

The health of children and young people

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Chapter 12

Mental health

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Introduction

Systematic data on mental health problems in childhood are of relatively recent origin. The first British epidemiological studies were undertaken in the 1960s,¹ and it was not until 1999 that the Office for National Statistics (ONS) carried out the first large-scale national survey of child mental health in the UK.² This revealed the key public health significance of psychiatric disorders in childhood: almost one in ten 5- to 15-year-olds were facing handicapping emotional or behavioural problems at the time of the survey. Longitudinal evidence has confirmed that many child psychiatric disorders persist well into adult life, increasing risks for mental health problems and difficulties in social functioning. For young people, their families and the wider society, the cost of child mental problems is high.

This chapter draws on findings from the 1999 ONS study that aimed to provide an overview of the prevalence and correlates of the common mental disorders in children of school age. National statistics also give a picture of trends in the related problems of suicide and youth offending. For data on behaviour problems in pre-school children, on rates of disorder in older adolescents, and on the longer-term outcomes of child psychiatric disorders, evidence is drawn from more specialised research studies in the UK and abroad.

The chapter concludes by considering some groups at especially high risk of psychiatric disorder: children in the care system, young people who are homeless, and young offenders. For more detailed discussions of these and other aspects of child mental health, readers are referred to several recent overviews.³⁻⁵

Defining and assessing children's mental health

Child and adolescent mental health problems span many different types of disorder. The main classifications used in the 1999 ONS survey (shown in Table 12.1) are now reasonably well validated, although some sub-categories still require supporting evidence.⁶ As many child mental health problems go untreated, prevalence estimates can only be derived from epidemiological surveys. However, assessing clinically significant problems in community studies presents challenges: with no reliable biological markers yet identified, diagnoses must be based on interviews with those who know the child.

The epidemiological literature reveals a range of methodological approaches, and a parallel range of prevalence estimates.⁷ Studies have repeatedly shown that assessing symptom counts alone produces highly inflated prevalence estimates. As a result, diagnostic criteria require that, in addition to a clinically recognisable set of symptoms or behaviours, a child must show distress, or substantial interference with functioning, for a diagnosis to be made.

The 1999 ONS survey used a newly developed package of interviews for parents, teachers and young people to assess child mental health problems in large-scale samples – the Development and Well-Being Assessment (DAWBA).⁸ The rates of disorder presented here are based on the ICD-10 Classification of Mental and Behavioural Disorders.⁹

Prevalence

5- to 15-year-olds

The ONS study surveyed approximately 10,500 5- to 15-year olds in private households in



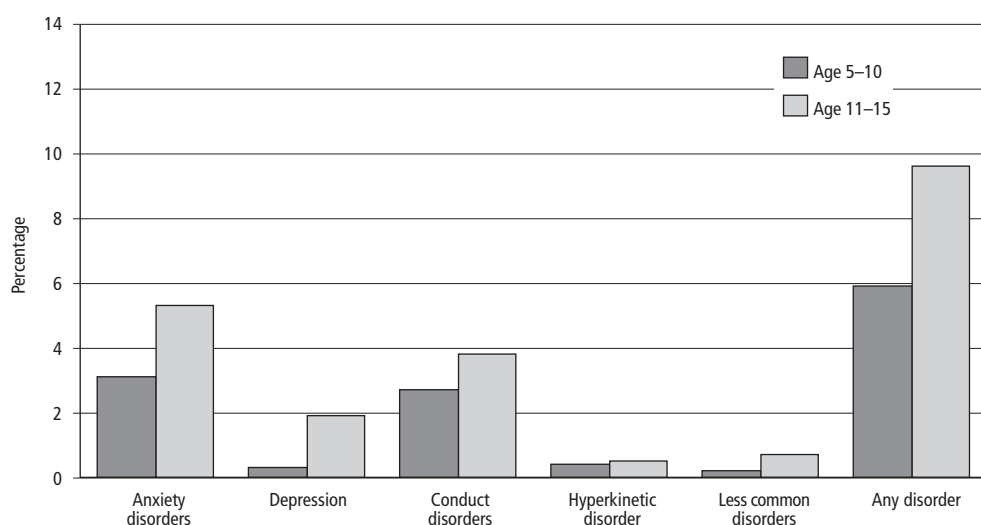
England, Scotland and Wales. Figures 12.1 and 12.2 show the prevalence of the main categories of disorder identified through the survey. Alongside these major diagnostic groupings, a much smaller proportion of children (0.5 per cent in the sample as a whole) showed less common disorders: 0.3 per cent of boys had pervasive developmental disorders, around 0.1 per cent of both sexes had tic disorders, and 0.1 per cent of boys and 0.4 per cent of girls (all in the 11 to 15 year age group) had eating disorders.

As other community studies have found, rates of disorder varied by both sex and age. Overall, boys were more likely to have a mental disorder than girls, and this pattern was evident in both the 5 to 10 year age group (10 per cent of boys compared with six per cent

