

PART 2

Prevalence of mental disorders in children and adolescents

A key aim of the survey was to provide current estimates of the prevalence of mental disorders in Australian children and adolescents.

Parents and carers were asked to complete a questionnaire with a trained interviewer consisting of 22 modules. This included a number of diagnostic modules to determine the prevalence of mental disorders in children and adolescents.

The *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) is a validated tool for identifying mental disorders in children and adolescents according to criteria specified in the *Diagnostic and Statistical Manual for Mental Disorders Version IV* (DSM-IV). The DISC-IV was the main tool used to assess mental disorders in children and adolescents. Modules from the DISC-IV administered to parents and carers included:

- Anxiety disorders
 - Social phobia
 - Separation anxiety disorder
 - Generalised anxiety disorder
 - Obsessive-compulsive disorder
- Major depressive disorder
- Attention-deficit/hyperactivity disorder
- Conduct disorder

Responses from parents and carers provided the information necessary for diagnoses of each of these mental disorders according to the DSM-IV diagnostic classification, as well as a measure of the impact of these disorders.

2 OVERVIEW OF MENTAL DISORDERS (DISC-IV)

Diagnostic modules from the *Diagnostic Interview Schedule for Children Version IV* (DISC-IV) were used to assess the seven most common and disabling mental disorders experienced by children and adolescents. These included major depressive disorder, attention-deficit/hyperactivity disorder (ADHD), conduct disorder, and four anxiety disorders. Anxiety is not a single disorder, but a class of disorders, and children and adolescents were assessed for the four anxiety disorders that are most common and cause the greatest distress, namely: social phobia, separation anxiety, generalised anxiety and obsessive-compulsive disorder. The DISC-IV is a standardised instrument used worldwide and developed under the auspices of the United States National Institute of Mental Health. It was used in the first child and adolescent survey in Australia in 1998 and again in this survey to assess the prevalence of mental disorders and the severity of impact of these on Australian children and adolescents.

2.1 Overall prevalence of mental disorders in children and adolescents

In the 12 months prior to the survey around one in seven (13.9%) children and adolescents aged 4-17 years experienced a mental disorder (Table 2-1). This is equivalent to an estimated 560,000 Australian children and adolescents.

ADHD was the most common mental disorder overall, with 7.4% of children and adolescents assessed as having ADHD in the previous 12 months. Anxiety disorders were the next most common (6.9%), followed by major depressive disorder (2.8%) and conduct disorder (2.1%).

2.1.1 Sex and age differences

The prevalence of mental disorders varied considerably between males and females, with 16.3% of males and 11.5% of females having had a mental disorder in the previous 12 months.

The difference between the sexes was mainly due to the higher prevalence of ADHD in males (10.4% compared with 4.3% for females). Conduct disorder was also more common in males (2.5%) than females (1.6%). However, the rate of depression was slightly higher in females (3.1% compared with 2.5% in males). There was little difference in the prevalence of anxiety disorders.

Table 2-1: 12-month prevalence of mental disorders among 4-17 year-olds by sex

Disorder	Males population estimate	Males prevalence (%)	Females population estimate	Females prevalence (%)	Persons population estimate	Persons prevalence (%)
Anxiety disorders	145,000	7.0	133,000	6.8	278,000	6.9
Major depressive disorder	50,900	2.5	61,300	3.1	112,000	2.8
ADHD	215,000	10.4	83,200	4.3	298,000	7.4
Conduct disorder	52,400	2.5	31,200	1.6	83,600	2.1
Any mental disorder (a)	335,000	16.3	225,000	11.5	560,000	13.9

(a) Totals are lower than the sum of disorders as children and adolescents may have had more than one class of mental disorder in the previous 12 months.

There were some distinct differences in the prevalence of disorders between children and adolescents (Table 2-2).

ADHD continued to be the most common disorder for males into their teen years (10.9% for 4-11 year-olds and 9.8% for 12-17 year-olds), but the prevalence halved for females (5.4% for 4-11 year-olds to 2.7% for 12-17 year-olds).

The prevalence of major depressive disorder was higher in adolescents compared to those aged 4-11 years for both sexes. Among those aged 4-11 years prevalence was almost the same at 1.2% for females and 1.1% for males. However, among adolescents the prevalence of major depressive disorder was 5.8% for females and 4.3% for males.

Table 2-2: 12-month prevalence of mental disorders among 4-17 year-olds by sex and age group

Disorder	Males 4-11 years (%)	Males 12-17 years (%)	Females 4-11 years (%)	Females 12-17 years (%)	Persons 4-11 years (%)	Persons 12-17 years (%)
Anxiety disorders	7.6	6.3	6.1	7.7	6.9	7.0
Major depressive disorder	1.1	4.3	1.2	5.8	1.1	5.0
ADHD	10.9	9.8	5.4	2.7	8.2	6.3
Conduct disorder	2.5	2.6	1.6	1.6	2.0	2.1
Any mental disorder	16.5	15.9	10.6	12.8	13.6	14.4

2.2 Social and demographic characteristics

Several socio-demographic characteristics were examined for their association with the prevalence of mental disorders. These included family type, household income, level of parent and carer education, parent and carer labour force status, area of residence and family functioning. Table 2-3 to Table 2-8 show the relationships of these characteristics to the prevalence of mental disorders.

Children and adolescents in low-income families, with parents and carers with lower levels of education and with higher levels of unemployment had higher rates of mental disorders in the previous 12 months. There was also a strong relationship with where they lived with higher rates of mental disorders in non-metropolitan areas. This was particularly evident in males. However, while it is possible to identify sub-groups in which the prevalence of mental disorders is relatively high, it is not possible to draw conclusions about the causal relationships between these demographic characteristics and mental illness, or to exclude the possibility that the association may be due to another factor with which both are associated.

2.2.1 Family type

Table 2-3 shows the prevalence of mental disorders for children and adolescents in different types of families. Young people in step, blended and one parent or carer families had higher rates of mental disorders than young people living in original families, that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The prevalence was higher for males than females in both two parent and one parent families.

Table 2-3: 12-month prevalence of mental disorders among 4-17 year-olds by family type and sex

Family type	Males (%)	Females (%)	Persons (%)
Families with two parents or carers	13.9	9.6	11.8
Original family	12.4	8.4	10.4
Step family	21.1	15.6	18.3
Blended family	24.0	16.4	20.2
Other family (a)	29.5	18.4	23.7
Families with one parent or carer	25.3	19.2	22.4

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

2.2.2 Household income

Table 2-4 shows the association of the prevalence of mental disorders with income. Children and adolescents in families in the lowest income bracket (less than \$52,000 per year or \$1,000 per week) had the highest rate of mental disorders in the previous 12 months, with this being almost double that of young people in the highest income bracket (\$130,000 or more per year or \$2,500 or more per week) (24.4% and 12.3% respectively in males and 16.1% and 8.8% respectively in females).

Table 2-4: 12-month prevalence of mental disorders among 4-17 year-olds by household income and sex

Household income before tax	Males (%)	Females (%)	Persons (%)
\$130,000 or more per year	12.3	8.8	10.5
\$52,000-\$129,999 per year	13.8	10.8	12.3
Less than \$52,000 per year	24.4	16.1	20.5

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

2.2.3 Parent and carer education

Table 2-5 shows the highest level of education of either the young person's primary or secondary parent or carer where present.

Males from families where the highest level of education of either parent or carer was year 10 or below had the highest rates of mental disorders in the previous 12 months (26.2%). This was over twice as high as females in the same category (12.7%) and males whose primary and/or secondary parent or carer had a bachelor or higher degree (12.5%).

Table 2-5: 12-month prevalence of mental disorders among 4-17 year-olds by parent or carer education and sex

Highest level of education of either primary or secondary parent or carer	Males (%)	Females (%)	Persons (%)
Bachelor degree or higher	12.5	8.8	10.6
Diploma or certificate III/IV	17.0	14.5	15.8
Year 11 or 12	19.4	10.6	15.4
Year 10 or below	26.2	12.7	19.7

2.2.4 Parent and carer labour force status

Children and adolescents with no parents or carers in employment had higher rates of mental disorders than children and adolescents living in households with one or both parents or carers in employment (Table 2-6). The highest rates of mental disorder were in families in which the sole parent or carer was not in employment, where 29.6% of children and adolescents had mental disorders in the previous 12 months. The rate was markedly less when the sole parent or carer was employed (17.0%).

