The Survey of the Mental Health of Children and Young People 2016

Responses to the Consultation on survey content

Version 2.0

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At NatCen Social Research we believe that social research has the power to make life better. By really understanding the complexity of people’s lives and what they think about the issues that affect them, we give the public a powerful and influential role in shaping decisions and services that can make a difference to everyone. And as an independent, not for profit organisation we’re able to put all our time and energy into delivering social research that works for society.
Executive Summary

Key findings

- More than 600 people and organisations viewed the online consultation about the content of the forthcoming survey of the Mental Health of Children and Young People (MHCYP) 2016. 225 of these submitted responses.

- Respondents covered a range of areas including academic, clinical, public, private and the voluntary sector. There were also responses from members of the public.

- Most of the topics included in the 2004 survey were considered important to include again in 2016.

- A range of more than 47 new topics were suggested by respondents. The most popular topics for inclusion were online activity (i.e. the impact and use of social media, gaming and the internet) and its impact on children and young people’s mental health. Bullying was the second most popular suggestion.

- Respondents also suggested broadening the scope of certain topics such as the use of mental health services to include a range of additional questions (i.e. provision of regional services and their accessibility; services access and awareness of access from parent; understanding and perception of services; and so on).

- Some respondents also suggested content to be removed. Overall, the most popular content chosen to be removed appeared to be the smoking, drinking and drug use section of the children and young people self-completion. Other elements commonly suggested for removal or reduction was demographic information and elements within the teacher questionnaire.

- There is great support for MHCYP 2016 and the data is widely anticipated.
1 Our approach

1.1 Introduction

NatCen Social Research, together with the Office for National Statistics (ONS) and Youthinmind have been commissioned by the Health and Social Care Information Centre (HSCIC) to carry out the Survey of the Mental Health of Children and Young People (MHCYP) 2016. Funding for this survey comes from the Department of Health and the Scottish Government.

This will be the first survey of children and young people to focus on their mental health since 2004. The survey will provide data on the prevalence of mental illness among children and young people in England and Scotland and collect robust data on a range of topics relating to the mental health of these groups. It will be similar to the 2004 Child and Adolescent Mental Health Survey in order to look at change over time and will collect information from children and young people and from their parents and teachers.

On 26 November 2015, NatCen launched an online consultation on about the survey content of MHCYP 2016 in order to understand from people:

- Which existing topic areas the survey should continue to cover;
- Whether there are new question areas that should be included;
- Where new question areas are suggested, which areas these should replace in the survey.

Comments were invited from all interested parties. The consultation closed on 5 January 2016. In addition, NatCen conducted a group discussion with 10 young people.

This report summarises the findings from the consultation and the discussion group.

1.2 Methods

1.2.1 Online consultation

People who responded to the online consultation were asked to read a short summary document about the survey and current content before answering the questions. This document provided some background about the MHCYP 2016 and briefly described its methodology. It also included a table showing the list of topics covered in 2004 and which topics are part of the Development and Wellbeing Assessment (DAWBA) and the Strengths and Difficulties Questionnaire (SDQ). A copy of the document can be found in Appendix A. Topics that formed part of the DAWBA and SDQ were not considered in this consultation as these measures constitute the core diagnostic measures of the survey.

Most respondents responded to the consultation through the online questionnaire. Seven respondents sent in their views in the form of a written reply. A copy of the questionnaire can be found in Appendix B. Respondents were not required to answer every question and so the numbers of responses vary for the different questions.
All of the responses to two open-text questions (i.e. “Which additional topics do you think should be included in MHCYP 2016?” and “What would you choose to remove from the survey in order to make space for the new topics you have suggested?”) can be found in Appendices E and F\(^1\). The responses have been anonymised.

1.2.2 Discussion group with young people

Involving young people in the survey process is crucial – it means that we can ensure that the voice of this group is included in the project in a meaningful way. Having young people’s views on the content of the survey is important. It offers the opportunity to understand first-hand the issues young people feel most affect the mental health of their peers. As part of this effort, NatCen talked to a group made up of ten 16-24 year olds in December 2015.

Participants were identified through an existing mental health research network. They came from across England and had a wide range of experiences and interests and a common interest in mental health.

Before the discussion group, participants were sent some information about the Child and Adolescent Mental Health Survey series (see Appendix A). Discussions were mainly dominated by which additional topics and questions should be covered in MHCYP 2016.

\(^1\) Please note that one respondent has asked for their comments to not be included in the Appendices.
2 Responses to the Consultation

The consultation went live on 26 November 2015 and closed on 5 January 2016. During this time, the online consultation questionnaire was viewed 630 times and 225 respondents left responses. As none of the questions in the questionnaire were compulsory, bases for each question reported on are different.

2.1 Respondents

182 respondents left details of the type of respondent they were or organisation they were responding on behalf of. Table 2.1 shows the different types of respondents. 132 respondents left individual responses and 50 responses represented organisational responses. The most common respondent/organisation types were charity or voluntary organisations (21%), academic/researchers (20%) and clinicians (15%).

<table>
<thead>
<tr>
<th>Organisation/respondent type</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Academic/researcher</td>
<td>37&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Clinician (from the NHS, or other organisations)</td>
<td>28&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Charity or voluntary organisation</td>
<td>38</td>
</tr>
<tr>
<td>Member of the public</td>
<td>25</td>
</tr>
<tr>
<td>Public sector (Local Authorities and local or regional government/organisation)</td>
<td>21</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
</tr>
<tr>
<td>Public sector (national government department/organisation)</td>
<td>10</td>
</tr>
<tr>
<td>Private sector</td>
<td>7</td>
</tr>
<tr>
<td>Other public sector organisation</td>
<td>5</td>
</tr>
<tr>
<td>Youth Service</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>183</td>
</tr>
</tbody>
</table>

<sup>a</sup> 3 of the 183 respondents described themselves as an academic and a clinician. These respondents are represented twice in this table but only once in the base.

2.2 Using the outputs

Respondents were asked about what they had used previous outputs from the Child and Adolescent Mental Health Survey series for. Respondents could choose as many uses as applied and 170 respondents provided information. Figure 2.1 shows the results from this question. The most commonly reported uses were to inform policy making and to examine trends and behaviours.
169 respondents provided details about their planned use of the MHCYP 2016 survey outputs. The most commonly reported planned uses of the data were to examine trends and behaviours, for planning services and to inform policy making.
2.3 Repeating existing topics

Respondents were asked to rate the importance of covering topics again in 2016 that were included in the 2004 survey. For each topic covered in the 2004 parent, child and teacher questionnaires (excluding the DAWBA or SDQ) respondents were asked to rate the importance of repeating this on a scale from 1 (not at all important) to 5 (very important). Table 2.2 shows the mean score for each topic ranked from highest to lowest. Higher mean scores signify topics seen to be of greater importance to include in the 2016 survey. Mean scores varied from 4.77 to 3.76.

Table 2.2 Mean importance for each topic to be included

<table>
<thead>
<tr>
<th>Source</th>
<th>Topic</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Use services for mental health problems</td>
<td>4.77</td>
</tr>
<tr>
<td>P</td>
<td>Parent mental health</td>
<td>4.73</td>
</tr>
<tr>
<td>P</td>
<td>Whether looked after by local authority</td>
<td>4.69</td>
</tr>
<tr>
<td>P</td>
<td>Family relationships/conflict</td>
<td>4.69</td>
</tr>
<tr>
<td>P</td>
<td>Learning difficulties, intellectual disabilities</td>
<td>4.67</td>
</tr>
<tr>
<td>P</td>
<td>Stressful life events</td>
<td>4.66</td>
</tr>
<tr>
<td>T</td>
<td>Help from school for mental health problems</td>
<td>4.61</td>
</tr>
<tr>
<td>CYP</td>
<td>Social support and social networks</td>
<td>4.59</td>
</tr>
<tr>
<td>P</td>
<td>General health</td>
<td>4.57</td>
</tr>
<tr>
<td>P</td>
<td>Neurological conditions (e.g. cerebral palsy, epilepsy)</td>
<td>4.51</td>
</tr>
<tr>
<td>P</td>
<td>Long term physical conditions e.g. diabetes, asthma</td>
<td>4.51</td>
</tr>
<tr>
<td>P</td>
<td>School exclusions</td>
<td>4.51</td>
</tr>
<tr>
<td>P</td>
<td>Strengths of the child/young person</td>
<td>4.48</td>
</tr>
<tr>
<td>CYP</td>
<td>Strengths of the young person</td>
<td>4.47</td>
</tr>
<tr>
<td>P</td>
<td>Medication</td>
<td>4.45</td>
</tr>
<tr>
<td>CYP</td>
<td>Drug use (self-completion)</td>
<td>4.40</td>
</tr>
<tr>
<td>P</td>
<td>Household composition (including age, sex, relationships)</td>
<td>4.36</td>
</tr>
<tr>
<td>CYP</td>
<td>Drinking (self-completion)</td>
<td>4.34</td>
</tr>
<tr>
<td>P</td>
<td>Bullied by teacher</td>
<td>4.31</td>
</tr>
<tr>
<td>CYP</td>
<td>Educational attainment</td>
<td>4.28</td>
</tr>
<tr>
<td>CYP</td>
<td>Social life/capital</td>
<td>4.28</td>
</tr>
<tr>
<td>P</td>
<td>Parent employment</td>
<td>4.27</td>
</tr>
<tr>
<td>T</td>
<td>Teacher report of special needs</td>
<td>4.24</td>
</tr>
<tr>
<td>P</td>
<td>Registered with GP</td>
<td>4.22</td>
</tr>
<tr>
<td>P</td>
<td>Income (including receipt of benefits)</td>
<td>4.21</td>
</tr>
<tr>
<td>P</td>
<td>Parent education</td>
<td>4.03</td>
</tr>
<tr>
<td>CYP</td>
<td>Smoking (self-completion)</td>
<td>4.02</td>
</tr>
</tbody>
</table>
Table 2: Mean importance for each topic to be included

<table>
<thead>
<tr>
<th></th>
<th>Mean Importance</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>T</td>
<td>3.99</td>
<td>Teacher assessment of child’s academic abilities (reading, spelling, maths)</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>3.87</td>
<td>Ethnicity of each household member</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>3.86</td>
<td>Estimated mental age</td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>3.81</td>
<td>Personality</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>3.76</td>
<td>Housing tenure</td>
<td></td>
</tr>
</tbody>
</table>

a P denotes topics asked in the parent interview, CYP denotes those asked in the children/young person interview and T denotes topics included in the teacher questionnaire.
b Topics that are about the parent or household in general and not about the child or young person specifically.
c The mean score was calculated from valid answers at each question and has a maximum score of 5. Bases vary for each question. The highest base is 225 and the lowest is 189. Respondents also had the option to code each question as ‘don’t know’ or ‘no answer’. These responses have not been included in the calculation of mean score. A higher mean score does not necessarily mean that a topic is more important than another. No statistical testing has been carried out on mean scores. When scores are similar, there may be no significant difference between the scores when compared using a statistical test.
3 Additional content

205 respondents provided a response to the question about whether additional topics should be covered in the MHCYP 2016. 54% of respondents reported that additional topics were needed.

3.1 New topics

Respondents were asked “Which additional topics do you think should be included in MHCYP 2016? Please explain why you think they should be included.” 105 respondents made suggestions. The anonymised responses to this question can be found in Appendix E.

It is important to note that not all the suggestions made by respondents were new topics. Some respondents suggested broadening the scope of certain topics already covered in 2004 (see Table 3.2).

A number of additional topics for the MHCYP 2016 were also discussed during the discussion group with young people.

Overall, a total of 47 new topics for the MHCYP 2016 were suggested (as listed in Table 3.1 below). They varied widely and the most commonly suggested topics for inclusion were online activity and bullying.

Table 3.1 Additional topics suggested for MHCYP 2016

<table>
<thead>
<tr>
<th>Additional topics</th>
<th>Number of responses</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Online activity and social media</td>
<td>18</td>
<td>Amount of time spent online:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• especially at night</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• link to self-image</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• amount of ‘screen time’ should divided into several questions</td>
</tr>
<tr>
<td>Bullying</td>
<td>15</td>
<td>• Experiences of cyber-bullying (6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Type of bullying (physical, indirect, and verbal)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Content of bullying: religious, racist, homophobic, special educational needs and disability (SEND), etc.</td>
</tr>
<tr>
<td>Topic</td>
<td>Score</td>
<td>Suggestions/Comments</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Sexual violence                     | 7     | • Witnessing and own experiences  
• Sexual exploitation  
• Psychosis symptoms  
• Experiences of rape/sexual trauma  
• Understanding of rape/sexual consent  
• Sexual harassment  
• Suggestion to include:  
  o the Domestic Abuse, Stalking and Honour Based Violence Risk Identification, Assessment (DASH) and Management Model  
  o the Comprehensive Health Assessment Tool (CHAT)  
  o the Child Sexual Exploitation Risk Assessment Tool |
| Caring responsibilities             | 6     | • Use the multidimensional assessment of caring activities  
• Need to measure both practical/emotional impact in sections relating to prevalence of MH disorders by personal/family characteristics |
| Gender beliefs                      | 6     | • Gender identity disorder |
| Experience of discrimination/stigma | 5     | • Discrimination from family, friends, teachers and in services  
• How this influences the experience and recovery |
| Parent substance abuse              | 5     | • Suggestion to use Parental substance Misuse Assessment |
| Physical activity                   | 5     | • Regularity/ Access |
| Relationships/sexuality             | 5     | • Sexual experience  
• Concerns about sexuality  
• Teenage relationships  
• Access to porn/ revenge porn |
| Sensory impairments                 | 5     | |
| Sexual orientation of the child     | 5     | |
| Wellbeing (general/subjective)      | 5     | • Important to separate out a measure of wellbeing from mental health  
• Suggestion to use the Stirling/ Warwick-Edinburgh Mental Well-Being Scales  
Perceived levels of happiness |
| Domestic abuse/violence             | 4     | • Witnessing and own experiences  
• Relevant to child presentation |
| Role of faith/religion              | 4     | • Parent/Child involvement in religious activities  
• Important in relation to Minority Ethnic groups |
| Child protection/in need status     | 3     | Is the child under a plan? |
| Experiences with the justice system | 3     | • Parent experiences  
• Child experiences |
<table>
<thead>
<tr>
<th>Domain</th>
<th>Rating</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Family physical health         | 3      | - Parent physical health, especially chronic health conditions  
|                                |        | - Sibling physical health (e.g. prolonged separation due to other child complex health needs, hospital admissions)                      |
| Immigration status/length of residency | 3      | - Experience of being a refugee or asylum seeker  
|                                |        | - Pre-migration trauma                                                                                                              |
| Pregnancy                      | 3      | - Experience in utero (use of drug/alcohol; stressful experience including domestic violence)  
|                                |        | - Traumatic events including prematurity and admission into a Special Baby Care Unit/Neonatal Intensive Care Unit at birth.              |
| Body dysmorphia                | 2      |                                                                                                                                 |
| Language                       | 2      | - Language spoken at home/in education  
|                                |        | - Language ability rather than ethnicity (as impacts on communication during assessment)                                             |
| Resilience                     | 2      | - Suggestion to look at the measurement framework developed by Headstart (including the Student Resilience Survey)                   |
| School burnout or academic related stress | 2      |                                                                                                                                 |
| Self esteem                    | 2      | Questions around popularity                                                                                                          |
| Sense of self and sense of agency | 2      |                                                                                                                                 |
| Support provided by school     | 2      | Support provided in school:  
|                                |        | - awareness by children  
|                                |        | - would they/do they use the services available  
|                                |        | - support in regards to provision of information about mental health and support services                                          |
| Decision-making                | 1      | Are you (the child) engaged in the decision-making about your needs?                                                                 |
| Eligibility to free school meals | 1      |                                                                                                                                 |
| Family Dynamics                | 1      | - Separated parents: how is your life different with your mother and with your father?  
|                                |        | - Sibling relationships                                                                                                              |
| Food/Drink intake              | 1      |                                                                                                                                 |
| Fuel poverty                   | 1      | Include a question about whether the household is adequately heated to explore the relationship between fuel poverty and children's mental health |
| Having to stay in education until 18 | 1      |                                                                                                                                 |
| Home/kinship care              | 1      |                                                                                                                                 |
In addition to discussing which topics should be included in the MHCYP 2016, participants from the young person discussion group came up with a list of questions for a number of topics that they thought should be included in the MHCYP 2016, as follows:

- **Social media (addiction)**
  - How long do you think you spend on social media each day?
  - How do you think social media affect you? Your mood? Your life?
  - Have you already been late to something/ missed something because of the time you spend on social media?
  - Do you compare yourself to others on social media? (self-esteem)
  - Do you think your social media accounts are a true reflection of yourself?
  - Link to self-worth (do you monitor how many 'likes' you get? Does the number of Facebook friends you have impact on your mood?)
  - Cyberbullying: do you ever receive comments that make you feel bad about yourself?

<table>
<thead>
<tr>
<th>Topic</th>
<th>Score</th>
<th>Comments/Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household, income and employment information about young people aged 16+</td>
<td>1</td>
<td>Add questions about household composition and demographics, tenure, education and employment, occupation and income to young people aged 16-19 (particularly important information to capture about young people living independently).</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Involvement in any research/projects about mental health</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lack of jobs/ pressure</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Male role models</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Mobility/ number of schools attended</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Non-acrimonious conflict (parents)</td>
<td>1</td>
<td>Suggestion to add the question: “Which of the following best describes how you and your partner deal with disagreements and differences?”</td>
</tr>
<tr>
<td>Peer pressure</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sense of hope</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Source of information beyond the school</td>
<td>1</td>
<td>Does the child pay attention to news? Political affiliation?</td>
</tr>
<tr>
<td>Teacher stress/depression/anxiety</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Type of schooling</td>
<td>1</td>
<td>Mainstream / special / pupil referral unit/ home educated.</td>
</tr>
<tr>
<td>Understanding of mental health</td>
<td>1</td>
<td>Important to bring up good mental health (as the term ‘mental health’ tend to have a negative connotation)</td>
</tr>
<tr>
<td>Use of abuse from children towards parents/carers/partner</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Whether parent had a fit to work assessment</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
• Gaming (addiction)
  • Do you think games can or/and do affect your behaviour in everyday life?
  • How often do you play computer games? For how long?
  • Do you have friends outside of gaming?
  • Do you find that you get angry when you play these games? Do they trigger anger?

• Having to stay in education until 18
  • How do you feel about having to stay in education until 18?
  • Do you feel pressure to do well academically (e.g. GCSEs)?

• Understanding of mental health
  • Do you know what a mental health problem is?
  • Do you know where to get support?
  • Do you know who to speak to?

• Lack of jobs/pressure
  • How do you feel about the future and getting a job?
  • Do you know what you’d like to do for work?
  • Do you think it would be possible?
  • How does it feel?

