

# Mental Health of Children and Young People in England, 2017

## Professional services, informal support, and education

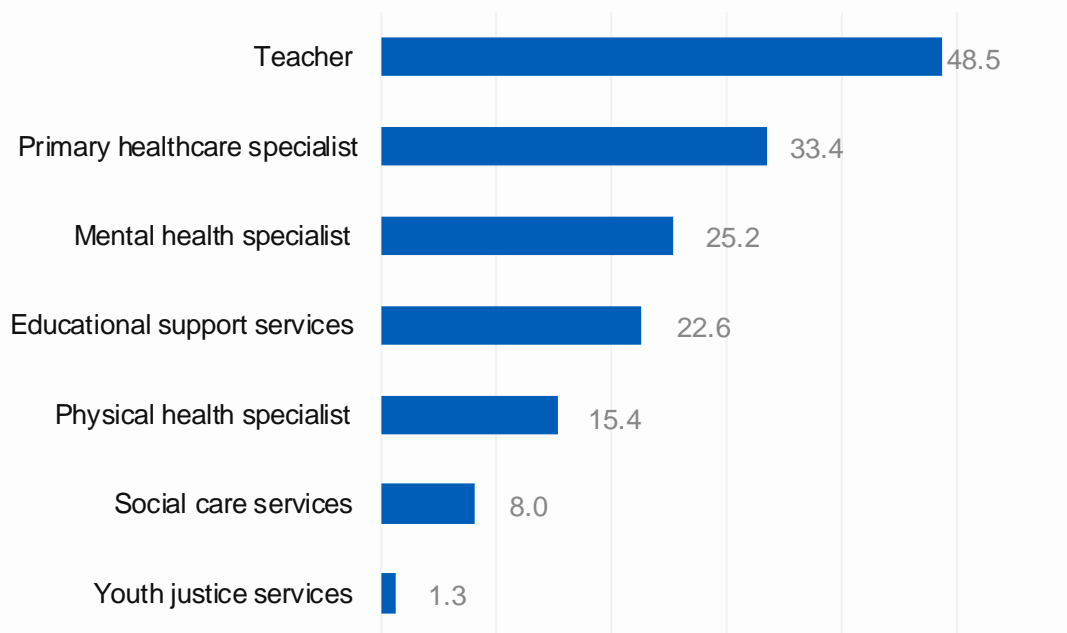
This survey series provides England’s best source of data on child mental health. This topic report presents findings on contact with professional services and informal support due to worries about mental health. Children’s experiences with services are explored, as well as educational factors.

Two-thirds (66.4%) of 5 to 19 year olds with a disorder had contact with a professional service in the past year because of worries about mental health. Teachers were the most commonly cited source of support (48.5%), followed by primary care professionals (33.4%), mental health specialists (25.2%), and educational support services (22.6%).

**Type of professional service contact in past year for mental health reason in 5 to 19 year olds with a disorder, 2017**

Base: 5 to 19 year olds with a disorder

**Type of professional service**



Per cent

Source: NHS Digital

## Main findings

### Contact with professional services and informal support

- Parents of 5 to 16 year olds were asked about contact with professional services and/or informal support because of worries about their child's emotions, behaviour, concentration, or how their child was getting on with other people. 17 to 19 year olds were asked directly about such contact. In this topic report, contact with services and support is described in relation to children, although that contact may sometimes have been only with the parent (in relation to concern about the child).
- Overall, 28.5% of children had contact with professional services (20.9%) or informal support (18.2%) due to mental health worries in the past year. Contact with services and support was more likely in children identified by the survey as having a disorder.
- Two-thirds (66.4%) of children with a disorder had contact with professional services. Contact with teachers was the most likely (48.5%), followed by primary care professionals (33.4%), mental health specialists (25.2%), and educational support services (22.6%).
- About half (48.6%) of children with a disorder had contact with informal sources of support due to mental health worries. Family and friends were the most common source of informal support (44.6%). One in five (19.6%) sought help from the internet.
- About one in four (24.1%) children with a disorder had no contact with either professional services or informal support in relation to worries about mental health.

### Professional services: perceived helpfulness and waiting times

- Most children with a disorder who had contact with professional services found it to be helpful. This ranged from 73.1% who found educational support services to be helpful, to 60.5% who found social care services to be helpful. Most (84.8%) children with a disorder who had informal support from friends and family described this as helpful.
- Around one in five children with a disorder reported waiting more than six months for contact with a mental health specialist (20.7%), a physical health specialist (21.6%), or educational support services (21.9%). Perceived waiting times tended to be longest for neurodevelopmental disorders like hyperactivity and autism spectrum disorders.

## Mental health medication

- Overall, about one in fifty (2.5%) 5 to 19 year olds was taking psychotropic (or 'mental health') medication at the time of the interview.
- One in six (16.4%) children with a disorder was taking psychotropic medication. This ranged from about 15% of children with a behavioural (14.8%) or emotional disorder (15.2%), up to approaching half (45.9%) of those with a hyperactivity disorder. In 5 to 16 year olds with a disorder stimulants and melatonin were the most likely types of medication to be prescribed, reflecting the higher rate of hyperactivity disorder in this age group. 17 to 19 year olds with a disorder were most likely to be prescribed antidepressants.

## Education: special educational needs, truancy, and exclusion from school

- Over a third of children with a disorder (35.6%) had recognised special educational needs, ranging from a quarter (26.8%) of those with an emotional disorder to about two thirds of children with a hyperactivity disorder (62.9%) or other less common disorder (64.8%). The survey did not establish to what extent these special educational needs related directly to the disorder itself.
- Half of children (49.6%) with recognised special educational needs had an Education, Health and Care Plan in place.
- 5 to 16 year olds with a disorder were around ten times more likely to have played truant from school or to have been excluded from school than those without a disorder. One boy in ten (10%) with a disorder had been excluded, around half of whom had been excluded multiple times.

## Contents

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|   |           |
|---|-----------|
| <b>Main findings</b>  | <b>2</b>  |
| <b>Acknowledgements</b>   | <b>6</b>  |
| <b>Introduction</b>   | <b>7</b>  |
| <b>Background</b>   | <b>8</b>  |
| <b>Terminology</b>  | <b>9</b>  |
| <b>Contact with professional services and informal support</b>          | <b>10</b> |
| <b>Types of services and support had contact with</b>                   | <b>12</b> |
| <b>Whether service or support was helpful</b>                           | <b>14</b> |
| <b>Length of time to access services</b>                                | <b>15</b> |
| <b>Psychotropic (mental health related) medication use</b>              | <b>16</b> |
| <b>Recognition of difficulties</b>                                      | <b>17</b> |
| <b>Recognition of difficulties by contact with services and support</b> | <b>18</b> |
| <b>Recognition of special educational needs</b>                         | <b>19</b> |
| <b>Presence of an Education, Health and Care (EHC) Plan</b>             | <b>20</b> |
| <b>Truancy from school</b>  | <b>21</b> |
| <b>Exclusion from school</b>  | <b>22</b> |
| <b>Discussion</b>   | <b>23</b> |
| <b>Methods</b>  | <b>25</b> |
| <b>Definitions</b>  | <b>27</b> |
| <b>References</b>   | <b>30</b> |

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This report may be of interest to people working with children and young people in mental health, social care or educational settings, as well as to policy officials, commissioners of health and care services, and parents, young people and the general public.