Figure 12.1

Prevalence of psychiatric disorders among girls aged 5 to 15 years, 1999

Great Britain

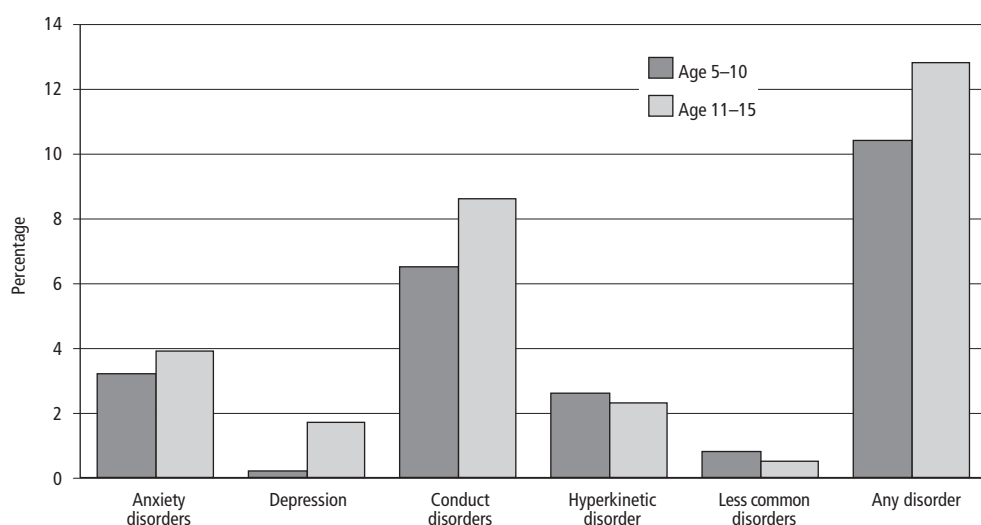


Source: *Mental Health of children and adolescents in Great Britain, 1999 ONS Survey*

Figure 12.2

Prevalence of psychiatric disorder among boys aged 5 to 15 years, 1999

Great Britain



Source: *Mental Health of children and adolescents in Great Britain, 1999 ONS Survey*



of girls) and the 11 to 15 year age group (13 per cent of boys and 10 per cent of girls). Differences by sex were especially marked in conduct and hyperkinetic disorders while the prevalence of emotional disorders was relatively similar in boys and girls of school age. With the exception of hyperkinetic disorders, rates of all other main disorder categories increased from childhood to adolescence.

Like other studies,¹⁰ the ONS survey also found that co-morbidity between disorders was common, so that young people with one psychiatric disorder were at greater risk of having others. In particular, conduct and hyperkinetic disorders frequently overlapped, as did anxiety disorders and depression.

By definition, these disorders caused distress or incapacity to the young people themselves. Responses from parents showed that they also often impacted on other family members. The great majority of parents were worried about their child's problems, and over half felt that their child's disorder had caused them to be depressed. In a minority of families the child's difficulties caused significant disruption to parents' social and leisure activities, and in approaching a third of cases parents felt embarrassed and stigmatised by their child's problems. In all of these areas conduct and hyperkinetic disorders had a more marked impact on family functioning than did emotional disorders.

Early childhood precursors

With the exception of severe developmental disorders, formal psychiatric diagnoses are less commonly made in preschool children. Nonetheless, community studies of young children have found that they show emotional and behavioural problems that cluster in meaningful ways; around seven per cent of three-year-olds can be expected to show moderate to severe behaviour problems, and a further 15 per cent to present with more mild difficulties.¹¹ Many early developmental and habit problems (such as delays in toilet training, or 'comfort' habits such as rocking and thumb-sucking) resolve by middle childhood, and rates of specific fears decline as children mature. Other early difficulties (such as being hard to manage) seem more persistent, and some problems (such as worrying) are rare in pre-school children, but tend to increase with age.

Many preschool problems will be transient, but some persist. Prospective studies have found that a substantial proportion of the most severely troubled pre-schoolers will go on to develop defined psychiatric disorders later in childhood, and longer-term follow-ups have shown modest continuities between preschool behaviour problems and both psychiatric disorders¹² and criminality¹³ in early adult life.

Later teenage years

The ONS survey focused on 5- to 15-year-olds, so data from other surveys have to be used to trace rates of disorder later in the teens. Figures 12.3 and 12.4 show one-year rates of psychiatric disorders at ages 15 and 18 years from the Christchurch Health and Development Study in New Zealand.¹⁴ Partly because the Christchurch study assessed disorder over the whole of the previous year (rather than at the time of the interviews, as in the ONS survey), rates at age 15 were higher than in the UK study. By age 18, however, the proportion of young people showing mental health problems had risen still further, with especially marked increases in the levels of mood disorders (predominantly depression) in girls, and in alcohol and drug-related problems in boys. Other studies¹⁵ have confirmed this

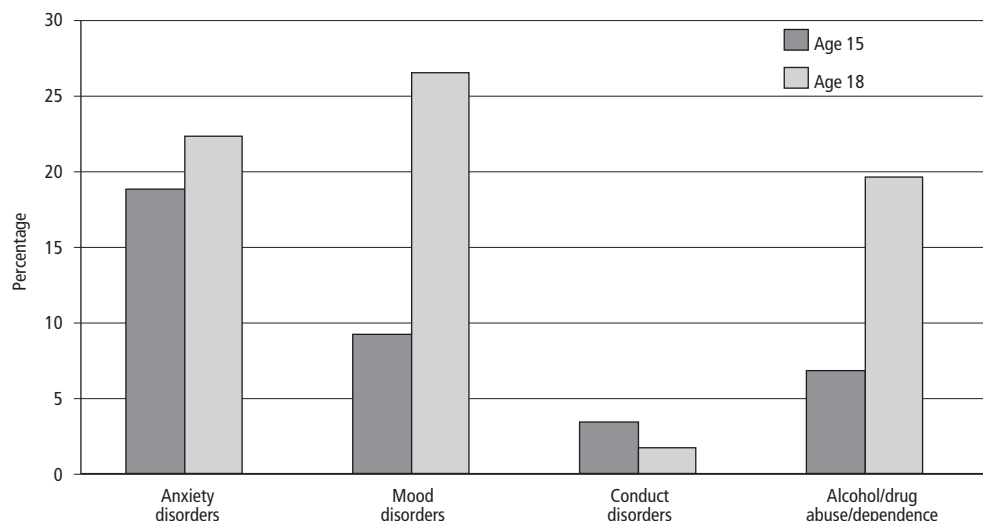


pattern, suggesting that the late teens and early twenties are periods of especially high risk for mental health problems – possibly the highest at any stage in the life course.

