

The mental health of young people looked after by local authorities in Scotland

The summary report
of a survey carried
out in 2002/2003
by the Office for
National Statistics on
behalf of the Scottish
Executive



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About the Office for National Statistics

The Office for National Statistics (ONS) is the government agency responsible for compiling, analysing and disseminating many of the United Kingdom's economic, social and demographic statistics, including the retail prices index, trade figures and labour market data, as well as the periodic census of the population and health statistics. The Director of ONS is also the National Statistician and the Registrar General for England and Wales, and the agency that administers the registration of births, marriages and deaths there.

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1

Focus of the survey

Background

The survey of the mental health of young people looked after by local authorities in Scotland is the second, major, national survey focusing on the development and well-being of young people to be carried out by ONS. The first survey, carried out in 1999, obtained information about the mental health of nearly 900 young people living in private households in Scotland (Meltzer *et al*, 2000). Both surveys were commissioned by the Scottish Executive Education Department and the Scottish Executive Health Department.

The rationale for a national survey of the mental health of young people looked after by local authorities in Scotland was exactly the same as that for the private household population. In order to plan mental health services effectively, it is necessary to know how many children looked after by local authorities have mental health problems, what their diagnoses are, and how far their needs for treatment are being met.

Therefore, it was hoped that this first national survey of the mental health of children looked after by local authorities in Scotland would be invaluable in taking forward a number of key policy initiatives:

- Strategic service planning with health agencies.
- Understanding the stresses on placements.
- Training and support requirements of carers with a view to improve placement stability.
- Work on health inequality targets.

- Improving the health outcomes of looked after children.

Aims of the survey

Prevalence

The primary purpose of the survey was to produce prevalence rates of three main categories of mental disorder: conduct disorder, hyperactivity and emotional disorders (and their comorbidity), based on ICD-10 (International Classification of Diseases, tenth revision) and DSM-IV (Diagnostic and Statistical Manual, fourth revision) criteria.

Impact and burden

The second aim of the survey was to determine the impact and burden of children's mental health problems in terms of social impairment and adverse consequences for others. Social impairment is measured by the extent to which each particular mental problem interferes with relations with others, forming and keeping friendships, participation in leisure activities, and scholastic achievement. More broadly, impact reflects distress to the child or disruption to others as well as social impairment.

Service use

The third main purpose of the survey was to examine service utilisation. The examination of service use requires the measurement of contextual factors (lifestyle behaviours and risk factors).

Coverage of disorders

Age

The survey focused on the prevalence of mental health problems among young people aged 5–17. Although young people aged 16 and 17 were included in the previous adult surveys (Meltzer *et al*, 1995; Meltzer *et al*, 1996; Gill *et al*, 1996; Foster *et al*, 1996; Singleton *et al*, 2001), those looked after by local authorities were excluded from the previous surveys. These young adults are of particular interest in respect of the transition between the use of child and adult mental health services.

Children under the age of 5 were excluded primarily because the assessment instruments for these children are different and not so well developed as those for older children.

Childhood psychopathology

The survey concentrated on the three common groups of childhood mental disorders: emotional disorders such as anxiety, depression and obsessions; hyperactivity disorders involving inattention and overactivity; and conduct disorders characterised by awkward, troublesome, aggressive and antisocial behaviours. Some questions were included in the survey to look at the less common mental disorders: tics and twitches, pervasive developmental disorders such as those in the autistic spectrum, and eating disorders.

Placement (Type of accommodation)

The sampling design for the survey (see Chapter 2) involved taking a random sample of all children

looked after in each local authority stratified by sex, age and type of placement. Therefore, the results will show prevalence of disorders and service use by whether the child is in foster care, placed with parents or family members or in some sort of residential care facility – residential care home or school.

Region

The surveyed population comprised children and adolescents looked after by local authorities in Scotland. Children looked after by local authorities in Scotland but placed outside the local authority were included in the survey – a few cases placed in England. Corresponding surveys took place in England in 2002 (Meltzer *et al*, 2003) and in Wales in 2002/2003 (Meltzer *et al*, 2004).

Assessment of mental disorders

The survey was designed to gather data from carers, young people (aged 5–17) and teachers. The measures designed for the present study were intended to combine some of the best features of structured and semi-structured measures. When health problems 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.

A case vignette approach was used to assess the clinical significance of these descriptions. This involved clinician ratings based on a review of all the information of each subject, 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.

Interpretation of results

The findings described in this summary report focus on the prevalence of mental disorders among 5- to 17-year-olds looked after by local authorities and on the associations between the presence of a mental disorder and biographic, socio-demographic, socio-economic and social functioning characteristics of the child and the carers.

Notes and References

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders (4th edn)*, American Psychiatric Association: Washington, DC.

Foster K, Meltzer H, Gill B and Hinds K (1996) *OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 8: Adults with a psychotic disorder living in the community*, HMSO: London.

Gill B, Meltzer H, Hinds K and Petticrew M (1996) *OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 7: Psychiatric morbidity among homeless people*, HMSO: London.

Meltzer H, Corbin T, Gatward R, Goodman R and Ford T (2003) *The mental health of young people looked after by local authorities in England*, TSO: London.

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

Meltzer H, Gill B, Petticrew M and Hinds K (1995) *OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 1: the prevalence of psychiatric morbidity among adults living in private households*, HMSO: London.

Meltzer H, Gill B, Hinds K and Petticrew M (1996) *OPCS Surveys of Psychiatric Morbidity in Great Britain, Report 4 The prevalence of psychiatric morbidity among adults living in institutions*, HMSO: London.

