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Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey

Publication, Part of [Mental Health of Children and Young People Surveys](#)

Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey

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Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey

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Summary

This report presents findings from the third (wave 3) in a series of follow up reports to the 2017 Mental Health of Children and Young People (MHCYP) survey, conducted in 2022. The sample includes 2,866 of the children and young people who took part in the MHCYP 2017 survey.

The mental health of children and young people aged 7 to 24 years living in England in 2022 is examined, as well as their household circumstances, and their experiences of education, employment and services and of life in their families and communities.

Comparisons are made with 2017, 2020 (wave 1) and 2021 (wave 2), where possible, to monitor changes over time.

Key findings

In 2022, 18.0% of children aged 7 to 16 years and 22.0% of young people aged 17 to 24 years had a probable mental disorder.

In children aged 7 to 16 years, rates rose from 1 in 9 (12.1%) in 2017 to 1 in 6 (16.7%) in 2020. Rates of probable mental disorder then remained stable between 2020, 2021 and 2022.

In young people aged 17 to 19 years, rates of a probable mental disorder rose from 1 in 10 (10.1%) in 2017 to 1 in 6 (17.7%) in 2020. Rates were stable between 2020 and 2021, but then increased from 1 in 6 (17.4%) in 2021 to 1 in 4 (25.7%) in 2022.

11 to 16 year olds with a probable mental disorder were less likely to feel safe at school (61.2%) than those unlikely to have a mental disorder (89.2%). They were also less likely to report enjoyment of learning or having a friend they could turn to for support.

1 in 8 (12.6%) 11 to 16 year old social media users reported that they had been bullied online. This was more than 1 in 4 (29.4%) among those with a probable mental disorder.

11 to 16 year old social media users with a probable mental disorder were less likely to report feeling safe online (48.4%) than those unlikely to have a disorder (66.5%).

1 in 5 (19.9%) 7 to 16 year olds lived in households that experienced a reduction in household income in the past year. This was more than 1 in 4 (28.6%) among children with a probable mental disorder.

Among 17 to 22 year olds with a probable mental disorder, 14.8% reported living in a household that had experienced not being able to buy enough food or using a food bank in the past year, compared with 2.1% of young people unlikely to have a mental disorder.

People in England, 2022. NHS Digital, Leeds.

Data Sets

- [Mental Health of Children and Young People in England 2022 - wave 3 follow up to the 2017 survey: Data tables](#)
-

Resources

Mental Health of Children and Young People in England, 2022: Questionnaire and materials

PDF 3 MB

Pre-Release Access List

PDF 114 KB

ARTICLE

MHCYP Surveys - Mental Health of Children and Young People in England - Findings from the 2017 follow up surveys webinar

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Introduction

Since the onset of the coronavirus (COVID-19) pandemic in the UK in March 2020, children and young people have experienced major changes in their lives. These have affected their family situation as well as their access to education, leisure and other services.

The first and second follow ups to the 2017 Mental Health of Children and Young People (MHCYP) survey in England took place in 2020 (wave 1) and 2021 (wave 2) respectively and provided insight on the initial impact of COVID-19 on the mental health of children and young people.

In February 2022, most of the domestic measures in place to control the spread of COVID-19 were removed. This survey (wave 3) took place during April and May 2022.

This study was funded by the Department of Health and Social Care and the Department for Education, commissioned by NHS Digital, and carried out by the Office for National Statistics, the National Centre for Social Research, University of Cambridge and University of Exeter.

About the survey series

The [Mental Health of Children and Young People \(MHCYP\)](#) survey series provides England's Official Statistics on trends in child mental health.

The most recent face to face survey in the series took place in 2017 and involved interviews with a random probability sample of children and young people (aged 2 to 19 years) and their parents.

Those that agreed to future research were invited to take part in the wave 1 MHCYP online follow up survey in 2020, and again in Spring 2021 and Spring 2022 to complete the wave 2 and wave 3 online follow up surveys.

The age of those taking part has increased over time:

- in 2017 the cohort were aged 2 to 19 years
- in 2020 they were 5 to 22 years
- in 2021 they were 6 to 23 years
- in 2022 they were 7 to 24 years

Due to these changes in age groups, the cross-sectional analyses presented in this report are stand-alone, and should not be compared with those presented in previous reports.

Previous reports included breakdowns by ethnic group. The latest standards for ethnicity data published in July 2022 by the Race Disparity Unit recommend using the Government Statistical Service (GSS) harmonised categories when analysing ethnicity data. When reliable data for the full harmonised set of classifications is not available, then the 5 aggregated groups should be used. Binary categories should be avoided (an example of this is using white and other than white). Binary classifications have little analytical value as aggregated ethnic groups mask substantial differences in outcomes between their constituent detailed groups.

Comparisons between the 5 category ethnic groups are not possible in this report due to small sample sizes and therefore breakdowns by ethnic group have not been included.

What are the 5 aggregated groups of ethnicity?

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How to interpret the findings

How to interpret the findings

Assessing mental health

The MHCYP survey (2017) and the subsequent waves of data collection (2020, 2021 and 2022) all used the Strengths and Difficulties Questionnaire (SDQ) as the main measure of mental health.

The SDQ is a brief questionnaire which assesses different aspects of mental health including problems with emotions, behaviour, relationships, hyperactivity and concentration.

In this report, responses to the SDQ from parents, children and young people were used to estimate the likelihood that a child might have a mental disorder. Each child or young person was classified as either:

- unlikely to have a mental disorder
- has a possible mental disorder
- has a probable mental disorder

More detail on how this was done is available in the 2021 Survey Design and Methods Report.

It is important to note that although the SDQ was used in MHCYP 2017, the mental disorder prevalence estimates in the initial MHCYP 2017 survey report drew on a different and more detailed diagnostic assessment of mental disorder, the Development and Well-being Assessment (DAWBA).

For the 2020, 2021 and 2022 follow up waves, only the SDQ was used. This was mainly due to the shift towards online data collection during the pandemic, so a shorter, simpler questionnaire was deemed more suitable, whilst still producing robust estimates.

Therefore, please bear in mind the following:

- any comparisons between 2017, 2020, 2021 and 2022 must draw on the results presented in this report, which are based on a comparable measure: the SDQ
- comparisons with the MHCYP 2017 estimates may be affected by changes in survey design, such as the use of face to face interviews in the 2017 survey while the 2020, 2021 and 2022 follow up waves were online

How to interpret the statistics

These findings are based on a sample and the prevalence figures in this report are estimates weighted to represent the entire population of children and young people in England.

Estimates are subject to a margin of error, also known as a 95% confidence interval. For example, a survey estimate might be 24% with a 95% confidence interval of 22% to 26%.

When breaking down findings by some combinations of age, sex or mental health, numbers for some subgroups were small, meaning that the confidence intervals around some estimates are relatively wide.

Confidence intervals for each estimate are included in the [Excel data tables](#). When comparing estimates, they are considered to be different (statistically significant) from each other when their confidence intervals do not overlap, indicating a real difference in the estimates being compared. They are considered to be similar (no statistically significant difference) when their confidence intervals overlap. When sample sizes are small, confidence intervals tend to be wide so there is more chance of overlap. Therefore, it is strongly advised to refer to the confidence intervals provided when comparing estimates over time or by group.

An explanation of confidence intervals can be found in the [Glossary](#).

About this report

This report draws on data from the 2,866 children and young people aged 7 to 24 years who took part in the 2017 survey and 2022 follow up, as well as information provided by their parents for children aged 7 to 16 years.

The report has the following parts:

- Part 1: Mental health
- Part 2: Sleep, loneliness and health behaviours
- Part 3: Education and employment
- Part 4: Services and support
- Part 5: Social and economic context
- Data quality statement
- Technical appendix
- Glossary
- Acknowledgements
- Author, copyright and licensing

Each of the 5 parts presents the core findings on the topic area, accompanied by tables and figures.

Estimates are presented separately for 7 to 16 year olds (sometimes with breakdowns for 7 to 10 year olds and 11 to 16 year olds) and 17 to 24 year olds to reflect differences in questions asked of these age groups.

Breakdowns by sex and mental health and comparison with 2017, 2020 and 2021 are presented where available and appropriate.

□ The other sections contain quality and methodology information with details on the

methods used available in the [Technical appendix](#).

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[Part 1: Mental health](#)

Part 1: Mental health

This part of the report describes the mental health of children and young people in 2022, using the prevalence of probable mental disorders. Possible eating problems and psychotic-like experiences are also included, with trends over time where available.

Trends in mental health

This section describes the prevalence of probable mental disorder in children and young people aged 7 to 24 years living in England in April and May 2022.

Comparisons are presented as follows:

- for those aged 7 to 16, and 17 to 19 in 2017, 2020, 2021 and 2022
- for those aged 20 to 23 in 2021 and 2022 only, as this age group were not represented in the previous survey waves
- no comparisons over time are presented for those aged 24 in 2022, as this is the first wave of the survey series where participants have reached this age

Definition

The [Strengths and Difficulties Questionnaire \(SDQ\)](#) was used to assess different aspects of mental health, including problems with emotions, behaviour, relationships, hyperactivity and concentration.

Responses from parents, children and young people were used to estimate the likelihood that a child might have a mental disorder, this was classified as either 'unlikely', 'possible' or 'probable'.

Please note that the mental disorder prevalence estimates in the initial MHCYP 2017 survey reported on a different and more detailed diagnostic assessment of mental

disorder. Therefore, any comparisons between 2017, 2020, 2021 and 2022 must draw on the results presented in this report, which are based on a comparable measure of the SDQ using children that were aged between 7 to 19 years at the time of each survey.

Mental health in 2022

In 2022, 18.0% of children aged 7 to 16 years had a probable mental disorder, 10.8% had a possible mental disorder, and 71.2% were unlikely to have a mental disorder.

The prevalence of a probable mental disorder was 20.4% in children aged 11 to 16 years and 15.2% in those aged 7 to 10 years, but this difference was not statistically significant.

In young people aged 17 to 24 years, 22.0% had a probable mental disorder, 13.6% had a possible mental disorder, and 64.4% were unlikely to have a mental disorder.

In younger children aged 7 to 10 years, the prevalence of a probable mental disorder was nearly twice as high in boys (19.7%) as in girls (10.5%). Rates of a probable mental disorder were similar in boys (18.8%) and girls (22.0%) aged 11 to 16 years.

In young people aged 17 to 24 years, the pattern was reversed, with much higher rates in young women (31.2%) than young men (13.3%).

For more information see: Table 1.1 of the [Excel data tables](#).

Figure 1.1: Percentage of children and young people with a probable mental disorder, by age and sex, 2022

[Download the data for this chart Figure 1.1: Percentage of children and young people with a probable mental disorder, by age and sex, 2022](#)

Figure 1.1 base: 7 to 24 year olds.