Figure 12.3

One-year prevalence of psychiatric disorders among females aged 15 and 18 years, 2001

New Zealand

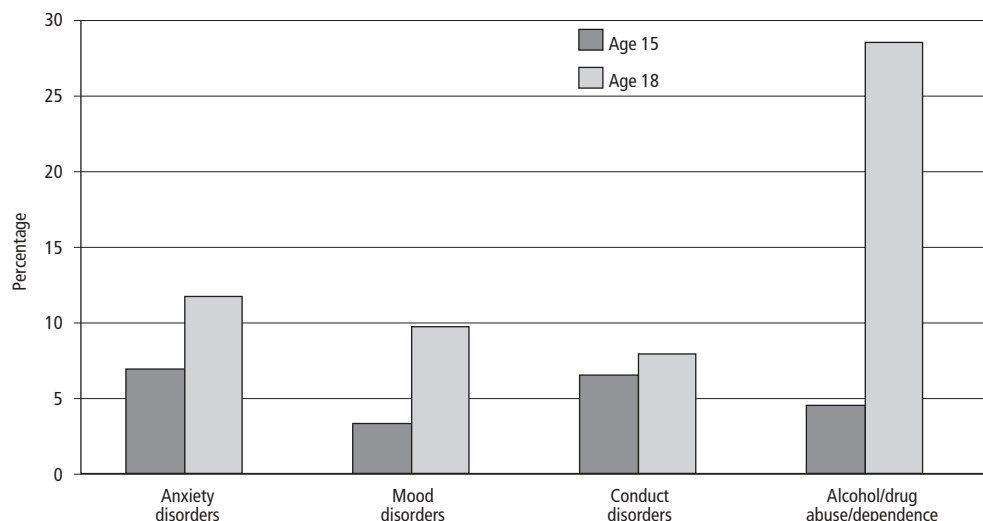


Source: Fergusson and Horwood, 2001

Figure 12.4

One-year prevalence of psychiatric disorders among males aged 15 and 18 years, 2001

New Zealand



Source: Fergusson and Horwood, 2001

Associated difficulties

Mental and physical health

The ONS survey identified strong links between children’s mental and physical health. Parents were asked to rate their child’s general health, and to report whether the child suffered from any of 30 physical complaints or disabilities. In children with no mental



health problems, six per cent were rated as showing fair, poor or very bad general health; the corresponding proportion among children with mental health problems was over three times higher, at 20 per cent. Just over half the children with no mental disorder had one or more of the individual physical complaints examined in the survey compared with two-thirds of those with mental health problems.

The conditions showing the largest disparities between those with and without mental disorders were bed-wetting (12 per cent compared with four per cent), speech or language problems (12 per cent compared with three per cent), co-ordination difficulties (eight per cent compared with two per cent) and soiling (four per cent compared with one per cent). Over a third of children with neurological problems (epilepsy and co-ordination difficulties) also had a mental health problem. Rates of accidents (head injury involving loss of consciousness, broken bones, burns requiring hospitalisation, accidental poisoning requiring hospital admission) were also more common among children with psychiatric disorders, as were reports of life-threatening illnesses at any point in the child's life-time (22 per cent among children with mental health problems compared with 11 per cent of those with no disorder).

In older children and adolescents, the survey revealed strong links between psychiatric disorder and rates of smoking, drinking and cannabis use. Over 40 per cent of 11-to 15-year-olds who regularly smoked were assessed as having a mental disorder (28 per cent had a conduct disorder, 20 per cent an emotional disorder and four per cent a hyperkinetic disorder). Psychiatric disorders were three times more common among young people who reported regular alcohol use than among teenagers who did not drink, and about half of the frequent cannabis users had a mental health problem compared with only one in 10 of those who reported never having used cannabis.

Educational needs and performance

Psychiatric disorders also showed strong overlaps with educational difficulties and needs. In the sample as a whole, about one in five children were reported by their teachers to have some level of special educational need (SEN). This figure was slightly lower (15 per cent) for children without psychiatric disorder, but much increased in those with mental health problems: over a third of children with emotional difficulties had SEN, as did over half of those with conduct disorders, and over 70 per cent of those with hyperkinetic disorders.

Even taking account of the strong socio-demographic correlates of SEN, the presence of a psychiatric diagnosis proved a strong predictor of educational needs in statistical terms. A similar picture emerged for performance on the reading and spelling tests administered in the course of the survey. While only four per cent of children without a psychiatric disorder were classified as showing specific literacy difficulties, rates were almost three times higher (11 per cent) for children with emotional problems, and over four times higher (17 per cent) for those with hyperkinetic disorders.

Persistence and long-term outcomes

Apart from revealing the high prevalence of mental health problems in childhood, research is also charting their impact over time. An 18-month follow-up of a sub-sample of the ONS survey children¹⁶ showed that while some disorders were relatively transient, many



persisted. The highest rates of persistence were for conduct and hyperkinetic disorders, where over 70 per cent of children with marked difficulties at the first study contact continued to show disorder at follow-up. The prognosis for emotional difficulties was better. However, over a third of children with problems at the initial survey were assessed as showing disorder 18 months later.