Meltzer H, Lader D, Corbin T, Goodman R and Ford T (2004) *The mental health of young people looked after by local authorities in Wales*, TSO: London.

Singleton N, Bumpstead R, O'Brien M, Lee A and Meltzer H (2001) *Psychiatric morbidity among adults living in private households, 2000*, TSO: London.

World Health Organisation (1993) *The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research*, World Health Organisation: Geneva.

Sample design

Sample selection

Scottish local authorities keep records (including case identifier, sex, date of birth, and placement type) of looked after children in their area. These databases were used to select a sample of children (identified by a serial number only – known as the ‘child identifier’) from each local authority taking part in the survey. A total sample of 877 children was drawn, (approximately 1 in 10 of all looked after children). The sample was selected to ensure representative proportions of boys and girls in each age band between 5 and 17 years although different sampling fractions were used in each local authority depending on the estimated number of children in each local authority and its geographical location within Scotland.

All directors of Scottish Local Authority Social Work Departments in Scotland – a total of 32 – were contacted, informing them of the survey and asking for their participation.

A letter was sent to the nominated contact in the Social Work Dept in each LA asking for details of each selected child eligible for the survey, i.e. aged between 5 and 17.

In each local authority, the contact person (usually the person responsible for the ‘looked after children’ section within Social Services) was sent all the ‘Child Summary Forms’ for that local authority giving the children’s serial numbers from the sampled database. The contact then distributed the forms to the social workers responsible for the children concerned and asked them to complete the forms, having obtained whatever consents

they felt were necessary (eg consent from the foster parent, residential care home, birth parent) and then to return them to the Office for National Statistics.

The Child Summary forms returned by the Local Authorities included a number of cases where no interview could be carried out:

- cases where the child was no longer ‘looked after’ by the local authority and where the social worker was no longer in touch with the family;
- cases where the family and child had moved away and no forwarding address was available;
- cases where the child had been adopted or was in the middle of adoption proceedings;
- cases where the child’s social worker felt it was not an appropriate time for an interview, eg the child and foster family were going through a bad patch; and
- cases where the current carer did not give consent to an interview.

Interviewers were also provided with photocopies of the Child Summary Form which gave them additional information:

- the name of the local authority ‘looking after’ the child;
- the name of the person completing the form;
- whether the child is still ‘looked after’;
- whether the local authority has ‘parental control’ for the child;

- what consents have been obtained by the social worker for the interview to be carried out;
- what type of placement the child is in;
- information about the best time to call; and
- any other relevant information eg whether the child is likely to move in the near future.

Response from local authorities

All 32 Scottish local authorities co-operated to some extent in the survey.

877 Child Summary Forms were sent out to the local authorities. After six months, 756 (86%) were returned. These forms were scrutinised to check that all relevant information was properly recorded (eg the appropriate consent had been given, addresses were complete with postcode etc.)

Of the 756 returned forms, 407 (54%) were eligible. The five main reasons for ineligibility were: carer refusal (28%); the local authority refused access (18%); carer felt it was an inappropriate time (17%); child no longer cared for (14%) and child no longer in contact with local authority (13%).

Survey response rates

Information was collected on 355 of the 407 children eligible for interview (87%) from up to three sources. Almost all the carers and most of the 11- to 17-year-olds took part.

Of the 355 children in the survey, 57 were not at school either because they had finished their secondary education or had been permanently excluded. 279 of the remaining 298 carers (94%) gave permission for ONS to send a questionnaire to the teacher of the sampled child. The number of teacher questionnaires returned was 242 representing – after an initial mail out and two reminder letters – a response rate of 87%.

Child's personal characteristics

Among young people, aged 5–17 years, looked after by local authorities, 45% were assessed as having a mental disorder: 38% had clinically significant conduct disorders; 16% were assessed as having emotional disorders – anxiety and depression – and 10% were rated as hyperactive. As their name suggests, the less common disorders (pervasive developmental disorders, tics and eating disorders) were attributed to 2% of the sampled population. The overall rate of 45% includes some children who had more than one type of disorder.

These rates are based on the diagnostic criteria for research using the ICD-10 Classification of Mental and Behavioural Disorders with strict impairment criteria – the disorder causes distress to the child or has a considerable impact on the child's day to day life.

Figures 3.1 and 3.2 illustrate how the prevalence of mental disorders differ between the survey of children looked after by local authorities and the 1999 survey of those living in private households.

Concentrating first on the 5- to 10-year-olds, those looked after by local authorities were about six times more likely to have a mental disorder; 52% compared with 8%. For each type of disorder the rates for looked after children compared with private household children were:

- Emotional disorders: 14% compared with 4%.
- Conduct disorders: 44% compared with 4%.
- Hyperkinetic disorders: 11% compared with 1%.