## Acknowledgements

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## Introduction

Major surveys of the mental health of children and young people in England were carried out in 1999 (Meltzer et al., 2000), 2004 (Green et al., 2005), and 2017. The latest survey was funded by the Department of Health and Social Care, commissioned by NHS Digital, and carried out by the National Centre for Social Research (NatCen), the Office for National Statistics (ONS) and *Youth@mind*.

In each of the three surveys, the Development and Well-Being Assessment (DAWBA) was administered to a stratified probability sample of children and young people and their parents and teachers (Goodman et al., 2000). Cases were reviewed by clinically-trained raters. As a general population survey of children and young people, this study is well placed to examine the extent to which children and young people are in contact with professional health, social and educational services and what proportion use mental health medication.

This topic report focuses on contact with professional services, informal support, and educational context in 5 to 19 year olds, and presents:

- Extent of contact with different types of professional services and informal support in the past year, by disorder and sex
- Perceptions of professional services in terms of helpfulness and waiting times, by disorder
- Recognition of mental health difficulties by parents of 5 to 16 year olds and young people aged 17 to 19 years
- Recognition of special educational needs and whether an Education, Health and Care Plan is in place, by disorder and sex
- Truancy and exclusion from school in 5 to 16 year olds, by disorder and sex.

As well as a Summary Report, a series of other topic reports are available focusing on:

- Trends and characteristics
- Emotional disorders
- Behavioural disorders
- Hyperactivity disorders
- Autism spectrum, eating and other less common disorders
- Predictors of mental disorders (to be released at a later date)
- Multiple conditions and wellbeing
- Behaviours, lifestyles and identities
- Preschool children.

Further information about the survey and methods can be found in the Methods and Definitions sections at the end of this report, and in the Survey Design and Methods Report. All reports are available at: [https://digital.nhs.uk/pubs/mhcypsurvey17](https://digital.nhs.uk/pubs/mhcypssurvey17).

## Background

Up to date national prevalence data on child mental health is essential for effective healthcare planning. The lack of such data has been challenging for those responsible for planning and commissioning Child and Adolescent Mental Health Services (CAMHS) and related provision (House of Commons Health Committee, 2014-15). An aim for this survey was to address this data need.

Teachers are the most likely source of support that parents turn to about their child's mental health (Ford et al., 2007; Newlove and Delgado, 2015). However, this additional burden on teachers can lead to large costs in terms of staff time and school resources (Snell et al., 2013). The role of schools supporting child mental health has gained prominence in recent policy developments. The Green Paper (Transforming children and young people's mental health provision, 2017) proposes that every school has a Designated Mental Health Lead and that School-Based Mental Health Teams are developed to work between schools and specialist mental health services (Department of Health and Social Care, 2017). Prevention and prompt, effective intervention for children and young people are also prominent themes in the *Five Year Forward View for Mental Health*, which recognises that most adults with poor mental health experience their first difficulties during childhood (Mental Health Taskforce, 2016).

Recognition that a child has poor mental health, by the parent, young person or other key adults, is an essential step in accessing support (Gronholm et al., 2015). Children with poor mental health may be supported by a number of different services. Primary health care and school staff provide front line mental health services, while CAMHS, paediatrics, educational specialists (such as educational psychologists or Behavioural Support Teachers) and social care workers comprise the common publicly provided specialist services. Children and young people may also gain informal support from family, friends, the internet / social media and self-help organisations, or from third sector or private organisations. The previous child mental health surveys in the series found that access to informal support was very common. Access to private forms of professional services and practitioners was extremely rare (Ford et al., 2005; Green et al., 2005).

As with most research, clear and precise definitions of the terms used are extremely important, and this can be particularly complicated when describing services for mental health. For example, counsellors are mental health practitioners who provide specialist mental health interventions / services. Yet they can work from mental health services, private practice, third sector organisations, primary health care or schools. Researchers have varied in whether such practitioners are classified according to the interventions that they offer, in which case they would be "counted" among the provision of mental health services, or the setting in which they work, which cover the range described above. Indeed, key stakeholders are likely to have differing views and needs about whether setting or intervention is the more important consideration, and these may change over time. This makes comparisons between studies about



the rates of service use and the characteristics of the children and families that use them difficult. Such comparisons can only be made with the clear understanding of how services have been defined and what is being reported.

## Terminology

**Professional services:** The current survey asked parents and young people to identify which professional services they had contact with in the past year, using the following categories and examples:

- Primary health care (such as a GP, family doctor, health visitor, practice nurse or school nurse)
- Teachers (such as a tutor, head of year, head teacher or special educational needs coordinator)
- Educational specialist (such as educational psychologist, educational social worker or specialist teacher from outside school)
- Mental health specialist (such as a mental health nurse, psychiatrist, psychologist or counsellor)
- Physical health specialist (such as a hospital or community paediatrician, or occupational therapist)
- Social care (such as a social worker)
- Youth justice (such as a probation officer or someone working in a youth offending team).

**Identification with mental disorder:** In this report some children are described as having a disorder. This relates to identification on the survey using the Development and Well-Being Assessment (DAWBA), and not to an assessment done in any other setting or in relation to eligibility for services. While we are sensitive to the negative connotations that the term 'mental disorder' can have, it is used here because the DAWBA does not just screen for general mental health problems, but applies operationalised diagnostic criteria for specific disorders.

It should not be assumed that mental health related contacts among children not identified with a disorder at the time of interview represents over-treatment. Children without a disorder at the time of the interview may have been in recovery, perhaps as a result of treatment they were still receiving.

**Children, young people and parents:** Parents of 5 to 16 year olds were asked about contact with professional services and/or informal support due to worries about their child's emotions, behaviour, concentration, or how their child had been getting on with other people. 17 to 19 year olds were asked directly about such contact. In this topic report, contact with services and support is described in relation to 'children', although that contact may sometimes have been only with the parent in the case of children aged 5 to 16.

In this report, the words 'children', 'boys' and 'girls' are used, even when 17 to 19 year olds are included in the group. This is to avoid the text becoming cumbersome.

## Contact with professional services and informal support

Parents of children aged 5 to 16 were asked whether in the past year they had been in contact with a range of types of professional services and informal sources of support because they were worried about their child's emotions, behaviour, concentration, or how their child was getting on with other people. Young people aged 17 to 19 were asked about their own contact with services and support directly. For ease, throughout this report contact with services and support is described in relation to children, although it should be noted that in the case of children aged 5 to 16 contact may have been with the parent, although due to their worries about their child.

