher SDQs, corresponding CBCL/YSR scores, and the clinical diagnostic classification. The self-rated version of the SDQ demonstrated good validity with respect to the differentiation between clinically defined cases and non-cases and in detecting various subcategories of psychiatric disorders within the clinic sample.

With the exception of the Goodman, Renfrew and Mullick study which was carried out in Britain and Bangladesh, all of the studies described above regarding the SDQ have been carried out in Europe. Relatively few reports have published SDQ results obtained in other parts of the world Woerner *et al* (2004) carried out a review of some of the non-European experiences with the SDQ. They presented a selection of projects that have either psychometrically evaluated the

questionnaire, applied it to screen for behaviour disorders, or employed its parent-, teacher- or self-rated versions as research tools. Many of these studies are still in progress or have yet to be published. However, the general conclusions seem to be that experience gained with the SDQ in other continents has supported European evidence of good psychometric properties and its clinical utility.

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