Trends over time in mental health

The prevalence of a probable mental disorder in children aged 7 to 16 years rose between 2017 and 2020, from 12.1% in 2017 to 16.7% in 2020. Rates in 2020, 2021 and 2022 were similar with no statistically significant differences between these years. In 2021, 17.8% of children in this age group had a probable mental disorder, and in 2022 the figure was 18.0%.

The prevalence of a probable mental disorder for both children aged 7 to 10 years and 11 to 16 years was higher in 2020 compared with 2017 but remained similar with no statistically significant changes between 2020, 2021 and 2022.

In young people aged 17 to 19 years, rates of a probable mental disorder rose from

10.1% in 2017 to 17.7% in 2020. Rates did not change between 2020 and 2021. However, there was an increase in the rate of a probable mental disorder between 2021 and 2022, from 17.4% in 2021 to 25.7% in 2022.

The overall rise in prevalence of a probable mental disorder between 2017 and 2022 was evident in boys and girls across both age groups (7 to 16 years, and 17 to 19 years).

Rates of a probable mental disorder for those aged 20 to 23 years were similar in 2021 (16.6%) and 2022 (18.7%). There was no 2017 or 2020 data for this age group.

For more information see: Table 1.2 of the [Excel data tables](#).

Figure 1.2: Percentage of children and young people with a probable mental disorder, by age, 2017, 2020, 2021 and 2022

[Download the data for this chart Figure 1.2: Percentage of children and young people with a probable mental disorder, by age, 2017, 2020, 2021 and 2022](#)

Figure 1.2 base: 7 to 19 year olds.

Possible eating problems

This section describes trends in possible eating problems over time.

Definition

Young people aged 11 to 24 years and parents of children aged 7 to 16 years completed 5 screening questions from the [Eating Disorders Development and Well-Being Assessment \(DAWBA\) module](#).

'Screening positive' for a possible eating problem was defined as scoring above the threshold (answering yes to 2 or more items where a parent is reporting on a child and answering yes to 1 or more items where a young person is reporting on themselves) on these questions. The questions are available in the [questionnaire and materials documentation](#).

- 'Screening positive' on the DAWBA Eating Disorders module does not mean that the child or young person had a clinically impairing eating disorder such as anorexia or bulimia, but indicates an increased likelihood of broader problems or difficulties with eating.

This section presents data on children and young people aged 11 to 23 years, to allow for comparison with previous waves. For children aged 11 to 16 years, the prevalence figures reported are based on parent report. For young people aged 17 to 23 years, these figures are based on self-report.

These questions were not included in 2020, hence this section presents data for 2017, 2021 and 2022 only.

The different mode of data collection in 2017 (face to face) compared with 2021 and 2022 (online or telephone) may result in modal effects in responses, particularly for sensitive questions such as eating problems. While it is not possible to quantify the effects of this, caution should be taken when comparing results over time.

Possible eating problems in 2022

- 12.9% of 11 to 16 year olds and 60.3% of 17 to 19 year olds had possible eating problems. This indicates an increased likelihood of problems with eating and does not mean that the child or young person had an eating disorder.

The rate of possible eating problems in 2022 was 12.9% in children aged 11 to 16 years. This rose to 60.3% in young people aged 17 to 19 years. Rates for young people aged 20 to 23 years were similar to those aged 17 to 19 years; 62.2% screened positive for a possible eating problem in 2022.

Across all age groups, the rate of possible eating problems was higher in girls than in boys:

- for children aged 11 to 16 years, the rate was 17.8% in girls compared with 8.1% in boys
- for young people aged 17 to 19 years, the rate was 75.9% in young women, compared with 45.5% in young men
- for young people aged 20 to 23 years, the rate was 76.6% in young women compared with 49.3% in young men

Trends in possible eating problems for 11 to 16 year olds

In children aged 11 to 16 years, the rate of possible eating problems rose between 2017 (6.7%) and 2021 (13.0%), and then remained stable between 2021 and 2022 (12.9%).

In girls aged 11 to 16 years, this pattern was the same. Rates rose between 2017 (8.4%) and 2021 (17.8%) and were stable between 2021 and 2022. In boys, rates were similar

between 2017 (5.1%), 2021 (8.4%) and 2022 (8.1%).

Trends in possible eating problems for 17 to 19 year olds

In young people aged 17 to 19 years, the prevalence of possible eating problems rose from 44.6% in 2017 to 58.2% in 2021. Rates remained stable between 2021 (58.2%) and 2022 (60.3%).

This trend was evident for young women and young men aged 17 to 19 years. In young women, rates rose from 60.5% in 2017, to 76.4% in 2021, and then remained stable in 2022 at 75.9%. In young men, rates were 29.6% in 2017 and 41.0% in 2021. The rate in 2022 (45.5%) was an increase on that in 2017 for young men.

Change between 2017 and 2022 in rates of possible eating problems could not be examined for those aged 20 to 23 years, for whom there was no 2017 data.

For more information see: Table 1.3 of the [Excel data tables](#).

Figure 1.3: Percentage of children and young people who screened positive for possible eating problems, by age and sex, 2017, 2021 and 2022

[Download the data for this chart Figure 1.3: Percentage of children and young people who screened positive for possible eating problems, by age and sex, 2017, 2021 and 2022](#)

Figure 1.3 base: 11 to 19 year olds.

Implications for prevalence of eating disorders

As in the Definitions section above: 'Screening positive' on the DAWBA Eating Disorders module does **not** mean that the child or young person had a clinically impairing eating disorder such as anorexia or bulimia but indicates an increased likelihood of broader problems or difficulties with eating.

The prevalence of 'clinical' eating disorders as classified by the [ICD-11](#) or [DSM-V](#) systems is likely to be much lower in children and young people than the prevalence of possible eating problems identified by 'screening positive' on the DAWBA module. For example, in the [MHCYP 2017 report](#), rates of eating disorder in girls aged 17 to 19 were 1.6%, while 60.5% screened positive. This is because the DAWBA screening questions are designed to detect all children and young people at risk, with very detailed follow up questions to determine the presence or absence of an eating disorder.

Recent research has tried to answer the question: what proportion of those who 'screen positive' on the DAWBA would be expected to have a clinically diagnosable eating disorder. To answer this, children, young people and parents of those who screened positive in 2021 were invited to complete the rest of the DAWBA Eating Disorder module. The findings suggest that only a small proportion would have a clinically diagnosable eating disorder, and that rates in the population remain low.

Findings from this 2022 wave therefore suggest that there has been an increase in the prevalence of children and young people who may have problems with eating since 2017. They cannot be taken to mean that there has been a similar increase in the prevalence of clinically diagnosable eating disorders.

Psychotic-like experiences

This section describes the prevalence of psychotic-like experiences in young people aged 17 to 24 years in 2022.

Definition

'Psychotic-like' experiences (sometimes known as PLEs) include a range of experiences such as hearing or seeing things that others cannot, or a belief in having special powers. These are also sometimes known as 'unusual subjective experiences (USEs)'

Experiencing 1 or more of these is relatively common and does not mean that a person necessarily has a mental health problem. Psychotic-like experiences can occur in people who do not have any mental health problems, as well as in those with conditions such as depression. Psychotic disorders themselves (such as schizophrenia) are rare, having a prevalence of less than 3% in young people.¹ However, experiencing psychotic-like experiences is thought to place young people at higher risk of developing problems in the future.

Young people completed the Adolescent Psychotic-Like Symptom Screener (APSS). Being 'at-risk' for psychotic-like experiences was defined as scoring 2 or more out of a possible 7 points. The questions are available in the questionnaire and materials documentation.

These questions were asked for the first time in 2022, and so no trends over time can be presented.

1 A Population-Based Cohort Study Examining the Incidence and Impact of Psychotic Experiences From Childhood to Adulthood, and Prediction of Psychotic Disorder | American Journal of Psychiatry (psychiatryonline.org).

Psychotic-like experiences by mental health of young person

In 2022, 18.4% of young people aged 17 to 24 years were in the 'at-risk' group for psychotic-like experiences (that is, reported 2 or more experiences). There was no statistically significant difference in the rates for young women (22.6%) and young men (14.4%).

Young people with a probable mental disorder were more likely to be in the 'at-risk' group for psychotic-like experiences than those unlikely to have a mental disorder. Of those with a probable mental disorder, 36.4% scored in the 'at-risk' range, compared with 10.0% of those who were unlikely to have a mental disorder.

For more information see: Table 1.4 of the [Excel data tables](#).

Figure 1.4: Percentage of young people reporting two or more psychotic-like experiences, by sex, 2022

[Download the data for this chart Figure 1.4: Percentage of young people reporting two or more psychotic-like experiences, by sex, 2022](#)

Figure 1.4 base: 17 to 24 year olds.

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[Part 2: Sleep, loneliness and health behaviours](#)

Part 2: Sleep, loneliness and health behaviours

This section of the report presents findings on problems with sleep and loneliness, as well as on substance use, online gambling and self-harm.

Sleep problems

Definition

Parents of 7 to 10 year olds were asked whether their child had problems getting to sleep, waking in the night, or waking early in the previous 7 days. They were also asked on how many days their child had experienced each problem. The number of nights they experienced each problem was added together to get the total number of times they had experienced a sleep problem over the previous 7 days.

Older children aged 11 to 16 years, and young people aged 17 to 24 years were asked these questions directly.

These questions were asked in 2021 and 2022.

Sleep problems by mental health of child

In 2022, 34.0% of children aged 7 to 16 years had a problem with sleep 3 or more times over the previous 7 nights.

Of children with a probable mental disorder, 72.3% had a sleep problem 3 or more times over the previous 7 nights compared with 22.9% of those unlikely to have a mental disorder. Girls with a probable mental disorder (82.4%) were more likely to have had a sleep problem 3 or more times than boys with a probable mental disorder (64.2%). Rates of sleeping problems were similar in 2021 and 2022.

Sleep problems by mental health of young person

In 2022, 64.0% of young people aged 17 to 23 years had a problem with sleep 3 or more times over the previous 7 nights; almost twice the rate in children aged 7 to 16 years. This figure was higher for young women (76.7%) compared with young men (52.3%).

Rates of sleep problems were higher in young people with a probable mental disorder, 89.5% had a sleep problem 3 or more times over the previous 7 days, compared with 51.5% of those unlikely to have a mental disorder.

Rates of sleeping problems were similar in 2021 and 2022.

For more information see: Table 2.1 of the [Excel data tables](#).

Figure 2.1: Percentage of children and young people who had a problem with sleep three or more times over the previous seven nights, by age and sex, 2021 and 2022

[Download the data for this chart Figure 2.1: Percentage of children and young people who had a problem with sleep three or more times over the previous seven nights, by age and sex, 2021 and 2022](#)

Figure 2.1 base: 7 to 23 year olds.

Loneliness

Definition

Children aged 11 to 16 years, and young people aged 17 to 24 years were asked how often they felt lonely. These questions were asked in 2020, 2021 and 2022. Comparisons are therefore presented for children and young people aged 11 to 22 years.