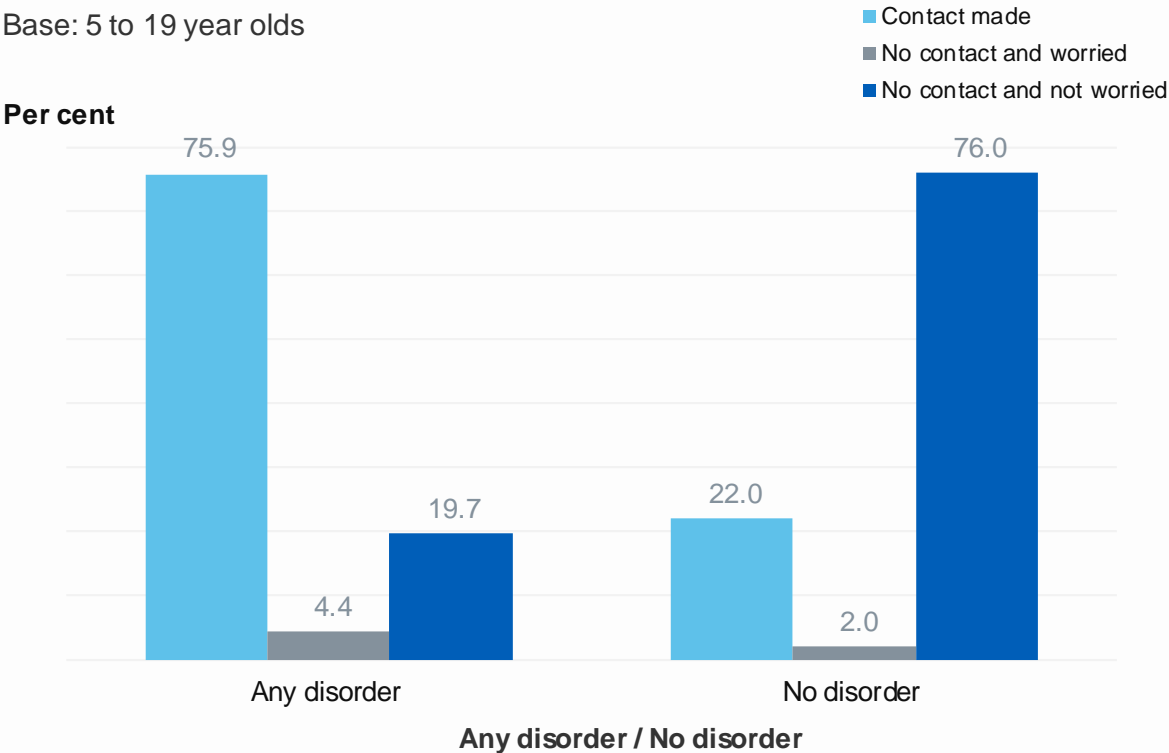
Overall, nearly a third (28.5%) of 5 to 19 year olds had contact with professional services or informal sources of support in the past year because of worries. 2.3% had no contact with services or support despite being worried about mental health.

Children with a disorder were more likely to have had contact with services and support than those without a disorder. Three quarters (75.9%) of 5 to 19 year olds with a disorder had contact with professional services or informal sources of support in the past year. 4.4% had no contact either with services or support despite there being worries about the child's mental health.

The prevalence of service and support contact varied by type of disorder present. It ranged from 89.1% of children with a hyperactivity disorder to 74.3% of those with an emotional disorder. (Figure 1; Table 1)

**Figure 1: Contact with professional services or informal support in past year in 5 to 19 year olds, 2017**

Base: 5 to 19 year olds



Source: NHS Digital

## Types of services and support had contact with

Overall, around one in five 5 to 19 year olds had contact with professional services (20.9%) in the past year because of worries about mental health, and a similar proportion had informal support (18.2%).

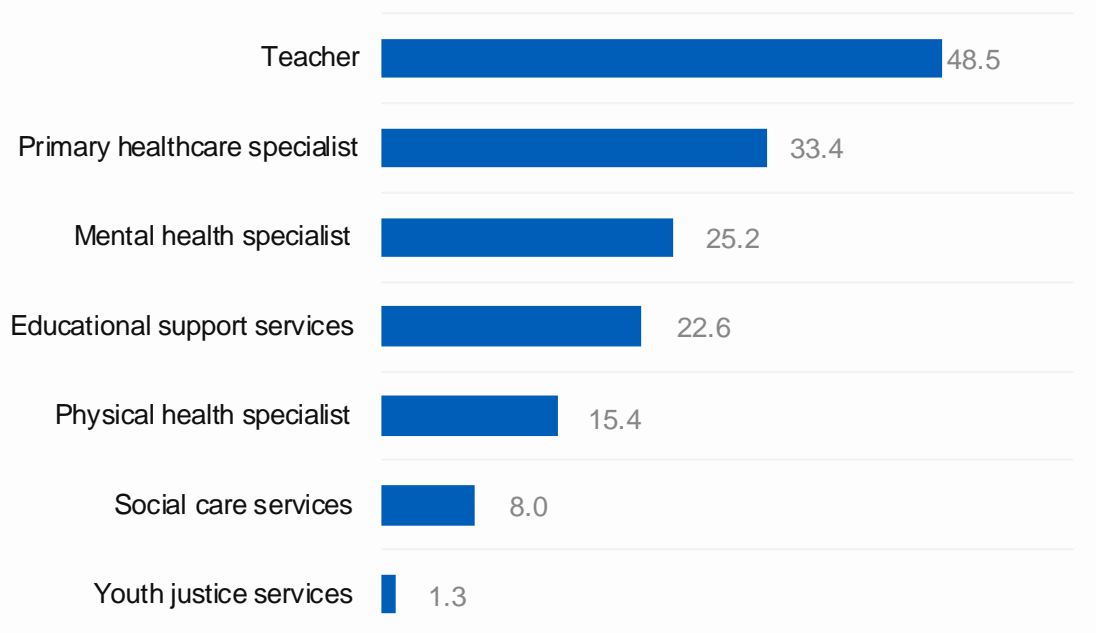
Contact with professional services was more likely for children with a disorder than for those without. Two-thirds (66.4%) of children identified by the survey as having a disorder had contact with professional services due to mental health worries, compared with around one in seven (14.6%) children without a disorder. Contact with teachers was the most commonly cited professional service, mentioned by about half (48.5%) of children with a disorder. This was followed by primary care professionals (such as a GP or practice nurse) (33.4%), mental health specialists (such as a psychologist) (25.2%), and educational support services (22.6%). 15.4% of children with a mental disorder had contact with a physical health specialist in the past year, such as a paediatrician, due to worries about mental health. Contact with social care (8.0%) and youth justice (1.3%) services were less common.

About half (48.6%) of children with a disorder had contact with informal sources of support because of mental health worries. Family and friends were the most common source of informal support (44.6%) to children with a disorder. 19.6% of children sought help from the internet, 5.2% had contact with a self-help group and 4.4% had used a telephone helpline. One in four (24.1%) children with a disorder had no contact with either professional services or informal support in the past year. (Figure 2; Table 2)

**Figure 2: Type of professional service contact in past year for mental health reason in 5 to 19 year olds with a disorder, 2017**