Table 2-6: 12-month prevalence of mental disorders among 4-17 year-olds by parent or carer labour force status and sex

Parent or carer labour force status	Males (%)	Females (%)	Persons (%)
Both parents or carers employed	12.6	9.0	10.8
One parent or carer employed, one parent or carer not in employment	15.5	10.1	12.9
Both parents or carers not in employment	23.4	18.7	21.3
Sole parent or carer employed	16.9	17.1	17.0
Sole parent or carer not in employment	36.0	22.0	29.6

'Not in employment' combines unemployed and not in the labour force.

2.2.5 Area of residence

Children and adolescents who lived outside of the greater capital city areas had higher rates of mental disorders compared with those living in other areas (Table 2-7). This was particularly so for males, with almost one in five (19.6%) young males residing outside of the greater capital city areas having had a mental disorder in the previous 12 months.

Table 2-7: 12-month prevalence of mental disorders among 4-17 year-olds by area of residence and sex

Area of residence	Males (%)	Females (%)	Persons (%)
Greater capital cities	14.2	11.0	12.6
Rest of state	19.6	12.4	16.2

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

2.2.6 Family functioning

A shortened version of the general functioning subscale of the McMaster Family Assessment Device was used to assess the level of family functioning. This covers issues such as communication and planning within the family, dealing with conflict, and levels of emotional and practical support. Of all families in the survey 3.7% had a level of family functioning assessed on the McMaster scale as poor, indicating unhealthy family functioning likely to require clinical intervention.

Table 2-8 shows that the prevalence of mental disorders increased with decreasing levels of family functioning. Just over one third (35.3%) of young people in families with poor family functioning had a mental disorder. However, 15.3% in families with good family functioning and 10.9% in those with very good family functioning had a disorder. Similar associations were observed for both sexes.

Table 2-8: 12-month prevalence of mental disorders among 4-17 year-olds by level of family functioning

Level of family functioning	Males (%)	Females (%)	Persons (%)
Very good	12.7	9.1	10.9
Good	16.7	13.8	15.3
Fair	25.3	13.5	19.7
Poor	36.4	33.8	35.3

2.3 Impact of mental disorders

2.3.1 Severity of impact on functioning

One of the key aims of the survey was to determine the severity of the impact of mental disorders on the functioning of young people and, in particular, how this impact was associated with various facets of their lives. The survey measured the severity of impact of mental disorders in four different domains of functioning: At school or work, with friends and social activities, on the family and on the children themselves. This information also allowed estimating the overall severity of impact of mental disorders across all of these domains. Severity of impact was classified to be mild, moderate or severe. To ease interpretation, throughout this publication, the terms “severity of impact on function”, “severity of impact”, and “severity of disorder” or just “severity” will be used interchangeably, or the phrases mild disorder, moderate disorder and severe disorder will be used.

Overall 13.9% of children and adolescents aged 4-17 years had mental disorders with 8.3% having mild severity of impact, 3.5% had moderate severity of impact and 2.1% had severe disorder (Table 2-9).

For children with anxiety disorders, ADHD and conduct disorder the majority of these had a mild impact on functioning, with fewer that were moderate and fewer again severe. However, the converse was true with major depressive disorder, with the largest proportion of children (42.9% of those with major depressive disorder or 1.2% of all 4-17 year-olds) classified as having a severe impact, less as moderate (1.0% of 4-17 year-olds) and less again as mild (0.6% of 4-17 year-olds).

Table 2-9: 12-month prevalence of mental disorders among 4-17 year-olds by type of disorder and severity

Disorder	Mild (%)	Moderate (%)	Severe (%)	Total (%)
Any anxiety disorder	3.7	1.9	1.3	6.9
Major depressive disorder	0.6	1.0	1.2	2.8
ADHD	4.9	1.8	0.8	7.4
Conduct disorder	1.2	0.5	0.4	2.1
Any mental disorder	8.3	3.5	2.1	13.9

Three fifths (59.8%) of children and adolescents with a mental disorder had disorders with a mild impact on functioning, one quarter (25.4%) were moderate, and 14.7% were assessed as severe. There was little difference in the proportions of males and females at each level of impact. There were, however, marked differences between children and adolescents, with almost three times as many adolescents as children with mental disorders with severe impact (23.1% for 12-17 year-olds compared with 8.2% for 4-11 year-olds). In contrast, far more children had disorders with mild impact than adolescents (72.1% of 4-11 year-olds compared with 44.1% of 12-17 year-olds) (Table 2-10).

Table 2-10: Severity of mental disorders among 4-17 year-olds with mental disorders by sex and age group

Sex	Age group	Mild (%)	Moderate (%)	Severe (%)
Males	4-11 years	69.8	20.4	9.9
	12-17 years	44.4	31.9	23.7
	4-17 years	59.2	25.2	15.6
Females	4-11 years	75.9	18.5	5.6
	12-17 years	43.8	33.9	22.4
	4-17 years	60.8	25.8	13.4
Persons	4-11 years	72.1	19.7	8.2
	12-17 years	44.1	32.8	23.1
	4-17 years	59.8	25.4	14.7

When children and adolescents had mental disorders, slightly more of these disorders had a severe impact in the domains of family and school or work than in the domains of friends and self (19.5% and 17.6% compared with 12.4% and 14.4% respectively). Overall 15.0% of children and adolescents with mental disorders had no impact on functioning in the domain of school or work, 26.5% had no impact in the friends domain, 14.4% had no impact in the family domain, and 14.8% had no impact on self (Table 2-11).

Table 2-11: Severity of impact in different life domains among 4-17 year-olds with mental disorders

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	15.0	26.5	14.4	14.8	
Mild	34.5	29.7	35.2	39.8	59.8
Moderate	29.3	31.4	30.8	31.0	25.4
Severe	17.6	12.4	19.5	14.4	14.7
Does not go to school or work	3.6				

2.3.2 Days absent from school

Where parents or carers reported symptoms of mental disorders in their children, they were asked how many days in the previous 12 months the child or adolescent was absent from school due to those symptoms. Because of the way the questions were asked it was not possible to calculate the total number of days absent from school due to any mental disorder if the child or adolescent had more than one disorder. Major depressive disorder was associated with the highest average number of days absent from school (20 days), followed by anxiety disorders (12 days), conduct disorder (8 days) and ADHD (5 days) (Table 2-12).

Table 2-12: Average days absent from school in past 12 months due to symptoms of mental disorders among 4-17 year-olds with mental disorders by type of disorder

Disorder	Average days absent
Any anxiety disorder	12
Major depressive disorder	20
ADHD	5
Conduct disorder	8

2.4 Comorbidity

Children and adolescents may experience more than one mental disorder within the same time period and this is referred to as comorbidity. Of the 13.9% of children and adolescents diagnosed with a mental disorder almost one third (30.0% or 4.2% of all 4-17 year-olds) had two or more disorders at some time in the previous 12 months. For this purpose the class of anxiety disorders have been considered as a single disorder and children could have a maximum of four disorders.

Over half of the children and adolescents with major depressive disorder (1.6% of all 4-17 year-olds) also had an anxiety disorder (Figure 2-1). Two thirds of the children and adolescents with conduct disorder also had another disorder (1.4% out of the 2.1% of all 4-17 year-olds with conduct disorders). One third of the children and adolescents with either anxiety disorders or major depressive disorder also had conduct disorder or ADHD in the previous 12 months (2.6% out of the 8.1% of all 4-17 year-olds with either or both). A small proportion of children and adolescents (0.4%) experienced three

classes of mental disorder (anxiety disorders or major depressive disorder, ADHD and conduct disorder) in the previous 12 months (Figure 2-2).