Loneliness by mental health of child

In 2022, 5.2% of children aged 11 to 16 years said they often or always felt lonely. This was similar for boys and girls.

Children with a probable mental disorder were more likely to feel lonely; 18.0% of those with a probable mental disorder said they felt lonely often or always, compared with 1.7% of those unlikely to have a mental disorder.

Rates of loneliness were similar in 2020, 2021 and 2022.

For more information see: Table 2.2a of the [Excel data tables](#).

Loneliness by mental health of young person

In 2022, 12.6% of young people aged 17 to 22 years reported often or always feeling lonely, this was more than double the figure for children aged 11 to 16 years (5.2%). Loneliness levels were similar for young men and young women.

Loneliness was higher among young people with a probable mental disorder, 28.9% reported that they often or always felt lonely, compared with 5.2% of those unlikely to have a mental disorder.

Rates of loneliness were similar in 2020, 2021 and 2022.

For more information see: Table 2.2a and Table 2.2b of the [Excel data tables](#).

Figure 2.2: Percentage of children and young people often or always feeling lonely, by mental health of child or young person and age, 2022

[Download the data for this chart Figure 2.2: Percentage of children and young people often or always feeling lonely, by mental health of child or young](#)

person and age, 2022

Figure 2.2 base: 11 to 22 year olds.

Substance use and online gambling

Definition

Children aged 11 to 16 years, and young people aged 17 to 24 years, were asked on how many of the past 7 days they had done each of the following:

- had a drink containing alcohol
- used cannabis or other drugs
- smoked 1 or more cigarettes
- gambled money online

Children aged 11 to 16 years were only asked about gambling money online in 2022. For the other behaviours, comparisons are presented for 2020, 2021 and 2022.

Substance use and online gambling for 11 to 16 year olds

In 2022, most children aged 11 to 16 years reported that they had **not** had alcohol (94.1%), cigarettes (98.5%), or cannabis and other drugs (98.8%) in the previous 7 days. The vast majority of children also reported that they had **not** gambled money online (99.6%).

For more information see: Table 2.3 of the [Excel data tables](#).

Substance use and online gambling for 17 to 22 year olds

- 5.8% of 17 to 22 year olds had gambled money online at least once in the previous 7 days.

In 2022, the majority of young people aged 17 to 22 years reported that they had **not** smoked cigarettes (86.0%) or used cannabis and other drugs (88.8%) in the previous 7 days.

In terms of alcohol consumption in the previous 7 days:

- 47.2% reported they had **not** drunk alcohol
- 42.4% said they had drunk alcohol on 1 to 3 days
- 6.8% said they had drunk alcohol on 4 to 5 days
- 3.6% had drunk alcohol on 6 or 7 days

Therefore, 52.8% of 17 to 22 year olds had drunk alcohol on at least 1 day in the previous 7 days.

In terms of gambling online in the previous 7 days:

- 94.2% said they had **not** gambled online at all
- 5.1% reported gambling online on 1 to 3 days
- 0.5% had gambled on 4 to 5 days
- 0.2% had gambled on 6 or 7 days

Therefore, 5.8% of 17 to 22 year olds had gambled money online at least once in the previous 7 days.

Rates of substance use were similar in young men and young women, but young men (8.7%) were more likely than young women (2.6%) to report having gambled with money online at least once in the past 7 days.

Young people with a probable mental disorder were less likely to say they had **not** smoked in the previous 7 days (77.0%) than those unlikely to have a mental disorder (91.1%).

There were no statistically significant differences between rates in 2020, 2021 and 2022 in this age group for any of the behaviours examined with 1 exception. The proportion of young people who had **not** drunk alcohol at all in the previous 7 days was higher in 2021 than in 2022. In 2021, 56.7% of young people had **not** drunk alcohol in the previous 7 days, compared with 47.2% in 2022. However, figures for 2022 were similar to those for 2020.

For more information see: Table 2.3 of the [Excel data tables](#).

Figure 2.3: Percentage of young people who used substances or gambled money online over the previous seven days, 2022

[Download the data for this chart Figure 2.3: Percentage of young people who used substances or gambled money online over the previous seven days, 2022](#)

Figure 2.3 base: 17 to 22 year olds.

Self-harm

Definition

Parents of those aged 7 to 16 years were asked whether their child had either talked about harming themselves or had tried to harm themselves in the past 4 weeks. They were also asked whether they had tried to harm themselves at any point in their life. The same questions were asked directly to young people aged 17 to 24 years.

These questions were included in 2022 only. Similar questions were asked in the 2017 survey, however the questions had to be modified to allow them to be asked in an online rather than face to face survey.

While the 2017 survey asked whether a child or young person had tried to harm or kill themselves, in 2022, the questions only asked about harming themselves. Direct comparisons should therefore not be made with the estimates in the 2017 report.

Self-harm by mental health of child

According to parent report, 2.9% of children aged 7 to 16 years had talked about harming themselves and 2.5% had tried to harm themselves in the past 4 weeks.

Regarding lifetime rates, 7.8% of children had ever self-harmed. Girls aged 7 to 16 years were more likely to have ever self-harmed than boys of this age (9.7% compared with 6.0%).

Self-harm was more common in children with a probable mental disorder:

- 12.6% of children with a probable mental disorder had talked about self-harm in the past 4 weeks compared with 0.6% of those unlikely to have a mental disorder
- 10.2% of children with a probable mental disorder had tried to harm themselves in the past 4 weeks, compared with 0.6% of those unlikely to have a mental disorder
- 28.3% of children with a probable mental disorder had ever tried to harm themselves, compared with 2.5% of those unlikely to have a mental disorder

Girls with a probable mental disorder were more likely to have ever tried to harm themselves. Over their lifetime, 38.6% of girls with a probable mental disorder had tried to harm themselves, compared with 19.9% of boys with a probable mental disorder.

For more information see: Table 2.4a of the [Excel data tables](#).

Figure 2.4: Percentage of children who talked about or tried to self harm in the past 4 weeks, by mental health of child, 2022

Download the data for this chart Figure 2.4: Percentage of children who talked about or tried to self harm in the past 4 weeks, by mental health of child, 2022

Figure 2.4 base: 7 to 16 year olds.

Self-harm by mental health of young person

Overall, 9.0% of young people aged 17 to 24 years reported having talked about harming themselves in the past 4 weeks, and 4.0% said they had tried to harm themselves in the same period. 32.8% of young people reported having ever self-harmed.

Young women were more likely to have talked about self-harm in the past 4 weeks than young men (12.4% compared with 5.8%). Rates of lifetime self-harm were also higher in young women (42.8%) than young men (23.3%). There was no statistically significant difference in rates of having tried to self-harm in the past 4 weeks between young men and young women.

As with children, self-harm was more common in young people with a probable mental disorder:

- 28.1% of young people with a probable mental disorder had talked about self-harm in the past 4 weeks, compared with 2.1% of those unlikely to have a mental disorder
- 15.8% of young people with a probable mental disorder had tried to harm themselves in the past 4 weeks, compared with 0.3% of those unlikely to have a mental disorder
- 68.6% of young people with a probable mental disorder had ever tried to harm themselves, compared with 17.8% of those unlikely to have a mental disorder

For more information see: Table 2.4b of the [Excel data tables](#).

Figure 2.5: Percentage of young people who talked about or tried to self harm in the past 4 weeks, by mental health of young person, 2022

Download the data for this chart Figure 2.5: Percentage of young people who talked about or tried to self harm in the past 4 weeks, by mental health of young person, 2022

Figure 2.5 base: 17 to 24 year olds.

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Previous Chapter

Part 1: Mental health

Next Chapter

Part 3: Education and employment

Part 3: Education and employment

Part 3 of the report describes experiences of education and employment for children and young people.

For children, this section presents data on:

- days of missed schooling
- feelings about school
- mental health and well-being support in school

For young people, this section presents data on:

- mental health by education and employment status
- isolation, support and opportunities by employment status

Days of missed schooling

Definition

Parents of children aged 7 to 16 years were asked about the number of days of school their child had missed for any reason during the Autumn term of 2021. The same question had been asked in the 2021 (wave 2) survey about the number of days of schooling missed in the Autumn term of 2020.

When comparing the number of days of missed school in Autumn 2021 and Autumn 2020, it is important to bear in mind that the educational environment differed between these points. In Autumn 2020 there were more opportunities for virtual learning and more measures in place to control the spread of COVID-19 including school closures. This context should be noted when comparing results over time.

Data from the Department for Education on school attendance during the pandemic can be found in the [Attendance in education and early years settings during the coronavirus \(COVID-19\) pandemic](#) publication.

Days of missed schooling by mental health of child

1 in 18 (5.6%) children aged 7 to 16 years missed more than 15 days of school in the Autumn term of 2021.

School absence rates were higher in children with a probable mental disorder; 12.6% missed more than 15 days of school compared with 3.9% of those unlikely to have a mental disorder.

The proportion of children missing more than 15 days of school fell between the 2021 and 2022 survey waves; according to parent-report 10.7% of children had missed more than 15 days in the Autumn term of 2020, compared with 5.6% reporting 15 or more days absence in the Autumn term of 2021.

However, the proportion of children who had not missed any days of school in the previous Autumn term also fell from 51.6% in the Autumn term of 2020 to 30.1% in the Autumn term of 2021. This appeared to be driven by an increase in the proportion of children missing between 1 and 5 days of school, which rose from 15.1% in Autumn 2020 to 41.5% in Autumn 2021.

For more information see: Table 3.1 of the [Excel data tables](#).

Figure 3.1: Missed days of schooling in the 2020 Autumn term and 2021 Autumn term

[Download the data for this chart Figure 3.1: Missed days of schooling in the 2020 Autumn term and 2021 Autumn term](#)

Figure 3.1 base: 7 to 16 year olds.

Feelings about school

Definition

Children aged 11 to 16 years were asked a series of questions about school, for example, how safe they felt at school and how much they enjoyed learning. Children were asked whether they agreed a lot, agreed a little, neither agreed nor disagreed, disagreed a little, or disagreed a lot, with 6 statements.

4 of the statements were phrased positively (for example, 'I can be myself at school'), and 2 of the statements were phrased negatively and focused on worries about the impact of COVID-19 at school (for example, 'I am worried about the effect COVID-19 has had on my

schoolwork'). These questions were only asked in 2022 and we focus on the proportion agreeing (a little and a lot) with each statement.

Feelings about school by mental health of child

The great majority of children (92.5%) agreed that they have at least 1 friend that they can turn to for support, and most (82.0%) reported that they felt safe at school. 75.8% agreed "I can be myself at school" and 65.8% agreed that they "enjoy learning at school".

In terms of worries about the impact of COVID-19 at school, 43.5% agreed that "I am worried about the effect COVID-19 might have on my future exam results" and 38.6% agreed that "I am worried about the effect COVID-19 has had on my schoolwork".

Figure 3.2: Feelings about school, 2022

[Download the data for this chart Figure 3.2: Feelings about school, 2022](#)

Figure 3.2 base: 11 to 16 year olds.