Base: 5 to 19 year olds with a disorder

**Types of professional service**



Source: NHS Digital

**Per cent**

## Whether service or support was helpful

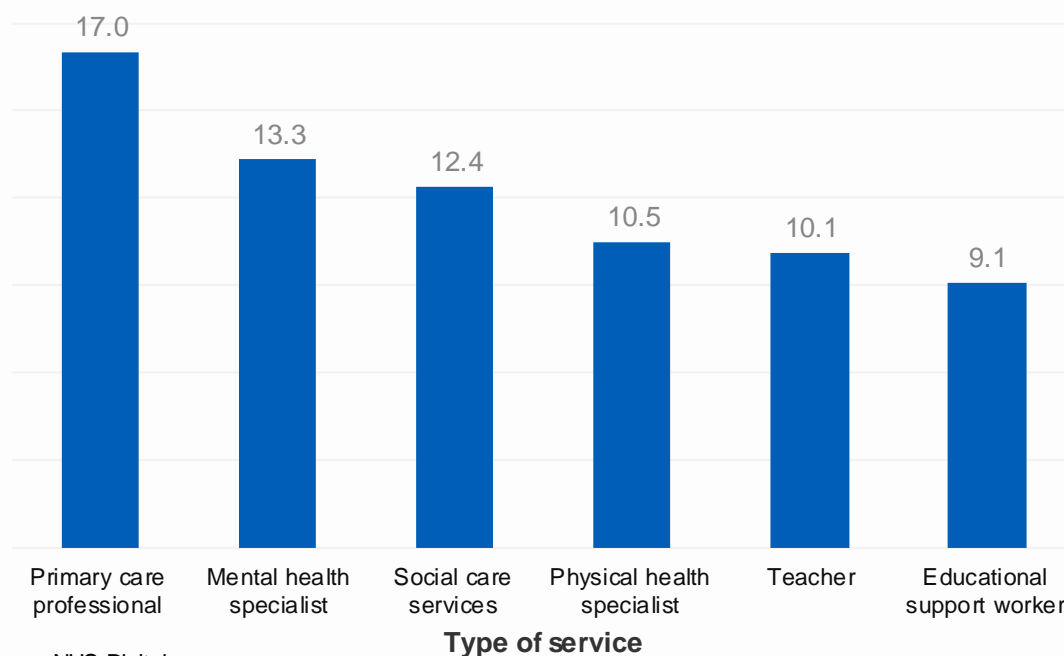
Children aged 5 to 19 who had contact with services or support for their mental health in the past year were asked whether it had been helpful.

Most children with a disorder who had used professional services found them to be helpful. This ranged from 73.1% who found educational support services to be helpful, to 60.5% who found social care services to be helpful. The great majority (84.8%) of children with a disorder who had informal support from friends and family described this as helpful. The service most likely to be rated as unhelpful by those who had contact was primary care. 17.0% of 5 to 19 year olds with a disorder who had contact with a primary care professional due to worries about mental health described this as unhelpful or very unhelpful. (Figure 3; Table 3)

**Figure 3: Proportion who found the professional service unhelpful/very unhelpful in 5 to 19 year olds with a disorder, 2017**

Base: 5 to 19 year olds with a disorder and service contact

Per cent



Source: NHS Digital

## Length of time to access services

Children in contact with each type of professional service in the past year were asked about the length of time taken to see that specialist.

Overall, more than two thirds of children who had accessed professional services reported waiting less than ten weeks to see the specialist: from 65.2% of those who had contact with a physical health specialist to 93.0% who had contacted teachers about mental health.

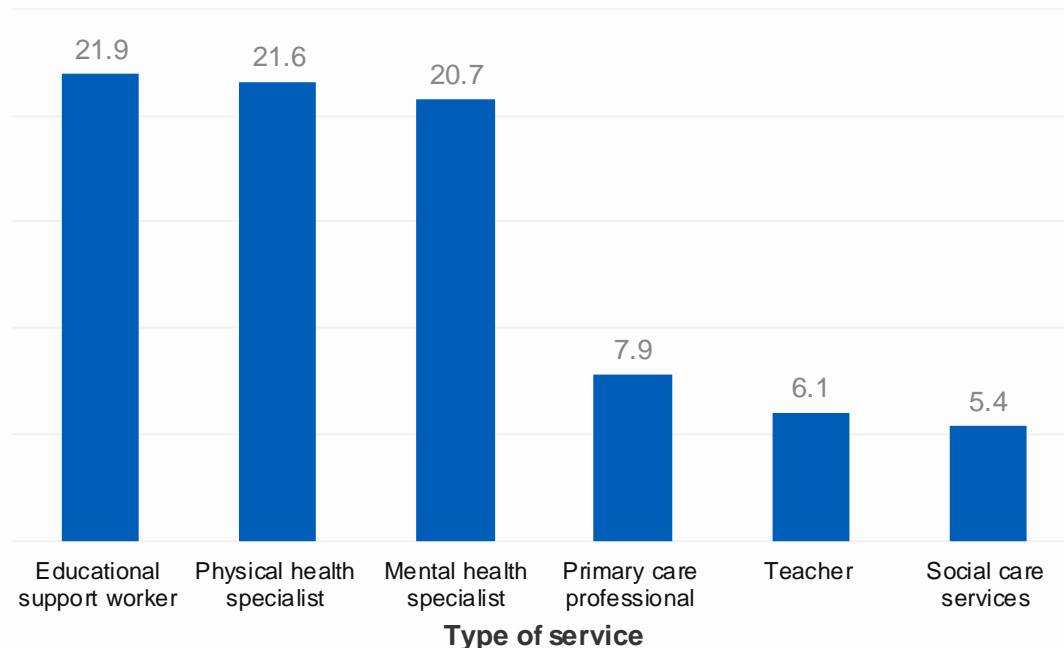
Among children with a disorder, around one in five waited more than six months before their contact with a mental health specialist (20.7%), a physical health specialist (21.6%), or educational support services (21.9%).

Waiting times tended to be longest for those with neurodevelopmental disorders like hyperactivity and autism spectrum disorders: around a third who had contacted a mental health specialist (30.4%) or educational support services (32.3%) waited more than six months to be seen. (Figure 4; Table 4)

**Figure 4: Proportion waiting more than 6 months to access a service in 5 to 19 year olds with a disorder, 2017**

Base: 5 to 19 year olds with a disorder and service contact

Per cent



Source: NHS Digital

## Psychotropic (mental health related) medication use

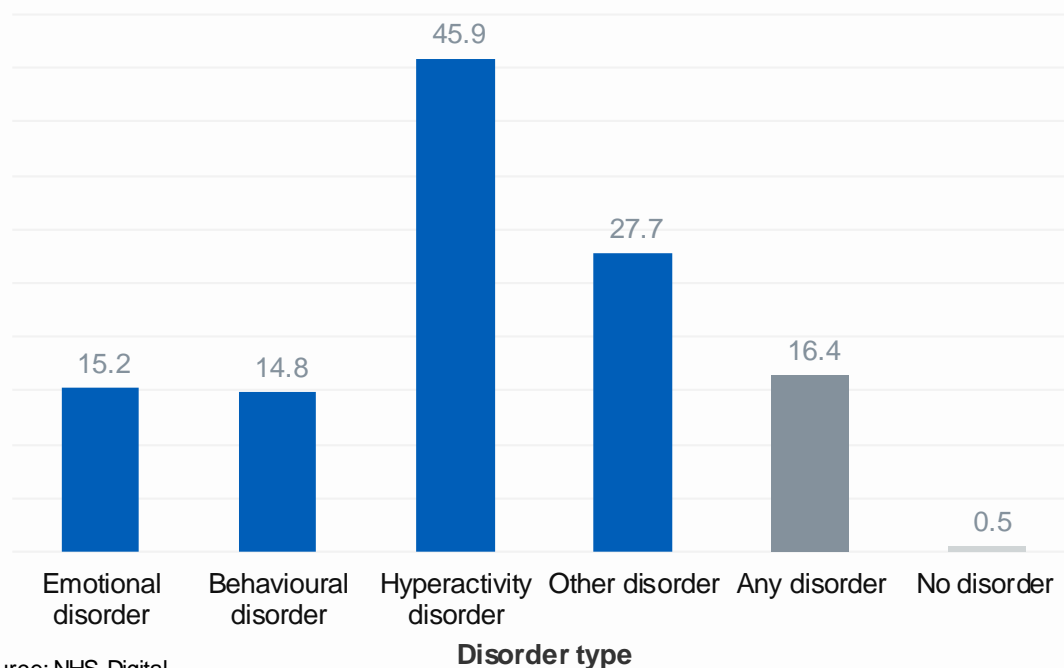
Overall, about one in fifty (2.5%) 5 to 19 year olds was taking psychotropic medication around the time of the interview. The most commonly reported drugs were those used for treating hyperactivity disorders (stimulants 0.8%, atomoxetine 0.1%) and emotional disorders (antidepressants 0.9%). Melatonin, which is a hormone found naturally in the body and used to treat sleep disturbance, was reported for 0.7% of children.