Figure 2-1: Comorbidity of anxiety disorders and major depressive disorder among 4-17 year-olds

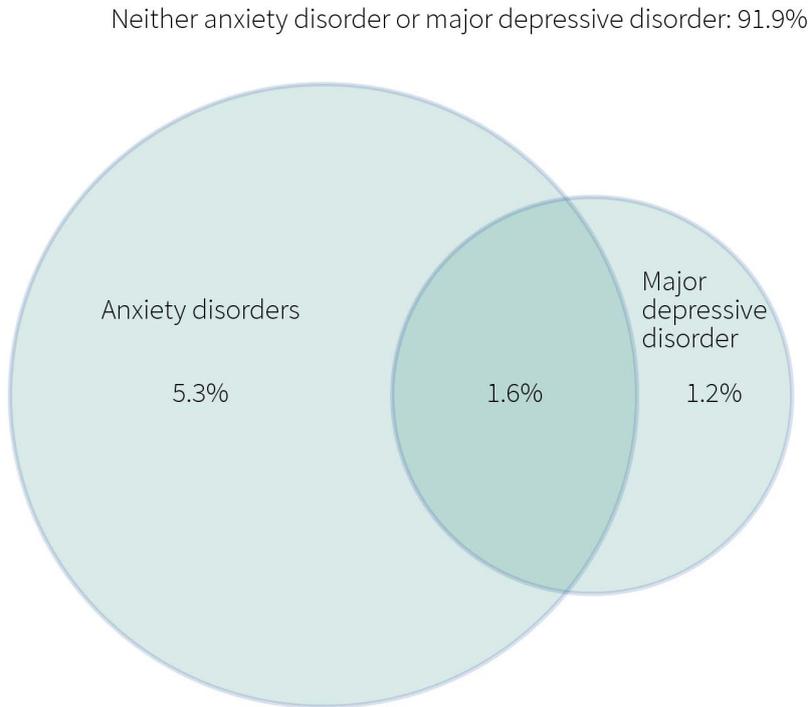
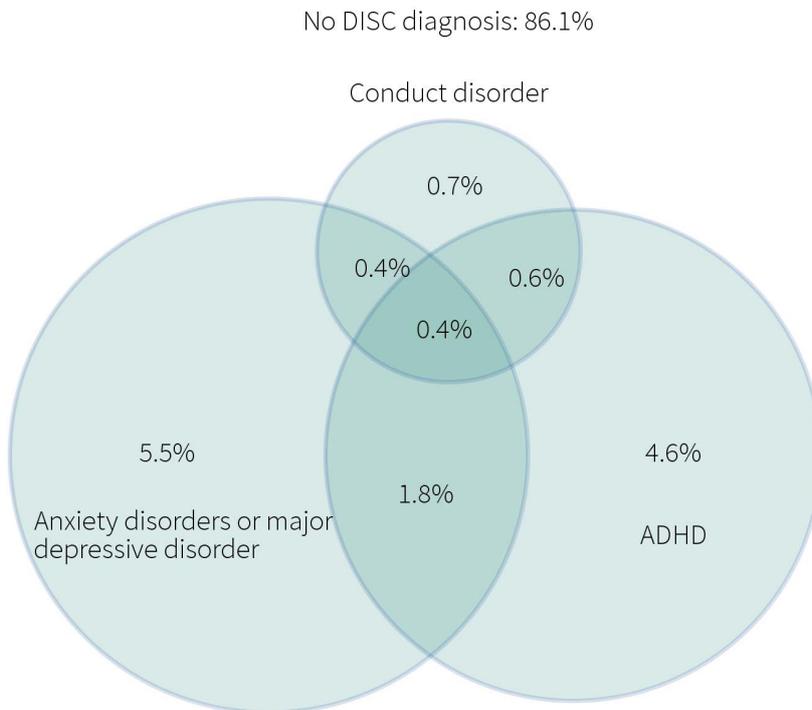


Figure 2-2: Comorbidity of anxiety or major depressive disorders, conduct disorder and ADHD among 4-17 year-olds



2.5 Principal condition

When a child or adolescent was found to have experienced more than one disorder in the previous 12 months, his or her parent or carer was asked which of the disorders caused the most distress to the child. This approach allows each person to be uniquely assigned to a principal condition.

ADHD and anxiety disorders were the most commonly identified principal conditions but their relative importance differed for males and females. ADHD was the most common principal condition for males (7.9%), while anxiety disorders were the most common principal condition for females (5.1%). Males and females had comparable rates of anxiety disorders (5.6% compared with 5.1%), major depressive disorder (1.6% compared with 2.4%) and conduct disorder (1.1% compared with 1.0%). However ADHD was more common identified as the principal condition in males than females (7.9% compared with 3.1%) (Table 2-13).

Table 2-13: Principal condition by sex

Disorder	Males (%)	Females (%)	Persons (%)
Any anxiety disorder	5.6	5.1	5.4
Major depressive disorder	1.6	2.4	2.0
ADHD	7.9	3.1	5.5
Conduct disorder	1.1	1.0	1.1
Any disorder	16.3	11.5	13.9

ADHD and anxiety disorders were both commonly identified as the principal condition for children and adolescents. However, ADHD was the most common principal condition for children aged 4-11 years while parents and carers identified that anxiety disorders were most common in adolescents aged 12-17 years (Table 2-14).

Table 2-14: Principal condition by age group

Disorder	4-11 years (%)	12-17 years (%)	4-17 years (%)
Any anxiety disorder	5.7	5.0	5.4
Major depressive disorder	0.6	3.8	2.0
ADHD	6.3	4.5	5.5
Conduct disorder	1.0	1.1	1.1
Any disorder	13.6	14.4	13.9

3 MAJOR DEPRESSIVE DISORDER

This chapter presents data on children and adolescents who met diagnostic criteria as specified in DSM-IV for major depressive disorder based on information reported by parents and carers. The prevalence of major depressive disorder based on information reported by young people themselves is presented in Chapter 10.

Major depressive disorder

The key feature of major depressive disorder is the presence of either depressed mood, loss of interest or pleasure or being grouchy, irritable and in a bad mood. The DSM-IV criteria specify that at least five symptoms of depression must be present for a minimum of a two-week period, that these symptoms cause clinically significant distress to the child or adolescent and that they must interfere with the child or adolescent's normal functioning at school, at home or in social settings. Symptoms of major depressive disorder may include significant weight loss or weight gain, loss of appetite, insomnia or hypersomnia, restlessness, fatigue and loss of energy, feelings of worthlessness and inability to concentrate.

3.1 Prevalence of major depressive disorder in children and adolescents

Overall 2.8% of children and adolescents aged 4-17 years met diagnostic criteria for major depressive disorder (Table 3-1). This corresponds to an estimated 112,000 children and adolescents in Australia with major depressive disorder. The prevalence of major depressive disorder in children aged 4-11 years was 1.1% in males and 1.2% in females. The prevalence of major depressive disorder was higher in the older age group. Some 4.3% of males 12-17 years and 5.8% of females 12-17 years had major depressive disorder.

Table 3-1: 12-month prevalence of major depressive disorder among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	1.1	1.2	1.1
12-17 years	4.3	5.8	5.0
4-17 years	2.5	3.1	2.8

3.2 Social and demographic characteristics

Table 3-2 through Table 3-7 show the 12-month prevalence of major depressive disorder by a range of socio-demographic characteristics, including family type, household income, parent or carer education and labour force status, area of residence and family functioning. Overall prevalence of depression was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

3.2.1 Family type

The prevalence of major depressive disorder was lowest in original families (1.7%), that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The prevalence of major depressive disorder was higher for young people in step families (4.7%), and in families with just one parent or carer (5.5%) (Table 3-2).

Table 3-2: 12-month prevalence of major depressive disorder among 4-17 year-olds by family type

Family type	Prevalence (%)
Families with two parents or carers	2.1
Original family	1.7
Step family	4.7
Blended family	3.5
Other family (a)	9.4
Families with one parent or carer	5.5

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

3.2.2 Household income

The prevalence of major depressive disorder was lowest in families with higher household incomes (1.8% in families with a household income of \$130,000 or more per year) and highest (3.8%) in families in the lowest household income bracket (Table 3-3).