Figure 3.1

Prevalence of mental disorders among 5- to 10-year olds: looked after and private household children

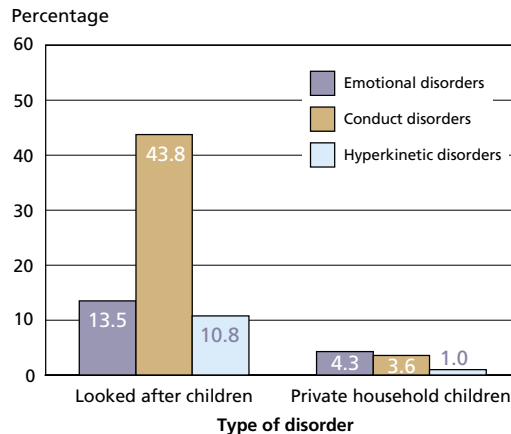


Figure 3.2

Prevalence of mental disorders among 11- to 15-year-olds: looked after and private household children

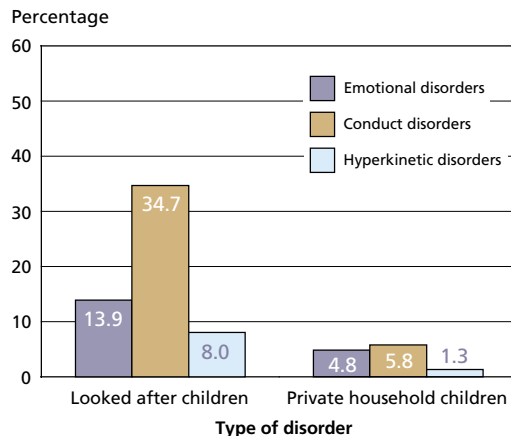
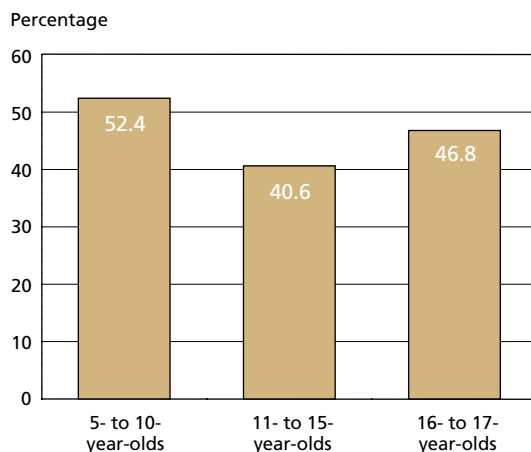


Figure 3.3
Prevalence of any mental disorder by age



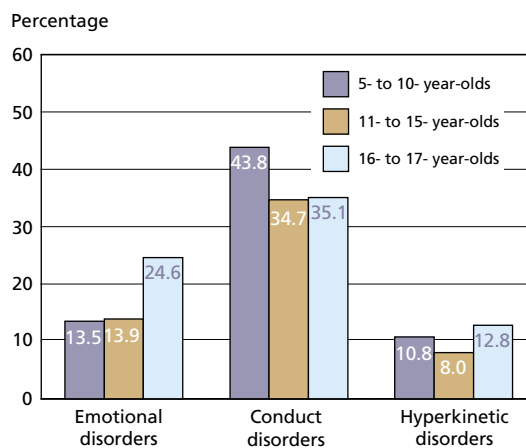
The 11- to 15-year-olds looked after by local authorities were also four times more likely to have a mental disorder: 41% compared with 9%, and the rates for each broad category of disorder were:

- Emotional disorders: 14% compared with 5%.
- Conduct disorders: 35% compared with 6%.
- Hyperkinetic disorders: 8% compared with 1%.

Therefore, conduct disorders seem to contribute to the largest difference in childhood psychopathology between the local authority and private household populations.

(Figures 3.1 and 3.2)

Figure 3.4
Prevalence of mental disorder by age



As the 16- to 17-year-olds were not covered in the private household survey of children and young people, comparisons can not be made.

Age

Although there appears to be some differences in the distribution of mental disorders by age (for example, children aged 5 –10 being more likely than older children to have conduct disorders) none of the differences are statistically significant. Because of the large sampling errors around proportions based on small samples, apparently large differences often fail to reach statistical significance.

(Figures 3.3 and 3.4)

Placement characteristics

Type of placement

Children looked after by local authorities were initially categorised into four types of placement:

- With foster carers.
- With their birth parents.
- In residential care.
- Living independently.

Half of the children placed with foster carers were assessed as having a mental disorder, compared with a 44% of those placed with their birth parents and 40% of those living in residential care. However, none of the differences was significantly different.

(Figures 4.1 and 4.2)

Range of family placements

Family placements can be divided into two categories: the child is placed with his/her own parents or a person with parental responsibility (124 children), or in foster care (137 children). For analytical purposes foster care can be further subdivided into three groups:

- Foster placement with relative or friend (17 children).
- Foster placement provided through the local authority (117 children).
- Other foster care arranged through an agency (3 children).

Figure 4.1

Prevalence of any mental disorder by placement type

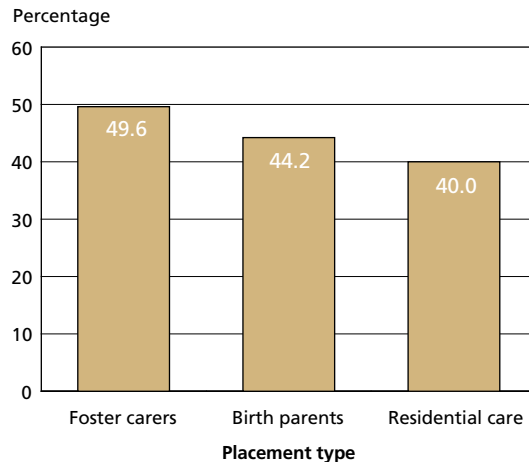
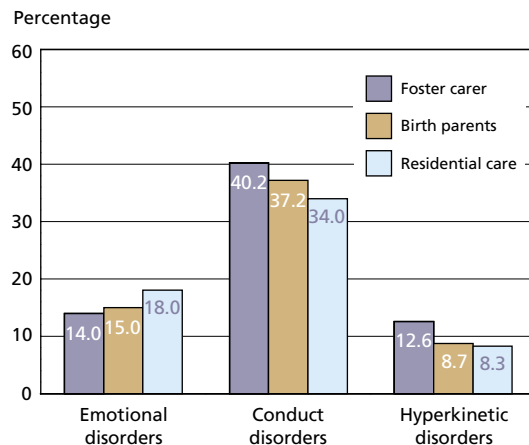


Figure 4.2

Prevalence of mental disorders by placement type



By far the largest group, were in foster care provided by the local authority or an agency. The prevalence of any childhood mental disorder among the children in this group was 51%. This rate was similar to that found among children living with their parents, 44%.