Longer-term longitudinal studies suggest that for many young people, mental health problems in childhood mark the early stages of difficulties that continue well into adult life. Later psychiatric sequelae show some specificity. In relation to conduct disorder, for example, a substantial minority of antisocial children go on to show severe antisocial behaviours in adult life, and risks for substance abuse and other adult psychiatric disorders are also increased.¹⁷ Adolescent depressive disorders show a significant continuity into adulthood, and are also associated with a greatly increased risk of completed suicide.¹⁸ The long-term course of anxiety disorders is less well established.¹⁹ Although most children with anxiety disorders do not go on to show marked anxiety in adulthood, most anxious adults do report anxiety earlier in development; childhood anxiety also increases risk for adult depression. And although the symptoms of attention deficit hyperactivity disorder (ADHD) typically reduce with age, previously hyperactive children have been found to be at increased risk for adverse psychiatric outcomes in adult life.²⁰

Other aspects of functioning are also frequently affected. Probably the widest spectrum of risks seems to follow oppositional and conduct disorders¹⁷ and ADHD.²⁰ By contrast with non-disordered groups, children with disruptive behaviour problems of this kind are more likely to:

- show poor educational attainments and drop out of school;
- have poorer early work histories with higher risks of unemployment;
- leave their homes and families at younger ages;
- enter romantic and sexual relationships earlier, and experience more difficulties and breakdown in those relationships;
- become pregnant or father children earlier than their peers;
- be involved in crime; and
- have poorer general health in their early adult lives.

Evidence on the psychosocial outcomes of emotional difficulties is less extensive, but suggests that problems in social functioning may be less pervasive, and possibly somewhat different in form. Early onset anxiety disorders and depression do appear to compromise educational achievement, and may be associated with difficulties in forming successful relationships.

Demographic correlates and risks

Regional and social variations

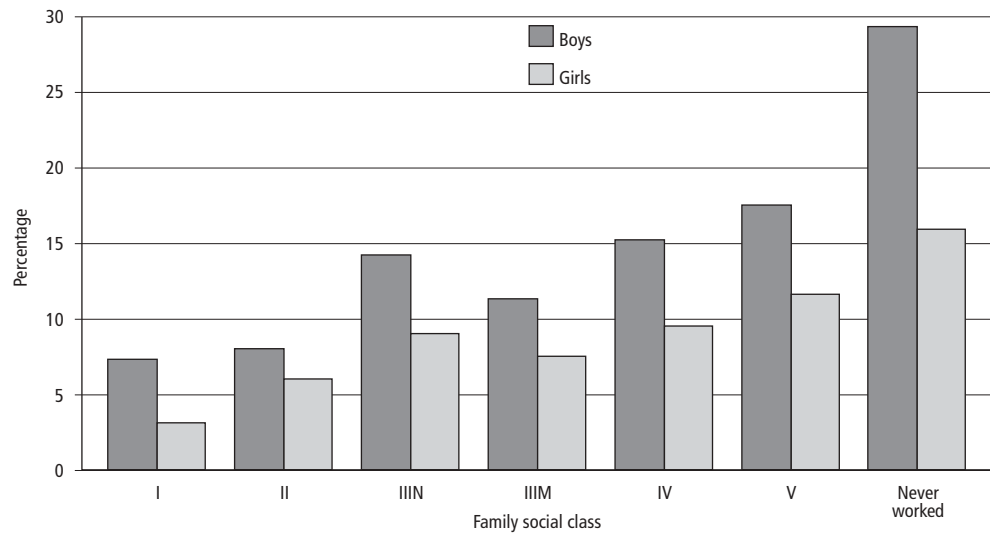
The ONS survey found no significant differences in the prevalence of any one mental disorder, or of all the main disorder categories, between England, Scotland and Wales, nor between the metropolitan and non-metropolitan areas of England. Rates of disorder did, however, vary with the geo-demographic characteristics of neighbourhoods, and with family income and social class.



Figure 12.5

Prevalence of psychiatric disorder among children aged 5 to 15 years by family social class, 1999

Great Britain



Source: *Mental Health of children and adolescents in Great Britain, 1999 ONS Survey*

Figure 12.5 shows associations with family social class, as measured by the occupation of the head of household. Children in families of Social Class V (unskilled occupations) were approximately three times more likely to have a mental health problem than those of Social Class I (professional occupations), and rates were at their highest among the small group of families where no parent had ever worked. Nearly 10 per cent of White children and 12 per cent of Black children were assessed as having a mental health problem. The rates among Asian children were eight per cent for those of Pakistani and Bangladeshi origin, and four per cent for those of Indian origin. Possible ethnic group variations were difficult to interpret due to the relatively small numbers of families interviewed in specific ethnic groups.

Family characteristics and child disorder

In general, epidemiological studies have concluded that associations between childhood disorder and broad indicators of economic and social circumstances are unlikely to reflect directly causal influences; instead, risks seem more likely to be mediated through family, peer and neighbourhood influences.

Like previous studies, the ONS survey found that rates of disorder varied by family type. Children of lone parents were twice as likely to have a mental health problem as those living with married or cohabiting couples (16 per cent compared to eight per cent). Mental disorders were also more common in reconstituted (step) families (15 per cent) than in non-step families (nine per cent). Children of cohabiting couples (11 per cent) were more likely to show disorder than those whose parents were married (seven per cent), and children in two-child families were at lower risk of disorder than those in large sibships (four or five children).