Children with a probable mental disorder were less likely to have positive views of school than those unlikely to have a mental disorder as follows:

- 47.6% agreed that "I can be myself at school", compared with 86.0% of those unlikely to have a mental disorder
- 61.2% agreed that "I feel safe when I am at school", compared with 89.2% of those unlikely to have a mental disorder
- 51.5% agreed that "I enjoy learning at school", compared with 73.1% of those unlikely to have a mental disorder
- 77.8% agreed that "I have at least 1 friend I can turn to for support" compared with 97.0% of those unlikely to have a mental disorder

For more information see: Table 3.2 of the [Excel data tables](#).

Mental health and well-being support at school

Definition

Children aged 11 to 16 years were asked whether they had accessed support at school for their mental health and well-being. They were also asked a series of questions about support at school, for example, whether they knew how to access support. These

questions were asked of all children, regardless of whether they reported accessing support and were only asked in 2022.

Access to mental health and well-being support at school

- 1 in 4 (25.1%) 11 to 16 year olds accessed mental health and well-being support at school in the past year; 59.8% of children with a probable mental disorder reported use.

1 in 4 (25.1%) children aged 11 to 16 years reported that they had accessed mental health and well-being support at school.

Children with a probable mental disorder were more likely to report accessing mental health and well-being support at school. Of those with a probable mental disorder, 59.8% reported accessing support, compared with 14.9% of those unlikely to have a mental disorder.

For more information see: Table 3.3 of the [Excel data tables](#).

Feelings about mental health and well-being support at school

The majority of children were positive about access to support at school: 83.0% knew how to get support and 75.9% agreed they were able to access support if they needed to. However, children were less likely to be positive about the value or appropriateness of the support available at school: 61.1% agreed it would be helpful and 57.0% felt they would feel comfortable talking about their mental health with adults at their school.

Figure 3.3: Feelings about mental health support at school, 2022

[Download the data for this chart Figure 3.3: Feelings about mental health support at school, 2022](#)

Figure 3.3 base: 11 to 16 year olds.

Agreement with the statements were similar for children who had and had not accessed mental health and well-being support at school. There were no statistically significant differences between these 2 groups for girls. However, in boys, there were some differences between these 2 groups:

- 96.8% of boys who had accessed support agreed that "I know how to get help for worries or concerns at my school", compared with 78.8% of boys who had not accessed support
- 83.4% of boys who had accessed support agreed that "The support available at my school is helpful", compared with 57.5% of boys who had not accessed support

For more information see: Table 3.4 of the [Excel data tables](#).

Young people's mental health

Definition

This section presents information about probable mental disorder by education or employment status for young people aged 17 to 24 years in 2022. 3 groups were identified:

- in education
- in employment
- not in education or employment

Young people could be counted in both the education group and the employment group, for example, if they were at university but also in a part-time job.

There were not many participants in the 'not in education or employment' group. Therefore, estimates for this group are imprecise and should be treated with caution and comparisons between young men and young women in this group were not possible.

The [Participation in education, training and employment: 2021](#) publication contains national participation figures for 16 to 18 year olds.

Mental health by education and employment status of young person

Rates of probable mental disorder were 22.2% among those in education, 20.8% in those in employment and 26.5% in those not in education or employment. There were no statistically significant differences between these rates.

For young people in employment, rates of probable mental disorder were higher in young women, 29.3% had a probable mental disorder compared with 11.2% of young men.

For more information see: Table 3.5 of the [Excel data tables](#).

Young people's isolation, support and opportunities

Definition

Young people aged 17 to 24 years were asked a series of questions about their experiences according to their education and employment status. The 3 groups identified were those:

- in education and employment (for example, at university but also in a part time job)
- in employment but not in education
- not in education or employment

These questions were included in 2022 only. Young people who were in education but not in employment were not asked the following questions, as the intention was to examine the experiences of young people who were in the workplace, or who were not in education or employment. Therefore, these groups are different to the groups used in the previous section on young people's mental health.

Young people were asked whether they strongly agreed, agreed, neither agreed nor disagreed, disagreed, or strongly disagreed, with 3 statements.

These statements varied slightly depending on whether the young person was in education or employment:

- "I feel isolated from others" (for those not in education or employment) or "I feel isolated from colleagues or others I work with" (for the other 2 groups)
- "There is support available for mental health and well-being" (for those not in education or employment) or "there is support available at my workplace for mental health and well-being" (for the other 2 groups)
- "I have access to opportunities for learning, training and development" (same question asked to all)

When separated by education and employment status there were few young people in some of the groups, in particular the not in education or employment group. Therefore, these estimates are imprecise and should be treated with caution.

Isolation, support and opportunities by employment status of young person

- 2 in 5 (40.5%) young people aged 17 to 24 years who were not in education or employment agreed they felt isolated from others.

Young people not in education or employment were more likely than other young people to agree (strongly agree or agree) that they felt isolated from others; 40.5% agreed with this statement compared with 15.5% of those in employment but not education, and 8.8% of those in employment and education. Differences between the latter 2 groups were not statistically significant.

Figure 3.4: Whether young people agreed they felt isolated from either people they worked with or others, by employment status, 2022

[Download the data for this chart Figure 3.4: Whether young people agreed they felt isolated from either people they worked with or others, by employment status, 2022](#)

Figure 3.4 base: 17 to 24 year olds.

The majority of young people in all 3 groups agreed with the statement: "There is support available for mental health and well-being" with no statistically significant difference between groups.

Young people in employment but not education were more likely than young people in the other groups to agree with the statement "I have access to opportunities for learning, training and development". In this group, 78.4% agreed, compared with 58.3% of those not in education or employment, and 58.9% of those in education and employment.

Comparisons between young men and young women in the not in education or employment group were not possible due to small sample sizes. Generally, there were no statistically significant differences in agreement with the statements between young men and young women in the other groups. The exception was that young women in education and employment were less likely than young men in this group to agree there was support for their mental health and well-being at their workplace (37.1% compared with 67.2%).

For more information see: Table 3.6 of the [Excel data tables](#).

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[Part 2: Sleep, loneliness and health behaviours](#)

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[Part 4: Services and support](#)

Part 4: Services and support

This section presents findings on help-seeking for mental health concerns, including sources of support and outcomes for children and young people reporting contact with services.

Seeking help or advice

Definition

Parents of children aged 7 to 16 years who reported that they had a concern about the mental health of their child were asked if they had sought help or advice for the concern. The same question was asked of young people aged 17 to 24 years who had a concern about their own mental health.

In the 2022 survey, which took place in April/May 2022, they were asked if they had sought support since 1st April 2021. Estimates therefore refer to a period of approximately 1 year.

Comparisons are presented for children aged 7 to 16 years, and young people aged 17 to 23 years (to allow comparisons with 2021, when 24 year olds were not included).

Estimates for 2021 are available in the [Excel data tables](#), but caution should be taken when comparing results over time due to different time periods being covered by each survey.

- Help or advice was sought for 3 in 4 (76.4%) 7 to 16 year olds with a parent concerned for their mental health, and by 1 in 2 (53.2%) 17 to 23 year olds concerned about their mental health.

Seeking help or advice for a concern by mental health of child

In 2022, for children whose parent had a concern about their child's mental health,

76.4% had a parent who reported seeking help or advice for this concern. This was similar for boys and girls, but more likely if the child had a probable mental disorder (85.1%) than children unlikely to have a mental disorder (64.3%).

For more information see: Table 4.1 of the [Excel data tables](#).

Seeking help or advice for a concern by mental health of young person

In 2022, 53.2% of young people aged 17 to 23 years who had a concern about their mental health reported seeking help or advice. Young people were less likely to report seeking help for a concern than parents of children aged 7 to 16 years (76.4% of children whose parent had a concern about their child's mental health had a parent who sought help for their concern).

For more information see: Table 4.1 of the [Excel data tables](#).

Sources of help and advice

Definition

All parents of children aged 7 to 16 years were asked whether they had sought any help or advice about their child's mental health since April 2021 from a list of informal sources (such as family and friends) and services (including health and education).

Health services included primary care, social care, paediatrics or child health, and specialist mental health services such as Child and Adolescent Mental Health Services.

Education included teachers or university staff, school, college or university based mental health support services, and educational support services. In 2022, the response options relating to education were updated to include someone from a school Mental Health Support Team as an example of school based mental health support services.

The question was asked to all parents, regardless of whether or not they reported having concerns about the mental health of their child. The same question was asked to all young people aged 17 to 24 years.

In the 2022 survey, which took place in April/May 2022, participants were asked if they had sought support since 1st April 2021. Estimates therefore refer to a period of approximately 1 year.

Comparisons are presented for children aged 7 to 16 years, and young people aged 17 to 23 years (to allow comparisons with 2021, when 24 year olds were not included).

Estimates for 2021 are available in the [Excel data tables](#), but caution should be taken

when comparing results over time due to different time periods being covered by each survey.

Sources of help and advice for children

Among children aged 7 to 16 years in 2022, the most commonly reported sources of help and advice for a mental health concern by parents were education services (32.6%), followed by friends or family (17.9%). The least commonly reported sources were Accident and Emergency (0.9%) and text chat mental health support (0.8%). Estimates for all sources of help and advice are presented in Table 4.2 of the [Excel data tables](#).

Figure 4.1: Common sources of help for children whose parents had sought help for a concern about the child's mental health, 2022

[Download the data for this chart Figure 4.1: Common sources of help for children whose parents had sought help for a concern about the child's mental health, 2022](#)

Figure 4.1 base: 7 to 16 year olds.

Sources of help and advice for children by mental health of child

In 2022, the most commonly reported sources of help and advice by parents for children with a probable mental disorder were:

- education services (82.7%)
- health services (51.1%)
- friends or family (46.5%)
- online or telephone support (38.0%)

Parents of children with a probable mental disorder were more likely than parents of those unlikely to have a mental disorder to have sought help or advice for a concern from each of the listed sources above. In addition, just over 1 in 9 (12.3%) children with a probable mental disorder had a parent who reported seeking help and advice from a private, paid for service, compared with fewer than 1 in 100 children unlikely to have a mental disorder (0.7%).

For more information see: Table 4.2 of the [Excel data tables](#).

Sources of help and advice for young people

The most commonly reported sources of help and advice for a mental health concern reported by young people aged 17 to 23 years in 2022 were family or friends (42.6%), followed by online or telephone support (19.3%). The least commonly reported source of help and advice was Accident and Emergency (2.0%). Estimates for all sources of help and advice are presented in Table 4.2 of the [Excel data tables](#).

Compared with parents of children aged 7 to 16 years, young people were more likely to report contacting friends or family for help and advice (42.6% of young people compared with 17.9% of children). As might be expected given that some young people were no longer in education, they were less likely to report contacting education services for mental health support (17.8% of young people compared with 32.6% of children whose parents reported this).