There were no differences between the type of family placements in the prevalence of the four main categories of childhood disorder.

Location of foster placement

Local authorities have different policies about placement of children in foster care. The vast majority of children throughout Scotland are placed within the boundaries of the local authority. About 9% of children in the survey lived outside the authority's boundaries. There were no significant differences in the proportions of children with emotional, conduct, and hyperkinetic disorders by location of foster placement.

Residential placements

Among the 355 survey respondents, 82 were in residential placements which comprised:

- Residential care homes (44).
- Homes and hostels (8).
- Residential schools (16).
- Secure Unit (7).
- Residential accommodation not subject to children's home regulations (1).
- Other residential placements (6).

Due to low numbers, it is not possible to look at prevalence of mental disorders for these different categories.

Residential care workers or heads of home who were interviewed about the sampled children were also asked to supply some details about their establishments: whether it specialised in children with particular problems, the number of children and the number of staff.

Of the 82 children in residential care, 34 (42%) were reported to be in placements which specialised in children with particular types of problems. The numbers were again too low to show any significant differences in the prevalence of mental disorders.

Time in current placement

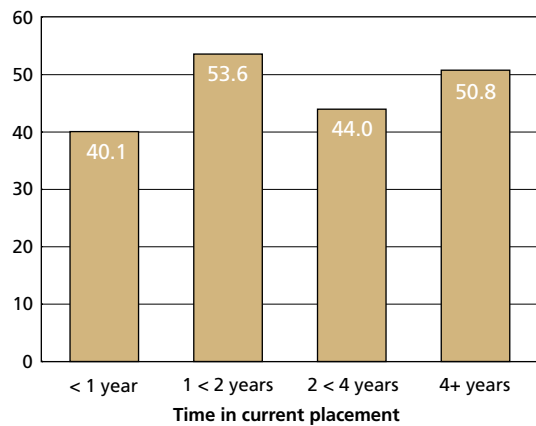
Analysis of prevalence data by time in current placement excludes the 10 children living independently and the 124 children living with their birth parents. One would expect time in current placement to have an effect, with children in relatively stable placements to show less psychopathology. However, this trend is not evident from the data. This may be due to small base numbers where huge differences are needed for statistical significance or the fact that children move placement so frequently that their current placement is a poor indicator of their placement history.

(Figure 4.3)

Figure 4.3

Prevalence of any mental disorder by time in current placement

Percentage



5

Physical complaints

This chapter looks at the extent to which general health, in particular physical complaints, co-occur with mental disorders among children and young people looked after by local authorities. In the survey, data were collected on several aspects of the health of children. All information on the child's health came from the interview with the carer.

The topics covered were:

- General health.
- Presence or absence of specified physical complaints.
- Medication.
- Life-threatening illnesses.
- Accidents and injuries.

General health

The child's general health was rated by carers on a five point scale: very good, good, fair, bad or very bad. Children with a mental disorder were no more or less likely to have fair, bad or very bad health than those with no disorder (11% compared with 17% respectively).

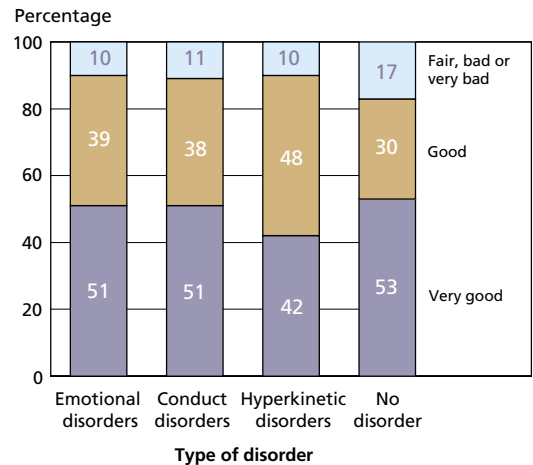
(Figure 5.1)

Physical complaints

This section looks in more detail at the characteristics of children with specific physical complaints and in particular the relationship between children's physical and mental health.

Figure 5.1

General health rating by type of mental disorder

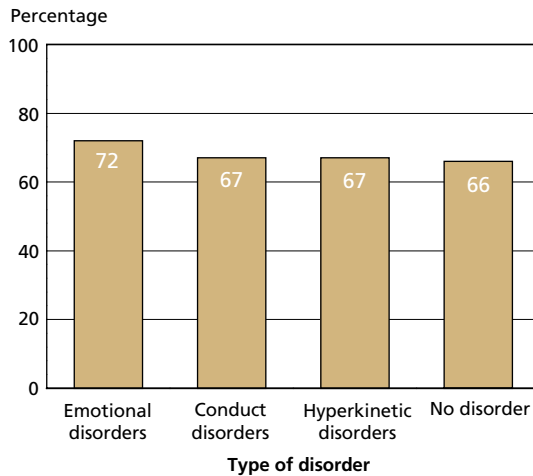


Specifically, the following question was addressed: to what extent are physical complaints more commonly found in children with mental disorders?