• Questions around discrimination (protected characteristics):
  • Have you ever felt stigmatised because of your sexuality/your religion?
  • How accepted do you feel?
  • How much support do you have?
  • Do you feel equal to other people around you?

3.2 Topics to broaden

As mentioned above, a number of respondents to the online consultation suggested broadening the scope of certain topics already covered by the 2004 survey. These suggestions are included in the table below:
### Table 3:2  Topics suggested to be broadened in MHCYP 2016

**Base: 104 respondents**

<table>
<thead>
<tr>
<th>MHCYP 2004 topics</th>
<th>Number of responses</th>
<th>Further areas to explore</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of services for mental health problems</td>
<td>15</td>
<td>• Provision of regional services and their accessibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Services access and awareness of access from parents</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Understanding and perception of services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Experience of transition between services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What is being provided and who to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Length of waiting lists</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of voluntary health services (in addition to use of CAHMS and NHS services)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of telephone, counselling and online help</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Views on new early health care plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Satisfaction with services</td>
</tr>
<tr>
<td>Looked after by local authority</td>
<td>6</td>
<td>• Identification of care leavers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is the child under special guardianship order or adopted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pre-adoption experiences, broken attachments and early experiences of trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How old the child was when they were first looked after, and how old they were at the start of their most recent placement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How many different care placements has the child had while they were in care, including all episodes of care</td>
</tr>
<tr>
<td>Specific physical conditions- learning disabilities/ intellectual disability</td>
<td>4</td>
<td>• Distinction between intellectual disabilities and specific learning difficulties</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A more specific question/measure than 'educational attainment' is required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Education, Health and Care plans</td>
</tr>
</tbody>
</table>
| Household Composition and Family History | 4 | - Is other birth parent resident in the household  
- Is one parent in the armed forces  
- Live in rural or urban area  
- Whether the CYPs live with one or both of their parents (and the parents’ relationship) and – if not – what contact (if any) they have with the parent they don’t live with;  
- Step-parents/brothers/sisters (as essential within the household, but ideally also new partners/children of non-resident parents);  
- Experience of changes in family structure (step-parents, partners, etc). |
| Parent Mental Health | 3 | Family history of mental disorders:  
- Parental Mental Health (expand)  
- Sibling or other close relationship mental health |
| Sleep | 3 | Bedtime and getting up time: self-report from children/young people |
| Socio-economic position | 3 | - Financial difficulties, collect information about being in debt and the impact it can have on children and families  
- Housing: Overcrowding; housing security (length of time in accommodation, how likely or unlikely do you think it is that you will need to leave your accommodation within the next 6 months) and tenancy length/type. |
| Bereavement | 2 | Split death parent/death sibling question into two questions |
| Child substance abuse | 2 | Suggestions to use the young people misuse assessment scale |
| Engagement/satisfaction with school (parent and child) | 2 | - Support from teachers, trusted people in school  
- Engagement in outside interests/extra-curricular activities |
| Stressful life events | 2 | - Identification of adverse childhood experiences.  
- Add to the current question to include transition between schools, especially at non-standard times and cyber bullying |
| Suicide | 2 | - Suicide ideation  
- Suicide attempts  
- Does the child know someone close to them who have experienced suicide |
A number of respondents suggested a range of topics already covered in the survey in 2004. It is not clear whether these were suggested due to unfamiliarity with the detailed content or if they were suggested for retention or expansion in the survey. The topics included:

- symptoms of trauma
- early help
- speech and language impairments
- relationships and relationships breakdown
- history of trauma
- history of intervention
- psychosis symptoms
- services already accessed
- social support
- experiences of accessing support
- satisfaction with service
- alcohol/ substance abuse
- eating disorders/ dietary issues
- experiences of services
- anxiety
- understanding of how their behaviours impact on others
- whether a child has a diagnosis, e.g. autism
- disability parent/child
- being bullied by teachers
3.3 Coverage by age group

Respondents were asked for which age groups additional topics should be included in the MHCYP 2016.

While some respondents agreed on which topics should be covered by the survey, their opinions on the age groups these new questions should be asked of sometimes differed. All responses are listed in table 3.3.
<table>
<thead>
<tr>
<th>MHCYP additional topics identified by respondents</th>
<th>Age groups suggested</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to talk/ cope with emotions</td>
<td>All age groups</td>
</tr>
<tr>
<td>Bereavement</td>
<td>All age groups</td>
</tr>
<tr>
<td>Body dysmorphia</td>
<td>8+</td>
</tr>
<tr>
<td>Bullying</td>
<td>• All age groups</td>
</tr>
<tr>
<td></td>
<td>• Teenagers</td>
</tr>
<tr>
<td></td>
<td>• 11+</td>
</tr>
<tr>
<td>Caring responsibilities</td>
<td>• 11+</td>
</tr>
<tr>
<td></td>
<td>• 2-19</td>
</tr>
<tr>
<td>Engagement/satisfaction with school (parent and child)</td>
<td>• All age groups for parents</td>
</tr>
<tr>
<td></td>
<td>• 11+ for C/YP</td>
</tr>
<tr>
<td>Domestic abuse/ violence</td>
<td>11+</td>
</tr>
<tr>
<td>Experience of discrimination/ stigma</td>
<td>All age groups</td>
</tr>
<tr>
<td>Experience of the justice system</td>
<td>• Adolescents</td>
</tr>
<tr>
<td></td>
<td>• 10+</td>
</tr>
<tr>
<td>Family physical health</td>
<td>All age groups</td>
</tr>
<tr>
<td>Family Mental Health</td>
<td>All age groups</td>
</tr>
<tr>
<td>Food/ drink intake</td>
<td>All age groups</td>
</tr>
<tr>
<td>Gender beliefs</td>
<td>• 10+</td>
</tr>
<tr>
<td></td>
<td>• Key stage 3 and upwards</td>
</tr>
<tr>
<td>Household, income and employment information about young people aged 16+</td>
<td>16+</td>
</tr>
<tr>
<td>Household Composition</td>
<td>All age groups</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>All age groups</td>
</tr>
<tr>
<td>Looked after by local authority</td>
<td>16+ for care leavers</td>
</tr>
<tr>
<td>Male role models</td>
<td>• 6-14  for role models inside the family</td>
</tr>
<tr>
<td></td>
<td>• 14-18 male mentor outside immediate family</td>
</tr>
<tr>
<td>Non acrimonious conflict</td>
<td>All age groups</td>
</tr>
<tr>
<td>Physical activity</td>
<td>All age groups</td>
</tr>
<tr>
<td>Psychosis</td>
<td>Teenagers</td>
</tr>
<tr>
<td>Online activity</td>
<td>• All age groups</td>
</tr>
<tr>
<td></td>
<td>• 7+</td>
</tr>
<tr>
<td></td>
<td>• 8+</td>
</tr>
<tr>
<td></td>
<td>• 11+</td>
</tr>
<tr>
<td>Relationships/Sexuality</td>
<td>• 11+</td>
</tr>
<tr>
<td></td>
<td>• From 10</td>
</tr>
<tr>
<td>Resilience</td>
<td>8/9 to 16</td>
</tr>
<tr>
<td>Topic</td>
<td>Age Groups</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Role of faith / religion</td>
<td>All age groups</td>
</tr>
<tr>
<td>Self-harm</td>
<td>All age groups</td>
</tr>
<tr>
<td>Sense of self and sense of agency</td>
<td>0-19</td>
</tr>
<tr>
<td>Sensory impairments</td>
<td>All age groups</td>
</tr>
<tr>
<td>Sexual orientation</td>
<td>• 11+</td>
</tr>
<tr>
<td></td>
<td>• Teenagers</td>
</tr>
<tr>
<td></td>
<td>• 15+</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>• 8+</td>
</tr>
<tr>
<td></td>
<td>• 11+</td>
</tr>
<tr>
<td></td>
<td>• Teenagers</td>
</tr>
<tr>
<td>School burnout or academic related stress</td>
<td>All age groups</td>
</tr>
<tr>
<td>Sleep</td>
<td>All age groups</td>
</tr>
<tr>
<td>Socio-economic position</td>
<td>All age groups (questions for parents)</td>
</tr>
<tr>
<td>Source of information beyond the school</td>
<td>Secondary school age</td>
</tr>
<tr>
<td>Specific physical conditions - learning disabilities/ intellectual disability</td>
<td>All age groups</td>
</tr>
<tr>
<td>Stressful life events</td>
<td>All age groups</td>
</tr>
<tr>
<td>Suicide</td>
<td>12+</td>
</tr>
<tr>
<td>Support provided by school</td>
<td>All age groups</td>
</tr>
<tr>
<td>Use services for mental health problems</td>
<td>• Provision of regional services and their accessibility: all age groups; 0-19; 4-19; 4-18</td>
</tr>
<tr>
<td></td>
<td>• Services access: 5+; 13-16.</td>
</tr>
<tr>
<td></td>
<td>• Understanding and perception of services: 7-18; adolescents</td>
</tr>
<tr>
<td></td>
<td>• What is being provided/ who to: 0-19</td>
</tr>
<tr>
<td></td>
<td>• Length of waiting lists: 0-25</td>
</tr>
<tr>
<td></td>
<td>• Use of voluntary services (in addition to CAHMS/ NHS services): 0-25</td>
</tr>
<tr>
<td></td>
<td>• Use of phone, counselling and online help: school age and young adults</td>
</tr>
<tr>
<td></td>
<td>• Views on new early health care plans: 2-25</td>
</tr>
<tr>
<td></td>
<td>• Transition between services: 14-19; 12-19</td>
</tr>
<tr>
<td>Wellbeing (general/ subjective)</td>
<td>• 8+</td>
</tr>
<tr>
<td></td>
<td>• 10+</td>
</tr>
<tr>
<td>Whether parents just had fitness to work assessment</td>
<td>All age groups</td>
</tr>
</tbody>
</table>

### 3.4 Removing content

Respondents were asked “What would you choose to remove from the survey in order to make space for the new topics you have suggested? Please explain your choices.”

More than 100 responses were given and 42 separate topics/questions were suggested to be removed (see table 3.4 below). They varied widely and the most
common content chosen to be removed was the smoking, drinking and drug use section from the self-completed child questionnaire.

It is also important to note that 12 respondents did not want anything to be removed from the survey. In fact, this was the most common suggestion.

Table 3.4 Topics respondents think should be removed in MHCYP 2016

<table>
<thead>
<tr>
<th>Topics/questions</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nothing to be removed</td>
<td>12</td>
</tr>
<tr>
<td>Smoking (child self-completion)</td>
<td>11</td>
</tr>
<tr>
<td>Drug use (child self-completion)</td>
<td>8</td>
</tr>
<tr>
<td>Drinking (child self-completion)</td>
<td>7</td>
</tr>
<tr>
<td>Personality measures</td>
<td>7</td>
</tr>
<tr>
<td>Estimated mental age</td>
<td>5</td>
</tr>
<tr>
<td>Teacher assessment of academic abilities</td>
<td>5</td>
</tr>
<tr>
<td>Bullied by teacher</td>
<td>5</td>
</tr>
<tr>
<td>Strengths of the young person</td>
<td>5</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>5</td>
</tr>
<tr>
<td>Parent income</td>
<td>4</td>
</tr>
<tr>
<td>Housing tenure</td>
<td>3</td>
</tr>
<tr>
<td>General health (reported by parents)</td>
<td>2</td>
</tr>
<tr>
<td>Parent education</td>
<td>2</td>
</tr>
<tr>
<td>Less common disorders</td>
<td>2</td>
</tr>
<tr>
<td>Measures of family functioning</td>
<td>2</td>
</tr>
<tr>
<td>Reduce number of questions within each issue</td>
<td>2</td>
</tr>
</tbody>
</table>

The most popular content chosen to be removed was the smoking, drinking and drug use section. Some reasons for this were:

- “There are other surveys that already undertake studies here and, given that it is self-completion, often participants will drastically understate or overstate the extent of this.”

- “I think there are too many questions in these sections. This topic is already extensively covered on a number of other surveys of children and young people. These sections could be substantially reduced to a few basic indicators.”

- “These activities are so pervasive in adult society that it seems wrong to equate them in any way with mental health issues although I don’t doubt that they come to affect mental wellbeing in the longer term.”

- “[These] are extremely detailed and could be cut back in length.”

- “These are self-completed questions and I am not sure whether you will get accurate data. Also, the adverse experiences should provide information about substance misuse within the family or by the child.”
The next most popular content to be removed was the personality measures section which 7 respondents suggested. Reasons for its removal were given:

- “These will give the usual results, e.g., - Openness predicts attainment - Neuroticism predicts mental health difficulties - Agreeableness will correlate with conduct problems and prosocial behaviour. Personality won't add anything.”

- “If you take a group of surveyed ‘happy people’, they will have different personalities, very different. Their characteristics (resulting in happiness) may overlap, but not as much their personalities - therefore seems irrelevant to discover the mental well-being of our youngsters.”

- “It is a personal view rather than a yes/no answer”

- “This is also likely to be biased”

Bullied by teacher, asked in the parent/carer interview, was also suggested by a few respondents to be removed. Comments to justify this were:

- “Possibly I would also remove the teacher bullying questions in favour of a broader measurement of perceived support from school (as per the subscale of the student resilience scale).”

- “It seems just too specific. May be covered under stressful events.”

- “[These] were weak in 2004 and similar could be captured in proposed section on school engagement.”

Ethnicity and strengths of young person also had a relatively high number of respondents suggesting to remove them. Ethnicity was felt to be less important and “can go someway to helping us to comprehend variations/inequalities, but introducing ethnicity as a key marker to a child is counterproductive”. One respondent commented that reporting the strengths of the young person may not reflect reality due to possible poor parenting skill to assess them or having undisguised strengths. It was also felt that strengths questions were repeated at times, and as they are included in the SDQ there is no need for further questions on this topic.

The idea of reducing sections was also fairly common, especially in the teacher questionnaire. It appears that most people feel the teacher questionnaire is the least important section, as well as demographic data (parent income, ethnicity of each household member, teacher estimated mental age of child and teacher assessment of academic ability were all suggested by 4 or more people to be removed). Teacher assessment of academic abilities and estimated mental age of the child were viewed to be easily influential, open to subjective reports and may be poorly validated, which is why they were chosen to be removed.

A couple of respondents stated that some questions are over-laboured and could be condensed in order to allow for additional questioning and to have more issues with fewer questions on each. Although this may impact on comparable data from the 2004 survey, they felt it was acceptable.

A respondent also suggested that some of the questions relating to health and disability should be grouped together and placed into the monitoring information rather than being survey questions as such.

Table 3.5 below shows the suggestions for how to make space and what could be removed that were given by just one respondent each. A common reason given for
some of the below suggestions was that respondents were unclear of the relevance that certain information may add and felt that in 2004 the questions did not provide useful data (e.g. Registered with GP and Social Life sections), or respondents felt they were less important than other sections in the survey.

3.5 Other comments

The consultation asked “Please use the space below to make any other comments you would like to submit as part of the consultation on the content of the survey.”

The ‘other comments’ provided have been grouped into various categories that respondents spoke about and a selection of these comments is provided.

Content:

Table 3.5 Topics respondents think should be removed in MHCYP 2016

<table>
<thead>
<tr>
<th>Topics/questions</th>
<th>Other concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open ended description of significant problems</td>
<td>Parent employment</td>
</tr>
<tr>
<td>Parent employment</td>
<td>Stressful events</td>
</tr>
<tr>
<td>Whether child is looked after by local authority</td>
<td>Child’s sources of emotional support</td>
</tr>
<tr>
<td>Child’s paid work</td>
<td>Region, county and area question</td>
</tr>
<tr>
<td>Medication</td>
<td>Social life</td>
</tr>
<tr>
<td>Social support and social networks</td>
<td>Registered with GP</td>
</tr>
<tr>
<td>Troublesome behavior</td>
<td>SDQ</td>
</tr>
<tr>
<td>Teacher assessment of child’s mental health</td>
<td>Social context of last smoking, drinking etc occasion</td>
</tr>
<tr>
<td>Merge together ‘Social Support’ and ‘Social life’ sections</td>
<td>Reduce the number of questions relating to parent &amp; family information</td>
</tr>
<tr>
<td>Reduce the ‘Other Information’ section on teacher questionnaire</td>
<td>Reduce the teacher elements</td>
</tr>
<tr>
<td>Reduce some of the parental demographic data</td>
<td>Reduce some of the parental demographic data</td>
</tr>
<tr>
<td>Remove some details of teacher questionnaire that have no clear evidential relationship to mental health</td>
<td>Remove question R8 to do with language and age level</td>
</tr>
<tr>
<td>Just 1 question on SEN status and reason for SEN is needed</td>
<td>Remove question 1, 2 and 4 from teacher questionnaire</td>
</tr>
<tr>
<td>Access to mental health services</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- “The survey appears deficit and diagnosis focused rather than concentrating on the strengths and positive characteristics which could be useful to determine resilience factors.”

- “The survey is an opportunity to include a measure of sexual orientation and gender identity and create a national dataset that can help prevent mental health problems in this high risk group. In the US these measures are included on a regular basis on state-wide youth health surveys (aged 12-18)”

- “I would re-iterate the need to include questions that address the growing uptake of social media and technology among young people. Never before have we witnessed a generation who are so technologically literate, and understanding the effects of this are absolutely crucial.”

- "The National Autistic Society (NAS) believes that autistic spectrum disorder should be included as a specific category within the survey, as in 2004, because it affects a large number of children (approx 1 in 100) and brings with it some specific challenges that can affect children and young people's day to day experiences.”

- “It is very important and useful to have a measure of the educational attainments of the children. I would prefer a directly administered test rather than teacher report because: 1. It is more reliable and consistent across children. 2. Previously there was a large amount of missing data with teacher report.”

- “It is important that the items can be used to calculate the Adverse Childhood Experiences Scale since this is a widely used and very predictive public health measure”

Age range of survey:

- “Whilst I appreciate that you have been commissioned to survey 2-19 yr olds, we would like to raise the fact that we believe that the survey should definitely cover up to 25 years. This is because the brain doesn't fully mature until then, so they are still developing. Whilst the adult psychiatric morbidity report covers this age, the diagnostic language is different, so it is impossible anyone other than a clinician to look across the 2 report and draw any conclusions. At the other end of the age spectrum, we know that mental health problems can have their roots in utero. So whilst starting at age 2 is better than age 5, it would be more useful to start from age 0, and if possible to include questions regarding the mother during pregnancy. So we can really understand what the issues are at this really early stage. This should give some evidence about what is happening at this really early stage.”

- “A national survey of the mental health of children and young people should cover the whole 0-18 years age range and should not exclude the 0-2 years age group. This is discriminatory on the basis of age, it is unscientific and ideologically driven, and it produces an incomplete national picture. There is a
vast international body of knowledge, research and evidence about mental health disorders in the 0-2 years age range.”