Almost all children taking psychotropic medication were identified by the survey as having a disorder. One in six (16.4%) children with a disorder was taking psychotropic medication. Prescribing rates ranged from about 15% of children with a behavioural (14.8%) or emotional disorder (15.2%), up to approaching half (45.9%) of those with a hyperactivity disorder. In 5 to 16 year olds with a disorder stimulants and melatonin were the most likely types of medication to be prescribed, reflecting the higher rate of hyperactivity disorder in this age group. 17 to 19 year olds with a disorder were most likely to be prescribed antidepressants. This is consistent with emotional disorders being the most common type of disorder identified at this age. (Figure 5; Table 5)

**Figure 5: Current psychotropic medication use in 5 to 19 year olds by disorder, 2017**

Base: 5 to 19 year olds with a disorder

Per cent





## Recognition of difficulties

The first item of the impact supplement for the Strengths and Difficulties Questionnaire (SDQ) asked parents whether their child (if aged 5 to 16) had difficulties with emotions, concentration, behaviour, or how they got on with other people. Young people (aged 17 to 19) were asked if they felt that they themselves had such difficulties.

### Children aged 5 to 16 years

Overall, 9.8% of children aged 5 to 10 were recognised by their parent as having definite or severe difficulties. A similar level was found for children aged 11 to 16, with 12.0% recognised with definite or severe difficulties.

Where children were identified on the survey as having a disorder, parents also generally reported that their child had difficulties. Among children aged 5 to 10 with a disorder, 69.3% had parents who recognised that they had definite or severe difficulties. And where children were not identified on the survey as having a disorder, parents generally did not think that their child had mental health difficulties: 4.0% of 5 to 10 year olds with no disorder had parents who felt their child had difficulties. For children aged 11 to 16, a similar pattern was evident.

Among children with a behavioural disorder, hyperactivity disorder, or other less common disorder, at least three quarters were recognised by their parent as having definite or severe difficulties. Among children with emotional disorders, such difficulties were recognised in just over half.

### Young people aged 17 to 19 years

Overall, one in six (15.6%) young people reported that they experience definite or severe difficulties with their emotions, concentration, behaviour, or how they get on with other people. Difficulties were about six times more likely to be reported by young people with a disorder (51.6%) than by those without a disorder (8.2%). (Table 6)

## Recognition of difficulties by contact with services and support

Contact with professional services or informal support was more likely where parents and young people recognised that there were severe and definite difficulties with emotions, concentration, behaviour, or getting on with others.

### Children aged 5 to 16 years

Definite or severe difficulties were recognised in about a third of the children who had been in contact with professional services or informal support in past year (32.2% of 5 to 10 year olds and 36.4% of 11 to 16 year olds). In contrast, around 3% (2.7% of 5 to 10 year olds and 3.3% of 11 to 16 year olds) of children who had not had contact with services or support were recognised as having definite or severe difficulties.

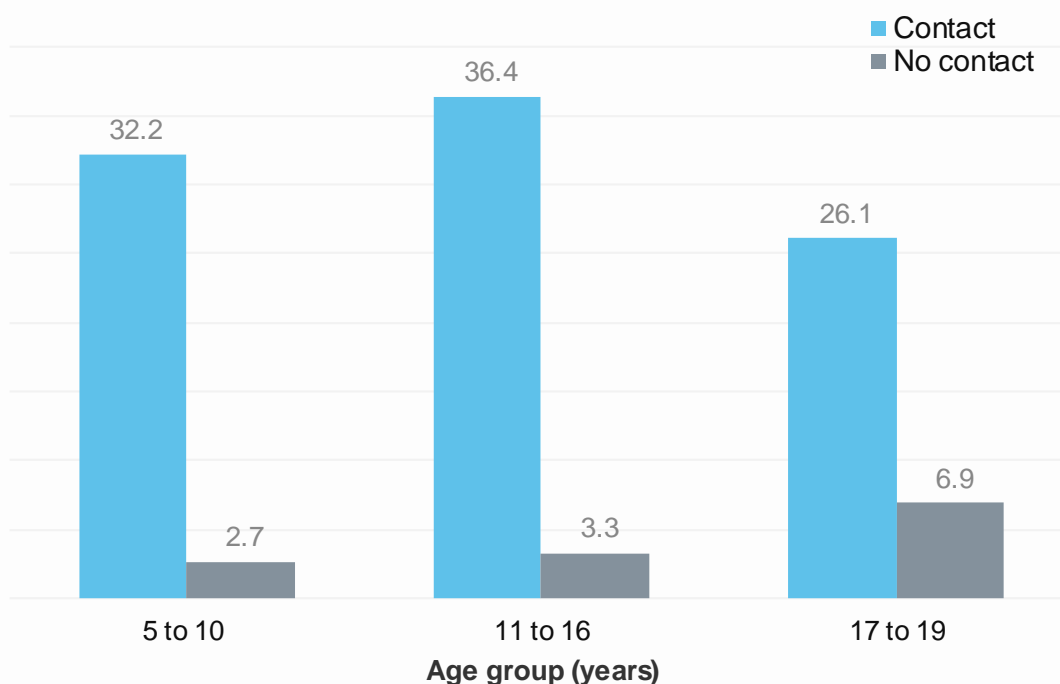
### Young people aged 17 to 19 years

About a quarter (26.1%) of 17 to 19 year olds who had contact with professional services or informal support in the past year reported that they had definite or severe difficulties. (Figure 6; Table 7)

**Figure 6: Recognition of difficulties in 5 to 19 year olds by contact with services or support in past year, 2017**

Base: Parent report (5 to 16) and young person (17 to 19)

Per cent



Source: NHS Digital

## Recognition of special educational needs

Special educational needs were indicated as recognised in 5 to 16 year olds if either the child's parent or their teacher reported them as present. For 17 to 19 year olds, the presence of special educational needs was based on the parent report.

Overall, one in ten (9.6%) 5 to 19 year olds was recognised as having special educational needs, with rates higher in boys (12.5%) than girls (6.4%).