Two-thirds of all looked after children were reported to have at least one physical complaint. The most commonly reported physical complaints among the sample were: eye and/or sight problems (19%), bed wetting (14%), speech or language problems (12%), asthma (12%) and difficulty with co-ordination (10%).

There was no difference between children with a mental disorder and those who were assessed as not having a mental disorder in the prevalence of physical complaints. Children with all of the four

Figure 5.2
Any physical complaint by type of mental disorder



types of disorder were no more likely to have any physical complaint than those with no disorder.

(Figure 5.2)

Medication

Only 6% of the children surveyed were reported to be taking any of 14 listed forms of medication usually prescribed for childhood mental disorders. There was no difference in the prevalence of drug use between children diagnosed as having any disorder and those children with no disorder.

Three per cent of the children were taking psycho-stimulants used in the control of attention and hyperactivity disorders (Methylphenidate/ Equasym/Ritalin), less than 1% were taking anti-depressants (Fluoxetine/Prozac) and 1% were

taking anti-psychotic drugs used in the treatment of conditions including autism, manic depression and severe anxiety (Risperidone/Risperadal).

Around a fifth of children diagnosed as having hyperkinetic disorders were taking some form of medication used in the treatment of mental disorders. A seventh of those diagnosed as having hyperkinetic disorders were taking psycho-stimulants (Methylphenidate, Equasym, Ritalin), a very common form of treatment for this type of disorder, and a further 6% of this group were taking Dexamphetamine/ Dexedrine.

Life-threatening illness

Carers were asked if the child had ever been so ill that they thought s/he may die. Because many of the carers had no access to information about the child's history, they were given the option of answering that they didn't know.

There was little difference in the responses between carers of children with a disorder and those without: 6% of those with a disorder were reported to have been life-threateningly ill compared with 10% of those with no disorder.

Accidents and injuries

The general health section of the questionnaire asked carers to say whether the child had ever had four types of accident or injury.

- Head injury with loss of consciousness.
- Accident causing broken bone (excluding head injury).

- Burn requiring hospitalisation.
- Accidental poisoning requiring hospital admission.

Not unexpectedly, a broken bone was the most frequently mentioned accident, reported for 22% of children. Nine per cent of children had suffered a head injury causing loss of consciousness at some time in their lives, 6% of children had ever received a burn requiring hospital admission and 5% of children had been accidentally poisoned to the extent that they required hospitalisation in their lives.

There was no apparent association between whether the child had experienced any of the accidents and whether or not they had a mental disorder.

Service use

This chapter examines the use of health, social, educational, voluntary and juvenile justice services by children looked after by local authorities. The first part of the chapter covers general health services that the child has recently used, for example visits to the doctor, while the second part of the chapter concentrates on services contacted within the last 12 months that are more specifically related to childhood mental disorders. The first set of questions were asked of all carers while the second set of questions were asked only of those carers who indicated that the child had a significant mental health problem.

General health care services

The child's recent contact with general health care providers was examined in relation to four services:

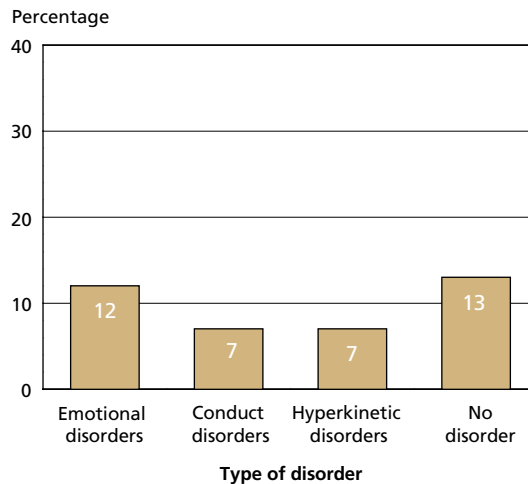
- GPs (excluding consultations for immunisation, child surveillance or development tests).
- Accident and Emergency departments.
- In-patient departments.
- Out-patient or day patient services.

GP contacts

Overall, 11% of children reported that they had visited a GP *in the past two weeks*. Nine per cent had seen their doctor once and 2% had seen the doctor two or more times.

Figure 6.1

Any GP visit in the past two weeks by type of mental disorder



Children with a mental disorder were no more or less likely to have visited their GP in the past two weeks than those without a disorder (8% compared with 13%).

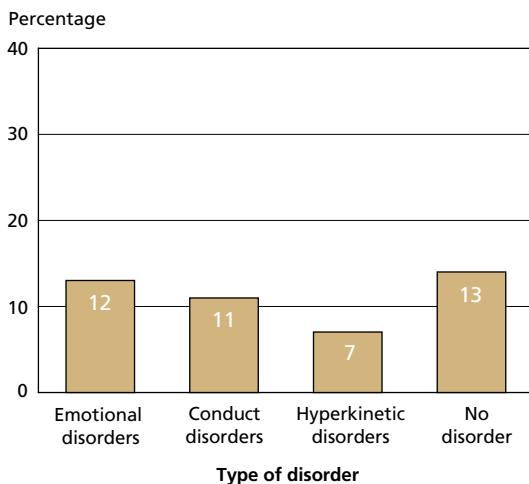
(Figure 6.1)

Accident and Emergency departments

Thirteen per cent of all the children had visited an Accident and Emergency department *in the past three months*.