Table 3-3: 12-month prevalence of major depressive disorder among 4-17 year-olds by household income

Household income before tax	Prevalence (%)
\$130,000 or more per year	1.8
\$52,000-\$129,999 per year	2.7
Less than \$52,000 per year	3.8

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

3.2.3 Parent and carer education

The differences in the prevalence of major depressive disorder by parent or carer education were small and not statistically significant (Table 3-4).

Table 3-4: 12-month prevalence of major depressive disorder among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Prevalence (%)
Bachelor degree or higher	2.1
Diploma or certificate III/IV	3.0
Year 11 or 12	4.1
Year 10 or below	3.5

3.2.4 Parent and carer labour force status

The prevalence of major depressive disorder was higher in families with a sole parent or carer not in employment (6.9%) compared with families with two parents or carers both in employment (1.8%) (Table 3-5).

Table 3-5: 12-month prevalence of major depressive disorder among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Prevalence (%)
Both parents or carers employed	1.8
One parent or carer employed, one parent or carer not in employment	2.4
Both parents or carers not in employment	4.9
Sole parent or carer employed	4.6
Sole parent or carer not in employment	6.9

'Not in employment' combines unemployed and not in the labour force.

3.2.5 Area of residence

There was no difference in the prevalence of major depressive disorder for children and adolescents living in greater capital city areas compared with those living in other areas (Table 3-6).

Table 3-6: 12-month prevalence of major depressive disorder among 4-17 year-olds by area of residence

Area of residence	Prevalence (%)
Greater capital cities	2.8
Rest of state	2.8

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

3.2.6 Family functioning

The prevalence of major depressive disorder was higher in children and adolescents from families with poorer levels of family functioning, varying from 2.1% for those with very good family functioning up to 7.7% for those with poor family functioning.

Among adolescents aged 12-17 years, the prevalence of major depressive disorder was 4.2% in families with very good functioning and 11.6% in families with poor functioning (Table 3-7).

Table 3-7: 12-month prevalence of major depressive disorder among 4-17 year-olds by level of family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	0.8	4.2	2.1
Good	1.5	4.8	3.0
Fair	1.5	7.0	4.1
Poor	3.8	11.6	7.7

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

3.3 Impact of major depressive disorder

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity that symptoms of major depressive disorders had across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of major depressive disorder symptoms.

3.3.1 Severity of impact on functioning

The severity of major depressive disorder in four different domains (school or work, friends and social activities, family and self) and overall is reported in Table 3-8. Two fifths (40.3%) of 4-17 year-olds experienced a severe level of impact on self (that is, where the young person experienced a severe level of distress due to their symptoms). A third (34.3%) of children and adolescents experienced a severe level of impact in the school or work domain. Overall two fifths (42.8%) of 4-17 year-olds with major depressive disorder experienced a severe level of impact. This was the highest proportion of severe cases among those with a disorder of any of the disorders measured in the survey.

Compared with other disorders, a higher proportion of children and adolescents with major depressive disorder had severe impact in the self, friends and school/work domains (40.3%, 23.4% and 34.3% respectively). A large proportion of young people with social phobia also had severe impact in the friends' domain (23.4%) while a large proportion with obsessive-compulsive disorder had severe impact in the school/work domain (33.0%).

Table 3-8: Severity of impact in different life domains among 4-17 year-olds with major depressive disorder

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	9.6	14.4	8.4	np	
Mild	17.3	19.1	30.6	np	21.4
Moderate	34.1	43.1	33.5	37.5	35.8
Severe	34.3	23.4	27.4	40.3	42.8
Does not go to school or work	4.8				

np Not available for publication because of small cell size, but included in totals where applicable.

3.3.2 Days absent from school

Approximately three quarters (74%) of children and adolescents with major depressive disorder attending school had been absent from school for one or more days in the previous 12 months due to their depressive symptoms.

Young people with major depressive disorder averaged 20 days absent from school in the previous 12 months due to their depressive symptoms. The average was higher for adolescents, with those aged 4-11 years averaging 14 days absent compared with an average of 23 days absent for young people aged 12-17 years (Table 3-9). Compared to other disorders, children and adolescents with major depressive disorder missed on average the most days of school due to their symptoms.

Table 3-9: Average days absent from school in past 12 months due to depressive symptoms among 4-17 year-olds with major depressive disorder by age group

Age group	Average days absent
4-11 years	14
12-17 years	23
4-17 years	20

4 ANXIETY DISORDERS

This chapter presents data on children and adolescents who met diagnostic criteria identified in DSM-IV for social phobia, separation anxiety disorder, generalised anxiety disorder or obsessive-compulsive disorder.

Anxiety disorders refers to a group of conditions rather than a single disorder. The common characteristic of the conditions that make up this category is that individuals affected experience persistent, excessive worry or fears that typically interferes with their ability to carry out their daily tasks or take pleasure in day-to-day life. It is common for young people to be fearful and anxious, but some may be more anxious than other children of their age and developmental level, and this may stop them participating in activities at school or socially, or interfere with their ability to do what other children and adolescents of their age do.

Social phobia

This disorder is characterised by a marked and persistent fear or avoidance of social or performance situations in which embarrassment may occur. To meet DSM-IV criteria, the fear or avoidance must interfere significantly with the child or adolescent's normal routine, academic functioning, or social activities or relationships, or the person must experience marked distress about the phobia.

Separation anxiety disorder

This disorder is characterised by excessive anxiety concerning separation from the home or from those to whom the child is attached. To meet DSM-IV criteria, the anxiety must be beyond that which is expected for the child or adolescent's developmental level, and cause significant distress in social, academic or other important areas of functioning. While separation anxiety disorder may be more common in younger children it can cause significant impairment in older children.

Generalised anxiety disorder

This disorder is characterised by excessive anxiety, worry or apprehension about a number of different events or activities, occurring more days than not for a period of at least six months. DSM-IV criteria specify that for children the anxiety must be associated with at least one of the following symptoms: restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension or sleep disturbance. The constant worry causes distress to the individual. The child or adolescent has difficulty controlling the worry, and experiences impairment in social, academic or other important areas of functioning.

Obsessive-compulsive disorder

Key features of this disorder are recurrent obsessions and/or compulsions that are severe enough to be time consuming and cause marked distress or significant impairment. Obsessions are persistent ideas, thoughts, impulses or images that are intrusive and difficult to control and that cause anxiety or distress. Common obsessions include worrying about things being dirty or having germs, or that the person might do something bad in public. Compulsions are repetitive behaviours, such as washing hands or changing clothes over and over, repetitively checking things, or counting or ordering things over and over. To meet DSM-IV criteria the obsessions or compulsions must cause marked distress, be time consuming or significantly interfere with the child or adolescent's normal routine, academic functioning, usual social activities or relationships.

The survey focussed on the four anxiety disorders that are most common and cause greatest distress in children and adolescents. These were social phobia, separation anxiety disorder, generalised anxiety disorder and obsessive-compulsive disorder.

4.1 Prevalence of anxiety disorders in children and adolescents

Half of all children and adolescents aged 4-17 years with mental disorders had an anxiety disorder. This is equivalent to 6.9% of all children and adolescents or an estimated 278,000 children and adolescents. There was little difference between males and females (7.0% and 6.8%).

The prevalence of anxiety disorders was very similar in children and adolescents, with 6.9% of children aged 4-11 years and 7.0% of young people aged 12-17 years having one or more anxiety disorders (Table 4-1). However, there were differences between children and adolescents in the prevalence of individual anxiety disorders. Separation anxiety disorder was the most common anxiety disorder in children (4.9% of those 4-11 years). Among adolescents both social phobia and separation anxiety disorder were equally common (3.4%) and generalised anxiety disorder was almost as common (2.9%).

Among children aged 4-11 years, the prevalence of anxiety disorders was slightly but not significantly higher in males than females (7.6% compared with 6.1%) due mainly to the higher prevalence of obsessive-compulsive disorder in males in this age group. Among young people aged 12-17 years, the prevalence of anxiety disorders was slightly but not significantly higher in females than males (7.7% compared with 6.3%) due mainly to the higher prevalence of generalised anxiety disorder in females in this age group.