**Interview protocol:**

- “I am interested in the content of the interview protocol for the following reasons: - sensitivity of topics - wide range of potentially emotionally draining & triggering questions - the length of the interviews. To get the strongest data & provide a positive experience for participants, I anticipate that researchers will have mental health training, and that there will be safeguards in place: signposting to services and provision to mental health support if participants are distressed or identify a mental health issue that they would like to have support around. I suggest support is available to researchers too given the emotionally risky content of this study (supervisory and peer).”

**Sample:**

- “Oversampling of BAME (Black, Asian and Minority Ethnic) young people”

- “It is understood that the sample size for this questionnaire cannot produce statistically significant information for highly vulnerable groups due to small numbers and that these are excluded from scope. However, future application of these instruments should be considered for specific groups so that they can be compared with the general population in terms of their increased vulnerability to poor mental health. These groups include: looked after children, children managed within the Troubled Families Programme, children at risk of sexual exploitation and sexual abuse, children with a parent in prison etc.”

**Data linkage:**

- “link to national pupil database for education attainment and special education needs (more reliable than teacher report)”

- “can add area deprivation from census/area based crime”
4 Next steps

NatCen would like to thank all those who took part in the consultation and provided information. This will be used to inform discussions about the content of the survey in 2016.

NatCen will make recommendations on survey content to the Health and Social Care Information Centre (HSCIC), based on the findings of the consultation and the scope of the survey in 2016. Once content areas are agreed, NatCen will begin detailed survey question design to ensure that the areas included provide high quality, meaningful data that will meet users’ needs.

New content may contain standardised questions, such as those suggested by respondents. However, there are areas where completely new questions may be needed. Cognitive testing will be used to test new or significantly revised questions. We will develop detailed interview guides and protocols to explore issues such as:

- understanding of key term/concepts
- appropriateness of answer options
- participants’ ability to recall information
- ability to complete the task.
Appendix A. MHCYP 2016: background, methodology and content

The Survey of the Mental Health of Children and Young People 2016 will be the first survey of children and young people to focus on mental health since 2004. The survey will collect robust data on a range of topics relating to the mental health of children and young people.

Background
The 2004 survey report described the prevalence of mental disorders among 5 to 16 year olds in Great Britain in 2004 and any changes since the previous survey in 1999. It profiled children in each of the main disorder categories (emotional, conduct, hyperkinetic and autistic spectrum disorders) and, where the sample size permitted, profiled subgroups within these categories. It reported whether parents had sought help for their child’s problems and if the child had special educational needs. It also described the characteristics of children with multiple disorders.

The 2004 survey found that overall around 10% of children had one or more mental disorders. Prevalence of disorders was higher among 11-16 year olds than among 5-10 year olds.

Methodology
The 2016 survey will use the same data collection methods, screening and diagnostic tools as in the 2004 survey. The age range has been extended in 2016 and will now include children and young people in England aged between 2 and 19.

The data collection methods will include:
- face to face interviews with parents, taking 90-120 minutes;
- face-to-face interview with 11-19 year olds, taking on average 45 minutes;
- an online self-completion questionnaire for teachers;

Content
It is expected that the 2016 survey will include most of the topics covered in the 2004 survey to allow for the assessment of change over time. For each of the questionnaires, the diagnostic tool for assessing child mental health – Development and Wellbeing Assessment (DAWBA) – and the Strengths and Difficulties Questionnaire (SDQ) comprise a large part of the questionnaire. It is important to note that the Strengths and Difficulties Questionnaire (SDQ) and the Development and Well-Being Assessments (DAWBA) constitute the core of the survey series and are essential for assessment of mental disorders. Their content is therefore not considered for review.

Table 1 below shows a list of topics covered in 2004 and shows which topics are part of the DAWBA and SDQ.
### Table 1: 2004 Survey of the Mental Health of Children and Young People content

<table>
<thead>
<tr>
<th>DAWBA/SDQ ITEMS</th>
<th>Parent interview sections</th>
<th>Child aged 11-16 interview sections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DAWBA/SDQ ITEMS</strong></td>
<td><strong>Mental health of the child:</strong></td>
<td><strong>Mental health self-report:</strong></td>
</tr>
<tr>
<td></td>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
</tr>
<tr>
<td></td>
<td>Autism / developmental disorders</td>
<td>Separation anxiety</td>
</tr>
<tr>
<td></td>
<td>Separation anxiety</td>
<td>Specific phobias</td>
</tr>
<tr>
<td></td>
<td>Specific phobias</td>
<td>Social phobias</td>
</tr>
<tr>
<td></td>
<td>Social phobias</td>
<td>Panic attacks and agoraphobia</td>
</tr>
<tr>
<td></td>
<td>Panic attacks and agoraphobia</td>
<td>Post-Traumatic Stress Disorder</td>
</tr>
<tr>
<td></td>
<td>Post-Traumatic Stress Disorder</td>
<td>Compulsions and obsessions</td>
</tr>
<tr>
<td></td>
<td>Compulsions and obsessions</td>
<td>Generalised anxiety</td>
</tr>
<tr>
<td></td>
<td>Generalised anxiety</td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>Self harm</td>
</tr>
<tr>
<td></td>
<td>Self harm</td>
<td>Attention and activity</td>
</tr>
<tr>
<td></td>
<td>Attention and activity</td>
<td>Awkward and troublesome behaviour</td>
</tr>
<tr>
<td></td>
<td>Awkward and troublesome behaviour</td>
<td>Eating disorders</td>
</tr>
<tr>
<td></td>
<td>Eating disorders</td>
<td>Less common disorders</td>
</tr>
<tr>
<td></td>
<td>Tics</td>
<td>Open ended description of significant problems</td>
</tr>
<tr>
<td></td>
<td>Other concerns</td>
<td>Other concerns</td>
</tr>
<tr>
<td></td>
<td>Open ended description of significant problems</td>
<td>Other concerns</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER INFORMATION</th>
<th>Other child information:</th>
<th>Other information provided:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OTHER INFORMATION</strong></td>
<td>General health and specific health conditions</td>
<td>Child’s strengths – child report</td>
</tr>
<tr>
<td></td>
<td>Stressful life events</td>
<td>Social Support</td>
</tr>
<tr>
<td></td>
<td>Medication</td>
<td>Social Life (neighbourhood, trust, care, clubs)</td>
</tr>
<tr>
<td></td>
<td>Service use for mental health problems</td>
<td>Educational attainment</td>
</tr>
<tr>
<td></td>
<td>School exclusions</td>
<td>Smoking cigarettes (self-completion)</td>
</tr>
<tr>
<td></td>
<td>Looked after by Local Authority</td>
<td>Use of alcohol (self-completion)</td>
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<td>Child’s strengths – parent report</td>
<td>Experience with drugs (self-completion)</td>
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| **Parent/family information:** | | |
|--------------------------------|-----------------------------|
| Household composition and demographics | |
| Tenure, education, employment, occupation | |
| Income (including state benefits) | |
| Parent mental health (self-completion) | |
| Family functioning (self-completion) | |

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<tr>
<th>Teacher Questionnaire (self-completion) sections</th>
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<th>DAWBA ITEMS</th>
<th><strong>Mental health of the child:</strong></th>
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<td>Strengths and Difficulties Questionnaire (SDQ)</td>
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<td>Attention, activity and impulsiveness</td>
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<td>Awkward and troublesome behaviour</td>
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<td>Other concerns</td>
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<tr>
<th><strong>OTHER INFORMATION</strong></th>
<th>Scholastic Achievement, estimated mental age and special needs</th>
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<tr>
<td>Help from school for mental health problems</td>
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<th><strong>DAWBA ITEMS</strong></th>
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Appendix B. Survey Content Consultation

Thank you for taking part in the consultation of survey content for The Survey of the Mental Health of Children and Young People 2016. Please ensure that you have read the short summary document about the survey and content before answering the questions. [http://www.natcen.ac.uk/media/1075116/mhcyp-background-method-and-content.pdf](http://www.natcen.ac.uk/media/1075116/mhcyp-background-method-and-content.pdf)

About the consultation
This consultation will run from 25th November 2015 to 5th January 2016. We will prepare a report of consultation comments and recommendations. If you would like to be informed about the report, please leave your contact details in the questionnaire.

Getting in Touch
If you have any queries or comments about the consultation process, please email MHCYP@natcen.ac.uk

You can also write to us at the following address:

NatCen Social Research
35 Northampton Square
London
EC1V 0AX

Confidentiality and data protection
Individual responses will not be disclosed when we report the outcomes of this consultation though the names of organisations contributing to the consultation will be included in the report. We intend to keep all individual responses anonymous. If you prefer, you can complete the consultation without leaving your name and contact details.

Accessibility
If you would like to receive materials relating to this consultation in an alternative, accessible format, please email MHCYP@natcen.ac.uk

Start of questions
1. The next page shows the content of the survey from 2004, not including the DAWBA or SDQ (the diagnostic tools used to assess mental health problems).

On a scale from 1 to 5, where 1 represents ‘not important at all’ and 5 represents ‘very important ’, how important do you think it is that each topic is included in the 2016 survey?
<table>
<thead>
<tr>
<th><strong>PARENT/CARER INTERVIEW</strong></th>
<th>Not important at all</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Very important</th>
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<tr>
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<td>Household composition (including age, sex, relationships)</td>
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<td>Ethnicity of each household member</td>
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<td>Housing tenure</td>
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<td>Income (including receipt of benefits)</td>
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<td>Parent employment</td>
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<td>Parent education</td>
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<td>Information about the child/young person</td>
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<td>General health</td>
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<td>Registered with GP</td>
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<td>Specific physical conditions</td>
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<td>• Neurological (e.g. cerebral palsy, epilepsy)</td>
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<td>• Learning difficulties, intellectual disabilities</td>
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<td>• Long term conditions e.g. diabetes, asthma</td>
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<td>Medication</td>
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<td>Use services for mental health problems</td>
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<td>Stressful life events</td>
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<td>Bullied by teacher</td>
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<td>School exclusions</td>
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<td>Strengths of the child/young person</td>
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<td>Whether looked after by local authority</td>
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<td><strong>Parent/carer self-completion</strong></td>
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<td>Parent mental health</td>
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<td>Family relationships/conflict</td>
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<td><strong>CHILD/YOUNG PERSON INTERVIEW</strong></td>
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<td>Strengths of the young person</td>
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<td>Social support and social networks</td>
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<td>Social life/capital</td>
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<td>Educational attainment</td>
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<td><strong>Child/young person self-completion</strong></td>
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<td>Drinking</td>
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<td>Drug use</td>
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<td><strong>TEACHER QUESTIONNAIRE</strong></td>
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<td>Teacher assessment of child’s academic abilities (reading, spelling, maths)</td>
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<td>Estimated mental age</td>
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<td>Teacher report of special needs</td>
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</table>
Before answering the next question, please take a few minutes to (re)familiarise yourself with the topics covered by the Development and Wellbeing Assessment (DAWBA) – and the Strengths and Difficulties Questionnaire (SDQ) (http://www.natcen.ac.uk/media/1075116/mhcyp-background-method-and-content.pdf). These measures will be included in the 2016 survey to assess the prevalence of mental disorders.

2. Are there any additional topic areas that you think should be included in the MHCYP 2016 survey?

   Yes ☐
   No ☐

   **If NO, go to Q6**

3. Which additional topics do you think should be included in MHCYP 2016? Please explain why you think they should be included.

   If YES at Q3 THEN

4. For which age groups do you think the additional topics should be included?
5. What would you choose to remove from the survey in order to make space for the new topics you have suggested? Please explain your choices.

6. Please use the space below to make any other comments you would like to submit as part of the consultation on the content of the survey.

**Personal details**

Please complete the following details:

1. Name: 

2. Type of respondent or organisation:

   - Academic/researcher
   - Clinician
   - Charity or voluntary organisation
   - Public Sector - Local or regional government / organisation
   - Public Sector - National government department/ organisation
   - Other Public sector organisation
   - Youth Service
   - Member of the public
   - Private sector
   - Other

3. Name of organisation: 

4. Are you responding individually or on behalf of your organisation?
   - Individual response ☐
   - Organisation response ☐

5. May we contact you to discuss your responses?
   - Yes ☐
   - No ☐
   - Email address: 

6. Telephone number: 
Your use of MHCYP

7. For what purpose(s) have you used the previous Child and Adolescent Mental Health Survey series outputs? These were published under the title of The Mental Health of Children and Young People in Britain in 1999 and 2004. 
Tick all that apply

To inform policy making ☐
Policy monitoring and evaluation ☐
Comparing local indicators with national figures ☐
Planning services ☐
To examine trends and behaviours ☐
Research and analysis – academic ☐
Research and analysis – other ☐
Personal interest ☐
Haven’t used previous outputs ☐
Other(s) (please specify) ☐

8. For what purpose(s) do you intend to use the MHCYP 2016 outputs? Tick all that apply

To inform policy making ☐
Policy monitoring and evaluation ☐
Comparing local indicators with national figures ☐
Planning services ☐
To examine trends and behaviours ☐
Research and analysis – academic ☐
Research and analysis – other ☐
Personal interest ☐
Other(s) (please specify) ☐

Thank you for taking part in the consultation. The consultation will close on 5th January 2016. We will feed back the findings of the consultation on our website. If you would like to be notified by email when these are available, please tick this box ☐
Appendix C. Survey Content Consultation

FAQs

How long is the consultation open for?
This consultation will run until 5th January 2016.

Can anyone reply?
Anybody who has expertise or an interest in child and adolescent mental health is welcome to respond.

If you are part of an organisation or group invited to take part in the consultation, please consider submitting one combined response to the consultation.

Can I have a Word version of the questionnaire to complete?
Yes. Please email us on MHCYP@natcen.ac.uk if you would like a Word version of the questionnaire.

I have questions about the survey. Who should I contact?
If you have any queries or comments about the consultation process, please email MHCYP@natcen.ac.uk

You can also write to us at the following address:
NatCen Social Research
35 Northampton Square
London
EC1V 0AX

How will the responses I give be used?
Your comments will be collated, and we will prepare a report of consultation comments and recommendations on:

- Which existing areas you think the survey should continue to cover;
- Whether there are new question areas you think should be included;
- Where new question areas are suggested, which areas these should replace in the survey.

Do I have to leave my contact details?
No, you don’t have to. However, if you would like to be informed about the report, please leave your contact details in the questionnaire.

Are responses confidential?
Individual responses will not be disclosed when we report the outcomes of this consultation though the names of organisations contributing to the consultation will be included in the report. We intend to keep all individual responses anonymous. If you prefer, you can complete the consultation without leaving your name and contact details.
Appendix D. Discussion group information sheet

The Survey of the Mental Health of Children and Young People 2016 will be the first survey of children and young people to focus on mental health since 2004.

The survey will collect robust data on a range of topics relating to the mental health of children and young people. Findings will be reported in 2018.

Why this survey matters

**Child mental health matters.** It matters to children now and it continues to matter across their whole life course. Currently, the development and planning of health and social services, policies and interventions for children and young people are hampered by a lack of current evidence.

The Survey of the Mental Health of Children and Young People 2016 is a hugely exciting opportunity to update and extend what is known about child mental health and wellbeing in England. Critically, it will answer whether children and young people’s mental health and self-harming behaviours are improving, remaining stable, or getting worse.

Methods

The survey will target children and young people in England aged between 2 and 19.

The data collection methods will include:
- face to face interviews with parents;
- face-to-face interview with 11-19 year olds;
- an online self-completion questionnaire for teachers.

The 2004 survey

The 2004 survey found that overall around 10% of children had one or more mental disorders. Prevalence of disorders was higher among 11-16 year olds than among 5-10 year olds.

Content Review

We are currently reviewing all existing content from the Survey of the Mental Health of Children and Young People 2004 in order to ensure that the questions retained are still appropriate and relevant in the current context.

**Table 1: 2004 Survey of the Mental Health of Children and Young People content**

<table>
<thead>
<tr>
<th>Parent questionnaire sections</th>
<th>Child aged 11-16 questionnaire</th>
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<tbody>
<tr>
<td>Details of the child:</td>
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<tr>
<td>General health</td>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
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<tr>
<td>Social aptitudes</td>
<td>Separation anxiety</td>
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<tr>
<td>Friendships</td>
<td>Specific phobias</td>
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<tr>
<td>Strengths and Difficulties Questionnaire (SDQ)</td>
<td>Social phobias</td>
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<td>Developmental disorders</td>
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<td>Separation anxiety</td>
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<td>Specific phobias</td>
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<td>Social phobias</td>
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<td>Parent questionnaire sections</td>
<td>Child aged 11-16 questionnaire</td>
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<tr>
<td>Panic attacks and agoraphobia</td>
<td>Panic attacks and agoraphobia</td>
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<td>Post-Traumatic Stress Disorder</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>Compulsions and obsessions</td>
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<td>Generalised anxiety</td>
<td>Generalised anxiety</td>
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<td>Depression</td>
<td>Depression</td>
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<td>Self-harm</td>
<td>Self-harm</td>
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<td>Attention and activity</td>
<td>Attention and activity</td>
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<tr>
<td>Awkward and troublesome behaviour</td>
<td>Awkward and troublesome behaviour</td>
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<tr>
<td>Dieting, weight and body shape (eating disorders)</td>
<td>Dieting, weight and body shape (eating disorders)</td>
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<tr>
<td>Tics</td>
<td>Less common disorders</td>
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<td>Other concerns</td>
<td>Significant problems</td>
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<td>Personality</td>
<td>Strengths</td>
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<td>Significant problems</td>
<td>Social Life (neighbourhood, trust, care, clubs)</td>
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<td>Service use</td>
<td>Social Support</td>
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<td>Stressful life events</td>
<td>Educational attainment</td>
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<td>Education of child</td>
<td>Looked after by Local Authority</td>
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<td>Strengths</td>
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<th>Parent/family details:</th>
<th>Child Self-completion component:</th>
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<tr>
<td>Household composition and demographics</td>
<td>Awkward and troublesome behaviour</td>
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<tr>
<td>Education and employment</td>
<td>Smoking cigarettes</td>
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<tr>
<td>State Benefits</td>
<td>Use of alcohol</td>
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<tr>
<td>GHQ12 (indicates mental health of parents)</td>
<td>Experience with drugs</td>
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<td>Family Functioning (self-completion)</td>
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<th>Teacher Questionnaire (self-completion) sections</th>
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<td>Other concerns</td>
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<td>Help from school</td>
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In addition, we are developing questions for new areas that are important to cover. Potential new topics include:
- wellbeing,
- bullying and cyber-bullying;
- self-esteem;
- resilience;
- stigma and discrimination,
- the impact of violence and trauma – especially child sexual exploitation.

**Have your say!**
Involving children and young people in the survey process is so important – it means that we can ensure that the voice of this group is included in the project in a meaningful way. Having your views on the survey materials and on the new content areas is invaluable.
Appendix E. Additional topic suggestions

Responses to ‘which additional topics you think should be included in the MHCYP 2016 survey and why?’ are listed below. All the comments have been anonymised. Names and references to organisations have been removed.