There was no marked difference in the prevalence of emergency department visits within the last

Figure 6.2

Any A&E visit in the past three months by type of mental disorder

three months between children assessed as having and not having a mental disorder.

(Figure 6.2)

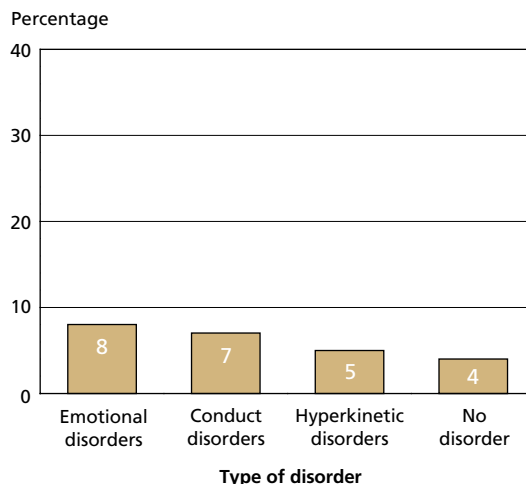
Inpatient stays

Carers were asked whether the child had had any inpatient stays in hospital, overnight or longer, *in the past three months*. Only 5% of the young people been in hospital in this time.

There was little difference between those with any childhood mental disorder and those without a disorder in the proportion of children that had had an inpatient stay in hospital.

(Figure 6.3)

Figure 6.3

Any inpatient stay in past three months by type of mental disorder**Outpatient and day patient visits**

Carers were asked whether the child had been to a hospital or clinic at all for treatment or check-ups *in the past three months*, i.e. excluding any contact with their GP, visits to casualty departments or inpatient stays. Sixteen per cent of the children had attended an outpatient department or been a day patient *in the past three months*.

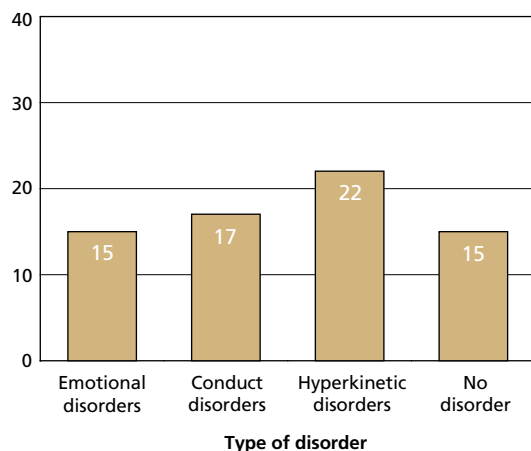
Children with any disorder were no more likely than those with no disorder to have visited a hospital either as an out patient or a day patient (18% compared with 15%).

(Figure 6.4)

Figure 6.4

Any outpatient or day patient visit in past three months by type of mental disorder

Percentage

**Use of services for significant mental health problems**

Carers who reported that the child had a significant mental health problem were shown a list of people that they or the child might come into contact with in order to get help. They were asked to say who they had sought help from *in the past year*.

For descriptive purposes, the sources of help were subsumed under three headings: specialist services (for example, mental health experts and special education services); front line services (including GPs and social workers); informal sources of help (such as self-help groups or the internet). Contact with the Children's Panel is shown separately.

Although this question was asked of every carer who indicated the child had a significant mental health problem, not all of these children were subsequently found to have a mental disorder after clinical review. Similarly, not all the children assessed as having a mental disorder after clinical review were asked the question if the carer did not regard the child as having a significant mental health problem.

The majority of the children with a significant mental health problem had been in contact with at least one of the services during the past year (88%). Front line services were by far the most common source of help with 76% of children having been in contact with a social worker in the past year and two-fifths, 40%, having seen a teacher. A fifth of children had also received advice or treatment from a GP or family doctor.

Specialist services were also commonly used with a quarter of children having been in touch with a specialist in child mental health, 27%, and 22% having had some contact with special education services (eg Special Educational Needs Co-ordinators and Education Welfare Officers).

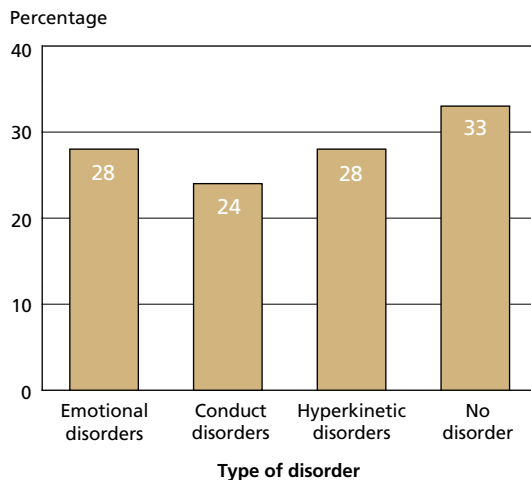
Over a third (36%) of children had been in contact with a Children's Panel.

Other than talking to a family member or friend, which 30% of carers reported doing, informal services were very rarely used.

In trouble with the police

Overall, 29% of children had been in trouble with the police in the past 12 months.

Figure 6.5
Ever been in trouble with the police by type of mental disorder



Children with a mental disorder were no more likely than those with no disorder to report that they had been in trouble with the police.

(Figure 6.5)

Carers who had indicated that the child had a significant problem were additionally asked if the child had been seen by a youth justice worker. Overall, 6% of the children had seen a youth justice worker.