There were some differences in sources of support by sex in this age group. Whilst 51.4% of young women reported contacting friends and family for help and advice, this was reported by 34.5% of young men. Young women were also more likely to use online or telephone support than young men (25.4% compared with 13.7%).

Figure 4.2: Common sources of help for young people for a concern about their mental health, 2022

[Download the data for this chart Figure 4.2: Common sources of help for young people for a concern about their mental health, 2022](#)

Figure 4.2 base: 17 to 23 year olds.

Sources of help and advice for young people by mental health of young person

The most commonly reported sources of help and advice for a mental health concern in young people aged 17 to 23 years with a probable mental disorder were:

- friends or family (58.5%)
- online or telephone support (39.6%)
- health services (34.9%)
- education services (34.1%)

Young people with a probable mental disorder were more likely than those unlikely to have a mental disorder to have sought help or advice for a concern from all the listed sources above.

For more information see: Table 4.2 of the [Excel data tables](#).

Outcomes of contact with services

Definition

A question about the outcomes of service contact was asked to parents of children aged 7 to 16 years and young people aged 17 to 24 years if they said they had been in contact with any of the following services since 1st April 2021, because of a mental health concern:

- school or university mental health support services
- primary health care
- specialist mental health services such as Child and Adolescent Mental Health Services or Adult Mental Health Services
- Accident and Emergency or an emergency department

The question was asked if they reported being in contact with any of the above services regardless of whether they were unlikely to be, possibly or probably demonstrating a mental health condition. The question asked what happened after contact with each of the specified services, for example, whether they received treatment or were referred elsewhere. More than 1 outcome could be given. This question was only asked in 2022. Sample sizes are small for some groups; therefore, these estimates are imprecise and should be treated with caution.

Outcomes of contact with specified services by mental health of child

Among children who had contact in the previous 12 months with the specified services regarding a mental health concern, commonly reported outcomes were:

- 35.5% were signposted to sources of support
- 35.1% were referred to a different service or professional
- 33.3% received treatment, such as medication or counselling
- 22.9% received an assessment for a mental health condition

Of those who had contact with the specified services, 10.4% reported receiving a mental health diagnosis.

Figure 4.3: Commonly reported outcomes of contact with services for children, 2022

Download the data for this chart Figure 4.3: Commonly reported outcomes of contact with services for children, 2022

Notes for Figure 4.3

Among children who had contact in the previous 12 months with services, those with a probable mental disorder were more likely than those unlikely to have a mental disorder to report receiving an assessment for a mental health condition (29.0% compared with 9.5%). They were also more likely to report receiving a diagnosis (13.9% compared with 3.3%) and to be referred elsewhere (45.2% compared with 17.5%).

For more information see: Table 4.3 of the [Excel data tables](#).

Outcomes of contact with specified services by mental health of young person

Among young people aged 17 to 24 years who had contact with the specified services regarding a mental health concern, the most commonly reported outcome was receiving treatment, such as medication or counselling with 62.5% reporting this. Other reported outcomes included:

- 42.1% were signposted to sources of support
- 35.8% received an assessment for a mental health condition
- 27.9% were referred to a different service or professional
- 21.9% reported receiving a mental health diagnosis
- 20.8% felt no further support or treatment were needed

Figure 4.4: Commonly reported outcomes of contact with services for young people, 2022

Download the data for this chart Figure 4.4: Commonly reported outcomes of contact with services for young people, 2022

Notes for Figure 4.4

There were some differences between outcomes reported by parents for children aged 7 to 16 years, and outcomes reported by young people. Young people were more likely to

report receiving a diagnosis following service contact (21.9% compared with 10.4%) and to report receiving treatment (62.5% compared with 33.3%).

For more information see: Table 4.3 of the [Excel data tables](#).

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[Part 3: Education and employment](#)

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[Part 5: Social and economic context](#)

Part 5: Social and economic context

This section of the report presents findings on the household and wider circumstances of children and young people, their experiences on social media, and their feelings about the area where they live.

Household circumstances

Definition

The parents of children aged 7 to 16 years were asked about their household's circumstances over the past year (since 1st April 2021). The questions asked about negative changes, such as a reduction in household income in the past year, as well as about adverse events, such as not being able to buy enough food or having to use a food bank.

Young people aged 17 to 24 years were asked a similar but not identical set of questions about circumstances in their own household in the past year. The questions for young people included both neutral or positive changes and included life events which this age group might experience, such as having a baby or moving in with a partner.

Comparisons are presented for children aged 7 to 16 years, and young people aged 17 to 22 years (to allow comparisons with 2020, when 23 or 24 year olds were not included).

Estimates for 2020 and 2021 are available in the [Excel data tables](#), but caution should be taken when comparing results over time due to different time periods being covered by each survey.

Household circumstances by mental health of child

- Children with a probable mental disorder were more likely than those unlikely to have a mental disorder to live in households that could not afford to keep the house warm enough (13.6% compared to 6.0%) or that had not been able to buy enough food, or had to use a food bank (11.8% compared to 4.4%).

Overall, 36.9% of children aged 7 to 16 years lived in a household that had experienced at least 1 of the negative changes or events in the past year.

The most commonly reported circumstance was a reduction in household income, experienced by the families of 1 in 5 children (19.9%). Just over 1 in 8 children lived in a household where a parent or someone close to them had been seriously ill (13.4%). About 1 in 10 lived in a household that had fallen behind with rent, bills or mortgage (9.6%).

Other negative circumstances included not being able to afford to keep the house warm enough (7.8%), not being able to buy enough food, or having to use a food bank (5.9%), and a parent or partner losing their job or business (5.6%).

Children with a probable mental disorder were more likely than those unlikely to have a mental disorder to live in households that had experienced at least 1 of these events or changes (49.3% compared with 34.0%).

Differences included:

- 28.6% of children with a probable mental disorder lived in a household that experienced a reduction in household income, compared with 18.1% of those unlikely to have a mental disorder
- 21.0% of children with a probable mental disorder lived in a household where a parent or someone close to them had been seriously ill, compared with 11.6% of those unlikely to have a mental disorder
- 17.8% of children with a probable mental disorder lived in a household that had fallen behind with bills, rent or mortgage, compared with 7.6% of those unlikely to have a mental disorder
- 13.6% of children with a probable mental disorder lived in a household where they could not afford to keep the house warm enough, compared with 6.0% of those unlikely to have a mental disorder
- 11.8% of children with a probable mental disorder lived in a household where they had not been able to buy enough food, or had to use a food bank, compared with 4.4% of those unlikely to have a mental disorder

For more information see: Table 5.1a of the [Excel data tables](#).

Figure 5.1: Percentage of children living in a household that experienced the specified changes, by mental health of child, 2022

Download the data for this chart Figure 5.1: Percentage of children living in a household that experienced the specified changes, by mental health of child, 2022

Figure 5.1 base: 7 to 16 year olds.

Household circumstances by mental health of young person

In 2022 for 17 to 22 year olds, the most commonly reported change or event in the past year was starting a new job or course of study, experienced by 2 in 5 young people (40.0%). Someone close to them, or themselves, being seriously ill was experienced by 15.7% of young people and 12.6% moved out of a parent or carer's home.

Other negative changes or events reported were a reduction in household income (9.6%), falling behind with bills (5.7%), not being able to buy enough food or using a food bank (5.1%) and not being able to afford to keep the house warm enough (4.9%).

Young people with a probable mental disorder were more likely than young people who were unlikely to have a mental disorder to report experiencing some of the changes or events:

- young people with a probable mental disorder were more likely to report moving in with a partner than those unlikely to have a mental disorder (9.1% compared with 1.2%)
- young people with a probable mental disorder were more likely to report not being able to buy enough food or using a food bank than those unlikely to have a mental disorder (14.8% compared with 2.1%)

For more information see: Table 5.1b of the [Excel data tables](#).

Figure 5.2: Percentage of young people that experienced the specified changes, by mental health of young person, 2022

Download the data for this chart Figure 5.2: Percentage of young people that experienced the specified changes, by mental health of young person, 2022

Figure 5.2 base: 17 to 22 year olds.

Experiences of social media

Definition

Children aged 11 to 16 years and young people aged 17 to 24 years who reported using social media were asked about their experiences online. Participants were asked whether they agreed a lot, agreed a little, neither agreed nor disagreed, disagreed a little, or disagreed a lot, with 2 statements:

- "I have been bullied online"
- "I feel safe using social media"

These questions were only asked in 2022.

Information on the use of social media by children and young people can be found in the [Children and parents: media use and attitudes report 2022](#).

Experiences of social media by mental health of child

1 in 8 children (12.6%) aged 11 to 16 years who used social media agreed (a lot or a little) with the statement "I have been bullied online".

Nearly 2 in 3 children who used social media (62.8%) agreed that they felt safe using social media. Girls were less likely than boys to agree with the statement "I feel safe using social media"; 56.1% of girls agreed compared with 69.8% of boys.

Children who used social media with a probable mental disorder were more likely to have been bullied online; 29.4% agreed with the statement compared with 7.9% of children unlikely to have a mental disorder. They were also less likely to agree that they felt safe online; 48.4% of those with a probable mental disorder agreed with the statement compared with 66.5% of those unlikely to have a mental disorder.

Experiences of social media by mental health of young person

- Young women were almost twice as likely to report having been bullied online than young men (19.5% compared with 11.3%), and less likely to agree that they felt safe using social media than young men (48.6% compared with 65.9%).

Among young people aged 17 to 24 years who used social media, 15.3% agreed with the

statement "I have been bullied online". Young women were almost twice as likely to report having been bullied online than young men (19.5% compared with 11.3%).

In this age group, 57.5% of social media users agreed "I feel safe using social media". Again, young women were less likely to agree with this statement, with 48.6% agreeing compared with 65.9% of young men. There were no statistically significant differences between young people with a probable mental disorder and those unlikely to have a mental disorder for this statement.

Young people who used social media with a probable mental disorder were more likely to report that they had been bullied online; 26.3% of those with a probable mental disorder agreed with this statement compared with 10.7% of those unlikely to have a mental disorder.

For more information see: Table 5.2 of the [Excel data tables](#).

Figure 5.3: Whether child or young person agreed they felt safe using social media, by age and sex, 2022

[Download the data for this chart Figure 5.3: Whether child or young person agreed they felt safe using social media, by age and sex, 2022](#)

Figure 5.3 base: 11 to 24 year old social media users.

Feelings about local area

Definition

Children aged 11 to 16 years were asked about their feelings towards their neighbourhood and local area. Children were asked whether they agreed a lot, agreed a little, neither agreed nor disagreed, disagreed a little, or disagreed a lot, with 4 statements. These questions were only asked in 2022.

Feelings about area by mental health of child

For all children aged 11 to 16 years, the highest levels of agreement were with the statements "I like living in my neighbourhood" (83.9% agreed) and "I feel safe in my neighbourhood/my local area" (83.8% agreed). The lowest level of agreement was with the statement "In my area there are enough places to play and/or have a good time" (69.8% agreed).