- We welcome the survey of the mental health of children and young people 2016 as it will provide important information on the current prevalence of mental health problems amongst children in the UK and time trends (e.g. since 2004). Our contribution to this consultation draws in particular on our expertise in relation to children’s subjective well-being, as well as our knowledge and direct practice experience of working with young people who are at risk of experiencing poor outcomes because of their experiences of poverty and neglect.

  a. Subjective well-being

  Our view is that this survey provides an important opportunity for children’s subjective well-being to be explored alongside their mental (ill-) health. Other key stakeholders - such as the ONS, NatCen and Public Health England - have also highlighted the value of including subjective well-being measures in surveys of children. In NatCen’s report Predicting Well-being, the authors highlight the fact that there is limited data on subjective well-being in large, national, probability samples of the UK population, while Public Health England’s recent report Measuring Mental Well-being in Children and Young highlights our work to develop well-being measures for children.

  If subjective well-being measures were included in this survey, it would be possible to explore in great detail the relationship between children’s mental health, subjective well-being, and other key variables e.g. social support etc. This would be enormously useful in deepening our understanding of the factors that are important for children’s mental health and well-being, and in helping us to draw conclusions for policy and practice.

  Specifically, we would recommend that the survey includes the following:

  1. Three of the four ONS questions on Personal Well-being i.e.:

  2 Casas F, Tillouine H & Figuer C (2013) ‘The subjective well-being of adolescents from two different cultures: Applying three versions of the PWI in Algeria and Spain’ Social Indicators Research. Published online: 13th January 2013. DOI: 10.1007/s11205-012-0229-z


o Overall, how satisfied are you with your life nowadays?
  o Overall, to what extent do you feel the things you do in your life are worthwhile?
  o Overall, how happy did you feel yesterday?

These questions use a 0-10 scale, which we have found in our ongoing research on children’s well-being to work well with this age group (better than the 7-point scale that is used in the Understanding Society survey).

2. Subjective well-being measures for different domains of life e.g. the Good Childhood Index asks about the following ten domains:

How happy are you with…
  … your relationships with your family?
  … your relationships with your friends?
  … your appearance (the way that you look)?
  … your school?
  … your health?
  … the things that you have (like money and the things you own)?
  … the way you use your time?
  … what may happen to you later in your life (in the future)?
  … the home that you live in?
  … how much choice you have in life?

The Good Childhood Index was developed as part of the ongoing research programme on children’s well-being conducted by The Children’s Society and the University of York (e.g. see Rees et al 2010a and 2010b below). Some of the proposed domains and wordings were originally proposed by Robert Cummins in Australia in the Personal Well-Being Index – School Children version (Cummins & Lau, 2005). This index has been used in various countries (e.g. Casas et al, 2013). We can provide more information on the psychometric properties of these questions.

b. Household, income and employment information about young people aged 16+

Last summer we launched our Seriously Awkward campaign highlighting how being 16 and 17 years old - that awkward age between childhood and adulthood - makes young people vulnerable to abuse and exploitation as they are not always treated as children in law or by agencies with safeguarding responsibilities. For those who do not have the support of loving families or carers to help them stay safe, this lack of protection can lead to serious long-term issues that can last well into adulthood. 16 and 17 year olds who cannot live at home with their families face an extremely difficult transition to adulthood and need consistent support and care in order to overcome the many risks they face. Some young people live independently because they have left care arrangements or have left home due to a breakdown of relationships with their families and carers. The need to escape domestic violence, abuse or substance misuse are some of the key reasons why young people leave home. There are currently an estimated 8,400 16 and 17-year-olds across the country living independently in accommodation such as hostels, and semi supported accommodation. Many of these young people face severe
risks including drugs and legal highs, violence and deteriorating mental health\(^3\). Many of them also find it difficult to find employment and engage in full-time education\(^4\). We recommend asking questions about household composition and demographics, tenure, education and employment, occupation and income to young people aged 16-19 in order to gain an understanding about young people feel about their living situation and some of difficulties this might pose. This will be particularly important information to capture about young people living independently.

c. Internet and social media use
Young people have become the most active users of the Internet and social media. Having regular access to the Internet can be a source of support for young people dealing with mental health related problems, for example, by providing access to online counselling services. However, the impact of Internet and social media usage on young people’s mental health, particularly when unsupervised, has yet to be studied in-depth. There has been growing concerns about the negative effect of digital culture on children’s mental health, for example, cyber-bullying has been associated with emotional distress in young people and has become a major cause of concern for parents and teachers. The Health Committee expressed concerns about digital culture and its links to bullying and has called for detailed consideration about the impact it has on children’s mental health. This issue was further echoed in the ministerial report Future in Mind.
This survey presents an opportunity to explore associations between Internet and social media usage and young people’s mental health by collecting information about:

- How much time young people use the internet and access social media platform
- The types of interactions young people have online and the relationships they form online or through applications

These can be included as an additional item in the sections about social support or social networks to capture a greater variety of social interactions given that many young people are heavy social media users.

d. Young carers
Large numbers of children and young people in the UK are involved in some kind of care for members of their families, often a parent. It is estimated that 700,000 children and young people are young carers in the UK. When collecting information from young people about their caring responsibilities, we believe follow-up questions are required to help make inferences about how caring responsibilities impact on their lives. We have recently included questions about caring responsibilities in a number of local well-being surveys conducted in different parts of England (as yet unpublished), and these reveal that children's concepts of caregiving are broad-ranging and, importantly, that having caring responsibilities *per se* is not necessarily linked to lower well-being. The follow-up questions that we asked helped us to explore the types/levels of care that may be harmful to their well-being (e.g. we found that missing school because of caring responsibilities was related to their well-being).

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\(^3\) [https://www.childrenssociety.org.uk/sites/default/files/Supported_Accomodation_Report_2015.pdf](https://www.childrenssociety.org.uk/sites/default/files/Supported_Accomodation_Report_2015.pdf)

For this reason, we would recommend asking a follow-up question (to the questions YFam/YFamoft) about whether children have missed important events/appointments because of these activities.

Around one in 20 young carers miss school because of the amount of support they have to provide at home. As part of the parent’s questionnaire and under the school exclusion section where parents/carers are asked “Why did NAME CHILD miss school?” the survey should include a response about missing school because of NAME CHILD’S caring responsibilities.

e. Fuel poverty
As part of the accommodation/tenure section, or in the child/young person questionnaire, it would be helpful to include a question about whether the household is adequately heated to explore the relationship between fuel poverty and children’s mental health. Previous studies have found that children and young people living in cold homes were at greater risk of developing mental health problems. For example, in 2011, the Marmot Review Team concluded that “more than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems compared to 1 in 20 adolescents who have always lived in warm housing”. The Government in its most recent Fuel Poverty Strategy has made a commitment to monitor and review the numbers of children and young people living in fuel poor homes. Additional information around the mental health impact of living in a cold homes and fuel poverty can be used to inform policies that seek to reduce the numbers of children and young people living in fuel poor homes.

For this reason, the following question from the Poverty and Social Exclusion survey should be included:

*Which sentence below best describes the overall level of warmth in your home last winter?*

*Please tick one box only*

- Much colder than you would have liked
- A bit colder than you would have liked
- About right
- A bit warmer than you would have liked
- A lot warmer than you would have liked
- Both too warm and too cold

f. Post traumatic stress resulting from sexual abuse
There is growing understanding in both policy and research that children and young people who experience a range of adverse childhood experiences, such as living with abuse or neglect, witnessing violence or substance abuse at home or experience sexual exploitation, alongside any pre-existing mental health needs, are particularly at risk of developing mental health problems. It is important that as part of the DAWBA survey the questions about stressful life experiences which physical and sexual abuse are kept in the new survey. However, children and young people may not always view themselves as victims of sexual abuse.

The questions asked as part of the post-traumatic stress section should give examples of what might be considered as sexual abuse as is given for ‘a severe attack or threat’ and ‘being involved in a disaster’. An example used in the Crime Survey for England and Wales asks whether ‘someone has touched you

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in a sexual way (e.g. touching, grabbing, kissing or fondling), when you did not want it’.

g. Poverty and mental health
There are a wide range of factors that contribute to children in poverty suffering from mental health problems. For many children, the chance of developing mental health problems are heightened by exposure to a variety of different vulnerabilities combined – including debt, poor housing and inadequate access to services. The survey currently captures information about state benefits and income which we believe should remain as part of the new survey. However, there is scope to collect information about being in debt and the impact it can have on children and families. Around half of parents surveyed as part of our The Debt Trap report (47%) who were in arrears, said that their financial situation caused their children emotional distress, with a quarter saying that it resulted in their children feeling stressed or anxious and 19% saying that it contributed to them having mood swings.

As part of income related questions to parents/carers, we would suggest including the following question used as part of our survey for the Debt Trap report.

Which of these statements best describes how well you are keeping up with household bills and / or credit commitments over the last 12 months?

…..Keeping up without any difficulty
…..Keeping up, but it is a struggle from time to time
…..Keeping up, but it is a constant struggle
…..Falling behind with payments (“in debt / arrears”)
…..Falling a long way behind with payments (“seriously in debt / arrears”)
…..Don’t have this type of bill / credit commitment

Mental health problems can be a particular problem for families already struggling to maintain the everyday costs of supporting their children. Parents should also be asked about how much they spend on housing costs each month.

Using a child reported material deprivation index (based on whether children had access to a set of items and experiences such as pocket money, clothes to fit in with peers and family day trips) our recent well-being research conducted in partnership with the University of York found that children who lack a greater number of basic items have significantly lower subjective well-being. Further information about this index can be found in the report: http://www.childrenssociety.org.uk/sites/default/files/tcs/Images/missing_out.pdf.

We believe the latest survey on children and young people’s mental health should explore this issue in relation to children’s mental health and should ask young people about subjective wealth and material possessions.

• General wellbeing
Public mental health considers the emotional and general wellbeing of the whole population as well as that of specific vulnerable groups. These aspects were recently considered in a survey of the health and wellbeing of 15 year olds (What about YOUth?) which output statistically significant information at both national and local levels (national report http://www.hscic.gov.uk/catalogue/PUB19244, local benchmarked statistics

http://fingertips.phe.org.uk/profile/what-about-youth). This survey made use of the wellbeing questions from the Office of National Statistics (ONS) and the Warwick-Edinburgh Mental Health Wellbeing Scale. In the 2004 survey approximately 10% of children were suffering with a mental health disorder, the prevalence of which was unchanged since 1999. However, by comparison in the 2015 'What about YOUth?' survey 13.7% of 15 year olds were found to have a low life satisfaction.

Childhood obesity
Tackling childhood obesity has been identified as a priority for the lifetime of the current parliament. A new strategy is due to be published in early 2016. This survey provides a unique opportunity to take a closer look at the issues such as of self-reported weight status, body image and associations with the prevalence of emotional disorders and or poor levels of wellbeing. For example, from the 2015 ‘What about YOUth?’ survey only half of all 15 year olds (52.4%) think their body is about the right size. The same questions could be re-used in this survey.

Vulnerable groups
It is understood that the sample size for this questionnaire cannot produce statistically significant information for highly vulnerable groups due to small numbers and that these are excluded from scope. However, future application of these instruments should be considered for specific groups so that they can be compared with the general population in terms of their increased vulnerability to poor mental health. These groups include: looked after children, children managed within the Troubled Families Programme, children at risk of sexual exploitation and sexual abuse, children with a parent in prison etc.

Parental Physical Health
Evidence taken directly from NHS Scotland Children and Young People’s Mental Health Indicators – Final Report:

physical health of parents is associated with an increase risk of a range of psychological disturbances in children, including emotional and behavioural problems and also low self-esteem and life satisfaction (Pederson and Revenso, 2005; Coldstream and le May, 2008; Stein et al., 2008; Bogosain et al., 2010; Sieh et al., 2010). A relatively consistent increase in emotional problems (anxiety and depression) has been found in adolescents of parents with cancer. Overall, children in families where a parent has a long term physical illness have higher rates of anxiety and depression than children in ‘healthy’ families but broadly similar rates to those seen in families where a parent has a mental health problem

However ….. there are mediating factors, some of which will be explored through questions in the survey (social support, strengths of the young person)? The extent of the increased risk is, dependent on a number of factors e.g. family structure, social situation, functioning and developmental stage of child. The impact of a parent with a physical health problem may not, however, always be negative as a caring role may lead to positives such as enhanced self-esteem, gaining a sense of fulfilment and building up a coherent support system (Coldstream and le May, 2008; see references cited in Sieh et al., 2010 and caring in section 3.3.1 Family relations).

Caring
The responsibility of caring for other family members can have negative impacts on children and young people’s mental wellbeing. It may also result in feelings of being different to peers, isolation, worries about the future and loss of self-identity, however, being a young carer is also not always seen as being
detrimental to mental wellbeing, for some it can boost self-esteem, self-confidence and coping skills. It is the nature of the caring experience which is important when understanding how being a carer affects children and young people’s mental wellbeing.

**Views about school**
To assess influences on CYP engagement with learning and to support the questions on educational attainment in the child/young person interview and bullied by teacher and school exclusions, in the information about the child/young person section.
Evidence I have taken directly from page 83 of NHS Scotland Children and Young People’s Mental Health Indicators – Final Report: *For children’s mental wellbeing, evidence indicates that ensuring that educational experiences provide opportunities for individual engagement in tasks considered fulfilling and worthwhile is crucial for those aged 5-12 (Foresight, 2008). While, disaffection with or exclusion from school are risk factors for children’s mental health from an early age (Department for Education and Skills, 2001 cited in Barry and Friedli, 2008).*

**Being bullied or taking part in bullying**
To supplement the question on being bullied by teacher. Evidence summarised from page 86 of NHS Scotland Children and Young People’s Mental Health Indicators – Final Report: *Bullying has a negative impact on the development of positive inter-personal relationships and increases the risk of school absenteeism and thus the lowering of academic achievement. Evidence suggests there are negative mental health correlations with participation in bullying behaviour. Childhood bullying can have long term effects into adulthood and is associated strongly with anti-social behaviour.*

- **Engagement/satisfaction with school, support from teachers, trusted people in school, engagement in outside interests/extra-curricular activities** – These variables have been shown, for example in the Health Behaviours in School Age Children, to be a factor in wellbeing with a range of questions and measures used there. Their relationship to Mental health does not seem as well understood. The intention of suggesting this for inclusion is to understand the role of schools in a sense of belonging, self-worth etc and any link with poor mental health. Understanding this better would help show how schools can be better protectors of mental health. This section is envisaged as a replacement for the current teacher bullying and social life/capital sections

**Support provided in school** – we know that support provided by and in schools is increasing, and this is an area of focus for government activity. It would be desirable to develop the previous questions further and improve them in terms of the detail they can provide about support used in school. This would provide valuable insights around how/if school support is used for children with different needs. This could be asked of teachers, parents and C&YP. For the latter group we would like to understand how level and type of need relates to knowledge of support provided by schools, whether they would use support provided and whether their school offers any support in the way of lessons or provision of information.
Service use – can the parent’s use of service section also assess whether they are waiting to access services?

Stressful life events – add to the current question to include transition between schools, especially at non-standard times and cyber bullying.

Bullying – can we add more on bullying to the C&YP survey, we know this is a factor in poor MH for C&YP. It would be helpful to identify incidence of bullying, nature – cyber, emotional, physical, and main focus such as actual or perceived sexual orientation, physical appearance, academic performance etc.

Risk factors – it would be good to explore risk factors further with C&YP including cyber bullying, online activity, sexual activity.

LGB&T – Can consideration be given to the protected characteristics of sexual orientation and gender identity? We know that LGB&T young people are at increased risk of mental health problems. However we have virtually no understanding of prevalence.

The ONS have designed a sexual identity question (eg. used on the Integrated Household Survey)

http://www.ons.gov.uk/ons/taxonomy/search/index.html?newquery=%26nscl=Sexual+Identity%26nscl-orig=Sexual+Identity%26content-type=publicationContentTypes%26sortDirection=DESCENDING%26sortBy=pubdate).

For gender identity, EHRC have done some work on how to ask questions on gender identity/reassignment


We suggest considering asking questions of both the age 16+ young people and those under 16 in the self-complete section, which ask whether people identify as LGB or T but also trying to understand whether C&YP are currently questioning their orientation or gender identify.

Research has been done before in the US which asks children as young as 12 about their sexual identity (affiliation) and attraction (eg. Minnesota Adolescent Health Survey, a large random, representative sample of approx 34,000 young people aged 12-18 years old). However there is little experience/evidence of asking adolescents questions about their sexual orientation/identity in a UK-context, which is really something we need to change if we are to better understand how the sexual orientation of young people is linked to disadvantage/inequality.

We understand the achieved sample size is likely to be small, but with data so scarce this would still be a big step forward and would be helpful in shaping future research.

General health – is it possible to ask about amount of physical activity?
Support and vulnerabilities – it would be helpful if as well as SEN and LAC the data could capture whether the child has an EHC Plan/statement, and also identify if they are adopted or a young carer or potentially subject to a child protection plan.

• (1) The Survey of the Mental Health of Children and Young people can tell us a lot about the prevalence of mental disorders in youth today, as well as giving us an idea of the correlates of and risk factors for emotional, behavioural and hyperkinetic disorders.

In terms of expanding our knowledge about the correlates of these disorders, we would like you to consider the evidence that:

a) In the average primary school class, at least 2 children have suffered abuse or neglect. 1 in 20 children in the UK have been sexually abused (Radford et al., 2011)7.

b) Experiencing abuse and neglect is a substantial risk factor for the development of psychopathology both in childhood and later in adulthood.

Mental health problems are common in children and young people who have been maltreated. Problems include anxiety, depression, post-traumatic stress disorder and conduct disorders (for a review see Gilbert et al., 2009)8. We are happy to offer assistance in helping you to consider how this evidence could be incorporated in to the survey.

We understand that asking children and young people about such experiences is extremely sensitive, but given the safeguards that are already likely in place due to the sensitive nature of the interview, it is felt that any potential disclosures could be handled appropriately. We would be happy to help provide any advice or support on how to respond to disclosures of child abuse.

(2) Furthermore, we would like you to review the list of traumatic experiences included in the PTSD prompt question from the DAWBA:

- A serious and frightening accident, e.g. being run over by a car, being in a bad car or train crash etc.
- A bad fire, e.g. trapped in a burning building
- Other disasters, e.g. kidnapping, earthquake, wars etc.
- A severe attack or threat, e.g. by a mugger or a gang
- Severe physical abuse that you still remember
- Sexual abuse
- Rape
- You witnessed severe domestic violence, e.g. saw your mother being badly beaten up at home
- Saw a family member or friend severely attacked or threatened, e.g. by a mugger or a gang
- You witnessed a sudden death, a suicide, an overdose, a serious accident, a heart attack etc.
- Heard that a close relative or close friend had been severely attacked or threatened, e.g. by a mugger or a gang

- Heard that a close relative or close friend had been badly hurt in an accident, e.g. was in intensive care after a car crash
- Some other severe trauma

Whilst we understand that the primary aim of the PTSD questionnaire is to establish if the young person is displaying symptoms of PTSD, we are nonetheless concerned as to why the categories of traumatic experiences are limited to those in the list, and if there is scope to change them to better reflect the variety of experiences that may be considered traumatic particularly in the field of abuse and neglect. For example, emotional abuse and neglect are not included; rape and sexual abuse are listed as separate categories; domestic abuse is limited to severe physical abuse. We are happy to advise as to the more appropriate categories and examples.