Table 4-1: 12-month prevalence of anxiety disorders among 4-17 year-olds by sex and age group

Sex	Age group	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%) (a)
Males	4-11 years	1.8	4.9	1.8	1.3	7.6
	12-17 years	3.3	3.8	2.3	0.9	6.3
	4-17 years	2.4	4.4	2.0	1.1	7.0
Females	4-11 years	1.3	4.8	1.5	0.3	6.1
	12-17 years	3.4	3.1	3.4	0.7	7.7
	4-17 years	2.2	4.1	2.3	0.5	6.8
Persons	4-11 years	1.6	4.9	1.7	0.8	6.9
	12-17 years	3.4	3.4	2.9	0.8	7.0
	4-17 years	2.3	4.3	2.2	0.8	6.9

(a) 'Any anxiety disorder' is not the sum of individual anxiety disorders as some children and adolescents had more than one type of disorder.

4.2 Social and demographic characteristics

The relationships between parental, family and household characteristics and anxiety disorders are shown in Table 4-2 through to Table 4-7. Overall, the prevalence of anxiety disorders was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

4.2.1 Family type

For three of the four anxiety disorders the prevalence was higher in families with one parent or carer than families with two parents or carers. Except for obsessive-compulsive disorder, prevalence was lower in original families, that is where at least one child lives with both their natural, adoptive or foster parents and there were no step children, compared with step or blended families. Of children or adolescents living in families with one parent or carer, 9.0% had separation anxiety disorder compared with 2.7% in original families, 5.7% in step families and 4.8% in blended families (Table 4-2).

Table 4-2: 12-month prevalence of anxiety disorders among 4-17 year-olds by family type

Family type	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Families with two parents or carers	1.8	3.0	1.8	0.6	5.4
Original family	1.6	2.7	1.4	0.6	4.7
Step family	2.8	5.7	2.9	np	9.3
Blended family	3.3	4.8	4.1	np	9.0
Other family (a)	5.5	6.8	5.3	np	15.0
Families with one parent or carer	4.2	9.0	3.8	1.6	12.9

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

np Not available for publication because of small cell size, but included in totals where applicable.

4.2.2 Household income

The prevalence of anxiety disorders was highest in families with the lowest incomes, with the rates of each of the anxiety disorders being almost double in households with incomes below \$52,000 per year (\$1,000 per week) than in families with higher household incomes (Table 4-3).

Table 4-3: 12-month prevalence of anxiety disorders among 4-17 year-olds by household income

Household income before tax	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
\$130,000 or more per year	1.8	2.3	1.8	0.3	5.0
\$52,000-\$129,999 per year	1.9	3.8	1.7	0.8	5.8
Less than \$52,000 per year	3.6	6.8	3.2	1.4	10.6

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

4.2.3 Parent and carer education

There was no association between parent and carer education and obsessive-compulsive disorder. However, for each of the other anxiety disorders the lowest prevalence was in families where at least one parent or carer had a bachelor degree or higher. The highest prevalence occurred in families where the highest level of education achieved by either parent or carer was Year 10 or below (Table 4-4).

Table 4-4: 12-month prevalence of anxiety disorders among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Bachelor degree or higher	1.8	3.4	1.5	0.6	5.3
Diploma or certificate III/IV	2.7	4.9	2.6	1.0	8.1
Year 11 or 12	2.4	4.1	2.5	1.1	7.0
Year 10 or below	3.5	6.0	3.1	1.0	9.6

4.2.4 Parent and carer labour force status

In families with two parents or carers, the prevalence of all four anxiety disorders was lower where both parents or carers were currently in employment (Table 4-5). Among children and adolescents living in households with a sole parent or carer, separation anxiety disorder was more common where the parent or carer was not in employment (13.6% compared with 5.8%).

Table 4-5: 12-month prevalence of anxiety disorders among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Both parents or carers employed	1.5	2.4	1.6	0.2	4.6
One parent or carer employed, one parent or carer not in employment	2.1	4.5	1.8	1.1	6.5
Both parents or carers not in employment	4.3	3.5	5.4	2.6	10.6
Sole parent or carer employed	4.4	5.8	3.4	0.8	9.8
Sole parent or carer not in employment	4.4	13.6	3.7	3.0	17.2

'Not in employment' combines unemployed and not in the labour force.

4.2.5 Area of residence

All four anxiety disorders were more common in children living outside greater capital city areas (Table 4-6).

Table 4-6: 12-month prevalence of anxiety disorders among 4-17 year-olds by area of residence

Area of residence	Social phobia (%)	Separation anxiety (%)	Generalised anxiety (%)	Obsessive-compulsive (%)	Any anxiety disorder (%)
Greater capital cities	2.1	3.9	2.1	0.7	6.3
Rest of state	2.7	4.8	2.3	1.1	7.9

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

4.2.6 Family functioning

Table 4-7 shows the relationship between family functioning and the prevalence of anxiety disorders in children and adolescents. There was a strong relationship between level of family functioning and the prevalence of separation anxiety disorder, with 12.9% of children aged 4-11 years living in families with poor family functioning having separation anxiety disorder as compared with 3.8% of children living in families with very good functioning. Similarly 10.4% of 12-17 year-olds in families with poor family functioning had separation anxiety disorder, compared with 3.0% of 12-17 year-olds in families with very good family functioning.

Table 4-7: 12-month prevalence of anxiety disorders among 4-17 year-olds by family functioning and age group

Anxiety disorder	Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Social phobia	Very good	1.1	3.7	2.1
	Good	2.4	2.2	2.3
	Fair	2.5	3.3	2.9
	Poor	np	5.9	3.7
Separation anxiety	Very good	3.8	3.0	3.5
	Good	7.0	3.3	5.3
	Fair	4.5	3.1	3.9
	Poor	12.9	10.4	11.7
Generalised anxiety	Very good	1.2	2.5	1.7
	Good	1.8	2.1	2.0
	Fair	3.3	4.2	3.7
	Poor	3.4	8.1	5.7
Obsessive-compulsive	Very good	0.8	0.6	0.7
	Good	0.6	0.9	0.7
	Fair	np	1.5	1.0
	Poor	3.5	np	2.3
Any anxiety disorder	Very good	5.4	6.2	5.7
	Good	9.3	6.1	7.8
	Fair	7.9	8.3	8.1
	Poor	15.4	18.1	16.8

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).
np Not available for publication because of small cell size, but included in totals where applicable.

4.3 Impact of anxiety disorders

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity that symptoms of anxiety disorders had across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of anxiety disorder symptoms.

4.3.1 Severity of impact on functioning

The severity of anxiety disorders in four different domains (school or work, friends and social activities, family and self) and overall is reported in Table 4-8. Overall 18.7% of children and adolescents with anxiety disorders had a severe disorder, while 27.5% had a moderate disorder.

The type and severity of impact varied considerably between the four anxiety disorders. There was a lower proportion of cases with severe impact in each domain for separation anxiety compared with the other anxiety disorders. Obsessive-compulsive disorder was the disorder with the largest proportion of cases experiencing severe impact across the functioning domains with the exception of friends.

In contrast to other disorders, a higher proportion of children and adolescents with social phobia had severe impact in the friends domain (23.4%) while a high proportion with generalised anxiety had severe impact in the family domain (30.9). A high proportion of children and adolescents with obsessive-compulsive disorder also had severe impact in the school/work domain and family domains (33.0% and 37.4% respectively).