Figure 5.4: Feelings about area, 2022

[Download the data for this chart Figure 5.4: Feelings about area, 2022](#)

Figure 5.4 base: 11 to 16 year olds.

- 11 to 16 year olds with a probable mental disorder were less likely to feel safe in their neighbourhood, to like living in their neighbourhood or to trust people where they live than those unlikely to have a mental disorder.

There were differences between responses for children with a probable mental disorder and those unlikely to have a mental disorder. Those with a probable mental disorder were less likely to agree with several of the positive statements:

- 74.2% agreed: "I feel safe in my neighbourhood/my local area" compared with 87.4% of those unlikely to have a mental disorder
- 72.9% agreed: "I like living in my neighbourhood" compared with 88.1% of those unlikely to have a mental disorder
- 57.4% agreed "I can trust people around here" compared with 79.0% of those unlikely to have a mental disorder

For more information see: Table 5.3 of the [Excel data tables](#).

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Data quality statement

Introduction

This report highlights aspects of quality and methodology that users may consider when interpreting results of the **Mental Health of Children and Young People (MHCYP) 2022, wave 3 follow-up to the 2017 survey**. Information contained within this report should be

considered alongside the Survey Design and Methods Report.

Background

This is the third in a series of follow up reports to the 2017 Mental Health and Young People Survey (MHCYP) 2017, exploring the mental health of children and young people in April/May 2022, following the coronavirus (COVID-19) pandemic and changes since 2017. Experiences of family life, education and services are also examined.

The sample for the Mental Health Survey for Children and Young People, 2022 (MHCYP 2022), wave 3 follow up was based on children and young people who took part in the MHCYP 2017 survey. Information about the sampling strategy adopted in 2017 can be found in the [MHCYP 2017 Survey Design and Methods Report](#). The consent for follow up studies was originally asked during the MHCYP 2017 fieldwork period, and has been re-asked at each follow up survey.

For 7 to 10 year olds, parents or legal guardians (referred to as parents throughout this report) were able to complete an online questionnaire about their child in the survey. For 11 to 16 year olds, children were able to complete an online questionnaire as well as a separate questionnaire for completion by the parent. Young people aged 17 to 24 were asked to complete an online questionnaire. As in 2021, for 2022, there was also an option to complete via telephone for all respondents.

In 2017, the detailed and comprehensive Development and Well-Being Assessment (DAWBA) (Goodman et al., 2000) was used to assess a range of mental health conditions, including emotional, hyperactivity, behavioural and less common disorders, like autism. After interviews had been completed, trained clinical raters reviewed the data collected to assess for a range of mental disorders for each participant. The questionnaire also covered many aspects of people's lives that are linked to mental health, and this information can be used to profile the circumstances of children and young people with mental disorders. However in 2017, the Strengths and Difficulties Questionnaire (SDQ) was also included. For the 2020, 2021 and 2022 follow-up surveys, the DAWBA was not included and was replaced with the SDQ. This was mainly due to the shift towards an online survey during the pandemic, so a shorter, simpler questionnaire was deemed more suitable, whilst still producing robust estimates across the time series.

This report provides users with an evidence based assessment of the quality of the statistical output of the Mental Health of Children and Young People in England, 2022 publication by reporting against those of the nine European Statistical System (ESS) quality dimensions and principles. In addition to being appropriate to this output, these dimensions and principles are also consistent with the UK Statistics Authority (UKSA) Code of Practice for Official Statistics.

This section briefly describes how each of the nine quality dimensions applies to the publication. We will continue to provide clear and comprehensive information about the

methods used in our analysis and the quality of the data to assist users in interpreting our reports.

Relevance

This dimension covers the degree to which the statistical product meets user needs in both coverage and content.

From our engagement with customers, we know that there are many users of these statistics. They are used by the Department of Health and Social Care (DHSC), Office for Health Improvements and Disparities (OHID), the Department for Education (DfE), NHS organisations, charities, academics, educators, the public and the media. Uses of the data include: informing and monitoring policy; monitoring the prevalence of health or illness and changes in health or health related behaviours in children and young people; informing the planning of services for this age group; and writing media articles. Universities, charities and the commercial sector use the data for health and social research.

User needs have been gathered and considered at all points in the collection and publication of this information. This has been guided by a steering group consisting of representatives from NHS Digital, DHSC, Office for Health Improvements and Disparities, DfE, NHS England, the Children's Society, the Children's Commissioner for England, the Royal College of Paediatrics and Child Health, Children and Young People's Mental Health Coalition, the Royal Collage of Psychiatrists, a Young Service User Representative, academic leads in Child and Adolescent Mental Health, and academic leads in Contemporary Psychoanalysis and Developmental Science.

All information used in this publication is taken from a sub sample of MHCYP respondents in the 2017 survey. The 2017 survey had a sample of 9,117 respondents and the 2022 follow-up survey had a sub sample of 2,866 respondents. All surveys are subject to bias. Some people, for example those who live in an institution, could not have been selected to take part. Non-response means that some selected households or individuals could either not be contacted or refused to take part. Others may not have been well enough or may have lacked the cognitive capabilities to complete an online or telephone questionnaire. Social desirability biases may mean some people, did not answer fully or honestly. These limitations, while ameliorated to some extent with use of validated measures, weights, understanding of the population they relate to and how the data should appropriately be applied, should be acknowledged. The strengths and limitations of this information, detailed information on the survey methodology, and how the statistics in this report should be interpreted in light of this methodology can be found in more detail in the Survey Design and Methods Report for wave 2 and the wave 3 Technical Appendix.

Descriptions of concepts and terms used in this publication can be found at the start of each topic chapter or at the end in the Glossary. More detailed definitions can be found in the Survey Design and Methods Report.

The purposes of the survey, agreed following user engagement and guided by the steering group, were:

- To collect recent data on the state of children and young people's mental health during the pandemic in order to compare with 2017, 2020 and 2021.
- To estimate what proportion of children and young people in England are living with a mental disorder in 2022.
- Produce trends in disorders through comparisons with the MHCYP 2017, 2020 and 2021 surveys on a cross-sectional basis.
- Enable the circumstances of children and young people with different mental disorders to be compared with those of children and young people without a disorder.
- Improve understanding of the state of children and young people's mental health and wellbeing since the COVID-19 pandemic.
- Inform the design of mental health services for children and young people.

We try to engage with people to gain a better understanding of the uses and users of these statistics and to ensure they remain relevant and informative. This was done via the MHCYP Steering Group for the purpose of this follow up survey and reporting. An extensive public consultation was carried out for the main MHCYP 2017 survey which received 183 responses that were considered.

Feedback is very welcome at any time via [\[email protected\]](#).

Accuracy and reliability

This dimension covers the degree to which the statistical product meets user needs in both coverage and content.

As the data are based on a sample (rather than a census) of the population, the estimates are subject to sampling error. For the 2017 survey a stratified multistage random probability sample of 18,029 children was drawn from the 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. The sample was designed to be representative of the population of children and young people aged 2 to 19 living in England. A sub-sample was followed up for the 2022 survey via consent that was sought for such future research during the fieldwork for the MHCYP 2017 survey, and refreshed in the 2020 and 2021 surveys. The survey was introduced via a letter sent in advance of the survey going live online. The main characteristics of the sample are provided in Table A of the MHCYP 2022 data tables in Excel, alongside previous survey waves. Any differences in characteristics was accounted for in the MHCYP weighting methodology. Details of the weighting methodology can be found in the Weighting and non-response section of the [Survey Design and Methods Report](#)

One of the effects of using the complex design and weighting is that standard errors for survey estimates are generally higher than the standard errors that would be derived

from an unweighted simple random sample of the same size. The calculation of standard errors and comments on statistical significance has been included in the report, all of which have taken into account the clustering, stratification and weighting of the data.

Details of the sample design, response rates, survey methods, design effects, sampling errors, measurement errors and activities undertaken to understand and address sources of error, including piloting and cognitive testing of individual survey elements, are available in the Survey Design and Methods Report.

The uncertainty in how reflective the estimates produced are of the resident population is dependent on the size of the sample or sub sample achieved for each survey/wave. Each prevalence estimate must be understood to sit inside confidence intervals, giving a range of likely true prevalence values for the population. Confidence intervals are included for all estimates and are available on the right-hand side of each data table in Excel. Reported estimates which may be less precise are noted within each topic chapter. See the Survey Design and Methods Report for relative standard errors (RSEs) for key estimates, which provide further detail about the likely precision of these results.

Given the small number of respondents screening positive for a probable or possible disorder from certain groups within the population (for example, young people not in education, employment or training), the results of the survey may not find significant differences between estimates for these groups if the true differences are relatively small.

Throughout the report, comparisons between estimates are commented on where there appears to be a statistically significant difference between two estimates. Where estimates show no statistically significant difference, then this has been made clear in the text and worded appropriately (such as 'no change' or 'findings are similar').

Methods used to limit the likelihood of errors being introduced in the data capture, preparation and analysis stages of the production of this publication are detailed in the Survey Design and Methods Report. Further information regarding NatCen's quality assurance policies can be found at: <https://natcen.ac.uk/about-us/commitment-to-quality/>

As with all NHS Digital publications this publication has been subject to the NHS Digital Statistical Governance Policy, section 8 'Policy on Principle 4: Sound Methods and assured Quality' of which details NHS Digital's roles and responsibilities in quality assuring the methods and results of this publication. Quality assurance of methods and production standards began at the procurement stage with detailed quality standards and requirements being included in a detailed specification. Following the award of the contract to NatCen and the Office for National Statistics with support from researchers from the University of Cambridge and University of Exeter, ongoing quality assurance of methods was incorporated into regular contract management meetings and engagement with NHS Digital. Methods were also informed by the MHCYP Steering Group and drew upon a range of statistical and clinical expertise. Further details on the quality assurance of the methods used in this publication can be found in the Survey

Design and Methods Report.

Prior to publication results were subject to further quality assurance by NHS Digital, for example in checking for internal consistency, spotting any errors, ensuring that the report is clear and understandable and describes the data appropriately and objectively. This involved NHS Digital being provided with four draft versions of each topic chapter within the publication alongside associated reference tables and having the opportunity to comment on all aspects of the report at each stage. All aspects of the publications were reviewed and approved by the Lead Analyst for this publication prior to release.

Timeliness and punctuality

Timeliness refers to the time gap between publication and the reference period.

Punctuality refers to the gap between planned and actual publication dates.

Data collection for the follow-up survey was done via online or telephone questionnaires in April and May 2022 with results made available within 6 months of data collection.

Accessibility and clarity

Accessibility is the ease with which users are able to access the data, also reflecting the format in which the data are available and the availability of supporting information.

Clarity refers to the quality and sufficiency of the metadata, illustrations and accompanying advice.

The report is published online and is available free of charge. Excel tables are included with associated reference data.