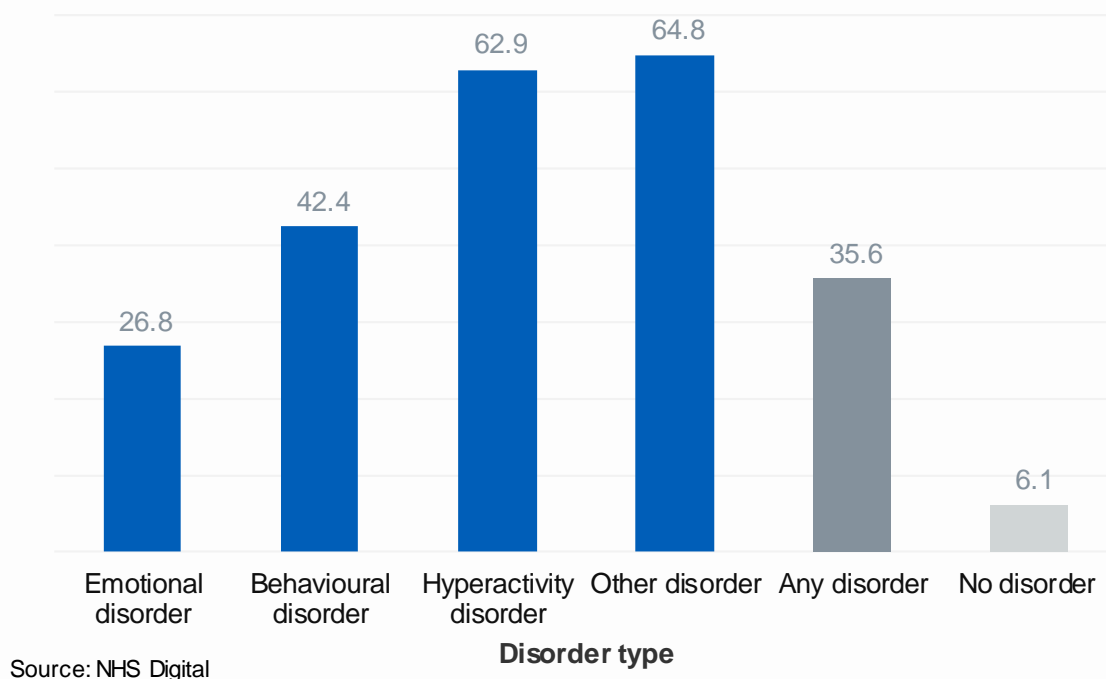
Special educational needs were more common in children with a disorder (35.6%) than in those without a disorder (6.1%). Sometimes, the special educational need may have been related to an aspect of the mental disorder itself. Half (47.9%) of boys with a disorder were recognised as having special educational needs, compared with a fifth (20.9%) of girls with a disorder.

Nearly two thirds of children with a hyperactivity (62.9%) or other less common disorder (64.8%) were recognised as having special educational needs, compared with about a quarter of children with an emotional disorder (26.8%). (Figure 7; Table 8)

**Figure 7: Recognition of special educational needs in 5 to 19 year olds by disorder, 2017**

Base: 5 to 19 year olds

Per cent



## Presence of an Education, Health and Care (EHC) Plan

Where 5 to 16 year olds were recognised as having special educational needs, parents and teachers were asked whether an EHC plan was in place at the school. Parents of young people aged 17 to 19 who reported that the young person had special educational needs were asked about EHC plans.

Among children with recognised special educational needs, half (49.6%) had an EHC plan in place. This rate was the same for boys (50.4%) and girls (50.4%).

In children with special educational needs, EHC plans were equally likely to be in place for those with (53.2%) and without (47.3%) a mental disorder.

However, there was some variation in rate of EHC plans by type of disorder. An EHC plan was more likely to be in place for children with hyperactivity (61.6%) or other less common disorder (65.5%), than in children with an emotional (48.7%) or behavioural (53.0%) disorder. (Table 9)

## Truancy from school

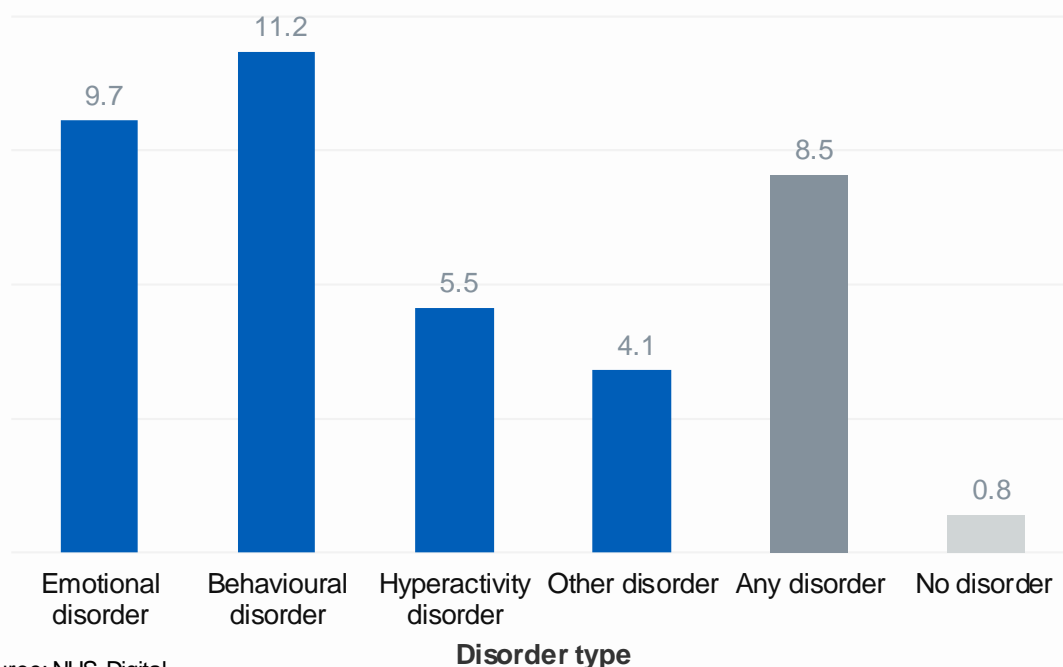
Teachers of children aged 5 to 16 were asked about unauthorised absences from school.

Overall, 1.7% of children aged 5 to 16 were reported to have ever played truant from primary or secondary school. Children with a disorder (8.5%) were more likely to report having played truant than children without a disorder (0.8%). Truancy rates varied by type of disorder present, and ranged from 4.1% of children with less common disorders and 5.5% of children with a hyperactivity disorder, up to 9.7% of those with an emotional disorder and 11.2% of those with a behavioural disorder. (Figure 8; Table 10)

**Figure 8: Ever played truant from school in 5 to 16 year olds by disorder, 2017**

Base: Teacher report (5 to 16 year olds)

Per cent



Source: NHS Digital

## Exclusion from school

Parents of 5 to 16 year olds were asked whether their child had ever been excluded from primary or secondary school.