Table 4-8: Severity of impact in different life domains among 4-17 year-olds with anxiety disorders

Anxiety disorder	Severity	School/ work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
Social phobia	None	8.8	17.7	19.0	7.5	
	Mild	28.3	21.7	21.3	25.5	39.4
	Moderate	28.6	37.2	30.5	39.6	28.8
	Severe	29.4	23.4	29.1	27.4	31.8
	Does not go to school or work	4.9				
Separation anxiety	None	21.2	24.3	15.2	10.0	
	Mild	30.8	31.0	42.0	33.5	54.3
	Moderate	22.3	32.0	22.8	37.0	26.8
	Severe	20.0	12.7	20.0	19.6	18.9
	Does not go to school or work	5.8				
Generalised anxiety	None	14.3	16.7	10.9	3.8	
	Mild	23.4	18.7	25.4	28.1	38.1
	Moderate	28.5	43.4	32.8	38.2	30.7
	Severe	29.4	21.2	30.9	30.0	31.1
	Does not go to school or work	4.4				
Obsessive-compulsive	None	15.2	12.2	8.2	7.9	
	Mild	24.4	13.8	24.4	34.1	32.5
	Moderate	21.1	44.2	30.0	36.2	35.7
	Severe	33.0	29.7	37.4	21.8	31.8
	Does not go to school or work	6.3				
Any anxiety disorder	None	20.0	23.5	17.4	9.9	
	Mild	31.7	28.2	36.2	35.0	53.8
	Moderate	23.9	34.6	27.2	36.7	27.5
	Severe	19.7	13.7	19.2	18.4	18.7
	Does not go to school or work	4.7				

4.3.2 Days absent from school

Most children and adolescents in the survey were attending school (94%). Over half of 4-11 year-olds (58%) and almost three quarters of 12-17 year-olds (73%) attending school who had an anxiety disorder were absent from school for at least one day in the previous 12 months due to their anxiety symptoms. The average number of days absent from school due to anxiety symptoms was more than double in 12-17 year olds compared with 4-11 year-olds (20 days compared with 6 days) (Table 4-9).

Generalised anxiety disorder was associated with the highest number of days off school due to anxiety symptoms for children aged 4-11 years, while separation anxiety disorder was associated with the highest number of days off school due to anxiety symptoms for those aged 12-17 years.

Table 4-9: Average days absent from school in the past 12 months due to anxiety symptoms among 4-17 year-olds with anxiety disorders by age group

Anxiety disorder	4-11 years (days absent)	12-17 years (days absent)	4-17 years (days absent)
Social phobia	8	20	15
Separation anxiety	6	30	14
Generalised anxiety	10	22	17
Obsessive-compulsive	7	22	14
Any anxiety disorder	6	20	12

5 ATTENTION-DEFICIT/HYPERACTIVITY DISORDER

This chapter presents data on children and adolescents who met diagnostic criteria identified in DSM-IV for Attention-deficit/hyperactivity disorder (ADHD).

Attention-deficit/hyperactivity disorder

ADHD is a persistent pattern of inattention and/ or hyperactivity-impulsivity more frequent and severe than in other individuals at a similar developmental stage. Children and adolescents may find it difficult to pay attention and see tasks or activities through to the end or make careless mistakes with school work or other tasks. Children and adolescents with problems in the area of hyperactivity may talk excessively, have trouble staying still when it is appropriate or expected and act like they are always “on the go”.

There are three subtypes of ADHD based on the most common symptoms. Those with mostly inattentive symptoms are diagnosed with ADHD, predominantly inattentive type and individuals with primarily hyperactivity-impulsivity symptoms are diagnosed with ADHD, predominantly hyperactive-impulsive type. Those children and adolescence with symptoms of both inattentiveness and hyperactivity are diagnosed with ADHD, combined type.

The DSM-IV criteria require at least six symptoms of either inattention or hyperactivity-impulsivity to have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level. Symptoms must be present in at least two settings (e.g. at school and at home), and some symptoms causing impairment must have been present before the age of 7 years.

5.1 Prevalence of ADHD in children and adolescents

In the 12 months prior to the survey 7.4% of children and adolescents had ADHD, equivalent to an estimated 298,000 children and adolescents across Australia (Table 5-1).

Of the three sub-types of ADHD, inattentive type was the most common, with 3.4% of children and adolescents having inattentive type, 1.2% hyperactive type and 2.8% combined type. The tables in this chapter report data which includes all three subtypes of ADHD.

The prevalence of ADHD was higher in males than females, with more than twice as many males as females having had ADHD in the previous 12 months (10.4% compared with 4.3%). The prevalence of ADHD was lower in adolescent females compared with females aged 4-11 years (2.7% compared with 5.4%). There was little difference in the prevalence between males from either age group; 10.9% of males aged 4-11 years and 9.8% of males aged 12-17 years had ADHD (Table 5-1).

Table 5-1: 12-month prevalence of ADHD among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	10.9	5.4	8.2
12-17 years	9.8	2.7	6.3
4-17 years	10.4	4.3	7.4

5.2 Social and demographic characteristics

Table 5-2 through to Table 5-6 report the prevalence of ADHD by a range of socio-demographic characteristics. These include family type, household income, carer education and labour force status, area of residence and family functioning. Overall prevalence of ADHD was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

5.2.1 Family type

The lowest prevalence of ADHD was in children and adolescents living in original families (5.7%), that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The prevalence of ADHD was twice as high in children and adolescents from lone parent or carer families (11.1%) and slightly higher again (13.4%) in those from blended families (Table 5-2).

Table 5-2: 12-month prevalence of ADHD among 4-17 year-olds by family type

Family type	Prevalence (%)
Families with two parents or carers	6.5
Original family	5.7
Step family	7.9
Blended family	13.4
Other family (a)	12.5
Families with one parent or carer	11.1

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

(a) Data to be treated with caution due to low respondent numbers in this category.

5.2.2 Household income

The prevalence of ADHD was highest in children and adolescents in households in the lowest income bracket (less than \$52,000 per year or \$1,000 per week), with just over one in ten (11.7%) young people who lived in these households having had ADHD in the previous 12 months (Table 5-3). This was significantly higher than the prevalence of children and adolescents in households in the middle and highest income brackets (6.6% and 5.2% respectively).

Table 5-3: 12-month prevalence of ADHD among 4-17 year-olds by household income

Household income before tax	Prevalence (%)
\$130,000 or more per year	5.2
\$52,000-\$129,999 per year	6.6
Less than \$52,000 per year	11.7

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

5.2.3 Parent and carer education

Children and adolescents from families in which the highest level of education of a parent or carer was a bachelor degree or higher had the lowest prevalence of ADHD. In contrast, children and adolescents from families where the highest level of education of either parent or carer was Year 10 or below had the highest prevalence of ADHD (5.4% compared with 11.7%) (Table 5-4).

Table 5-4: 12-month prevalence of ADHD among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Prevalence (%)
Bachelor degree or higher	5.4
Diploma or certificate III/IV	8.6
Year 11 or 12	8.0
Year 10 or below	11.7

5.2.4 Parent and carer labour force status

The prevalence of ADHD was lowest (5.8%) among children and adolescents in households in which both parents or carers were employed and highest where no parent or carer in the household was employed (Table 5-5). The prevalence of ADHD in children and adolescents with both parents or carers not in employment was twice as high (15.6%) as children or adolescents in families where one parent or carer was employed (7.0%). For children and adolescents with a sole parent or carer, prevalence rates for ADHD were 15.3% where the sole carer was not in employment, double the rate where the parent or carer was employed (7.7%).

Table 5-5: 12-month prevalence of ADHD among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Prevalence (%)
Both parents or carers employed	5.8
One parent or carer employed, one parent or carer not in employment	7.0
Both parents or carers not in employment	15.6
Sole parent or carer employed	7.7
Sole parent or carer not in employment	15.3

'Not in employment' combines unemployed and not in the labour force.

5.2.5 Area of residence

While children and adolescents living in greater capital city areas had a slightly lower prevalence of ADHD than those living in other areas, the difference was not significant (Table 5-6).

Table 5-6: 12-month prevalence of ADHD among 4-17 year-olds by area of residence

Area of residence	Prevalence (%)
Greater capital cities	6.7
Rest of state	8.6

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

5.2.6 Family functioning

There was a strong relationship between level of family functioning and prevalence of ADHD. Just under one fifth (18.1%) of children and adolescents living in families with poor family functioning had ADHD compared with one in twenty (5.6%) living in families with very good family functioning. This pattern was most obvious in children 4-11 years but was also evident in adolescents aged 12-17 years (Table 5-7).

Table 5-7: 12-month prevalence of ADHD among 4-17 year-olds by family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	6.1	4.9	5.6
Good	9.3	6.1	7.8
Fair	14.6	9.7	12.3
Poor	20.9	15.3	18.1

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

5.3 Impact of ADHD

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity of symptoms of ADHD across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of ADHD disorder symptoms.