Scholastic ability and education

The aim of this chapter is to describe the educational profile of children looked after by local authorities and to examine the relationship between mental disorders and scholastic achievement. The data presented here mainly come from the postal questionnaire returned by the child's teacher and focus on 5- to 15-year-olds.

The topics covered in this chapter are:

- Teachers' assessments of the child's reading, spelling and mathematical abilities.
- Whether the child is behind for his/her age, and if so, how far behind.
- Whether the child has special educational needs (SEN).
- Absenteeism from school.
- Truancy.

Reading, mathematics and spelling

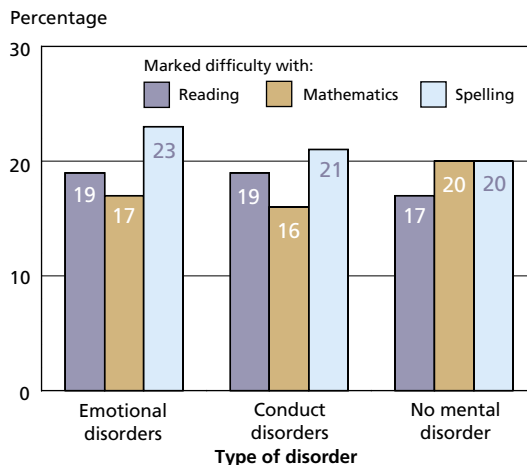
Teachers were asked to rate each child in terms of whether they were above average, average, had some difficulty or experienced marked difficulty with reading mathematics and spelling. Between 50% and 60% of all looked after children had some degree of difficulty with at least one of these three abilities.

Children with a mental disorder were no more likely than children with no disorder to have marked difficulties with each of the three abilities.

(Figure 7.1)

Figure 7.1

Marked difficulty with reading, mathematics and spelling by type of mental disorder



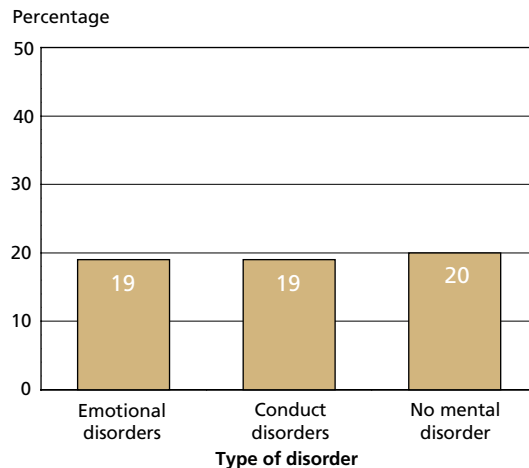
Overall scholastic ability

Teachers were asked to estimate at what age the child was at in terms of his/her scholastic and intellectual ability. For analytical purposes the child's age was subtracted from his/her functioning age. Overall, 59% of all children were reported to be at least one year behind in their intellectual development. This comprised 41% of children who were one or two years behind and 19% who were three or more years below the level expected for their age.

There were no significant differences between those children with and those without a mental disorder.

(Figure 7.2)

Figure 7.2
Scholastic ability (3 or more years behind) by type of mental disorder



Special educational needs

Teachers were asked whether the child had any officially recognised special needs, and if so, to rate the level of special needs according to the five recognised stages:

- Stage 1 – Class teacher or form/year tutor has overall responsibility.
- Stage 2 – SEN co-ordinator takes the lead in co-ordinating provision and drawing up individual educational plans.
- Stage 3 – External specialist support enlisted.
- Stage 4 – Statutory assessment by Local Education Authority (LEA).
- Stage 5 – SEN Statement issued by LEA.

About a third of children had officially recognised special educational needs, and only a small number, 5%, had a statement issued by the local education authority.

Although children with a mental disorder appeared more likely to have officially recognised special educational needs (39% compared with 26% of those with no mental disorder) the difference was not statistically significant.

(Figure 7.3)

Absenteeism from school

Teachers were asked how many days the child had been absent during the last term. Overall, 69% of all children had been absent from school for a day or more during the previous term. Forty-two per cent had been away from school for up to a week and 27% had been away for more than a week.

The presence of a mental disorder or a physical illness seemed to have little effect on absenteeism from school. Higher rates of school absence were found among children placed with birth parents.

Truancy

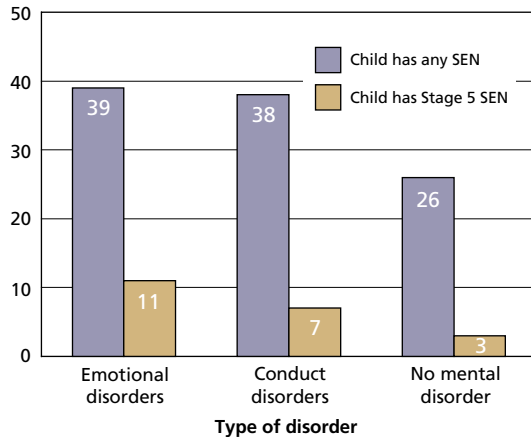
All three types of respondent (young person, carer and teacher) were asked about truanting. However, because of differences in question wording, type of administration and routing it is difficult to directly compare the information which was collected from the three sources.

The question directed at carers was: (In the past

Figure 7.3

Special educational needs by type of mental disorder

Percentage



12 months) Has s/he often played truant ('bunked off') from school? This was only asked of carers of children who were more troublesome than average. According to carers, 27% of the children had 'definitely' and 4% had 'perhaps' often played truant in the past year. Children who had a mental disorder were no more likely than those without a disorder to have 'definitely' played truant in the past year according to carers.