We are also interested in whether the data from the responses to this question are available from 2004, as they do not appear to be published in the final report?

(3) Finally, information about whether a child has been looked after is of great interest to the NSPCC given that the majority of children who are looked after are looked after because of abuse and neglect (Jutte et al., 2015). It would be of great value, we believe, to elicit more comprehensive information about these children, specifically:

a) How old the child was when they were first looked after, and how old they were at the start of their most recent placement. This would be important information to contribute to research which has shown that when children enter care at an older age, they tend to experience more emotional and behavioural difficulties and poorer outcomes than children who enter care when they are younger (Sempik et al., 2008).

b) How many different care placements has the child had while they were in care, including all episodes of care (or their most recent episode if previous information is not known) For example, if the child has had three separate placements with foster carers and one placement in a children’s home, this would add up to 4 placements. This will be important to contribute to research which has shown that children who experience more placements have poorer mental health outcomes (see Rubin et al., 2007). It should be possible to show that x% of children who have had only one placement have a mental health disorder versus x% of children who had 3 or more placements, for example. This will be important information to support the Department for Education’s agenda of monitoring placement stability and how this contributes to looked after children’s outcomes.

- Contextual information is very important and you have covered a lot of this but some of it is slightly patchy. Part of this is because sometimes you are very specific, e.g. teacher bullying. I would broaden the category, e.g. bullying, and if they say yes then ask by whom e.g. family, friends, online, teachers, etc. I would

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also ask them about internet/social media use, and also, sports and leisure activities and other things that are associated with contributing to mental health. Perhaps ask about perceived levels of happiness. Furthermore, I would ask about parental substance/alcohol use (to assess misuse) and also CIN or Child Protection status if possible.

- Something on whether the young person has somebody they can talk to about difficult topics, such as being bullied. This should clearly include friends as well as authority figures and have clear examples of the range of types of bullying, in case they don't want to use that particular term. Something on homophobia and gender identity-related bullying would be good too.

- Bullying experienced by children, including type of bullying (physical, indirect, and verbal) and content of bullying (such as SEND, religious, racist, homophobic etc). Frequency of bullying and in-depth experiences of bullying.

- Teacher stress/depression/anxiety - this could affect their ratings, there is currently no information on relationship between teacher and pupil mental health.


- Sleep Pattern - children receiving stimulant medications often suffer sleep exhibit poor sleep patterns. Also, common in excess social media exposure. Peer pressure (include as sub heading under Social Life) - commonly a cause of anti social behaviour and substance misuse.

- Anxiety Impulsivity Symptoms of trauma Speech and language impairments Gender identity disorder
• Where child / young person has accessed early help from e.g. pastoral support in school, school nurse, GP.

• CAADA DASH (Domestic Abuse, stalking and Honour Based Violence Risk Assessment) CHAT (Assessment for young people in secure estate) Child Sexual Exploitation Risk Young People Substance Misuse assessments Parental substance Misuse Assessment

• Attend churches or mosques - this is very important in relation to BME, particularly black carribean african, whereby church is first port of call when parents are facing challenging situations with children. Linking up with churches and mosques is a must in addressing mental health. Black people bme often do not access services at an early stage and over represented at a late stage and public sector does not understand black communities and the way they access services. Hence they are labelled hard to reach group, it is not bme that is hard to reach, instead it is health services etc that are hard to reach for bme. For example in my culture, I will meet with an elder in the church or outside the church or a pastor before making an appointment whilst making an appointment with the Dr. Therefore the latter is very important. BME simply access services in a different way and that needs to be taken into account in order to make services accessible for all

• Parental substance abuse - other (very specific) mental health conditions are listed under parent interview sections, but substance use/abuse/misuse is not mentioned anywhere apart from the the self-report questions around drinking/smoking/drugs on the child interview section. Parental substances abuse can have a massive impact on the mental health of a child, and is very widespread - but not even mentioned as a topic.

• with extension of age range, transistions becomes more important. including concerns about transistions between services CHYP to Adults and leaving care and transistion in life 'fear of being 18'

• Relationships, sexuality, gender beliefs

• Brief family history for common mental disorders, e.g. depression and/or blood samples for genotyping to ascertain genetic risk 2. Both parents' mental health if possible given mothers and fathers depression both linked with risk 3. Regular intense physical exercise/sport given possible protective effects for depression (single item question possible) 4. Whether parent has had to complete recent fitness to work assessment given recent reported link to increased mental ill health and suicide in adults

• Sleep, i.e. bedtime and getting up time self-report from children/young people Can add area deprivation score from Census data if parents’ consent to link administrative data with their postal code is present. Similarly, area based crime data can be added.
• Sexual violence teenage relationships abuse domestic abuse in the home. Over the last 5 years these have become more widely recognised as issues affecting young people, and should be incorporated in the new survey.

• Any history of trauma - individual or family. Any history of intervention - successful or otherwise.

• The new early health care plans, some parents find the whole process overwhelming.

• Boys and male role models! Please refer to any study and Child Psychologist Steve Biddulph: AGE 6-14 Is there a family male (or step-parent or close friend) who has a meaningful relationship with the boy/s who: owns his house, is financially and mentally stable and has a responsible job/profession OR runs his own business? AGE 14-18: Is there a male friend or extended family member (uncle) or older male worker who the boy/s has as a positive, responsible mentor? (eg at a part-time job) Please please investigate this. Not only is it effecting half the population of our 6-18 year olds, it might reduce the '10%' of mental health statistics considerably when finally recognised and rolled out across the country for needing good men in boys' lives!! Please...from the mother of a teenager boy who hasn't had one.

• As learning disabilities and neurological issues are identified, so too should sensory impairment eg blind or deaf/hearing impaired/hearing loss. These impact hugely on mental health outcomes. Also, it would be useful to know both the language/s in the home and the language/s in education. Also is it intended that the BSL SDQ be used for children who use BSL?

• Ease of access to mental health services. Do they know HOW to access these services - e.g. self-referral, GP, school etc. And where they are? Do they understand the different levels of support available? Any (perceived) gaps in service provision in local area? Child, parent and school/teacher’s awareness of support/services available with emotional and mental health problems? Education around MH in school.

• A measure or question which assess whether the child or young person: i) can talk about their emotions; ii) how they cope with difficult emotions e.g. sadness, anger.

• Relationships, sexual experience, attitudes, gender opinions or concerns about sexuality. I think these are important issues that young people consider when they think about their own well being.

• BDD - given that appearance is such a pre-occupation and it links with OCD.

• Care leavers aged 16 and 17 and if possible 18.

• This may not be a ‘topic’ but may be more to do with how carefully the survey will consider demographics but my group work primarily with deaf young.
people/deaf adults where we know there is a much higher prevalence of mental health difficulties than in the general population. Where will the survey consider sensory issues? Will the young people self report instruments/SDQ etc be available in BSL as standard?

- Friendships/relationships with peers

- Relationship with siblings.

- Specific focus on suicidal ideation, and any suicide attempts

- At present the survey meets the needs of psychiatrists and health service providers rather than the needs of children and young people. Questionnaires are heavily biased towards diagnosis deficits risk factors; need much more on wellbeing/protective factors. Common mental health deficits that fall short of diagnosis have significant implications for physical health and social functioning throughout life. The WEMWBS is the most widely used measure 13 up and the Stirling Children’s Wellbeing Scale the equivalent for children. Not nearly enough about the principle risk factors: eg an emotionally close respectful relationship with both parents; going to a school with a positive ethos; involvement in physical activity, the arts, Yoga, mindfulness etc etc

- Transition. The pathway between child and adult services I think this is particularly useful for individuals who are at the age of 12 who will be prepared to move to the adult services at the age of 16.

- psychosis symptoms rape/sexual trauma

- what services already accessed previous engagement

- Does the service user feel there is adequate service provision for dealing with mental health concerns and issues. As a school nurse I find that there is a gap in the service provision for children who do not meet the CAMHS criteria, therefore are bounced back to the school nurse who feel they cannot deal with the issue at hand appropriately with the existing interventions!

- 1.A question relating to the amount of time spent using internet / social media and if a device phone/tablet etc. is used during the night 2. If any cyber bullying has been experienced. 3. Consumption of caffeinated drinks

- Experience of discrimination/being treated unfairly (in child module) given it has been linked to mental health and is not covered elsewhere. Not a topic as such, but of great value to get data linkage to the National Pupil Database for educational attainment and special educational needs. Much more reliable than teacher report!

- Child sexual exploitation Impact of social media
social support - as this impacts on risk of developing Mh willingness to access talking therapies - young men and BME Yp are less likely to access but have more mh issues than other groups

young people's perceptions of how to access to mental health support and their experiences of accessing support (in school, youth hubs, camhs etc)

Information about whether they feel equipped to deal with the difficulties they are facing. Self efficacy, skills and strategies thta perhaps they have been taught in school or elsewhere. The DAWBA is negatively biased and I would imagine it being upsetting to complete. I would suggest splitting it up or finding a way to bring in the opportunity to answer a mix of questions. The SDQ also finishes with the negatives.

Satisfaction of the service they have received from mental health and nhs services

Sibling or other close relationship mental health, not just parental mental health that can impact. 2. Sibling physical health e.g prolonged separation due to other child complex health needs, hospital admissions. 3. Traumatic events include Prematurity and SCBU/NICU admission at birth.

Non-acrimonious conflict is very harmful to children (e.g. Harold, G. H., (2012) but Argue1 & Argue2 don’t capture data on this. Parents in non-acrimonious relationships, who are emotionally withdrawn from each other, put children as much, or more at risk for emotional problems (Booth, A. (2001). We suggest this question is added to the survey: Which of the following best describes how you and your partner deal with disagreements and differences? •

Parental PHYSICAL health, especially chronic health conditions, medication and health during pregnancy. Increasing evidence points to important links between maternal Physical health, esp chronic autoimmune conditions, and health during pregnancy as important risk factors. Physical health of child should also ask about gestation at birth and birth weight, and assess current BMI. Obesity and Activity Level is a further important risk factor to be investigated in its relationship with mental health, both excessive exercising and under-activity should be identified. DAWBA only asks about excessive exercise as an eating disorder symptom. Overeating disorders are an important mental health problem in children and adolescents, that the DAWBA does not seem to cover.

Whether the child is a young carer/young adult carer, eg using the Multidimensional Assessment of Caring Activities. • Whether the child has received support as a young carer/young adult carer through a specialist service • Whether the child has had their needs assessed as a young carer or at transition to adulthood under the Children and Families Act 2014/the Care Act 2014 • Whether the parent has been identified as a parent/carer and offered support. • Whether the child or parent have had their rights as a carer explained There is a serious gap in data on young carers’ mental health,
holding back policy development. There is a lack of information about the support for parent/carers of children with mental health problems. Data collection on some or all of these topics would be a much needed contribution to our understanding of caring as a factor in children’s mental health and the degree and effectiveness of support given to parents. Carers Trust can provide further information on this topic.

- Use of social media and technology - intimately linked to self-image and social expectations. Geography - where does the child live? urban/rural etc. Would go someway to helping us to understand the role of nature and nurture. Sources of information beyond school - does the child read/pay attention to the news? Again this is linked to use of technology, authoritative sources of information are now not exclusive to parent and teacher. Political affiliation - perhaps not as directly relevant to mental health, per se, but would add an extra dimension to understanding sources of authority.

- The survey should cover the entire 0-18 years age range, not just 2-18. It is discriminatory on the basis of age, and an impediment to obtaining a comprehensive scientific picture. There is no sound scientific reason to exclude the 0-2 years age range from the survey. It is also incongruent with the detailed and questions and areas of questioning about the individual's first 3 years of life in the DABWA. There is a vast international body of evidence, research and knowledge about infant mental health disorders, and infant mental health is the foundation of later mental health and therefore profoundly important to include. It is time the UK government took a leadership role in correcting this continuing discriminatory exclusion in the UK of the 0-2 years age range from proper recognition and service provision in relation to moderate to severe mental health disorders in this age group. This would be unacceptable in relation to physical health. Additional topic: Sense of self and sense of agency

- Additional specific areas: ‘Sense of self and sense of agency’ - these are a fundamental aspect of mental health not adequately captured/reflected in the current topics/questionnaires. (2) An infant's/child's/young person's baseline ability or lack of to enjoy and take pleasure and interest in things - and not just a change in this -is an important indicator of mental health in its own right.

- Break down of Mental health prevalence by locality or at least by risk factor would be really helpful as population not generic Very helpful for local service planning if local prevalence of disorder was known

- It would be useful identify whether the child or young person is LGBT. This is because they are a high risk group for mental health problems. There seems to be a lack of data relevant to this group and mental health issues. The other topic is related to experiences of trauma e.g. abuse etc. We aren't totally sure if this topic is already covered. This groups is also at high risk of developing mental health problems. use of social media and impact on mental health = both positive and negative.
• Effects of the media (including social media, cyberbullying, computer/ICT exposure and secondary socialisation e.g. role models etc.

• Is SDQ appropriate to 1-19 year olds? YPs use of social media and its impact on them. Their sense of hope for the future especially at 16+ Has yp ever been in Care on CP etc.

• that a specific question round caring responsibilities for children , both practical and emotional is drafted in sections relating to 1/ Prevalence of mental disorders by personal characteristics 2/Prevalence of mental disorders by family characteristics

• In addition to consideration of whether a child is looked after by the local authority, it would be helpful to also identify those children and young people who have previously been looked after by the local authority but are now subject to a special guardianship order (SGO) or have been adopted. Many young people who are subject to an SGO or have been adopted have needs relating to their mental health and wellbeing and it would be helpful to have a better understanding of this cohort of children.

• On the list of stressful events, we (the Childhood Bereavement Network) would find it very helpful if ‘death of a parent’ and ‘death of a sibling’ could be separated out, rather than conflated as they were in 2004. These different bereavement have very different implications for children, and it would be extremely useful to us to be able to look at them separately (while still being able to conflate the two experiences to compare prevalence with 2004).

• Experiences of abuse including domestic and sexual violence (witnessing at home but also own experiences), use of abuse from children towards parents/carers/dating partners Experiences of services - our research shows many young people who have experienced abuse are 'labelled' by CAMHS for instance with no explanation or support.

• Whether children are adopted and pre-adoption experiences- broken attachments and early experience of trauma is known to have adverse effects on mental health. use of drugs and alcohol in utero Stressful experience including domestic violence in utero.

• Whether a child is deaf or blind or has any sensory disabilities. This has been left out and yet we know they do far worse in schools and have much higher rates of mental health problems. Very important to include this!!

• Use of social media On-line bullying self harming eating disorders access to effective help and support though schools access to on-line advice and support

• suicide experienced thought of or know someone close to them who has committed suicide
• Opportunities for physical activity  Peer support available?  Use of technology

• Domestic abuse - very relevant to child presentation e.g. anxiety symptoms may be misinterpreted as ADHD - poor concentration / restlessness Language ability rather than ethnicity as impacts on communication during assessment especially if translators required.

• Identification of experience of adverse childhood experiences. This literature review provides a useful definition and list of experiences both within and external to the family. Kalmakis, K.A. and Chandler, G.E. (2013) 'Adverse childhood experiences: towards a clear conceptual meaning' Journal of Advanced Nursing  70(7) pp1489-1501. I suggest including experience of being a refugee or asylum seeker and pre-migration trauma if possible.

• Whether individual has a diagnosis eg autism etc

• Type of schooling: - Mainstream / Special / pupil referral unit (small units offsite to avoid classification as excluded) / Home educated.  (It is my impression that a number are home educated who have difficulties in school due to their conduct.)

• Parental/child experience with the justice system. 2. Parental/child involvement in religious activities on a daily/weekly basis.

• If at all possible, child and teacher reports of attainment, attendance and other educational data should be supplemented by data from the national pupil database. This should include exclusions, academic attainment (e.g., key stage scores) and also the child's free school meal eligibility, IDACI, special educational needs status, LAC status etc., as these are the most widely used and widely available educational data for children and young people. drawing on these sources reduces teacher burden and increases consistency with other existing datasets. Other factors associated with resilience and better mental health outcomes such as supportive school environment and social and emotional skills would be recommended. Headstart (BIG Lottery) is currently developing a measurement framework. It includes the Student Resilience Survey (Sun and Stewart) which covers many of these constructs.

• How important is it for the person to understand how their behaviours impact on themselves and others?

• Anxiety should be included because it's prevalent

• Participation and involvement in daily life activities affects mental health and wellbeing. Understanding what activities children and young people participate in and their relationship to their mental health will provide an indicator of what support should be in place to improve access and engagement. Participation questions could include areas such as looking after oneself (getting ready to go out, getting washed and dressed, eating a meal, organising belongings etc.), participating in leisure activities (playing sport, going to the cinema, playing on
the computer, watching TV, playing/socialising with friends etc.) and work/being productive (doing school/college work, volunteering, paid employment etc.).

- If the survey has expanded its reach to 19 year-olds, it would be fruitful to include sexual orientation as a topic of investigation. The mental health of LGBTQ+ teenagers is affected by the support they received from family and friends and the inclusiveness and tolerance of their environment.

- It's not so much an additional topic, but extra clarity - for self-harm, it's really important to separate out cutting & non-suicidal self-harm behaviours from suicide attempts. They are different behaviours that often stem from different motivations. Given the concern over the rising prevalence of non-suicidal self-harm, it's really important to have it separated out. I'm not sure off-hand the extent to which the SDQ can do this.

- The questionnaire should include questions related stigma and discrimination, Time to Change (Rethink Mental Illness and Mind)\(^{12}\) shows that stigma (self-stigma and stigmatising behaviour by others) and discrimination (from family, friends, teachers and in services) influence the experience and recovery. Answers relating to stigma and discrimination could explain the gap between prevalence of mental health difficulties and awareness of these to health services. Our evaluation shows YP experience stigma from their friends and families, this prevents leading normal lives, leads to loneliness, depression and loss of confidence, fear of stigma can be as damaging as actual discrimination and it stops YP from seeking help. It is important to understand the level of stigma and discrimination that YP experience in areas of their lives, from their own, their parents and their teachers perspective.

- I would like to see a section or opportunity for a question or questions to ask whether the child/young person is a child of a Service person. Or if it is difficult to include specific questions regarding this topic then may be some questions could include some responses that may indicate if the child is in a family in the Armed Forces Community. For example - requesting the profession of both parents could provide this information. Any question around education or in questions to teachers could ask whether the child receives the Service Pupil Premium. It would also be useful to have a question on mobility and the number of schools children have attended.