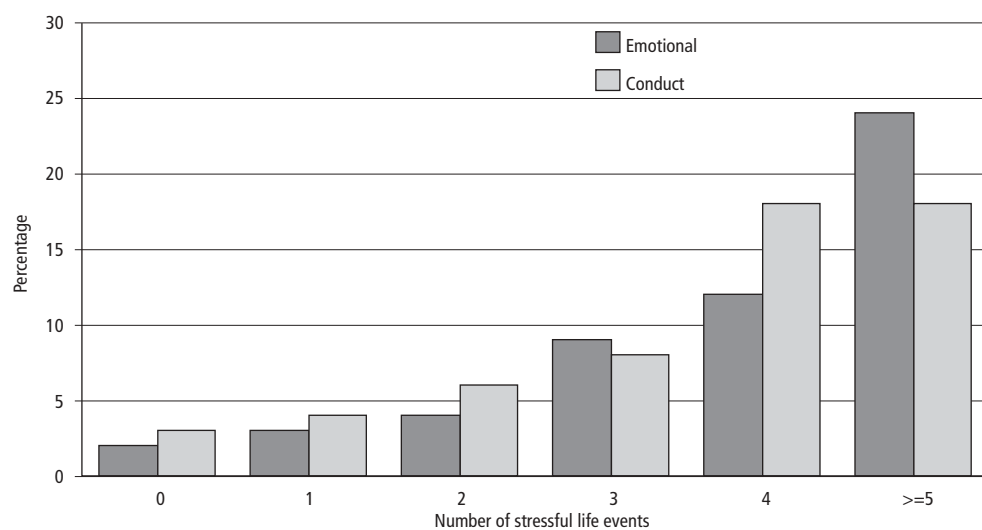
In addition, family discord and stressful life events showed strong links with disorder. Parents in the survey were asked if their child had experienced any of ten stressful events during his or her lifetime. Children with a mental disorder were more likely to have



Figure 12.6

Prevalence of psychiatric disorders among children aged 5 to 15 years by number of stressful life events, 1999

Great Britain



Source: *Mental Health of children and adolescents in Great Britain, 1999 ONS Survey*

experienced one stressful event (82 per cent) than children without a disorder (70 per cent). Additionally, children with a disorder were much more likely to have faced multiple stressors: 31 per cent, compared with only 13 per cent of children without disorder, had experienced three or more severely adverse events in their lifetime. As Figure 12.6 shows, rates of both emotional and conduct disorders increased systematically with the number of stressors that children had experienced.

Understanding risks for child mental health

These findings highlight just some of the range of family and social factors now known to be associated with variations in children's mental health. Others include parental psychopathology, repeated early separations from parents, harsh or inadequate parenting, exposure to abuse or neglect, and adverse peer group influences.²¹ Although identifying associations of this kind is crucial, it is still only the first step in understanding *how* they contribute to risk.

A variety of mechanisms has been proposed here, including:

- effects of stress on biological systems;
- development of negative cognitive sets and attributional biases;
- effects on the psychological structures needed for relationship formation;
- direct increases in negative emotionality and disruptive behaviours; and
- effects on children's self-concepts and coping skills.

Several other key issues have emerged from research on risks for child mental health. First, studies have consistently shown marked individual differences in children's responses to all but the most severe psychosocial stressors. In relation to family type, for example, there is known to be considerable variability in rates of disorder *within* as well as between family types.²² Many children in lone parent and step-families develop happily and well, while by no means all of those in traditional families escape untroubled.



Second, environmental adversities often overlap, so that any one difficulty may act as a proxy for many other risks.²³ The ONS survey showed that 21 per cent of lone parents, but only one per cent of married parents, fell into the lowest income category, and that parental psychological distress was almost twice as common among lone (30 per cent) as married parents (16 per cent). Identifying the key psychosocial factors involved is by no means a straightforward task.

Third, the advent of genetically informative studies has had a major impact on thinking about risk for child mental health. Most childhood disorders are now known to involve a heritable component;²⁴ equally important, many environmental factors have also been found to include some element of genetic mediation.²⁵ Because parents provide children with their environments as well as with their genes, nature and nurture often act to reinforce one another. In addition, genetic factors may contribute to variations in sensitivity to environmental risks, which may explain why some children seem vulnerable to psychosocial stressors while others are not.²⁶ Although further research is needed to take these issues forward, it is clear that correlations and interactions between genetic and environmental risks are essential for understanding the genesis of many emotional and behavioural disorders in childhood.²⁷

Service use

As suggested above, young people with mental health problems have complex needs, and may require a range of services. The ONS survey asked about contacts over the previous year with GPs, other health and educational services, and with social services. In addition, older children and adolescents were asked about contacts with the police.

Almost half of the children with a disorder had been in contact with a GP in the past 12 months compared with just over a third of those with no disorder. The survey questions focused on GP contacts for any reason, rather than for mental health problems *per se*. Studies in primary care settings have suggested that only a very small proportion of children and adolescents attending primary care present directly with psychological problems, but that many more have psychiatric disorders as associated features of somatic complaints.²⁸

GPs vary widely in their recognition of child psychiatric disorders, and only refer a small proportion of disordered children to specialist Child and Adolescent Mental Health Services (CAMHS).²⁸ Although the ONS study did not allow for any direct assessment of the proportion of children in touch with CAMHS, studies in other countries have consistently found that most children who need mental health services are not receiving specialised care.²⁹

A recent Audit Commission study of specialist child mental health services in England and Wales³⁰ found that children seen by CAMHS typically showed a range of complex difficulties. The most common problems (noted in 60–80 per cent of the cases audited) were:

- difficulties with family life and relationships;
- problems involving emotional and related symptoms (including eating disorders);



- problems with peer relationships; and
- disruptive, aggressive and antisocial behaviours.

In terms of family circumstances, a third of children attending CAMHS were in families where the main breadwinner was unemployed, 19 per cent were living with a parent with mental illness, and nine per cent (by contrast with 0.5 per cent in the population as a whole) were being looked after by the Local Authority.