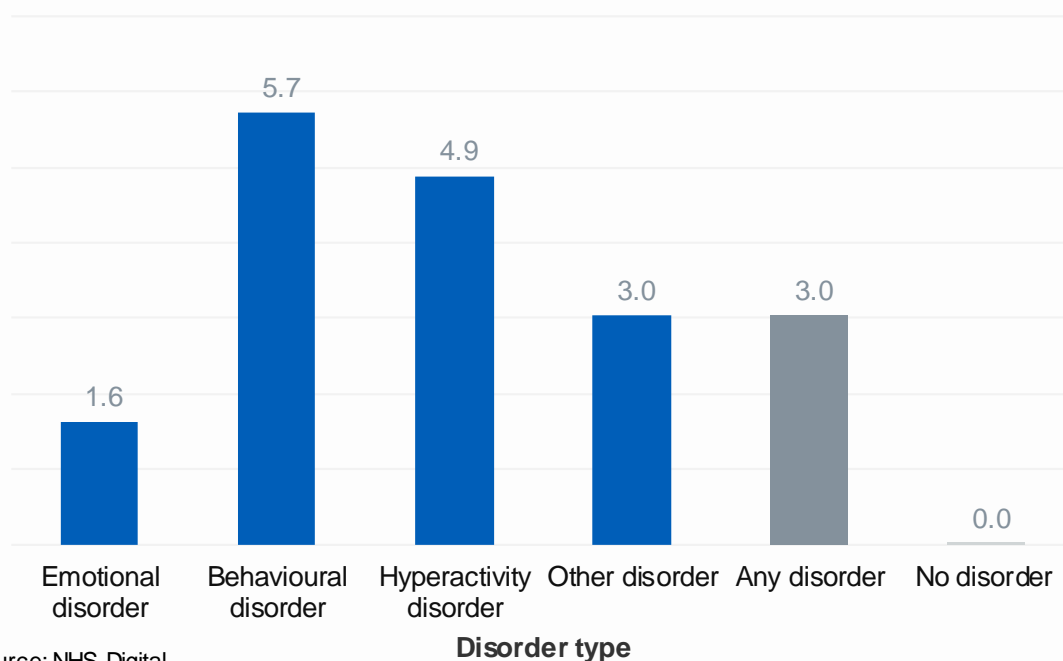
Overall, about one child in a hundred (1.2%) had been excluded from school. School exclusions were more common in children with a disorder (6.8%) than in those without (0.5%). Boys with a disorder (9.9%) were more likely than girls with a disorder (2.4%) to be excluded.

Exclusion rates varied by type of disorder present, and were highest in those with a hyperactivity (11.7%) or behavioural disorder (11.6%). Around one child in twenty with hyperactivity (4.9%) or behavioural (5.7%) disorders had been excluded from school on three or more occasions. (Figure 9; Table 11)

**Figure 9: Excluded from school three or more times in 5 to 16 year olds by disorder, 2017**

Base: Parent report (5 to 16 year olds)

Per cent



## Discussion

This report presents information on children's use of and experiences with professional services and informal support for mental health related reasons. Educational factors are also explored.

It is important to note that the survey relies to a large extent on self-report data from parents of 5 to 16 year olds. Parents are not always aware of the services their children are receiving. This is especially true of older children who might, for example, see a counsellor at school without their parent's knowledge. Under-reporting and over-reporting were both possible. This survey offered examples of the services asked about to reduce the further problem of misclassifying the type of service received.

We caution against comparing the rates of service use presented here with those produced by other studies, due to the use of different definitions. This is because of complex variations in how practitioners work. For example, counsellors can work from schools, third sector organisations, primary care and private practice as well as in mental health services. Surveys have differed in whether the setting (commercial, third sector, education or health) or the intervention offered (mental health) determines what gets counted.

This report has highlighted that the majority of children with a mental health disorder have had contact with at least one type of service in the past year. Help has mainly consisted of professional services, but informal support from family and friends was also widely cited by those with a disorder. Previous research has also found that even after accounting for a range of characteristics, the severity of a child's mental health difficulties predicted most types of service contact (Ford et al. 2008).

In line with previous research, the professional services most commonly contacted for mental health reasons were teachers and GPs (Ford et al. 2007; Newlove and Delgado, 2015). This is not surprising as families tend to have ongoing and easy access to both schools and primary health care. The Government's recent green paper 'Transforming children and young people's mental health provision' recognises the importance of schools. The paper proposes that mental health support teams should work with a cluster of schools ensuring they are offering support to children and young people not in mainstream education, and that designated mental health leads should be based in schools (DH and DoE, 2017).

Access to the right service and at the right time can ensure the needs of children and young people are identified and addressed early on (Annual Report of the Chief Medical Officer, 2013; A Framework for Mental Health Research, 2017). The results in this report show that overall, the service or support children were receiving was thought to be helpful. Contact with primary health care the service most likely to be considered unhelpful.

Among children in contact with professional services, two thirds with a disorder received help within ten weeks. One in five children with a disorder reported having to wait more than six months to be seen by a mental health specialist. Children with neurodevelopmental disorders were more likely than those with emotional or behavioural disorders to report waiting this long to be seen. Previous studies have indicated delays to both being referred and then receiving a clinical diagnosis for ADHD and autism spectrum disorders (ASD) (Ford et al., 2008).

Almost all the children being prescribed psychotropic medication had a mental disorder at the time of the interview, and one in six children with a disorder were taking medication. Nearly half of those with a hyperactivity disorder were taking such medications. Recent research suggests that although the number of children with ADHD on medication has risen as ADHD has become better understood, many do not get the appropriate treatment they need to cope in life and school (Cortese et al., 2018).

Recognising that there is a problem is one of the key filters to accessing services or support (Wolpert and Ford, 2015). This survey showed that both service access and having a disorder were associated with concerns about mental health being reported by parents and young people. Previous research has shown that if parents and young people are not concerned, practitioners can be fairly reassured that a child is mentally healthy, while concerns do indicate psychological difficulty, although not necessarily of the severity to indicate a mental disorder (Ford et al., 2005).

The school and educational context for children with a disorder were also explored in this report. Over a third of children with a disorder were identified with special educational needs. In some children, this may relate to the mental health disorder. The strong association between neurodevelopmental disorder and having special educational needs and an Education, Health and Care Plan probably reflects this. For example, children with ASD can find the social intensity, noisy bustle and repeated changes that school presents extremely difficult to deal with. Difficulties sitting still, focusing attention and controlling impulses, which are core to ADHD, present obvious difficulties in a classroom situation. There are strong associations between difficulties with reading and behavioural difficulties as well as neurodevelopmental disorders (Carroll et al., 2005). Other children may have special educational needs related to a long term physical health condition or disability, which may also undermine mental health (Stoppelbein et al., 2005).

One in ten children with a disorder had been excluded from school compared with one in a hundred children with no disorder. Secondary analysis of the earlier British Child and Adolescent Mental Health Surveys suggests a bi-directional relationship; that is children with poor mental health are more likely to be excluded, while children who are excluded subsequently experience deteriorating mental health (Ford et al., 2018). Together with the current survey, these findings underline the impact of poor mental health on children's ability to function in educational settings and emphasise



the important role of schools, which has been formally recognised in the green paper (DH and DoE, 2017).

Most children with a disorder had some recent contact with services due to their mental health, although only one in four had contact with specialist mental health services. Children whose difficulties were recognised by an adult in their lives were more likely to be in contact with services than other children. The survey found that levels of satisfaction with support were generally high, although some children do report waiting more than six months to be seen. The findings in this survey should provide a valuable resource for commissioners and providers in developing existing services and in taking forward the green paper's new proposals.