- Is alcohol or substance misuse a problem? Add question re substance misuse
  Looked after - include at home and kinship care Forensic issues, contact with police Parents physical health

- How much time they spend on social media, computer games, mobile phone, tv, separated so that it is not lumped together and minimised which could vastly underestimate the amount of time. I have noticed the people who regularly spend time writing up on facebook are those i know have been diagnosed with

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12 http://www.time-to-change.org.uk/sites/default/files/TTC%20CYP%20Report%20FINAL.pdf
mental health issues or had relationship breakdowns. Those who only occasionally update their walls tend to be 'happier with life'. what do you have for breakfast? not 'Do you have breakfast?' What flavoured drinks do consume in a day? As a first aider in school I find that when a child presents 'feeling unwell' or 'sore head' 'feeling dizzy' or 'feeling sick' on examining their food and drink intake for the past 24 hours interesting. always no water has been drunk, 90% have had a fizzy drink if not a sweetener/sugar enhanced drink. What time do you get up? What time do you go to sleep?(not go to bed) too much as well as too little are causes of concern.

- From a housing perspective (to allow for analysis of impact of housing on child health): Overcrowding in the home, would be a priority – just need number of bedrooms to derive this I think And housing security: length of time in accommodation, how likely or unlikely do you think it is that you will need to leave your accommodation within the next 6 months? Tenancy length/type Would be good if possible to get something on the physical conditions of their housing e.g.: Presence of damp, rot Is it a non-decent home? Other household characteristics that would be useful to add are: Disability for parent and child. Lots of questions on health but I can’t seem to find this and would help comparisons.

- Occupational Performance Ability to carry out daily activities of self care Sensory Processing issues

- Pressures of school testing, homework etc. Does the young person feel he/she has somebody to talk to who listens to them?

- I’m pleased to see the inclusion of parental mental illness in the survey but wonder whether this ought to be expanded to include the other elements of the ‘toxic trio’ - parental substance misuse and domestic abuse (although the latter may be covered by ‘Family Functioning’ or ‘Stressful Events’). Evidence suggests these three elements are significant risk factors for poor mental health in children and our local experience bears this out.

- Use of voluntary health services as well as use of CAMHS and other NHS services for mental health should be included. 2. There is no reference to peer bullying, which in the context of recent evidence, should be included in the survey. 3. It would be useful to track the amount and type of social networking, and other screen time use by children and young people. 4. Suggested Question: Are you (is your child) engaged in any research or other projects related to mental health problems? 5. Suggested question: Are you (is your child) engaged in the decision making around his/her needs? 6. There is no reference as to whether a child or young person is on the Child Protection register – the survey does extend to CYP under the care of the LA however.

- time in the UK (for non-natives) social exclusion? provision for play/interaction with age mates financial difficulties social support mechanisms
- Provision of regional services and their accessibility.

- It will be very important to include a set of questions about subjective well-being. There has been a growing interest in this issue since the last survey and there are important things to understand about the links and differences between mental ill-health and subjective well-being. I would recommend questions that have been developed by the ONS and by The Children's Society which capture the concept well. Just to clarify that I am referring specifically to the concept of subjective well-being, which should not be confused with the much narrower concept of 'mental well-being' - e.g. the Warwick-Edinburgh Mental Well-Being Scale. These are not interchangeable concepts, although it may be interesting (but in my opinion less important) to include the WEMWBS in addition to the above if space was available on the questionnaire.

- Children and young people's experiences of social media and the impact of negative experiences on mental health. What mental health services children and young people are accessing, and whether their parents or guardians are aware of them accessing these services?

- I would like to mental health services included. Much more data is needed on what is being provided and who to, the length of waiting lists and the ages of CYP receiving a service.

- Whether the child/young person has intellectual disabilities, and clear distinction between intellectual disabilities and specific learning difficulties e.g. dyslexia. For children with "special educational needs"/"additional support needs", clarify what type of needs these are rather than lumping all types of needs together. Children with intellectual disabilities have substantially greater mental and physical health needs than other children, and often experience other disadvantages, inequalities and deprivations. Hence the importance to include a focus on them, and hence the need for greater clarity on the terms used rather than non-specific terms like learning difficulties, developmental problems, and special educational needs. The significance of the number of years a child is scholastically behind depends upon their actual age. Intellectual disabilities are as common as autism which was included in the 2004 report.

- Is other birth parent resident in the household? Whilst current demographics are asked current relationship status does not reveal relationship history or child's experience of separation from one parent. As well as arguments between parents would be helpful to know about other negative communication e.g. disengagement or expression of contempt which are highly corrosive of relationships.

- Exercise and dietary lifestyle/issues. Dietary issues are commonly associated with Mental Health.

- Intellectual Disability/Learning Disability (ID)should be included in the 2016 census. Children/Young People (CYP) with ID have very high rates of mental health (MH)problems -1/3 of all with ID have additional MH problems, & 50% of
those with Severe/Profound ID. Of all CYP with MH problems, at least 15% have ID. There are high rates of co-morbidity of ID with other MH and physical health problems. Those with ID have unequal access to MH services. They are more likely to be abused &/or looked after and than the general population. ID occurs at a similar prevalence to Autism. A more specific question/measure than ‘educational attainment’ is required. Consideration is needed of the best way to get info on ID as some CYP do not get a formal diagnosis, with less specific labels such as ‘developmental delay’. ID needs to be distinguished from Specific Learning Difficulties such as Dyslexia. ID is a life-long condition with major implications for services and its inclusion of ID would aid service planning.

- Use of social media (hours per day whether bullied frequently or ever
Oversampling of BAME young people school burnout or academic related stress clearer information on numbers seeking help, numbers receiving help, range of services approached not just NHS services but also parenting, voluntary sector, telephone, counselling and online help, gang involvement and justice involvement

- We would ideally be looking for more information on equality characteristics in order to compare different groups. The 2004 questionnaire included questions on the child or young person’s sex, age and ethnic group, plus questions on disability/health problems. Both questions on ethnic group and disability/health would benefit from updating, drawing on harmonised questions on these topics. We would like you to consider adding questions on religion, pregnancy and maternity, sexual identity and/or gender identity which all relate to protected characteristics under the Equality Act 2010. For adults, both religion and sexual identity are associated with an increased risk of poor mental health, while links between pregnancy and maternity and mental health are well known. Anecdotal evidence also suggests that transgender people may be at higher risk of poor mental health.

- We consider stressful life events to be of particular importance during childhood. Since childhood bereavement is only examined through two questions (K6, K7 on page 316), we would recommend an additional question on this very important subject that is suggested by literature to have a significant effect on mental wellbeing:

  K7a. At any stage in his/her life, has an adult (for example, grandparent, adult relative, teacher) he/she was specially attached to died?

  (1) Yes
  (2) No

We would also suggest some slight amendments to questions K6, K8 (on page 316) and C1a (on page 333). Please read below for our suggested version of these questions:

  K6. Now turning to things that have happened to NAME CHILD. At any stage in his/her life, has a parent (biological, adoptive, step), brother or sister (biological, half or step) of his/hers died?
(1) Yes, a parent
(2) Yes, a brother or sister
(3) Yes, both a parent and a brother or sister
(4) No

K8. Since NAME CHILD was born, have you (or a partner of yours or a sibling of his/hers) had a serious physical illness such as cancer or a major heart attack?

(1) Yes
(2) No

C1a. Are you specially attached to any of the following children or young people?

(1) One or more brothers, sisters or other young relatives (including half/step siblings)
(2) One or more friends
(3) Not specially attached to anyone

- Important to separate out a measure of well-being from mental health - these are DIFFERENT concepts which need different measurement instruments and should not be conflated. There are some self-complete and informant well-being measures that could be used. For the mental health measures DAWBA and SDQ are good. Very important to clarify the looked after status (including LACYP and Adoption)

- Effects of social media/ electronic devices on children's mental health

- Social withdrawal/Isolation Pathological gaming/computer/internet use School refusal NEET status

- Overall, the same topics as 2004 plus some additions. Suggestions from our own consultation include:
  - Wellbeing
  - Bullying
  - Cyber bullying
  - Self-esteem
  - Resilience
  - Stigma and discrimination
  - Impact of violence and trauma

- Bolster data on family composition and family history: While the 2004 survey identified whether the parent respondent (a) currently lives with a partner and (b) whether they have ‘experienced marital breakdown or major relationship breakup’ since the child was born, it did not specifically identify separated families. So, as our top priority, we would suggest adding (largely by simply expanding the household grid to include relationships between household members):
• □ questions which capture whether the CYPs live with one or both of their parents (and the parents’ relationship) and – if not – what contact (if any) they have with the parent they don’t live with;
• □ whether there are step-parents/brothers/sisters (as essential within the household, but ideally also new partners/children of non-resident parents);
• □ given the evidence of the detrimental effects of multiple family changes, we would suggest asking a summary variable about the experience of changes in family structure (step-parents, partners, etc).

• Capture data to look at associations between family separation and mental health: In addition to the 2004 question on the parent respondent’s experience of marital breakdown/relationship breakup’, to look at family separation, the survey might ideally capture:
  • □ CYP’s experience of parental separation and when that was (or if never lived together);
  • □ Reason for the separation/retrospective data on level of acrimony before and during the breakup;
  • □ And currently: quality of co-parenting relationship of the separated parents (and perhaps quality of relationship/level of conflict between parents); contact and quality of the relationship between non-resident parent and CYP. Where CYPs are 11+, these questions could be asked of the CYP as well as the parent respondent. (These would complement the 2004 questions on family functioning within the CYP’s household (e.g. within intact families).)
• Capture data to look at associations between parenting/family relationships and mental health: The 2004 survey captured data on how well the family gets on, and whether the CYP witnesses arguments/aggression between adults in the household. Given the links between the quality of parenting and quality of relationships (including conflict) and CYP’s mental health, we suggest it would be useful to add additional questions on these issues, such as:
  • □ Parent’s perception of how well they parent (single measure, as fielded in MCS);
  • □ Parent:child relationship (including, if relevant, relationship with step-parents);
  • □ Involvement of one/both parents in childrearing (age-specific questions);
  • □ Quality of parents’ relationships.

Recommendations on the school questions for the MHCYP 2016
School questions for the parent questionnaire

It is recommended that the questions below replace / supplement questions on page 317-18 in the MHCYP 2004 survey report.

- *How many different schools has NAME CHILD ever attended? (report number)*
- *Is NAME child in full time education – yes / no*
  - If yes
    - *Over the last year has s/he had one or more teachers that s/he found very difficult to work with? (no, yes)*
    - *Did your child’s difficult relationship with this teacher(s) interfere with*
      - *Their learning?*
      - *Their attendance at school?*
      - *Did it upset or distress your child?*
        - (no, only a little, quite a lot, a great deal)
- *Has your child ever been home schooled (yes / no)?*
  - If yes – between what ages were they home schooled (record from x to y years of age)

(*for all children aged 4 or more*)

- *Has your child ever been excluded from primary school?*
  - Yes / no
  - If yes – *how many times did (name child) have a permanent exclusion / expulsion from primary school (report frequency)*
  - *how many times did (name child) have a fixed term / temporary exclusion / suspension from primary school (report frequency)*
- *Has (name child) ever had a managed move (where the school insists and organises the change) between primary schools?*
  - Yes/ no
  - If yes - *how many times did (name child) have a managed move between primary school? (report frequency)*
- *Has (name child) ever been sent home for behaviour from primary school without being excluded?*
  - Yes / no
If yes - how many times was name child sent home from primary school without being excluded (report frequency)

(for all children aged 12 or more as this in addition)

☐ Has (name child) ever been excluded from secondary / middle or high school or college?

Yes / no

☐ If yes – how many times did (name child) have a permanent exclusion / expulsion from secondary / middle/ high school or college? (report frequency)

☐ how many times did (name child) have a fixed term / temporary exclusion / suspension from secondary / middle/ high school or college? (report frequency)

☐ Has (name child) ever had a managed move (where the school insists and organises the change) between secondary / middle/ high schools or sixth form colleges?

yes / no

☐ Has (name child) ever been sent home for behaviour from secondary / middle, high school or college without being excluded?

Yes / no

For all parents answering yes to exclusion (permanent or fixed term) at either age group – only answer once for all occasions

☐ Was any support from school or educational specialist offered to NAME CHILD as a result of their exclusion(s) from school (yes / no)

If yes – was your child offered NAME CHILD – all yes no – tick as many as apply

- Assessment by the Special Educational Needs Coordinator
- Assessment by an educational specialist from outside school like an educational psychologist or behavioural support teacher
- Referral to Child and Adolescent Mental Health Services
- Time with a member of school staff in the same school
- Time in a special unit within the same school
- Attend a new special school or special unit outside school
- Home tutoring
- No additional support was provided
It is important to note that if the survey data can be linked to the National Pupil Database, we suggest that there is no need to gather data on attendance at school.

It is also recommended that the section about school moves in relation to being looked after (see page 318-319 Lookaft) should be amended as follows:

Has NAME CHILD ever spent any time being “looked after” by social services? Yes / no

How many times has NAME CHILD been looked over?

Did NAME CHILD move schools as a result of being looked after? Yes / no

If yes, how often did they move schools as a result of being looked after (report frequency)

We recommend not to ask how long the child was looked after for.

School questions for the young people questionnaire

This relates to page 360 of the 2004 survey report.

☐ How many schools have you gone to? (report number)

☐ Are you still in full time education at school, or sixth form college? Yes / no

If no – how old were you when you left school? (report age)

What do you do now (university, part time college, working, apprenticeship, NEET, other)

If in school, college or university

☐ Over the last year have you had a teacher / tutor or lecturer that you found very difficult to work with? (no, yes)

If yes – did this difficult relationship with your teacher interfere with:-

Your learning

Your attendance at school

Did your difficult relationship with this teacher upset you?

no, only a little, quite a lot, a great deal to all three

☐ Have you ever been excluded from primary school?

Yes / no

☐ If yes – how many times did you have a permanent exclusion / expulsion from primary school (report frequency)
- how many times did you have a fixed term / temporary exclusion / suspension from primary school (report frequency)

- Have you ever had a managed move (where the school insists and organises the change) between primary schools?
  
  Yes/ no

- If yes - how many times did you have a managed move between primary school? (report frequency)

- Have you ever been sent home from primary school for your behaviour without being excluded?
  
  Yes / no

  If yes - how many times were you sent home from primary school without being excluded (report frequency)

  (for all children aged 12 or more)

- Have you ever been excluded from secondary / middle or high school or college?
  
  Yes / no

  If yes – how many times did you have a permanent exclusion / expulsion from secondary / middle/ high school or college? (report frequency)

- how many times did you have a fixed term / temporary exclusion / suspension from secondary / middle/ high school or college? (report frequency)

- Have you ever had a managed move (where the school insists and organises the change) between secondary / middle/ high schools or sixth form colleges?
  
  yes / no

- Have you ever been sent home from secondary/ middle/ high school or college for your behaviour without being excluded?
  
  Yes / no

  If yes - how many times were you sent home from primary school without being excluded (report frequency)

If linked to the National Pupil database, information on attendance can be obtained. However, we need to consider whether we can ask to link retrospectively – i.e. for those that have already left school (can we go back to their school record?).

Recommendations on the service sections for the MHCYP 2016
Service use questions for the parent interview

This relates to page 310-318 of the 2004 survey report.

1/ Here is a list of people who parents and young people often turn to when they want advice and treatment about a young person’s emotions, behaviour, concentration or difficulties in getting along with people

In the past year, have you or NAME CHILD been in contact with any of these people because of worries about his / her emotions, behaviour, concentration or difficulties in getting along with people? (yes / no for all below – tick all that apply)

- A teacher (including head of year, head teacher or special educational needs coordinator)?
- Someone working in special educational services (for example an educational psychologist, educational social worker or specialist teacher from outside school)?
- Someone from primary health care such as your GP, family doctor, health visitor, practice nurse or school nurse?
- Someone specialising in mental health care, such as a mental health nurse, psychiatrist, psychologist or counsellor?
- Someone specialising in children’s physical health, such as a hospital or community paediatrician, or occupational therapist?
- Someone from social care, such as a social worker
- Someone from youth justice, such as a probation officer or someone working in a Youth Offending Team
- Other – please describe

3/ In the past year has NAME CHILD had to go to a clinic, unit or hospital for several hours each day over a period of time due to his / her emotions, behaviour, concentration or difficulties getting along with people?

Yes / no

4/ In the past year has NAME CHILD had to stay in hospital over one or more nights due to his / her emotions, behaviour, concentration or difficulties in getting along with people?

Yes / no

5/ In the past year has NAME CHILD received a police caution or conviction? Yes / no

if yes – how many cautions (state number), how many convictions (state number)

5/ Have you been so worried about your child’s emotions, concentration behaviour or difficulties getting alone with other people at any time before the last year, that you talked to any of these people about it: (yes / no for each)\(^3\)

- Your child’s teacher

\(^3\) This question aims to estimate past psychiatric history in the child that was severe enough to prompt service use – it would be used to adjust for previous problems in secondary analyses rather than to provide an accurate estimate of either past service use or past mental ill-health.
Service use questions for the young people questionnaire (from 13 up or 11)

It is suggested to include the following questions:

1/ Below is a list of people who parents and young people often turn to when they want advice and treatment about a young person’s emotions, behaviour, concentration or difficulties in getting along with people.

In the past year, have you been in contact with any of these people because of worries about your emotions, behaviour, concentration or difficulties in getting along with people? (yes / no for all below)

- A teacher or teaching assistant from school?
- Someone working in special educational services (for example an educational psychologist, educational social worker or specialist teacher from outside school)?
- Your GP, family doctor, health visitor, practice nurse or school nurse?
- Someone specialising in mental health care, such as a mental health nurse, psychiatrist, psychologist or counsellor?
- Someone specialising in children’s physical health, such as a hospital or community paediatrician, or occupational therapist?
- Someone from social care, such as a social worker
- Someone from youth justice, such as a probation officer or someone working in a Youth Offending Team
- Other – please describe

3/ In the past year have you had to go to a clinic, unit or hospital for several hours each day for several days or weeks due to your emotions, behaviour, concentration or difficulties getting along with people?

Yes / no

4/ In the past year have you had to stay in hospital over one or more nights due to your emotions, behaviour, concentration or difficulties in getting along with people?

Yes / no

5/ In the past year have you received a police caution or conviction? Yes / no

if yes – how many cautions (state number), how many convictions (state number)

Recommendations for Special Educational Needs and Disability (SEND) questions of MHCYP 2016

Please note that this relates to the English legislation. The terminology and legislation in Scotland might differ.

SEND questions for the teacher’s questionnaire

We suggest the following:
• To keep A1 questions on attainment related to peers and A2 on mental age (even though many did not response to these questions in 2004): to keep

• If the MHCYP 2016 data can be linked to the National Pupil Database, to drop the set of A3 questions on attendance over the last term.