Approved researchers seeking to undertake secondary analysis of the MHCYP 2017 follow up series will be able to apply for access via NHS Digital's Data Access Request Service (DARS) and the UK Data Service, more information is available on the [Population Health Data Access Webpage](#). Users interested in accessing data should contact [\[email protected\]](#).

Information on how users should interpret the results within this publication can be found in the [Survey Design and Methods Report](#), the wave 3 Technical Appendix and in the individual topic reports (for topic-specific guidance). Also, within the individual topic reports, there are references to other sources of information where users can find more information on the topics covered.

Coherence and comparability

Coherence is the degree to which data, which have been derived from different sources or methods but refer to the same topic, are similar. Comparability is the degree to which data can be compared over time and domain.

This is the third in a series of follow-up reports to the 2017 MHCYP survey. One of the key aims of the follow up surveys is to be able to compare children and young people's mental health between 2017, 2020, 2021 and 2022, overall and by sub-group (age and sex).

It is important to note that while the mental disorder prevalence estimates presented in this report are based on the Strengths and Difficulties Questionnaire (SDQ), the initial MHCYP 2017 survey used the Development and Well-being Assessment (DAWBA) (and drew on a larger sample (9,117 children and young people, aged 2 to 19 years old) which was used for reporting in MHCYP 2017, even though SDQ was also conducted.

It was decided that the SDQ was more suited to a shorter survey conducted online in 2020, 2021 and 2022, which still gave robust estimates on children and young people's mental health. <> When the 2022 report was produced, comparable SDQ measures were produced for 2017, 2020, 2021 and 2022 for mental disorder prevalence estimates.

Estimates in the MHCYP 2020 report were based on the 3,570 children and young people who took part in both the 2017 and 2020 surveys with estimates for both 2017 and 2020 based on this to allow like-for-like comparisons. This was seen as a strength in the survey methodology at the time. This methodology was reviewed for the 2021 report.

For the MHCYP 2021 and 2022 reports the full 2017 sample of 9,117 children and young people is used for the 2017 estimates. The decision to use the full 2017 sample for 2017 estimates in the MHCYP 2021 report was taken after assessing alternative options whilst considering the sample size to be used for 2021 estimates. Further details can be found in the Methodological Change Notice with some sensitivity analysis available in the Survey Design and Methods Report. The change in method also has the added benefit that if future follow up surveys of the 2017 cohort are conducted no further changes to the MHCYP 2017 estimates will be required.

Therefore, any comparisons between 2017, 2020, 2021 and 2022 must draw on the results presented in this report, which are based on a comparable measure of the SDQ using children that were aged between 7 to 19 at the time of each survey.

Furthermore, direct comparisons with the MHCYP 2017 estimates are not advised due to the changes in survey design, such as the 2017 survey was conducted face to face while the 2020, 2021 and 2022 follow-ups were completed online (or telephone in 2021 and 2022).

Trade-offs between output quality components

This dimension describes the extent to which different aspects of quality are balanced against each other.

Within this publication different aspects of quality have been balanced against each other in order to best meet the aims of the survey. For example, in order to best understand the prevalence of mental health disorders in the population, a survey of the resident population has been used. This allows for the results of this survey to be used to examine the 'treatment gap'. That is, the survey data can be used to explore what proportion of children and young with a condition are not in contact with services nor in receipt of any treatment, or who are in receipt of inappropriate treatment. This information would not be available if other methods of collection were used, such as sampling from lists of patients in contact with mental health services.

As this is a follow up to the 2017 survey, it is advised to look at the [MHCYP 2017 Background Data Quality Statement](#) for further background.

The 2022 survey was designed to represent the whole population of English children and young people. The statistics based on this survey are not the actual rates; instead they are estimates subject to a margin of error, which is presented in the form of a 95% confidence interval.

Confidence intervals are used to make inferences about the values of a variable within a population (such as the prevalence of mental disorders in children and young people). They aid interpretation of data by identifying the range, within which, the true population percentage (or another summary statistic) most likely lies. Typically, 95 per cent confidence intervals are calculated. These indicate that that if several random samples were drawn from the population the true percentage for a variable would lie within this range in 95 per cent of the samples. Confidence intervals are influenced by the size of the sample on which the estimate is based. Larger sample sizes typically result in smaller confidence intervals and, therefore, more precise estimates.

The 2022 survey utilised a complex sample design. Furthermore, weights were applied when obtaining survey estimates. Using complex designs and weighting can increase standard errors and confidence intervals for survey estimates compared to those that would be derived from an unweighted, simple, random sample of the same size. Standard errors have been calculated, taking sample design complexity and weighting into account.

The design factor (Deft) estimates the effects of design complexity on the precision of estimates. Specifically, it represents the ratio of the standard error under a complex design and the standard error that would have resulted from a simple random sample. For example, a design factor of 3 indicates that standard errors are three times as large as they would have been in the case of a simple random sample.

Confidence intervals have been presented for all key estimates in the data tables published on the NHS Digital website. The calculations were carried out using the statistical software R – with an additional procedure written to account for the effect of weighting to account for the complex sample design.

Details of the strengths and limitations of the results of this survey are detailed in full in

the Survey Design and Methods Report and wave 3 technical appendix.

Assessment of user needs and perceptions

This dimension covers the processes for finding out about users and uses and their views on the statistical products.

From our engagement with customers, we know that there are many users and uses of these statistics. Details of these uses and users have been included in the 'Relevance' section of this Data Quality Statement, along with details of previous consultations on this survey series. Regular consultation with customers and stakeholders is undertaken before each follow up survey to ensure that developments introduced to this publication and other NHS Digital publications meet their requirements.

Performance, cost and respondent burden

This dimension describes the effectiveness, efficiency and economy of the statistical output.

The 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 the 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. This was conducted via online questionnaires for the MHCYP 2022 follow-up survey (based on consent obtained for future research originally during MHCYP 2017 fieldwork, and refreshed during 2020 and 2021) and questionnaires completed as follows :

Online

- 7 to 10 year olds: parent online questionnaire (17.36 minutes)
- 11 to 16 year olds: child online questionnaire (11.20) and parent online questionnaire (19.58 minutes)
- 17 to 19 year olds: young person online questionnaire (18.96)
- 20 to 24 year olds: young person online questionnaire (17.58)

Telephone

- 7 to 10 year olds: parent telephone questionnaire (37.08 minutes)
- 11 to 16 year olds: child telephone questionnaire (23.42) and parent telephone questionnaire (39.62 minutes)

- 17 to 19 year olds: young person telephone questionnaire (38.66)
- 20 to 24 year olds: young person telephone questionnaire (39.99)

More details of the survey methodology and associated burden can be found in the [Survey Design and Methods Report](#)

Confidentiality, transparency and security

The procedures and policy used to ensure sound confidentiality, security and transparent practices.

No personal/individual level information is contained in the report. Information is presented at a high level of aggregation. As for all NHS Digital publications the risk of disclosing an individual's identity in this publication series has been assessed and the data are published in line with a Disclosure Control Method for the dataset.

Please see links below to relevant NHS Digital policies:

Statistical Governance Policy

<https://digital.nhs.uk/data-and-information/find-data-and-publications/statement-of-administrative-sources/a-z-of-nhs-digital-official-and-national-statistics-publications#user-documents>

Freedom of Information Process

<https://digital.nhs.uk/about-nhs-digital/contact-us/freedom-of-information>

A Guide to Confidentiality in Health and Social Care

<https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe>

Privacy and Data Protection

<https://digital.nhs.uk/about-nhs-digital/privacy-and-cookies>

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Technical appendix

Introduction

This appendix provides an update on the methodology used in the Mental Health of Children and Young People (MHCYP) 2022 follow up survey and contains information on any changes in methodology since the wave 2 survey that took place in 2021.

For all methodological details, including methodology that has not changed since the wave 2 follow up survey, see the [2021 Survey Design and Methods Report](#).

Sample design

The MHCYP 2022 sample was based on children and young people who took part in the 2017 MHCYP survey. All participants in the 2017 survey who agreed to be recontacted for future research during their interview and continued to agree to be recontacted during the 2020 survey and the 2021 survey if they participated in either or both of these, were invited to take part in the 2022 survey.

Consent to recontact was received for 7,351 children and young people aged 7 to 24 years. Contact details were updated using the NHS Patient Register database and any sampled children who were flagged as either passed away or not to be approached for data collection were removed. This resulted in a final issued sample of 7,253 children and young people (Table 1).

Table 1: Issued sample for the MHCYP 2022 survey

	Number
Achieved interviews in MHCYP 2017	9,117
Agreement to recontact for MHCYP 2022	7,351
Eligible for recontact in MHCYP 2022	7,253

Questionnaire content

The MHCYP 2022 data were collected via Computer Assisted Web Interview (CAWI) and

Computer Assisted Telephone Interview (CATI), with the type of questionnaire administered dependent on the age of the sampled child or young person (see Table 2).

Table 2: Types of questionnaires for children and young people of different ages, MHCYP 2022

7 to 10 year olds	11 to 16 year olds	17 to 24 year olds
Parent questionnaire only	Parent questionnaire and child questionnaire	Young person questionnaire only

Information on a variety of topics were collected either through questions developed specifically for this survey or using standardised measures. The full questionnaire can be found in the [questionnaire and materials documentation](#). The broad themes covered are listed below.

MHCYP 2022 topic coverage for children aged 7 to 16 years in the parent questionnaire:

- Demographics, household composition and tenure
- Employment status
- Strengths and Difficulties Questionnaire (SDQ)
- Self-harm
- General Health Questionnaire (GHQ-12)
- Loneliness
- Family functioning
- Service contact
- Outcome of service contact and waiting lists
- Physical health of child and COVID-19 status
- Education
- Special educational needs or disabilities (SEND)
- Household circumstances and changes
- Eating, sleeping and activities
- Consent to data linkage and future research

MHCYP 2022 topic coverage for children aged 11 to 16 years in the child questionnaire:

- Strengths and Difficulties Questionnaire (SDQ)
- Short Warwick-Edinburgh Wellbeing Scale (SWEMWBS)
- Loneliness
- Family functioning
- Neighbourhood

- Service contact
- Education
- Eating, sleeping and activities
- Social media

In 2022, children aged 16 years and their parents were asked the consent questions on data linkage and future research whereas in 2017, 2020 and 2021 only parents were asked this.

MHCYP 2022 topic coverage for young people aged 17 to 24 years:

- Demographics, household composition and tenure
- Education and employment
- Strengths and Difficulties Questionnaire (SDQ)
- General Health Questionnaire (GHQ-12)
- Loneliness
- Self-harm
- Psychotic-like experiences
- Family functioning
- Service contact
- Outcome of service contact and waiting lists
- Education or work
- Physical health and COVID-19 status
- Household circumstances and changes
- Eating, sleeping and activities
- Social media
- Feelings about the future
- Consents to data linkage and future research

Standardised measures

In the MHCYP 2022 survey the family connectedness scale was no longer included.

All other standardised measures included in the 2021 survey were also included in 2022. These are detailed in the [2021 Survey Design and Methods Report](#).