5.3.1 Severity of impact on functioning

The severity of impact of ADHD on children and adolescents in four different domains (school or work, friends and social activities, family and impact on self) and overall is reported in Table 5-8. Overall one in ten (10.5%) children and adolescents with ADHD had severe impact on functioning in at least one of these domains. Severe impact on functioning was reported most commonly in the domain of family (17.3%), and then school or work (12.8%). Only 3.7% of children and adolescents with ADHD had a severe level of impact on functioning in the self domain (that is, where the young person experienced a high level of distress due to their symptoms). Two fifths (40.9%) of children and adolescents with ADHD had no impact in the friends domain, while only 13.3% of children with ADHD had no impact in the school or work domain.

In contrast to other disorders, a higher proportion of children and adolescents with ADHD had mild impact on functioning overall as a result of their symptoms (65.7%).

Table 5-8: Severity of impact in different life domains among 4-17 year-olds with ADHD

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	13.3	40.9	18.1	29.3	
Mild	40.0	24.9	35.8	45.7	65.7
Moderate	31.1	23.6	28.8	21.3	23.8
Severe	12.8	10.6	17.3	3.7	10.5
Does not go to school or work	2.8				

5.3.2 Days absent from school

Table 5-9 reports the average number of days off school in the previous 12 months of those children who met diagnostic criteria for ADHD. Just under a third of 4-11 year-olds and a half of 12-17 year-olds (29% and 46% respectively) with ADHD had missed at least one day of school in the previous 12 months due to their ADHD symptoms.

The average number of days off school due to ADHD was higher for adolescents. On average, children aged 4-11 years had 4 days off, while 12-17 year-olds had 9 days off (Table 5-9). Compared to children and adolescents with other disorders those with ADHD missed on average the least number of days of school due to their ADHD symptoms.

Table 5-9: Average days off school in the past 12 months due to ADHD symptoms among 4-17 year-olds with ADHD by age group

Age group	Average days absent
4-11 years	4
12-17 years	9
4-17 years	5

6 CONDUCT DISORDER AND OPPOSITIONAL PROBLEM BEHAVIOURS

This chapter presents data on children and adolescents that met diagnostic criteria identified in DSM-IV for conduct disorder. It also presents information on oppositional problem behaviours.

Conduct disorder

Conduct disorder is defined as repetitive and persistent behaviour to a degree that violates the basic rights of others, major societal norms or rules in the following areas: aggression towards people or animals, destruction of property, deceitfulness or theft and serious violation of rules. Young people with conduct disorder exhibit a range of behaviours often including bullying, frequent physical fights, deliberately destroying other's property, breaking into properties or cars, staying out late at night without permission, running away from home or frequent truancy from school. DSM-IV criteria require at least three of these behaviours to have been present in the past 12 months, and for the disturbance in behaviour to cause clinically significant impairment in social, academic or occupational functioning.

6.1 Prevalence of conduct disorder in children and adolescents

Around 2% of all children and adolescents had conduct disorder. This is equivalent to around 84,000 children and adolescents across Australia. The prevalence was higher in males than females (2.5% compared with 1.6%). The prevalence did not vary across age groups for either sex (Table 6-1).

Table 6-1: 12-month prevalence of conduct disorder among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	2.5	1.6	2.0
12-17 years	2.6	1.6	2.1
4-17 years	2.5	1.6	2.1

6.2 Social and demographic characteristics

The 12-month prevalence of conduct disorder by a range of socio-demographic characteristics is reported in Table 6-2 to Table 6-7. These include family type, household income, carer education and labour force status, area of residence and family functioning. Overall prevalence of conduct disorder was higher in children and adolescents living in families with lower levels of income, education and employment and with poorer family functioning.

6.2.1 Family type

The prevalence of conduct disorders was lowest (1.0%) in original families, that is where at least one child was living with both their natural, adoptive or foster parents and there were no step children. The highest prevalences were in families with one parent or carer and step families, in which 4.8% and 4.4% of children and adolescents had conduct disorder respectively (Table 6-2).

Table 6-2: 12-month prevalence of conduct disorder among 4-17 year-olds by family type

Family type	Prevalence (%)
Families with two parents or carers	1.4
Original family	1.0
Step family	4.4
Blended family	3.4
Other family	np
Families with one parent or carer	4.8

'Original family' has at least one child living with their natural, adoptive or foster parents, and no step children.

'Other family' is where all children are not the natural, adopted, foster or step child of one or both carers.

np Not available for publication because of small cell size, but included in totals where applicable.

6.2.2 Household income

The prevalence of conduct disorder was associated with household income (Table 6-3). Children and adolescents from families in the highest income bracket, with incomes of \$130,000 or more per year, had the lowest prevalence of conduct disorder (0.8%). Over four times as many children and adolescents from families in the lowest income bracket (less than \$52,000 per year) had conduct disorder compared with families in the highest income bracket (4.3% compared with 0.8%).

Table 6-3: 12-month prevalence of conduct disorder among 4-17 year-olds by household income

Household income before tax	Prevalence (%)
\$130,000 or more per year	0.8
\$52,000-\$129,999 per year	1.7
Less than \$52,000 per year	4.3

Household income includes the combined income for the 2011-12 financial year of everyone living in the household before tax and other deductions are taken out.

6.2.3 Parent and carer education

The prevalence of conduct disorder was lowest in families in which at least one parent or carer had a bachelor degree or higher (1.2%) and highest in families in which the highest level of education achieved by either parent or carer was year 10 or below (4.6%) (Table 6-4).

Table 6-4: 12-month prevalence of conduct disorder among 4-17 year-olds by parent or carer education

Highest level of education of either primary or secondary parent or carer	Prevalence (%)
Bachelor degree or higher	1.2
Diploma or certificate III/IV	2.4
Year 11 or 12	2.6
Year 10 or below	4.6

6.2.4 Parent and carer labour force status

Children and adolescents from families with both parents or carers in employment had the lowest prevalence of conduct disorder at 1.0% (Table 6-5). In contrast, the prevalence of conduct disorder was 4.6% in children and adolescents in households where both parents or carers were not in employment. In households with a sole parent or carer, where the parent or carer was in employment, the prevalence was lower at 2.8%, however, it was almost three times (7.9%) higher for children and adolescents in families in which the sole parent or carer was not in employment.

Table 6-5: 12-month prevalence of conduct disorder among 4-17 year-olds by parent or carer labour force status

Parent or carer labour force status	Prevalence (%)
Both parents or carers employed	1.0
One parent or carer employed, one parent or carer not in employment	1.7
Both parents or carers not in employment	4.6
Sole parent or carer employed	2.8
Sole parent or carer not in employment	7.9

'Not in employment' combines unemployed and not in the labour force.

6.2.5 Area of residence

The prevalence of conduct disorder was twice as high in children and adolescents living outside greater capital city areas compared with those living within these areas (3.2% compared to 1.4%) (Table 6-6).

Table 6-6: 12-month prevalence of conduct disorder among 4-17 year-olds by area of residence

Area of residence	Prevalence (%)
Greater capital cities	1.4
Rest of state	3.2

Based on the ABS classification Greater Capital City Statistical Area (GCCSA).

6.2.6 Family functioning

The prevalence of conduct disorder was highest in families who had poor family functioning and lowest in families with very good family functioning. Only 1.4% of 4-11 year-olds and 1.0% of 12-17 year-olds in families with very good family functioning had conduct disorder. In contrast, 6.9% of 4-11 year-olds and 7.5% of 12-17 year-olds had conduct disorder in families with poor family functioning (Table 6-7).

Table 6-7: 12-month prevalence of conduct disorder among 4-17 year-olds by level of family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	1.4	1.0	1.2
Good	2.1	2.4	2.3
Fair	4.0	4.6	4.3
Poor	6.9	7.5	7.2

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

6.3 Impact of conduct disorder

Mental disorders impact on young people in a number of ways across different aspects of their lives. The severity that symptoms of conduct disorder had across four different life domains are reported as well as the number of days absent from school in the previous 12 months as a result of conduct disorder symptoms.