## Methods

The Mental Health of Children and Young People (MHCYP) survey was conducted with 5 to 15 year olds living in Britain in 1999 and 5 to 16 year olds living in Britain in 2004. The 1999 and 2004 surveys sampled from Child Benefit records. For the 2017 survey a stratified multistage random probability sample of 18,029 children was drawn from NHS Patient Register in October 2016. Children and young people were eligible to take part if they were aged 2 to 19, lived in England, and were registered with a GP. Children, young people and their parents were interviewed face-to-face at home using a combination of Computer Assisted Personal Interview (CAPI) and Computer Assisted Self Interview (CASI), between January and October 2017. A short paper or online questionnaire was completed by a nominated teacher for children aged 5 to 16 years old. Data collection varied with the selected child's age:

- 2 to 4 year olds: parent interview
- 5 to 10 year olds: parent interview and teacher interview
- 11 to 16 year olds: parent interview, child interview and teacher interview
- 17 to 19 year olds: young person interview and parent interview (if parent present at the same address)

Productive interviews (involving one or more participants in each household) were achieved for 9,117 children (1,463 2 to 4 year olds; 3,597 5 to 10 year olds; 3,121 11 to 16 year olds; 936 17 to 19 year olds), and 3,595 teachers (54% of eligible children). The survey included the detailed and comprehensive Development and Well-Being Assessment (DAWBA). This allowed the assessment of emotional, hyperactivity, behavioural and less common disorders, like autism. After interviews were complete, eleven trained clinical raters reviewed the data to reach disorder codings for each participant. Raters applied the diagnostic criteria for specific disorders set out in the tenth International Classification of Disease (ICD-10) (WHO, 1992) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (APA, 2013).

The 2017 survey was designed to be comparable with the 1999 and 2004 surveys. This included the continued use of the DAWBA, use of ICD-10, and consistent timing

of data collection. However, some differences in design have taken place which may affect comparability with previous survey results, including that the 2017 survey:

- Sampled from the NHS Patient Register, whereas the 2004 and 1999 surveys sampled from Child Benefit records
- Included 2 to 4 and 17 to 19 year olds for the first time
- Response rate (52%) was lower than that for the previous surveys
- Covered England, while previous surveys in the series covered Britain. Analyses of 1999 and 2004 data presented in this report have been run on participants aged 5 to 15 years old living in England only to maintain comparability in trends.

The 2017 interviews and analyses are based on participants' age at 31 August 2017, with participants grouped with their peers in terms of school year.

For further information on methodology see the Survey Design and Methods Report.

## Definitions

### Mental disorder

Mental disorders were identified on the survey according to the standardised diagnostic criteria in the tenth edition of the International Classification of Diseases (ICD-10). Specific mental disorders were grouped into four broad categories: emotional, behavioural, hyperactivity and other disorders. While some of the symptoms covered in this report may be present in many children, to count as a disorder they had to be sufficiently severe to cause distress to the child or impair their functioning (WHO, 1993).

### Emotional disorders

Emotional disorders include a range of different types of **anxiety disorder** (characterised by fear and worry), **depressive disorder** (characterised by sadness, loss of interest and energy, and low self-esteem) and a small number of cases of **mania** and **bipolar affective disorder**.

### Behavioural (conduct) disorders

A group of disorders characterised by repetitive and persistent patterns of disruptive and violent behaviour in which the rights of others, and social norms or rules, are violated. The umbrella term used in ICD-10 is conduct disorders, in this report we have used the term 'behavioural disorders' to avoid confusion with the sub-types of disorder included in the survey.

### Hyperactivity disorders

These are characterised by developmentally inappropriate patterns of inattention, impulsivity, and hyperactivity.

### Less common disorders

A number of less common mental and neurodevelopmental conditions were also identified on the survey. These included: autism spectrum disorders (ASD), eating disorders, tic disorders, and a number of very low prevalence conditions such as psychosis, stereotypic movement disorder, selective mutism, and attachment disorders. Feeding, sleeping, and toileting disorders were also assessed in the preschool population.

### Neurodevelopmental disorders

Due to the base size for the hyperactivity disorders and/or less common disorder groups falling below 50 cases for some analyses, some of these disorders have been combined for some sections of this report. Practitioners often apply the term neurodevelopmental disorder to refer to the combination of hyperactivity disorder, autism spectrum disorder (ASD), tic disorder, and stereotypic disorder.

Eating disorder, selective mutism, psychosis, and attachment disorder are not considered neurodevelopmental disorders and not included in this combined category.

## Measuring contact with professional services and informal support

Parents of 5 to 16 year olds and young people aged 17 to 19 were asked whether they had been in contact with any professional services (from a list of examples) or informal sources of support in the past year because of worries about the child or young person's mental health. Professional services included contact with a mental health specialist, GP or teachers. Informal sources of support included family and friends, the internet or self-help groups. Specialist service records were not examined in this survey. Note that while the wording of the question establishes that contact with services or support took place, the nature or extent of that contact was not established. In theory, contact could have involved a single interaction.

'In the past year have you been in contact with any of these people because of worries about his/her emotions behaviour or concentration or difficulties in getting along with people?'

Parents or young people who had not been in contact with professional services or informal support in the past year were asked whether or not they were worried about their child's or their own mental health.

## Measuring recognition of difficulties with emotions, concentration, behaviour or getting along with people

The perception of a problem is one of the key requirements to accessing support, so the extent to which poor mental health is recognised as such is an important factor to consider when thinking about access to services (Wolpert and Ford, 2015). Children, particularly those of primary school age, rarely access services on their own behalf, which means the perception of important adults is crucial to their access to services in relation to their mental health. The extent to which parents or young people recognise mental health difficulties can be inferred from response to the first question on the impact supplement of the Strengths and Difficulties Questionnaire. This asks the parent or young person whether they consider that the child or they have a problem with emotions, concentration, behaviour or getting along with people. A report of definite or severe difficulties was considered to indicate the recognition of poor mental health and a report of no or minor problems to suggest that the parent or young person saw no reason to be concerned.

## Measuring psychotropic medication use

Parents of children aged 5 to 16 and young people aged 17 to 19 were asked whether they were taking any pills or tablets. A show card prompt list of psychotropic medications (medicines used to treat mental disorders and related symptoms) was used to collect this data, and to produce grouped variables covering the use of:

- Stimulants: included methylphenidate (both short and long acting preparations) and dexamfetamine
- Atomoxetine
- Tricyclic antidepressants: included imipramine and amitryptaline
- Clonidine
- SSRI (selective serotonin re-uptake inhibitors) antidepressants: included fluoxetine, sertraline, citalopram, escitalopram.
- NASSA (Noradrenergic and specific serotonergic antidepressants): mirtazapine
- Antipsychotics: included aripiprazole, risperidone, clozapine
- Melatonin
- Mood stabilisers: included lithium, valproate, lamotrigine.

## Special education needs and Education, Health and Care Plan

For 5 to 16 year olds, recognition of special educational needs was based on information provided by the interviewed parent and teacher questionnaire. For 17 to 19 year olds, this was based on the parent report. Those who reported the presence of special educational needs were further asked whether they had an Education, Health and Care Plan in place.

## Truancy from school

A single question on whether a child aged 5 to 16 had ever played truant was asked as part of the teacher questionnaire.

## Exclusion from school

Parents of 5 to 16 year olds were asked whether their child had ever been excluded from primary or secondary school, and if so on how many occasions they had been excluded.

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