In addition to contacts with health services, the ONS survey highlighted high rates of other service use. Half of the children with a disorder had seen someone from the educational services in the past year, and a fifth had had contact with the social services. Among 11- to 15-year-olds, 43 per cent of young people with a disorder had been in trouble with the police at some point in their lives compared with 21 per cent of those without a disorder. As these findings suggest, the economic costs of service provision for children with mental health problems are likely to be high; health economic studies are now beginning to chart these costs.³¹

Related problems

Although not classified as disorders, a number of other childhood and adolescent difficulties show strong associations with mental health. Patterns of drug and alcohol use are examined in Chapter 4. This chapter examines two other key indicators: suicide and self-harm, and youth offending.

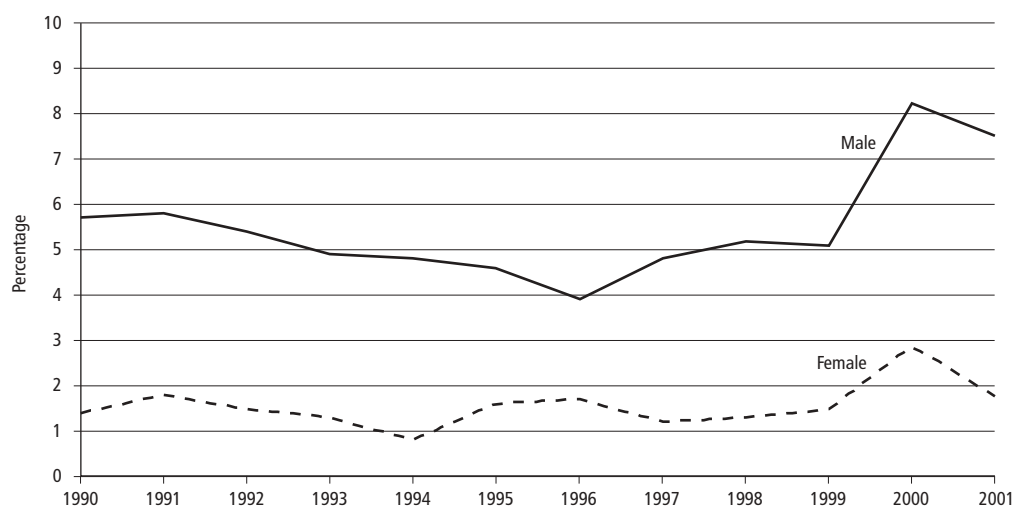
Suicide and deliberate self-harm

In all developed countries except the USA, suicide is the second leading cause of death among young people. Completed suicides are rare in pre-pubertal children, but the incidence of suicide increases steadily across the teens, reaching a peak in the early or mid-twenties. Official statistics may well underestimate the scale of the problem given that deaths recorded as of undetermined cause may often be suicides, as may accidents for

Figure 12.7

Suicide rate among children and adolescents aged 15 to 19 years

England and Wales



Sources: Mortality Statistics, Population Estimates



methods similar to suicide. By combining the figures for all three of these causes of death, the rates are between two and three times higher than for recorded suicides alone.³²

In England and Wales, the suicide rates were much higher for males aged 15 to 19 years than females aged 15 to 19 years. The suicide rates increased sharply among males in this age group during the 1970s and 1980s. The incidence rates of suicide remained relatively constant within the range five to six per 100,000 of males aged 15 to 19 years and one to two per 100,000 of females in the same age group, throughout the 1990s (Figure 12.8). In 2000, the suicide rates increased steeply to eight per 100,000 of males aged 15 to 19 and three per 100,000 of females, but these rates decreased slightly in 2001. Youth suicide rates were markedly higher in Scotland and Northern Ireland. Predominant methods have also changed with time. For young males, overdosing was the most common method in the 1970s, poisoning with vehicle exhaust gas the most common in the 1980s, and hanging the most common in the 1990s.

Psychological autopsy studies have found that almost all young people who commit suicide were suffering from one or more (often longstanding) psychiatric disorders.³³ Conduct or oppositional disorders, often complicated by substance and/or alcohol abuse were most common among males while depression and anxiety were more common among females. Although some young people who kill themselves may have contemplated suicide for some time, most suicides appear to be impulsive, triggered by stress events such as a disciplinary crisis, the breakdown of a close relationship, or (for those with predominant anxiety symptoms), the prospect of a feared event. Other immediate trigger factors include an altered state of mind, and the opportunity for suicide. In addition, variations in rates of youth suicide between countries and over time suggest that broader social factors are also likely to play a part.

Completed suicides are more common among males while suicidal ideation and deliberate self-harm are more common in girls. The ONS survey examined the characteristics of children and adolescents who tried to hurt, harm or kill themselves. The phrasing of the question posed in the interviews meant that positive responses could include children involved in self-mutilation, as well as those with suicidal intent. According to parents, one per cent of 5- to 10-year-olds and two per cent of 11- to 15-year-olds had ever tried to hurt, harm or kill themselves; the highest rate (three per cent) was among 13-year-old girls. In all age groups, children with mental disorders were much more likely than those without disorder to have been involved in self-harm. The prevalence of self-harm was also associated with exposure to adverse life events, with parental psychological distress, family discord and the frequency with which children were punished.

Youth offending

Data on youth offending are available from two main sources: official statistics on the numbers of young people formally sanctioned for offending and findings from self-report studies. Inevitably, neither can reflect the full extent of youth offending. Official data exclude young offenders who are not caught, and those who are dealt with informally, while self-report studies almost certainly under-represent young people at the highest risk of offending. It is also difficult to determine the accuracy of responses in self-report surveys. Taken together, however, these two sources of information provide important pointers to the extent and nature of youth crime.