• If the MHCYP 2016 data cannot be linked to the National Pupil Database, to include the following question:

  How does the attendance at nursery / school/ college/ university of (NAME CHILD) compare to their peers?

  (response options - attendance is better than average, attendance is average, attendance is poorer than average)

• To amend the A4 section on special education needs:

  A4 – Does this child / young person have officially supported special educational needs?

  Yes go to question A41

  No go to section B

  A41 Does this child / young person have an Education, Health and Care (EHC) Needs Plan?

  Yes / no – both go to QA5

• To amend the A5 questions on the type of special education needs:

  A5 Are these special needs related to needs in the following areas? Please tick all that apply.

  □ Communicating and interacting -(speech, language and / or communication difficulties that make it difficult for them to understand language or communicate effectively)\(^{14}\)

  □ Cognition and learning –(learning at a slower pace, which may be for everything or just some skills such as numeracy / literacy, and / or difficulties with memory and / or organisation)

  □ Social emotional and mental health (difficulties with emotions, behaviour, concentration or getting along with people that get in the way of learning or coping at school)

  □ Sensory and / or physical (difficulties with vision or hearing and / or physical ill health that gets in the way of learning or coping at school)

\(^{14}\) These are taken from the parents SEND guide from DH – we may not want them for teachers, as we would hope that they would know – however, may be helpful to keep in for parents and young people – after discussion with the colleagues, we have simplified the language further or parents and young people – as teachers should be familiar with this, we have kept the SEND terminology for teachers – an alternative would be to be consistent with either version across both
SEND questions for the parent questionnaire

The new questions suggested below are aimed to parents of children in formal education up to 18.

We would also like to consider but including children in further education and at university (as Education, Health and Care plans extend up to the age of 25 for young people who remain in education or training).

1. Does (NAME CHILD) have special educational needs (yes / no)
   - Yes  go to question 2
   - No  skip to next section

2. Does NAME CHILD have an Education, Health and Care (EHC) Needs Plan?
   - Yes / no

3. Which areas are these special needs related to? Please tick all that apply.
   - Difficulties with speech, language and/or communication (difficulties that make it hard for them to understand language or communicate effectively)
   - Learning difficulties (learning at a slower pace, which may be for everything or just for some skills such as reading/writing/maths, and/or difficulties with memory and/or organisation)
   - Social emotional and mental health (difficulties with emotions, behaviour, concentration or getting along with people that get in the way of learning or coping at school)
   - Sensory and / or physical (difficulties with vision or hearing and / or physical ill health that gets in the way of learning or coping at school)

SEND questions for the young person questionnaire

The new questions suggested below are aimed to young person aged 16 or more and who are in formal education. We recommend for such questions to added as parents won’t be interviewed for this group.

4. Do you have special educational needs?
   - Yes go to question 2
   - No  skip to next section

5. Do you have an Education, Health and Care (EHC) Needs Plan?
   - Yes / no

6. Which areas are these special needs related to? Please tick all that apply.
   - Difficulties with speech, language and/or communication (difficulties that make it hard for them to understand language or communicate effectively)
- Learning difficulties (learning at a slower pace, which may be for everything or just for some skills such as reading/writing/maths, and/or difficulties with memory and/or organisation)
- Social emotional and mental health (difficulties with emotions, behaviour, concentration or getting along with people that get in the way of learning or coping at school)
- Sensory and/or physical (difficulties with vision or hearing and/or physical ill health that gets in the way of learning or coping at school)
Appendix F. Suggestions for content to remove or reduce

Responses to ‘what would you choose to remove from the survey in order to make space for the new topics you have suggested? Please explain your choices’ are listed below. All the comments have been anonymised. Names and references to organisations have been removed.

- Our contribution to the consultation is primarily focused on why and what additional topics should be included in the survey. However, in acknowledgement of the fact that the consultation specifically asks what should be removed from the survey to make space for the topics that we have suggested, we would make the following suggestions:

  There are a number of questions that appear to duplicate each other to a certain extent. For example, some of the questions in the ‘strengths’ section of the child self-completion questionnaire are similar to the ‘pro-social’ questions in the SDQ, and some of the questions in the ‘troublesome behaviour’ section e.g. about lying (C3A4a) fighting (C3A4b) stealing (C3A4e and C3A6f) are similar to questions that are in the SDQ. Given the length and detail of the questionnaire, it does not seem necessary to have questions that are so similar.

  We also think that the drinking, smoking and drug use sections of the child self-completion questionnaire are extremely detailed and could be cut back in length.

- Information on looked after children is superfluous in this survey as they cannot be analysed separately due to small numbers in the sample size.

- Information on scholastic achievement might be deprioritised as this could be added at a later date by linking data from the survey to the National Pupil Database in order to follow up on educational outcomes at various stages.

- Parental income could be de-prioritised as this tells us only about the family income received rather than how it is prioritised and utilised and how much benefit the children may see from it. The ‘index of childhood material deprivation’ has been shown to correlate much more strongly with child wellbeing outcomes. Alternatively use Index of Multiple Deprivation derived from postcode as a proxy for poverty/ income etc.

- Various data that could be obtained from linking to the NPD and ILR for post 16 – attainment, attendance, exclusions, SEN, check of LAC status. NPD data is very complete and accurate, this could reduce burden on respondents and also by obtaining permission to link create a powerful research dataset.

  Bullied by teacher questions – these questions were weak in 2004 and similar could be captured in proposed section on school engagement

  Registered with GP – not clear what this adds

  Social support/life and networks – 2004 questions do not seem to have provided useful data. Might be beneficial to consider what new evidence there is of social factors in mental health
• Topics that I would cut if I needed to is maybe housing tenure, and many of the health or disability questions can be grouped together and placed into monitoring information rather than survey questions as such

• Personality measures. These will give the usual results, e.g., - Openness predicts attainment - Neuroticism predicts mental health difficulties - Agreeableness will correlate with conduct problems and prosocial behaviour. Personality won't add anything.

• scholastic achievement and estimated mental age.

• THE INCREASE IN SUICIDES. THE IRONY OF SSRI'S GIVEN TO PATIENTS WHO ARE EMOTIONALLY VULNERABLE, AND ARE TOLD THEY MAY FEEL WORSE, AND THEY SHOULD REACT NORMAL. FIRST LINE TREATMENT, LONG TERM TREATMENT? ANECDOTAL REPORTS SUGGEST THAT IT BLUNTS EMOTIONS (MAY BE DUE TO THE FEEDBACK ON NMDA/GLUTAMATE RECEPTORS) AND IS MEANT TO ENHANCE MOTIVATION AND MOOD? MDMA SHOULD BE CONSIDERED A LEGITIMATE ANTI DEPRESSANT IN THAT CASE AS IT ACTUALLY DOES WHAT IT CLAIMS, TO SAY THE LEAST.

• None. Both can be included as sub-categories of existing headings.

• Smoking questions Teacher bullying

• All this information is vital

• I can't see the topics now

• Other concerns' and 'Open ended description of significant problems' are pretty much the same thing, so one could be removed to make way for an additional topic.

• reduce teacher elements

• I think many of the topics are over -questioned, reducing the number of questions about a particular issue could make space for more topics. i.e. when asking about impact of feeling panicky could ask what else do you feel when feeling panicky, giving a suggested list rather than ask 14 separate questions

• Children's general health reported by parents - it does not add anything and biased. Personality reported by children's teachers - this is also likely to be biased. Children can answer about them by themselves.

• Smoking

• Perhaps information about parent education and income?

• Ethnicity, strengths of older child, personality: Ethnicity - to measure the well-being of children, the same criteria should apply for all of our UK families,
regardless of ethnicity (unless trends in different ethnic groups are also being studied); Older child’s strengths - reporting of these at this age might not reflect the reality, either by a poor parental skill to assess these or because whatever previous childhood the teen has experienced, it may have already disguised strengths which therefore go unreported, but are still there, just needing the right (male, for boys) to bring it out - therefore, high chance of inaccuracy; Personality - if you take a group of surveyed ‘happy people’, they will have different personalities, very different. Their characteristics (resulting in happiness) may overlap, but not as much their personalities - therefore seems irrelevant to discover the mental well-being of our youngsters.

- I would change access to mental health services and instead ask whether they have mental health needs. Also there should be a question if children are fostered or adopted included with the looked after question. I would omit the question on whether the teacher has bullied them as many children experience bullying from many sources. Also I would omit the question on personality as it is a personal view rather than a yes/no answer.

- Teachers assessment of CYP mental health. There is enormous room for teachers' perspectives to be influenced by norms of gender, ethnicity and socio-economic position. e.g. 'black' boys have more behavioural problems, girls who may act like boys could be characterised with a disorder.

- To make room for new questions, I think that some questions are over-laboured and could be condensed, e.g. they ask 14 questions about what else a young person feels when they feel panicky, this could be one question with a multiple tick box answer; creating a slimline questionnaire would allow additional questioning, more issues fewer questions on each.

- I would only include teacher info on objective behaviours and school attainment. Not sure that self reported stressful events are particularly useful /reliable here so perhaps remove those?

- Est mental age teacher assessment of academic abilities.

- More an issue of how it will be delivered. Will you have a BSL version of the whole survey to make it accessible for Deaf parents and Deaf young people who use BSL? If so how?

- teaching grades as some children are homeschooled or do not attend mainstream schools.

- General health/academic ability questions that are less easily translatable and are more open to subjective reports.

- The strengths questions in the SAS are repeated and don't need to appear twice. There is too much on rare risk factors for mental health problems like accidents and not nearly enough on the key ones like parenting.
• I think I would take out whether the child is looked after a local authority. I don't think this is as important as all the other questions in the survey.

• unsure - I think a lot of them repeat

• none

• I would not choose to remove anything listed.

• open questions on less common disorders

• Nothing!

• Less common disorders This is non specific

• none - we have little recent information. If a survey of this type is done every 10 years, it needs to be comprehensive

• some of the parental demographic data. this needs to be of use to shape services not just collect population data and this gives young people a proper voice (young people's responses should be more than parental responses)

• I know its difficult taking questions out of a validated tool. The questions in the SDQ are repeated in terms of difficulties that are comprehensively covered in the DAWBA. Perhaps replacing the SDQ with a more focused wellbeing tool that could be included within the DAWBA to break it up.

• Teachers score of academic marks

• Nothing

• The question(s) we are suggesting are not so much additions as measures to ensure that the issues (impact of parental conflict on children's mental health) is adequately addressed (the questions in the 2004 survey missed out entirely a whole area of children's experience - i.e. parents embroiled in non-acrimonious relationships but who are nevertheless emotional withdrawn from each other - which research shows is as much, or more, harmful to children than overt hostility between parents.

• Measures of family functioning - indices are quite possibly unreliable and these aspects of the interview will not generate any new knowledge subsequent to previous surveys.

• I don't feel able to answer that question

• I do not think that ethnicity is a particularly important metric. I understand that, as a protected characteristic, it can go someway to helping us to comprehend variations/inequalities, but introducing ethnicity as a key marker to a child is
counter productive, I feel. I would also get rid of smoking, drug use and alcohol consumption. There are other surveys that already undertake studies here and, given that it is self-completion, often participants will drastically understate or overstate the extent of this.

- Nothing - all important

- not so much extra questions - but ensuring enough people are surveyed so this local level granularity can be produced. If needed I would focus more on child self report measures and less on parent reported measures

- It is very difficult to decide what should be removed, but following are some suggestions. There are a few questions which aren't unhelpful in themselves, but you would need to know the scoring system to make sense of the data give. Example of this Child's sources of emotional support. In the report it is associated with table 5.25 for emotional disorders. Child's paid work question Region Country and Area question - not sure how useful the data is - table 6.5 in the report re emotional disorders. Children's paid work - there are other questions that seem to cover this as well. Social context of last drinking, smoking etc occasion - in conduct disorder table 6.35 Maybe rather than thinking about what you can remove, because it is likely that people will have different views, you could think about what definitely needs to be there. In our view it should cover the range of key risk factors, not be duplicated in the survey. We can help with that if required.

- Nothing

- Use of cigarettes, alcohol and drugs as collected elsewhere.

- It may be possible to rephrase the question of looked after status to include the issue of adoption and SGOs

- We don't think it would necessitate dropping anything. Death of a grandparent and of a pet were included in 1999 but lacked predictive power and were dropped in 2004, so space has perhaps already been made?

- I am not sure any should be removed. Abuse can have such an impact on all areas currently mentioned it should be possible to include all. However, please note that the SDQ is not always appropriate for measuring impacts of abuse and is not used because of this.

- Personality is too vague and impossible to measure or quantify. Whilst I can understand people might want to attempt it the information will not be helpful.

- housing status mental age income parent education ethnicity of each household member

- parental income - use postcode as proxy
• add to the survey if possible

• Housing tenure

• Substance use. These are self-completed questions and I am not sure whether you will get accurate data. Also, the adverse experiences should provide information about substance misuse within the family or by the child.

• Questions of ethnicity and income

• perhaps could be amalgamated within the educational section?

• Nothing can be deleted. All are potential risk factors for mental health problems and should be evaluated in a longitudinal manner.

• I would consider removing the personality measure, as I simply think these other measures are more crucial to understanding risks for mental health problems. Possibly I would also remove the teacher bullying questions in favour of a broader measurement of perceived support from school (as per the subscale of the student resilience scale).

• Nothing.

• The self reported smoking and drug use may not be as important as what activities are being undertaken.

• Within the Other Information Provided section, "Social Support" and "Social Life are clusters that could be merged together to make space for LGBTQ+ issues. Or sexual orientation could be included as part of the "child report".

• I would reduce items on smoking, drinking & drug use to the minimum - we have good data on these behaviours from the SDDU survey. I would probably also not include strengths, as I'm less clear what we do with those in an essentially epidemiological picture. The really important thing is to get the info on mental health disorders.

• Reduce the number and complexity of questions relating to parent/family information to those which are most relevant to factors of interest. Reduce section of 'other information' on the teachers questionnaire.

• I can't really pinpoint anything that should be removed. That is why I suggested that maybe some of the questions could be geared to ask for some specific information that would indicate whether the parent/parents are serving in the Armed Forces or that the child receives the Service Pupil Premium.

• Family dysfunction is prob not very reliably assessed. Parent physical health has a lot of influence of yp psych morbidity
• The food issues could replace certain questions in the eating disorder and compulsion/obsession sections. Social phobias should have references to the use of screen time and what type of screen time it is, as well as the compulsion/obsession sections.

• Hard to say but could some housing questions be squeezed into the parent/household section?

• Information about smoking or parents' employment/ethnicity.

• If anything, possibly the section on medication, given that there is already information about general health and health conditions - it seems strange that these are separated.

• Some of the teacher report questions (e.g. re mental age or personality) are poorly validated and unlikely to yield useful information.

• bullied by the teacher as it seems just too specific. may be covered under stressful events

• I would not remove anything. All of the topics are important.

• There are two topics on the child questionnaire that could be reduced. 1. ‘Social life’. I’m not convinced of the relevance of some of this section - e.g. questions about activities in free time. 2. 'Smoking, drinking and drug use'. I think there are too many questions in these sections. This topic is already extensively covered on a number of other surveys of children and young people. These sections could be substantially reduced to a few basic indicators.

• questions about drink drugs and smoking. these activities are so pervasive in adult society that it seems wrong to equate them in any way with mental health issues although I don't doubt that they come to affect mental wellbeing in the longer term. As a non-drinker it is more often that I find myself considered odd not the other way around

• The additional space needed is minimum.

• I do not believe that the addition of ID as a diagnostic category need add greatly to the length of the survey. It will cross-reference to many other existing aspects in the analysis.

• We believe that question R8 (on page 266) covers similar content to question R7. These are the questions and answers for them: R7. Thinking now about NAME CHILD’s ability to use language – to say what s/he means and to understand what other people are saying – is s/he about average, ahead of his/her age or behind his/her age? (1)Ahead (2)Average (3)Behind R8. At present, roughly what sort of age level is s/he at in his/her use and understanding of language? For example, like an average AGE year old? 0..16 Taking into consideration that both questions are included in the parent
questionnaire, R7 appears to be more appropriate to provide reliable information. Parents would probably have a rough idea of their child’s ability to use language (about average, ahead or behind his/her age). R8 refers to the age level of use and understanding of language with possible answers 0..16 and would seem more useful in case a professional/specialist was answering the question. We would recommend removing question R8.

- issues that have no clear evidential relationship to mental health - so for instance some details of school report etc

- Estimated mental age
Appendix G. Other Comments

Responses to ‘Please use the space below to make any other comments you would like to submit as part of the consultation on the content of the survey’ are listed below. All the comments have been anonymised. Names and references to organisations have been removed.

- **Age ranges.** With respect to the range, it seems really important to reflect the significant changes that have occurred since 2004 with respect to participation in education. Thus, since Sept, staying on in education of some description is necessary for all up to 18. It seems to make sense to end the survey at 18, if you’re picking an age somewhere around then - otherwise you will have young people in the older age group in very different kinds of situations. We would also argue, as I know others have, that it would make conceptual sense to go up to 25, given the range of the C&YP mental health taskforce etc. However, as far as I know the SDQ is not standardised even over 16, and certainly not up to 25? Would this provide a challenge for the 16-18 (as I’d prefer) or 16-19 groups anyway?

  Plus - cutting across this - is the need to be able to respond to the C&YP’s outcomes forum et al/HSCIC etc on providing information in quinary age bands (5-9, 10-14, 15-19...). Is there a way of providing the information in a format that people can rearrange the age bandings according to their uses of the info?

- **Other sampling issues.** There's no other source of info on ethnicity & mental health in these age groups & it may be that considering a booster sample would be important?

- **Focus on epidemiology.** I also wanted to make a plea for focusing on the epidemiological aspects of the survey and not worrying too much about risk factors or causes - its so difficult to tell what the associations mean cross sectionally anyway, and where we really need information on is what YP's mental health needs really are. That said, making sure there's enough on social determinants with respect to patterning of mental health needs is critical. But I'd be less concerned about things such as parental discord, or young people's strengths.

- **Consider alongside the SDDU.** I know the SDDU is undergoing consultation as well this week, but it does provide the most detailed information on smoking, drinking & drug use, and it seems a shame to use your space to replicate this unless you really have to. Some basic, overarching indicators would be useful just to make sure there's not something completely different going on in the samples, but in terms of detail, it won't be possible to capture the range of behaviours that come under these headings (including the importance of e-cigarettes to this age group, and new psychoactive substances). That depends, of course, of securing the future of the SDDU survey...

- **Importance of non-NHS/statutory services.** I agree that getting a picture of service use (and medication) is critical, but if you go down this route, it’s really important to include the full range including voluntary sector provision and also private provision - both of which form a significant part of the resources that people draw on when they can’t get what they need from beleaguered and rationed CAMHS.
• The role of schools in supporting and improving C&YP’s mental health has been increasingly recognised in the years since the previous survey. This changed context needs to be reflected in the survey content such that it provides as much evidence as possible which can support Government in shaping the work that schools do, and the support that can be offered by health organisations in the school setting. There is minimal data on how schools can and do support mental health needs. We are planning our own research to look into this but it would be of great value to be able to explore further here where we are able to look at the data for those with and without mental health problems.