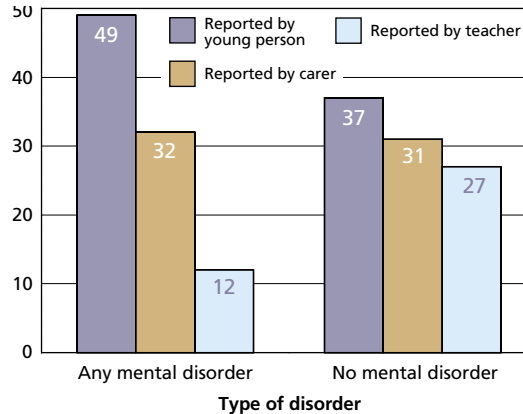
(Figure 7.4)

The wording of the truancy question for the 11- to 15-year-olds was the same as that asked of carers. Twenty-six per cent of the young people reported that they had 'definitely' and 17% had 'perhaps' played truant in the past year. Whereas carers may have been unsure whether their children were playing truant, the young people themselves must have known. Therefore, those in the 'perhaps' category were probably in the

Figure 7.4

Truancy by type of mental disorder by source of information

Percentage



'definitely' category but were concerned about admitting it. Young people with a disorder were not significantly more likely than other children to have reported truancy behaviour.

(Figure 7.4)

The question on truancy presented to teachers was different to those addressed to parents and children because teachers did not have a face-to-face interview but were sent a postal questionnaire. The questionnaire included the statement: 'plays truant' and the teacher was asked to respond by ticking one of three boxes labelled, not true, partly true or certainly true. According to the teachers, 19% of children played truant. Surprisingly, this percentage represents 12% of children assessed as having a mental disorder but 27% of those with no disorder.

(Figure 7.4)

8

Social networks and lifestyle behaviours

This chapter focuses on several aspects of the social life of children: their friendships, help-seeking behaviour and lifestyle. The term, lifestyle behaviour, is used here to cover smoking, drinking, drug use and sexual activity.

Friendships

The presence of a mental disorder seemed to have little effect on most of the friendship measures: having a best friend, having friends as confidantes, or belonging to clubs.

Help-seeking behaviour

All 11- to 17-year-olds were asked if they had ever felt so unhappy or worried that they had asked someone for help. Around a third of all children, 34%, had sought help because they had felt unhappy or worried.

There was little variation from the overall pattern of help-seeking behaviour when looked at by age, length of time in current placement or by mental disorder.

The majority of children who had sought help, 64%, wanted a chance to talk things over, 8% required practical advice and a just over a quarter (28%) were seeking both practical advice and a chance to talk things over.

Smoking, drinking and drug use

Questions on smoking, drinking and drug use were included in the survey so that the use of these substances among looked after children could be examined. The questions on these lifestyle behaviours were included in the self-completion part of the interview and were asked of all 11- to 17- year-olds.

Smoking

Children were categorised into four groups according to their smoking behaviour: current smokers, ex smokers, children who had tried it once and those who had never smoked. Children were classed as current smokers if they said 'yes' to the question; 'Do you smoke at all these days?'

Overall, 44%, of the 11- to 17-year-olds were current smokers and only 27% had never tried smoking. The existence of mental disorders was not associated with smoking behaviour.

Drinking

Children were placed into six groups in terms of their alcohol consumption: almost every day, once or twice a week, once or twice a month, a few times a year, does not drink alcohol now and never had an alcoholic drink: 38% of 11- to 17-year-olds had never had an alcoholic drink and a quarter drank at least once a month.

Young people with a mental disorder were no more likely to be regular drinkers than young people with no mental disorder.

Twelve per cent of all children who drink started doing so at the age of ten years or under. Children with a mental disorder were not significantly more likely to start drinking at a young age than those without a mental disorder.

Drug-taking

Children in the survey were asked a series of questions about ten different drugs they might have taken. The questions they were asked were:

- Had they heard of the drug?
- Had they ever been offered the drug?
- Had they ever used the drug?
- If they had used the drug, was this over a year ago, in the past year or in the past month?

The most frequently reported drug that had been used was cannabis which 39% of all children had used at some point in their lives. Of these children half, 21%, had used it in the past month.

Children with a mental disorder were no more likely than children with no disorder to have used cannabis in the past month.

The next most frequently mentioned drugs after cannabis were ecstasy and glue, gas or solvents. The pattern for use of these drugs was the same as that for cannabis use and the greatest proportions were found among children in residential care.

Sexual activity

Young people aged 11–17 were asked about two aspects of their sexual behaviour:

- their awareness of HIV/AIDS (including whether it had been taught in school and whether they discussed it with carers or other relatives); and
- their own sexual activity and use of contraception.

Nearly three-quarters (73%) of the young people reported that they had been taught about AIDS/HIV infection at school.

Over two-fifths, 43%, of the young people said that they had discussed HIV or AIDS with their carers or other adults. The presence of a mental disorder seemed to have no influence on whether the young person had talked about HIV or AIDS with their carer.

Around a third of all the young people (38%) reported that they had had sexual intercourse. Young people who had experienced sexual abuse or rape were excluded from the analyses as it is not possible to ascertain whether they were talking about this experience or separate sexual activity and as a result the level of sexual activity reported in the survey could be falsely high. Almost a fifth, 17%, of the young people had experienced some sexual abuse or rape.

Children who had a mental disorder were not likely than those with no disorder to report having had sexual intercourse.

Further information about the survey can be obtained from:

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