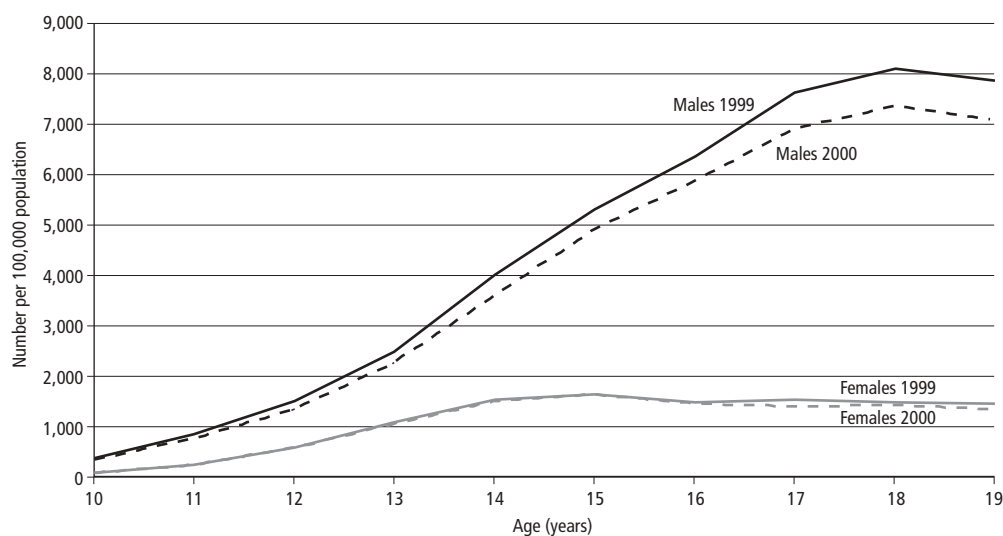


Both official data and self-reports have consistently confirmed two key features of offending. First, males are more likely to be involved in illegal activities than females, and second, rates of offending are related to age, with the peak ages for offending in both males and females occurring in the teens. Figure 12.8 shows the number of males and females per 100,000 population found guilty or cautioned for an indictable offence in 1999 and 2000. The peak ages for offending in males was 18 years (8,112 offenders per 100,000 of the population in 1999 and 7,368 per 100,000 in 2000), and for females it was 15 years (1,639 per 100,000 in 1999 and 1,641 per 100,000 in 2000).

Figure 12.8

Number per 100,000 population found guilty or cautioned for an indictable offence by age, 1999, 2000

England and Wales



Source: *Criminal Statistics: England and Wales, 1999 and 2000*

The second sweep of the Youth Lifestyles Survey (YLS)³⁴ investigated the extent of self-reported offending in a sample of over 4,000 12- to 30-year-olds in England and Wales in 1998/1999. Over half of the young men (57 per cent) and over a third of the young women surveyed (37 per cent) admitted committing an offence at some point in their lifetime. Focusing on the past year, rates of self-reported offending peaked for males aged 18 to 21 years (35 per cent) and females aged 14 to 15 years (18 per cent). The most common offences among young men reflected their involvement in fights, buying stolen goods, other forms of theft, and in criminal damage. For young women criminal damage, shoplifting, buying stolen goods and fighting were the most frequently reported forms of crime.

As numerous other studies have found, the overall group of offenders included many young people who committed only one or two offences, along with a small group of persistent offenders. In the YLS approximately 10 per cent of offenders were responsible for nearly half of all offences admitted; these very prolific offenders represented just two per cent of men and one per cent of women in the sample as a whole. Young men living in rural areas were less likely to have committed an offence than those in urban areas (21 per cent compared with 27 per cent), while serious or persistent offenders were especially concentrated in inner city areas (17 per cent compared with 13 per cent in other urban areas and only nine per cent in rural areas). Serious or persistent offenders (both male and female) were also markedly more likely to come from lower social class groups.



A large body of research has examined the predictors of youth crime.⁴ Many overlap with risk factors for psychiatric disorder. The most commonly identified predictors include individual factors such as:

- IQ, temperament, cognitive impairment, impulsiveness and hyperactivity;
- family structure and size, and criminality in other family members;
- poor family relationships and inadequate parental supervision;
- peer relationships, and association with deviant peers;
- poor experiences of schooling including low achievement, truancy, school exclusion and disaffection from school; and
- lifestyle factors such as drug and alcohol use.

Vulnerable groups

Some groups of young people are at particular risk of mental health problems. These include children with severe illnesses, disabilities and learning problems, and those in adverse family circumstances. In addition, a number of other groups seem especially vulnerable: looked-after children, young people who are homeless, and young offenders.

Looked-after children

Children looked after by Local Authorities are now recognised as among the most vulnerable in our society: many have histories of abuse or neglect, and most will have faced severe problems in their families of origin. In 2001/2002 ONS undertook the first national survey of the mental health of 5- to 17-year-olds looked after by Local Authorities in England,³⁵ using the same methods as the 1999 survey of young people in private households. Information was collected on just over 1,000 children and adolescents living with foster carers (67 per cent of the total), in residential care (18 per cent), with their own families or friends (11 per cent), or, among the older adolescents, living independently (four per cent).

The findings highlighted the very high levels of mental health need faced by children and adolescents in the care system. Among 5- to 10-year-olds overall rates of disorder were at least five times higher than for children in the general population (42 per cent versus 8 per cent), and contrasts were only slightly less marked for 11- to 15-year-olds (49 per cent versus 11 per cent). Although all types of disorder were found to be more common than in the household survey, the major contributor to the increased risk for looked after children came from conduct disorders. Among 5- to 10-year-olds, 36 per cent of looked after children (by contrast with five per cent in the private households survey) showed clinically significant conduct or oppositional disorders; figures for 11- to 15 year-olds were 40 per cent and six per cent respectively. Almost one in three children in Local Authority foster care were assessed as showing conduct disorders, as were 60 per cent of those in residential care homes. Many children in the care system face frequent changes of placement, or go in and out of care.