A key step forward from 2004 is an increasing understanding of features of ‘resilience’, those factors which can prevent a risk or combination of risks from causing a negative outcome. If possible it would also be helpful to improve evidence around prevention activity to understand the relationship between certain internal and external factors in resilience (e.g. emotional regulation, problem solving, coping, positive relationships and structures) and the presence or not of the range of mental health problems.

How far do the existing scales for diagnosis capture attachment disorders? We understand this to be a key issue for some vulnerable groups and would like it to be adequately considered.

• I wanted to raise a few points regarding methodology, which didn't seem to be covered in the survey. I don't know if there will be a separate consultation, but I wanted to raise this point with you now.

-Whilst I appreciate that you have been commissioned to survey 2-19 yr olds, we would like to the raise the fact that we believe that the survey should definitely cover up to 25 years. This is because the brain doesn't fully mature until then, so they are still developing. Whilst the adult psychiatric morbidity report covers this age, the diagnostic language is different, so it is impossible anyone other than a clinician to look across the 2 report and draw any conclusions.

-At the other end of the age spectrum, we know that mental health problems can have their roots in utero. So whilst starting at age 2 is better than age 5, it would be more useful to start from age 0, and if possible to include questions regarding the mother during pregnancy. So we can really understand what the issues are at this really early stage. This should give some evidence about what is happening at this really early stage.

-The issue we wanted to raise is why you aren't consulting with younger children directly? We do see the need for both parent and teacher input, but thought should be given as to how to consult with these younger children. There is some research that has shown that children's comments regarding their mental health, can be very different to that of their parents or teachers. Again, we appreciate that this isn't what you have been commissioned to do, but perhaps you could feed this back to Government.

-Finally, whilst there are questions about ethnicity, we would like to flag up concerns following the 2004 survey (see http://bjp.rcpsych.org/content/200/4/265.full) stating that as no oversampling techniques were employed for minority groups, their data lack power and reliability. We no there are big issues regarding the mental health of certain ethnic groups, and it would be useful to have reliable data to help commission appropriate services.
- There could be more link up between different forms of data collection. For example, if you are asking the teacher about personality, it would be good to ask the other groups about it in order to compare. There are things that both parents and teachers will know (or should know) but others they will vary in their perception.

- The topics and language used can be quite rigid and inaccessible particularly for young people. I would suggest piloting it and also consulting children and young people, parents and teachers, on the questions.

- It is very important and useful to have a measure of the educational attainments of the children. I would prefer a directly administered test rather than teacher report because 1. It is more reliable and consistent across children. 2. Previously there was a large amount of missing data with teacher report.

- Important work - looking forward to see the results!

- THE AREAS COVERED SEEM TO COVER MOST DOMAINS. Effects of social media on YP mental health may be of interest

- some detail of primary care service use and of issues concerning access to services would be helpful.

- There has been far too long in between surveys. Plans should be put in place for a regular survey.

- I am wondering if, as well as teachers, at least one medical team (GP) should have an input? Particularly where the subject has, or is perceived to have, an existing condition.

- The adverse childhood experience would be useful to incorporate

- I think the content is well-rounded, and has seemed to cover all the important topics regarding the mental health of young people and children.

- How have you consulted with bme communities? Has this consultation been sent out to churches and mosques?

- Are you going to be looking into the mental health of 18-25 year olds? (A group often neglected - too old to be a child but not old enough to be an adult)

- LD and movement into adult services when mental age is reduced

- Relationships with peers/boyfriends/girlfriends occupy a lot of young people’s thoughts and their ability to make these connections plays a significant part in their sense of well-being. Understanding how young people see themselves in their gender roles may give an insight into who may pose a risk to others (same or different gender) understanding young people view of their sexuality and how that fits with society view is important in understanding how we can protect
them from seeking confirmation in inappropriate ways.

- Fantastic news that this new survey is going ahead!

- Thank you for making this opportunity to add new considerations. The contrast between the well-being and thriving of boys with positive men in their lives and how much more quickly they attain well in their years compared with so many other boys who have not had this OR have only negative or irresponsible men around, is absolutely astounding. Thank you to Mr S Biddulph and other Psychologists who are trying to highlight this simple, straight-forward ‘elixir’ to many boys’ mental and emotional health.

- Deaf children are traditionally omitted from surveys such as this and research is lacking in terms of longitudinal studies. This is partly because the definition of deaf is not clear, as similar terms include hearing impaired or have a hearing loss. Many deaf children experience mental health problems in later life and struggle to access specialist mental health services both as children and adults so obtaining data would be beneficial.

- Young lesbian, gay, bisexual and trans people have 4-8 times the risk of depression, self-harm and suicide compared to their heterosexual counterparts. We do not have enough information about this risk and there are no prevalence studies in the UK. The survey is an opportunity to include a measure of sexual orientation and gender identity and create a national dataset that can help prevent mental health problems in this high risk group. IN the US these measures are included on a regular basis on state-wide youth health surveys (aged 12-18)

- We recognise that adding now will mean that no comparison is available to previous years, but we always have to start somewhere; and removing now stops any future comparison on specific questions, but not if the questions were smarter, can still get similar data from fewer questions.

- Social media and information for parents on it is important to know. How much time do yp spend on computer games

- Very pleased to see this has been commissioned. Will be important to know how people are accessing support, including non-traditional/professional routes (eg internet etc)

- So pleased that this is happening at last. Will be very important

- There is expertise out there in relation to this group of people (Deaf BSL users). Some of us are involved in guidance documents for health care services, research or direct mental health delivery. This represents an important opportunity to capture data on this group but only if the those designing the BSL versions of both survey and standard instruments know how to do this in BSL and what is available in BSL whose reliability and validity has been established.
• There should be questions first to make young person/family/carers feel comfortable and be able to trust the professional before moving on to the more formal questions to help people feel comfortable and give the right information

• Religious background

• It is important that the items can be used to calculate the Adverse Childhood Experiences Scale since this is a widely used and very predictive public health measure

• Within our school nursing organisation we use the SDQ for all school age children and is very useful for behavioural/mental health issues

• Use of social media (and want social media they use)

• I feel there should be a service for children to access who do not fit the criteria and are in-between school health and CAMHS service.

• I feel that the impact of social media / communication using technology on mental health must be measured.

• It will be important that the survey is short enough to get a good response rate therefore because strengths are included in the SDQ think no further qs should be asked on this topic. Similarly just one q on SEN status and reason for SEN which would pick up learning disabilities/ disability/

• This is a key survey as it should inform where priority for additional support is needed

• Content of the survey covers a wide range of contributing factors

• Make as full as possible

• For some young people lots of the questions wont be relevant. If they answer positively perhaps they can skip to the next section or question for some sections.

• Child and adolescent mental health services are overstretched and many young people and their families do not meet the threshold of these services leaving them alone and vulnerable. Many Young people feel they need to take more drastic action to receive help. Mental health services are firefighting and not preventing fires from lighting in the first place!

• Thank you for providing the opportunity to make comments.

• We can provide additional information on the existing questions that are used to measure children and adults' caring roles in national surveys and to find out about the level of support for their caring role.
• INCLUDE AREAS TO BETTER UNDERSTAND EXPERIENCE AND RESPONSES TO MENTAL HEALTH CARE
  1. Nature of therapeutic relationships with clinicians - particularly where shared decision making approaches are / aren't used
  2. Experience of stigma concerning use of mental health services
  3. Perceptions of transitions from CAMHS to adult mental health services
  4. Experiences of crisis care in particular would be helpful

  ALSO, I WONDER ABOUT THE APPROPRIATENESS / ETHICS OF THE QUESTIONS ASKING TEACHERS TO ESTIMATE MENTAL AGE AND PERSONALITY

  In addition to LAC, it would be good to also see if the child is fostered, adopted, in residential facility or under SGO. Look more into the impact of mental health issues on placements

  Questions asked about bullying from a teacher but did not address bullying from peers

• I would re-iterate the need to include questions that address the growing uptake of social media and technology among young people. Never before have we witnessed a generation who are so technologically literate, and understanding the effects of this are absolutely crucial.

• A national survey of the mental health of children and young people should cover the whole 0-18 years age range and should not exclude the 0-2 years age group. This is discriminatory on the basis of age, it is unscientific and ideologically driven, and it produces an incomplete national picture. There is a vast international body of knowledge, research and evidence about mental health disorders in the 0-2 years age range. Infancy is the foundation of mental health, and information about the prevalence of mental health disorders in the 0-2 years age group is critically important to national policy, the provision of specialist mental health services and equity of access to the latter. The UK government should take a leadership role in ending the systematic exclusion of the 0-2 years age range from this survey, which would be inconceivable in a national survey on the physical health of children and young people.

• "We would like to see the following question added regarding parental relationships
Which of the following statements best describes how you and your partner deal with disagreements and differences?
• We usually argue/have a big row
• We usually bicker
• We usually try and sort things out by talking about the problem
• We usually avoid each other/withdraw from each other
• None of these"

  Whilst there are existing questions, we feel that they don't keep up with evidence that in the context of both maritalily intact and separated households, conflict between parents need not be overtly hostile in order to adversely affect children.

• Whilst I appreciate that you have been commissioned to survey 2-19 yr olds, we would like to the raise the fact that we believe that the survey should definitely cover up to 25 years. This is because the brain doesn't fully mature until then, so they are still developing. Whilst the adult psychiatric morbidity report covers this age, the diagnostic language is different, so it is impossible anyone other than a clinician to look across the 2 report and draw any conclusions.
- At the other end of the age spectrum, we know that mental health problems can have their roots in utero. So whilst starting at age 2 is better than age 5, it would be more useful to start from age 0, and if possible to include questions regarding the mother during pregnancy. So we can really understand what the issues are at this really early stage. This should give some evidence about what is happening at this really early stage.

- This is an important and valuable survey as awareness of young people’s mental health needs to be raised.

- If the survey is to reach 16-19s needs to be focused on those who may not be living at home. What about homeless young people? Those in ad hoc foster/living arrangements/unaccompanied. migrants/income of these yps. Does this group share a bedroom/where do they sleep? Have they gone without food in the past week? Have they sought help from a charity or youth project in their community? Some of these will offer counselling and advice. What do they think about the effectiveness of any help they have sought.

- What the person feels about themselves, a self review section maybe

- It would be helpful if the DAWBA could additionally measure the age of onset specifier for DSM Conduct Disorder. Previous versions of the DAWBA have measured age of onset of Oppositional Defiant Disorder, but age of onset is relevant to subtyping CD not ODD. Therefor the age of onset question can be dropped regarding ODD and added regarding CD to improve the diagnostic variables that can be derived from the DAWBA.

- I believe it is important to discover if C&YP know where to access for early intervention services

- We believe that autistic spectrum disorder should be included as a specific category within the survey, as in 2004, because it affects a large number of children (approx 1 in 100) and brings with it some specific challenges that can affect children and young people’s day to day experiences.

- Re age range in Scotland the over 16’s are adults whereas in England it’s the over 18’s so that would need holding in mind re the design for the 16-18 years olds and parental consent and interviews etc. As Scottish CAMHS services go up to 18 I wonder if there should be an upper age limit of 18. If it just goes to 19 as proposed I’m not sure that this would be as helpful as up to 25 . Re LAAC I’d hope it would be the whole population rather than just those in LA care who are recorded ie will record if the LAAC status is kinship care etc. Other at risk groups are LGBT and children . In the summary I don't think it mentions psychosis - will this be covered?

- Looked after children and those subject to SGOs and adoption are a particular cohort of children who we know have increased vulnerabilities as compared to their non care experienced peers. Given this increased vulnerability, it would
be particular helpful if the survey could expand on this area of focus.

- It would be useful to establish if a child is eligible for benefits by reason of mental disorder. Children might be asked to report tics and troublesome habits. Epilepsy is a key diagnosis to elicit.

- The data on bereavement in the 'stressful events' table is the only national data source we have on the prevalence of bereavement among school-age children. As such, it is very very significant for planning and service development across the country eg http://www.childhoodbereavementnetwork.org.uk/research/key-statistics.aspx; Fauth, B, Thompson, M and Penny, A (2009) Associations Between Childhood Bereavement and Children’s Background, Experiences and Outcomes: Secondary Analysis of the 2004 Mental Health of Children and Young People in Great Britain Data. London: National Children’s Bureau

- Perhaps it would be useful to consider also whether children's mental health is adversely affected by the impact of early pressure of formal education (rather than play) and early testing.

- Important given large changes in practices for deaf children (e.g. inclusion policy, CI policy etc) to include information about them.

- It would be helpful to have children adopted from care as a separate category.

- would like more content on mental health and wellbeing

- I think its thorough but think it is important to worry less about the demographic of responses (ethnicity) and more about different stressful/traumatic life events.

- I would advocate for a survey which elicits sufficient information regarding levels of ability/learning disability and diagnosed or suspected developmental disorders

- wherever possible and to make useful it should be the same as 2004 survey, to enable comparison, although mindful diagnostic classification ahs changed? Also would like to capture sub-diagnostic mental distress, bereavement, anxiety, behavioural difficulties if possible. Theses children often struggle to access a service or support

- I am interested in the content of the interview protocol for the following reasons: - sensitivity of topics -wide range of potentially emotionally draining & triggering questions - the length of the interviews. To get the strongest data & provide a positive experience for participants, I anticipate that researchers will have mental health training, and that there will be safeguards in place: signposting to services and provision to mental health support if participants are distressed or identify a mental health issue that they would like to have support around. I suggest support is available to researchers too given the emotionally risky content of this study (supervisory and peer). There is an opportunity for innovative dissemination of this study to children, parents and schools. I am
interested in the NatCen's thoughts on who and how they could engage in this
e.g. NatCen could co-produce dissemination (including engaging presentation
of findings) with children and young people.

- Mental health and educational issues for children with autistic spectrum
disorders

- it would be helpful to have a provisional report date - sorry if this was given and
I've not spotted

- It is important to link data for each individual profiled in the survey
(parent/child/teacher) and to do so longitudinally where possible (we
understand that follow-up is planned for a subset of subjects. It would be
helpful to gain consent from participants to link to NHS/social/school/justice
records for further study. Is this planned for the study?

- Very specific questions

- The survey appears deficit and diagnosis focused rather than concentrating on
the strengths and positive characteristics which could be useful to determine
resilience factors.

- It's important that the content matches the new DSM criteria as well as ICD, but
also that you can compare with the earlier surveys. Most obviously an issue in
autistic spectrum? Is there enough on the distribution of social determinants?
Is there enough on help-seeking behaviour, particularly in relation to the role of
voluntary sector services and also private services? These tend to be the
places parents - and young people - resort to when stat services do not offer
enough. Plus primary care.

- To what extent would the existing questions help indicate levels of
discrimination, eg questions on friends, social behaviour etc?

- what is the best environment for children and young people to access
support/help with mental health issues

- For sometime we have been trying to collect data on the mental health and
well-being of Service children. I think that this National Survey of children's
mental health would be an ideal opportunity to try and collect some UK data for
Service children's mental health issues and the prevalence, this data could also
then provide comparison between Service children and their civilian
counterparts. We would welcome some data on the impact of mobility and
separation on Service children's mental health, there is a dearth of research
available on UK Service children and their mental health counterpart.

- With regard to school info (sections to be completed by teachers) Is Educational
psychology involved. Does child get support in classroom. Support for mh
issues in school may not provide clear response unless defined more exactly
keep up the good work.

I would like to propose a refinement in the way the information about the presence of 'intellectual disability' is captured during the parent stage of CAPI. Instead of including the item 'learning difficulties' in the card shown to parents when listing their child’s health problems, we propose a separate single item during the CAPI worded as such: "Has a professional ever told you that your child has a learning disability/difficulty or a global developmental delay? Y/N. Please note learning disability is also known as intellectual disability. Your child may also have other diagnoses such as Down syndrome, autism, or other genetic syndromes".

Maybe the children and young people could be asked about their aspirations for the future and what they would like to achieve for themselves?

This survey should be repeated every 5 years.

We would hope that the results of the survey would be analysed by all standard demographics including region (GOR) in order to highlight any particular disparities in prevalence.

Age should be increased to include young people up to the age of 25. Targeting of questions for young people not in family environments should be considered.

We feel it is extremely important to ensure the survey includes sufficient questions on long-term conditions and physical health (e.g. general health, disability). To exclude these would be to reinstate the split between mental and physical health that has for so long bedeviled mental health. Children with physical health problems and disability are some of those with the greatest mental health problems. Questions on school use of mental health services and the teacher questionnaire are essential – although some of the questions in the teacher survey (on mental age or personality) seem not useful and could be replaced by other teacher questions.

It would be very useful to consider specific questions in relation to children who are adopted ie attachment difficulties, disrupted attachments. Would also be useful to include issues such as Foetal Alcohol Syndrome.

what the young person thinks would help improve the situation

Analysis of services available by region, will help to highlight deficits in provision.

Ensuring that any interviews conducted with children and young people are done so in a confidential manner and, where appropriate, away from their parents or guardians to allow children and young people the opportunity to give full and frank answers to all questions. Why the Survey is limited to children and young people in England and Scotland? Could it be expanded to cover
Wales and Northern Ireland?

- We are keen that the transition from children's mental health services to adult mental health services is investigated as this is frequently a very problematic period from the young people we work with.

- Parental mental health, substance misuse and exposure to and experience of domestic violence

- ‘Is Britain Fairer?’, published in October 2015, presents evidence on a wide range of indicators across ten domains which form the Commission’s Measurement Framework (MF). Mental health is covered within the Health domain and the new survey of the mental health of children and young people would provide a valuable additional source for the next review, providing GB-wide coverage and comparable results for England, Scotland and Wales which are not available from existing health surveys and a wider age group. Results from the survey would be used to populate the measure on the prevalence of poor mental health as well as other measures for people at risk of poor mental health including access to mental health services.

- Childhood bereavement has a significant impact on children’s and young people’s wellbeing. Considering future research, for example, when this survey is next repeated, it would be very beneficial to collect data on other relevant parameters that may affect mental health, for example: (1) Cause of death (2) Length of time since the death (3) Child's or young person’s developmental stage/age at the time of the death (4) Support received after the death (5) Other life changes (e.g. home, school, parental income) after the death

- Important within the mental health aspects of the survey to include the full range of mental health problems including developmental disorders such as ADHD and autism as well as psychological problems such as depression, anxiety, obsession and Dougherty

- Availability and timeliness of support from CAMHS.

- There is anecdotal evidence that the manifestation of distress might be changing and that there could be many young people invisible to policymakers and other authorities as they are opting out of society and playing on computers in their parents’ home. See the research on Hikikomori in Japan and similar cases in Asia, US and Europe. Prevalence estimates in Japan for such cases are in excess of 1 million young people.