Table 3 presents the additional standardised assessment tools that were included in the MHCYP 2022 survey that were not included in the 2021 survey.

Table 3: Assessment tools added to MHCYP 2022

Topic	Assessment tool	Questionnaire
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Wellbeing	Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS)¹	Child
	SWEMWBS enables the monitoring of mental wellbeing in the general population. This survey used the 7-item scale. Further information can be found at https://warwick.ac.uk/fac/sci/med/research/platform/wemwbs/	
Psychotic-like experiences	The Adolescent Psychotic-Like Symptom Screener (APSS)²	Young people
	APSS is designed to assess a variety of psychotic symptoms over the past 12 months. The screener has 7-items with 3 possible response options: 'yes, definitely', 'maybe' and 'no, never.' Being 'at-risk' for psychotic-like experiences was defined as scoring 2 or more out of a possible 7 points. Further information can be found at: https://pubmed.ncbi.nlm.nih.gov/19542527/	

1. Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) © NHS Health Scotland, University of Warwick and University of Edinburgh, 2006, all rights reserved.

2. Kelleher, Harley, Murtagh, & Cannon, 2011

The Short Warwick Edinburgh Mental Wellbeing Scale was previously included in the 2020 survey. The Adolescent Psychotic-Like Symptom Screener (APSS) has not been included in any of the previous MHCYP surveys.

Measuring mental health

The MHCYP 2022 used the Strengths and Difficulties Questionnaire (SDQ) to assess the likelihood of a possible or probable mental disorder in children and young people.

Responses provided in the SDQ were combined using the pseudo diagnostic algorithm to indicate whether each child or young person was unlikely, possibly or probably demonstrating a mental health condition in the following domains: emotional, behaviour and hyperactivity disorders. This algorithm combines data from all available participants. Table 4 presents the participants used to inform the identification of unlikely, possible or probable mental disorder for the 2022 survey by age.

More information on the SDQ and the participants that were used for previous surveys is available in the 2021 Survey Design and Methods Report.

Table 4: Participants feeding into classification of unlikely, possible or probable mental disorders, by age

	7 to 10 year olds	11 to 16 year olds	17 to 24 year olds
2022 score	Parent questionnaire (online or telephone administered)	Parent questionnaire (online or telephone administered)	Young person questionnaire (online or telephone administered)
		Child questionnaire (online or telephone administered)	

Invitation letters

An invitation letter and information leaflet were sent to each sampled address. The letter was addressed to the parent or carer of the sampled child for children aged 7 to 16 years inviting the parent to take part. For those aged 11 to 16 years, the letter also invited the sampled child (via instruction to the parent) to take part.

For young people aged 17 to 24 years, the letter was either addressed to the parent or carer of the young person or the young person directly, depending on how consent to recontact was obtained in the 2017, 2020 or 2021 surveys. If the young person was old enough to give their own consent to be recontacted the last time they took part in the survey series, then the letter was addressed to the young person inviting them to take part. If the last time the young person had taken part it was their parent or carer that had given consent to be recontacted, then the letter was addressed to the parent or carer asking the young person to take part in the survey.

The letter explained how to complete the questionnaire online. An example of the advance letter is provided in the [questionnaire and materials documentation](#).

A copy of the survey information leaflets (1 aimed at parents and young people, and 1 aimed at children aged 11 to 16 years) is also available in the [questionnaire and materials documentation](#).

Data collection and survey response

The fieldwork took place over 7 and a half weeks (4 April to 25 May 2022). Participants

who had not responded 3 weeks into the survey period received a reminder letter. A copy of the reminder letter can be found in the [questionnaire and materials documentation](#).

Telephone interviews started 1 week after the online questionnaire had launched. The telephone unit phoned those participants that had not yet completed the online survey and offered support with the online survey or the ability to complete via telephone. The telephone unit focussed for the first week on ethnic minority participants and those living in the most deprived areas, before opening up to the whole sample. In addition to reminder letters, 2022 participants were also sent text and email reminders (where contact details were available). As a thank you for their participation, a £10 shopping voucher was given to each household that completed the questionnaire.

Table 5 presents the response rate to the survey, by age of the sampled child or young person. Of the 7,253 children and young people aged 7 to 24 years approached to take part, responses were received from 2,866 (40% response rate) children and young people or their parents/carers (following data cleaning and validation). Of these, 603 participants completed the survey via telephone. There were 1,682 children and young people who took part in the 2017, 2020, 2021 and 2022 surveys.

Table 5: Survey response by age of sampled child or young person, MHCYP 2022

	7 to 10 years	11 to 16 years	17 to 19 years	20 to 24 years	7 to 24 years
Issued sample	1,722	2,832	1,245	1,454	7,253
Cases with a phone number	1,679	2,668	1,158	1,390	6,895
Eligible achieved ¹ online or telephone / response rate	853 (50%)	1,052 (37%)	468 (38%)	493 (34%)	2,866 (40%)
Telephone completion	183	202	93	125	603
Child completion (online or telephone)		717 (25%)			

1. Eligible achieved are cases where interviews were achieved online or by telephone which have been validated and therefore have been used in the final analysis.

The response rate for those in the ethnic minority groups was 36% and 40% for those in the white ethnic group.

Table 6 presents the average questionnaire completion length by age of the sampled

child or young person.

Table 6: Average length of time to complete the questionnaire (minutes) by age of sampled child or young person, MHCYP 2022

	Online ¹ Parents/ young people	Online ¹ Child	Telephone ² Parents/ young people	Telephone ² Child
7 to 10	17.36	n/a	37.08	n/a
11 to 16	19.58	11.20	39.62	23.42
17 to 19	18.96	n/a	38.66	n/a
20 to 24	17.58	n/a	39.99	n/a

1. Based on those who took an hour or less to complete the questionnaire and reached the final timestamps. Outliers above 60 minutes were removed from this table.

2. Based on those who took 2 hours or less to complete the questionnaire and reached the final timestamps. Outliers above 120 minutes were removed from this table.

Weighting and non-response

The survey data were weighted to take account of non-response, so that the results were representative of the population aged 7 to 24 years in England.

The weighting method was consistent with the method used in 2021 as detailed in the 2021 Survey Design and Methods Report.

As in previous waves, calibration was used to ensure the weights sum to population totals. Due to the children and young people being older in 2022 than in 2021, the calibration groups were updated, and the achieved sample of 2,866 children and young people were calibrated to 2022 population totals. Calibration was split into 2 partitions. These are outlined in Table 7.

Table 7: Calibration of the 2022 cross-sectional weights to population totals

2022 cross-sectional weight
Age bands (age at 31 August 2022) by sex (Age bands = 7 to 10, 11 to 16, 17 to 19, 20 to 24)
Age bands (age at 31 August 2022) by region (former government office regions)

□

(Age bands = 7 to 10, 11 to 16, 17 to 24)

Data analysis and reporting

The age of the children and young people taking part has increased over time with the analysis based on the age of the sampled child or young person at specific points in time:

- in 2017 they were aged 2 to 19 years based on their age on 31 August 2017
- in 2020 they were aged 5 to 22 years based on their age on 31 August 2020
- in 2021 they were aged 6 to 23 years based on their age on 31 August 2021
- in 2022 they were aged 7 to 24 years based on their age on 31 August 2022

Therefore, the age groups used for analysis have been updated to reflect this.

In the MHCYP 2022 report, the cross-sectional analyses comparing 2017, 2020, 2021 and 2022 were based on those aged 7 to 16 years and 17 to 19 years, as these age groups were present at every wave. Comparisons between 2020, 2021 and 2022 are available for those aged 20 to 22 years for some questions and comparisons between 2021 and 2022 are available for those aged 20 to 23 years for some questions. The 2022 survey was the only one to capture 24 year olds; therefore, some standalone estimates for those aged 17 to 24 years have been included for 2022 where appropriate. There were no longer any 6 year olds in the cohort by 2022.

Analysis for 2017 includes the 9,117 children and young people who took part in the survey in 2017 (of these 6,419 were aged 7 to 19 years with 6,416 having a valid mental health category based on the SDQ). Analysis for 2020 includes the 3,570 children and young people who took part in the 2020 survey (of which 3,153 were aged 7 to 22 years), and analysis for 2021 draws on data from the 3,667 children and young people who took part in 2021 (of which 3,512 were aged 7 to 23 years). Analysis for 2022 includes all the 2,866 children and young people who took part in the 2022 survey.

The characteristics of the sample in 2017, 2020, 2021 and 2022 can be found in Table A in the associated [Excel data tables](#).

All analysis presented is cross-sectional with no longitudinal analysis included in the 2022 report. Throughout the report confidence intervals have been used to determine if differences between estimates are statistically significant. Estimates are considered very likely to be different if their confidence intervals do not overlap. No additional statistical hypothesis testing has been performed. Further details on confidence intervals are available in the [2021 Survey Design and Methods Report](#).

Data access for approved researchers

Approved researchers seeking to undertake further secondary analysis of data from the 2017, 2020, 2021 and 2022 surveys will be able to access the data from the UK Data Service under Special User Licence. Applicants will need to apply for permission to use the data via NHS Digital Data Access Request Service. Once approval has been granted, the data can be downloaded from the [UK Data Service](#). You can find out more about access at the UK Data Service webpage and the [Population health surveys - NHS Digital](#) webpage.

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Adolescent Psychotic-Like Symptom Screener (APSS)

[APSS](#) is designed to assess a variety of psychotic symptoms over the past 12 months. The screener has 7-items with 3 possible response options: 'yes, definitely', 'maybe' and 'no, never.' Being 'at-risk' for psychotic-like experiences was defined as scoring 2 or more out of a possible 7 points.

Children and young people with a probable mental disorder

The [Strengths and Difficulties Questionnaire \(SDQ\)](#) was used to identify children who may have had problems with aspects of their mental health to such an extent that it impacted on their daily lives. These include difficulties with their emotions, behaviour, relationships, hyperactivity, or concentration. Responses from parents, children and young people were used to estimate the likelihood that a child or young person might have a mental disorder, this was classified as either 'unlikely', 'possible' or 'probable'.

The initial [MHCYP 2017 report](#) used a different and more detailed diagnostic assessment of mental disorder, the [Development and Well-Being Assessment \(DAWBA\)](#), which drew on reports from young people, parents, and teachers and involved clinical consensus rating. Any comparisons between 2017, 2020, 2021 and 2022 must therefore draw on the

results presented in this report, which are based on a comparable measure (the SDQ).

Confidence interval

A measure of the statistical precision of an estimate and shows the range of uncertainty around the calculated estimate. Lower and upper 95% confidence intervals are provided in the [Excel data tables](#). At the 95% confidence level, over many repeats of a survey under the same conditions, one would expect that the confidence interval would contain the true population value 95 times out of 100. Narrower confidence intervals (difference between lower and upper interval) indicate a more precise estimate.

Statistical significance

The statistical significance of differences noted within the report are determined based on non-overlapping confidence intervals.

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