Overall risks of psychiatric disorder varied with the length of a child's current placement: rates were highest (at 49 per cent) for those in their current placement for less than one year and lowest (at 31 per cent) for those in the most stable placement group (five years or longer). In terms of service use, 44 per cent of looked after children with psychiatric



disorders had been in touch with specialist child mental health services in the year before the survey, and a third had used specialist educational services; 19 per cent of all looked after 11- to 15-year-olds, and 25 per cent of 16- to 17-year-olds, had been in trouble with the police over the same period.

Homeless young people

Homeless adults are known to be at high risk of psychiatric disorder. A study of 16- to 21-year-olds attending two London organisations for the homeless³⁶ confirmed a similar pattern among young people. Over 60 per cent met criteria for disorder at the time of the study, and over a third had made at least one suicide attempt at some point in their lives. The figures for a domiciled inner city comparison group were 25 per cent and nine per cent, respectively.

The majority of mental health problems among homeless young people were chronic – in the sense that they had persisted for at least one year and 70 per cent appeared to predate the first episode of homelessness. Homeless young people also reported poor educational attainments and high levels of childhood adversity. Many came from broken families, or had been abused or neglected, and 40 per cent had spent some time in Local Authority care. Although the causes of homelessness are complex, these findings suggest that prior psychiatric disorder may be one of the factors that put young people at risk.

Young offenders

Young offenders, and especially those receiving custodial sentences, constitute a further vulnerable group. In 1997 ONS undertook a survey of psychiatric morbidity among prisoners in England and Wales, and results relating to young offenders (aged 16 to 20 years) were the subject of a separate report.³⁷ Exceptionally high rates of mental health problems were identified among these imprisoned young offenders. Over 80 per cent of both remand and sentenced male prisoners met criteria for at least one personality disorder, with antisocial personality by far the most common diagnosis. Functional psychoses were identified in eight per cent of male remand prisoners and 10 per cent of those who had been sentenced. Comparable figures in a recent community sample were only two per thousand. Neurotic symptoms such as sleep problems, worry and depression were reported at roughly twice the rates found in general population surveys, and over 40 per cent of male young offenders and 68 per cent of females met criteria for at least one neurotic disorder.

Young people in the prison survey were also questioned about post-traumatic stress. Over a fifth of male young offenders and two-fifths of females reported experiencing an exceptionally threatening or catastrophic event at some point in their lives. Four per cent of males and seven per cent of females met the full criteria for post-traumatic stress disorder. About two-thirds of male young offenders and half of the females reported hazardous or harmful levels of alcohol use in the year before they came into prison. Illegal drug use was also common, with over half of both male and female offenders reporting dependence on drugs in the year before prison.

At least 95 per cent of young offenders, both male and female, showed evidence of one or more of the main types of disorder examined in the survey (personality disorder, psychosis, neuroses, hazardous drinking and drug dependence). In practice, most of these incarcerated



young offenders faced multiple mental health difficulties. Among males the most common pattern was of three co-occurring disorders and among females co-morbidity was even more marked, with almost a third of young female prisoners meeting the criteria for four or five psychiatric disorders.

Tendencies towards suicide and self-harm also emerged as key risks for young prisoners. Over a third of male young offenders on remand said they had thought of suicide at some point in their lifetime with 30 per cent in the past year and 10 per cent in the week prior to interview. One in five had made a suicide attempt, and three per cent had tried to kill themselves in the previous week. Female prisoners reported even higher rates of suicidal thoughts and attempts than their male counterparts. Half had experienced suicidal thoughts at some point in their lifetime, and a third – twice the proportion of sentenced male prisoners – had made at least one suicide attempt. Rates of parasuicide (self-harm without the intention of suicide) in the current prison term varied between seven per cent of male remand offenders and 11 per cent of young female sentenced prisoners.

Conclusions

Recent findings have emphasised the key public health significance of mental health problems in childhood. At any one time, some 10 per cent of the child population in the UK are likely to be facing emotional or behavioural problems severe enough to impact on their own functioning and to place a burden on their families. As we have seen, many of these problems are persistent, leaving legacies detectable well into adult life. Biological, psychological and social factors all seem likely to contribute to the risk of psychiatric disorders, and may often act in combination.

Although children with psychiatric disorders are more likely to be in touch with services than their peers, not all will have received the specialist help required to meet their needs. The burden of mental health problems is much elevated for children whose families are stressed or disrupted and some of the most vulnerable groups are those who are dislocated from their families completely, and are in care, in custody, or homeless.

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Table 12.1 Child psychiatric disorders assessed in the 1999 ONS Survey

Emotional Disorders

Anxiety Disorders

- Separation anxiety.
- Specific phobia.
- Social phobia.
- Panic.
- Agoraphobia.
- Post Traumatic Stress Disorder (PTSD).
- Obsessive-Compulsive Disorder (OCD).
- Generalised Anxiety Disorder (GAD).
- Other anxiety.

Depression

- Depressive episode.
- Other depressive episode.

Conduct Disorders

- Oppositional defiant disorder.
- Conduct disorder (family context).
- Unsocialised conduct disorder.
- Socialised conduct disorder.
- Other conduct disorder.

Hyperkinetic disorder

- Hyperkinesis.
- Other hyperkinetic disorder.

Less Common Disorders

- Pervasive developmental disorder.
- Psychotic disorder.
- Tic disorders.
- Eating disorders.
- Other psychiatric disorders.

Sources: Mental Health of children and adolescents in Great Britain, 1999 ONS Survey