6.3.1 Severity of impact on functioning

The severity of conduct disorder on children and adolescent's functioning was assessed in four different domains (school or work, friends and social activities, family and self) and overall. Overall 18.9% of children and adolescents with conduct disorder had severe disorder. The family domain was most severely affected by conduct disorder, with nearly one third (29.5%) of children or adolescents with conduct disorder having severe impact in the family domain (Table 6-8). Only 4.3% of children or adolescents with conduct disorder had no impact in the family domain. The self domain (that is, where the young person experienced distress due to their symptoms) showed the smallest proportion of children or adolescents with severe impact (3.6%).

In comparison to other disorders, a higher proportion of children and adolescents with conduct disorder had severe impact in the family domain (29.5%). A large proportion of families with young people who had generalised anxiety and obsessive-compulsive disorder also had severe impact in the family domain (30.9% and 37.4% respectively).

Table 6-8: Severity of impact in different life domains among 4-17 year-olds with conduct disorder

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	35.6	32.5	4.3	28.3	
Mild	18.1	26.2	30.7	43.6	58.7
Moderate	25.2	31.4	35.5	24.6	22.4
Severe	15.8	10.0	29.5	3.6	18.9
Does not go to school or work	5.4				

6.3.2 Days absent from school

One quarter of 4-11 year-olds (26%) and just over a half (54%) of 12-17 year-olds with conduct disorder attending school had missed at least one day of school in the previous 12 months due to symptoms of their conduct disorder.

The average number of days missed of school was higher in 12-17 year-olds than 4-11 year-olds (Table 6-9). Children aged 4-11 years missed an average of two days in the previous 12 months, while 12-17 year-olds missed an average of 17 days.

Table 6-9: Average days off school in the past 12 months due to conduct disorder symptoms among 4-17 year-olds with conduct disorder by age group

Age group	Average days absent
4-11 years	2
12-17 years	17
4-17 years	8

6.4 Oppositional problem behaviours

The DSM-IV includes a mental disorder category called *oppositional defiant disorder* and the DISC-IV module for oppositional defiant disorder was included in *Young Minds Matter*. However, unlike other disorders included in this publication, the diagnosis for oppositional defiant disorder includes an element of clinical judgement that could not be implemented within the DISC-IV questions. In particular, for each symptom assessed in oppositional defiant disorder the DSM-IV specifies that the symptom criterion is met only if the behaviour occurs more frequently than is typically observed in individuals of comparable age and developmental level. A mental health trained clinician is required to make this judgement. The data collection for *Young Minds Matter* was undertaken by lay professional interviewers who were not specifically trained in psychology or psychiatry and expert clinical review of each child or adolescent in the survey was not undertaken. As such it was not possible to implement all of the diagnostic criteria for oppositional defiant disorder.

Despite these limitations, information collected in the survey on the prevalence of oppositional problem behaviours in children and adolescents is useful for a broad range of purposes. The information from parents and carers on oppositional problem behaviours in their children that was

obtained from the DISC-IV module is presented in this section. These are referred to as oppositional problem behaviours to distinguish them from the diagnostic condition of oppositional defiant disorder.

Oppositional problem behaviours

Oppositional problem behaviours are negativistic, hostile and defiant behaviours lasting at least six months characterised by behaviour such as often losing temper, arguing with adults, actively defying adults' requests and rules, being angry, resentful, spiteful or vindictive.

If a child or adolescent met diagnostic criteria for conduct disorder, the oppositional problem behaviours module was not administered for that child or adolescent.

6.4.1 Prevalence of oppositional problem behaviours in children and adolescents

Around 5.1% of all children and adolescents had oppositional problem behaviours. This is equivalent to around 204,000 children and adolescents across Australia. The prevalence was higher in males than females (5.6% compared with 4.5%). The prevalence did not vary across age groups for either sex (Table 6-10).

Table 6-10: 12-month prevalence of oppositional problem behaviours among 4-17 year-olds by sex and age group

Age group	Males (%)	Females (%)	Persons (%)
4-11 years	5.6	4.4	5.0
12-17 years	5.6	4.6	5.1
4-17 years	5.6	4.5	5.1

6.4.2 Co-occurrence of oppositional problem behaviours and mental disorders

As conduct disorder is regarded as a more severe form of oppositional problem behaviours, an exclusion rule was applied so that no child or adolescent could be given the diagnosis of conduct disorder and oppositional problem behaviours. To reduce respondent burden in the survey, parents and carers of children or adolescents who met diagnostic criteria for conduct disorder were not asked questions about oppositional problem behaviours.

There was a substantial overlap between oppositional problem behaviours and the group of mental disorders included in the survey. Over half of children and adolescents with oppositional problem behaviours also met diagnostic criteria for a mental disorder (3.0% of all children and adolescents had oppositional problem behaviours and met diagnostic criteria for a mental disorder, and 2.1% had oppositional problem behaviours and did not meet diagnostic criteria for any mental disorders). Some 1.0% of children and adolescents had oppositional problem behaviours and ADHD, 1.1% had oppositional problem behaviours and anxiety or depression, and 0.9% of children and adolescents had oppositional problem behaviours and both ADHD and anxiety or depression (Table 6-11).

Table 6-11: Co-occurrence of oppositional problem behaviours and mental disorders among 4-17 year-olds

Problem or disorder	Prevalence (%)
Oppositional problem behaviours only	2.1
Oppositional problem behaviours and one or more DISC-IV disorder	3.0
Oppositional problem behaviours and ADHD	1.0
Oppositional problem behaviours and anxiety or depression	1.1
Oppositional problem behaviours and ADHD and anxiety or depression	0.9

6.4.3 Family functioning

The prevalence of oppositional problem behaviours was highest in families who had poor family functioning and lowest in those with very good family functioning. Only 3.5% of 4-11 year-olds and 4.0% of 12-17 year-olds in families with very good family functioning had oppositional problem behaviours. In contrast, 18.0% of 4-11 year-olds and 15.5% of 12-17 year-olds had oppositional problem behaviours in families with poor family functioning (Table 6-12).

Table 6-12: 12-month prevalence of oppositional problem behaviours among 4-17 year-olds by family functioning and age group

Level of family functioning	4-11 years (%)	12-17 years (%)	4-17 years (%)
Very good	3.5	4.0	3.7
Good	6.2	4.6	5.4
Fair	7.6	7.7	7.6
Poor	18.0	15.5	16.8

Family functioning was measured across a number of domains by the McMaster Family Assessment Device (see glossary).

6.4.4 Severity of impact on functioning

The severity of oppositional problem behaviours on children and adolescent's functioning was assessed in four different domains (school or work, friends and social activities, family and self) and overall. The overall impact on functioning was assessed as mild for more than two thirds (68.6%) of the children and adolescents with oppositional problem behaviours. One fifth (20.3%) of children and adolescents experienced moderate impact and just over one in ten (11.1%) experienced severe impact on functioning.

Family was the domain in which the most children and adolescents with oppositional problem behaviours had moderate or severe impact (35.1% moderate, 16.6% severe) (Table 6-13).

Table 6-13: Severity of impact in different life domains among 4-17 year-olds with oppositional problem behaviours

Severity	School/work (%)	Friends (%)	Family (%)	Self (%)	Overall severity (%)
None	43.3	46.5	11.0	30.2	
Mild	26.0	24.5	37.3	42.8	68.6
Moderate	18.3	23.3	35.1	20.7	20.3
Severe	9.7	5.7	16.6	6.3	11.1
Does not go to school or work	2.8				

6.4.5 Days absent from school

Some 40% of 4-11 year-olds and 13% of 12-17 year-olds with oppositional problem behaviours attending school had missed at least one day of school in the last 12 months due to their oppositional problem behaviours.

The average number of days missed of school was significantly higher in adolescents than 4-11 year-olds (Table 6-14). Children 4-11 years missed an average of four days in the past 12 months, while 12-17 year-olds missed an average of nine days.

Table 6-14: Average days off school in the past 12 months due to oppositional problem behaviours among 4-17 year-olds by age group

Age group	Average days absent
4-11 years	4
12-17 years	9
4-17 years	6