The National Study of Health and Wellbeing: Children and Young People 2017

Interviewer project instructions
P11529
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1 Overview and background of the survey

1.1 Our client
The National Study of Health and Wellbeing: Children and Young People 2017, has been commissioned by:

NHS Digital (formerly the Health and Social Care Information Centre – HSCIC)

To explain who they are, their website says:

“NHS Digital is the new name for the Health and Social Care Information Centre. We exist to improve health and care by providing national information, data and IT services for patients, clinicians, commissioners and researchers. NHS Digital collects, safeguards and analyses health care data and information to support better outcomes and world-leading research”.

1.2 Background to survey / Previous surveys
The Survey of the Mental Health of Children and Young People (MHCYP) 2017 (which will be called the 'National Study of Health and Wellbeing: Children and Young People' in the field) will be the first survey of children and young people to focus on mental health since 2004. The survey will collect robust data on a range of topics relating to the mental health of children and young people.

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

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

- in lone parent (16%) compared with two parent families (8%)
- in reconstituted families (14%) compared with families containing no stepchildren (9%)
- whose interviewed parent had no educational qualifications (17%) compared with those who had a degree level qualification (4%)
- in families with neither parent working (20%) compared with those in which both parents worked (8%)
- in families with a gross weekly household income of less than £100 (16%) compared with those with an income of £600 or more (5%)
- in households in which someone received disability benefit (24%) compared with those that received no disability benefit (8%)
- in families where the household reference person was in a routine occupational group (15%) compared with those with a reference person in the higher professional group (4%)
- living in the social or privately rented sector (17% and 14%) compared with those who owned accommodation (7%)
- living in areas classed as ‘hard pressed’ (15%) compared with areas classed as ‘wealthy achievers’ or ‘urban prosperity’ (6% and 7%).

One in five children with a disorder were diagnosed with more than one of the main categories of mental disorder (emotional, conduct, hyperkinetic or less common disorders).

Since these results are from 2004, they are now outdated but are still being used to inform local and national commissioning decisions. The primary aim of the 2017 survey is to provide updated estimates of the prevalence of mental disorders in England and Scotland. The 2017 survey will focus on 2-19 year olds, so we will be looking at two new age groups – 2-4 year olds and 17-19 year olds.
The 2017 survey consists of:

- Face-to-face and self-completion questionnaires with parents;
- Face-to-face and self-completion questionnaires with children and young people aged 11-19;
- Self-completion questionnaires (either paper or online) with teachers of children aged 5-16.

For each of these questionnaires, the diagnostic tool for assessing child mental health – the Development and Wellbeing Assessment (DAWBA) – and the Strengths and Difficulties Questionnaire (SDQ) comprise a large part of the questionnaire. The DAWBA is a standardised tool used to measure the presence of mental disorders in children and young people. It is a detailed measure of mental health, whereas the SDQ is a more brief measure. Both the DAWBA and SDQ were developed by Professor Robert Goodman of YouthInMind (see section 1.3 below for more about YouthInMind). The DAWBA collects information about the presence of symptoms of a range of common mental disorders like depression and anxiety and on less common disorders such as eating disorders and autism. This is the same tool that was used in previous surveys and is the key element which allows for the measurement of the prevalence of mental disorders in children and young people. The DAWBA tool involves collecting information about a respondent from three potential sources (the respondent themselves, a parent, and a teacher) – this ‘multiple informant interviewing’ allows for much more accurate diagnoses to be made.

1.3 The Consortium

NatCen Social Research are carrying out the study alongside the Office for National Statistics (ONS), and YouthInMind.

NatCen are the overall project lead, and are responsible for agreeing the survey content, respondent materials, and processing the data you will be collecting.

NatCen have carried out the two most recent surveys in the adult mental health series.

ONS are responsible for the sample design, questionnaire programming and weighting of the results.

ONS carried out all the previous surveys in the child mental health series, including the 1999 and 2004 surveys and the 2007 follow-up study.

Both NatCen and ONS will be sharing interviewing of respondents and writing the final report.

YouthInMind, a company set up by Professor Robert Goodman (Kings College London), working with Professor Tamsin Ford (University of Exeter), will be providing clinical expertise throughout the survey, and specifically overseeing
the clinical assessment of children's mental health using the responses you will be collecting from children and parents.

Professor Goodman developed the initial MHCYP survey, including writing the clinical assessment tools (the DAWBA and SDQ) from scratch, and development of the multiple informant design and clinical rating process (you can find out more here: www.youthinmind.com). Professor Goodman has written a short piece below, specifically for these instructions, explaining the importance of the survey.

1.4 Notes on Children and Young People’s Mental Health (Robert Goodman)

The importance of the 2017 survey of child and adolescent mental health

Increasingly, mental health problems affect the lives of children and their families: conditions such as anorexia nervosa, autism, ADHD, obsessive-compulsive disorder, challenging behaviour, post-traumatic stress disorder, depression and bipolar disorder. These mental health problems have been neglected, with far less spent on treating them than on treating physical disorders.

It was a great step forward when the government carried out national surveys of child mental health in 1999 and 2004. These surveys showed the government how common the problems were, and did a lot of good in terms of stimulating spending on clinical services, prevention, early intervention and treatment. The 1999 and 2004 surveys also helped policy makers and clinics plan service provision on the basis of good national data on how common the various disorders were in different places.

The original idea was to repeat the national survey of child mental health every 5 years, but there has been a 12 year gap since the last survey in 2004 – so collecting up-to-date information from the new 2017 survey is vital for planners. We will also learn whether child mental health has deteriorated since 2004, as some psychologists and doctors suspect.

The new survey is not just a repeat of the old survey – although it uses many of the previous measures for the sake of continuity, there are some exciting new features. Previous surveys covered 5-17 year olds, whereas the new survey covers 2-19 year olds. Inclusion of preschool children for the first time reflects concern that mental health issues in the early years may have a large and lasting impact on children's subsequent adjustment and progress in school. Inclusion of 19 year olds will help examine transition from youth to adult services. The 2017 survey will also break new ground in other ways. For example, it will look at cyber-bullying and at the extent to which children and teenagers are seriously dissatisfied with various aspects of their appearance.

One reason previous surveys in this series were so widely appreciated is that they relied not just on yes-no questions, but also collected a lot of open-ended comments from respondents that were then reviewed by very experienced child
psychologists and psychiatrists. This expert review made the subsequent diagnostic ratings much more clinically believable and relevant. In this survey, you will be playing a vital part in collecting open-ended comments – something that not only improves the quality of the data but that also makes the whole process more interesting for the respondents and you too.

1.5 Ethics

This survey gained ethical clearance from an NHS Health Research Authority ethics committee in April 2016, reference 16/LO/0155.
2 Fieldwork and Sample design

2.1 Overview (field periods etc)

Field periods

The fieldwork period runs from January to August 2017.

Fieldwork dates for each Wave are shown below, with work on each starting once you have attended a briefing.

Fieldwork dates

<table>
<thead>
<tr>
<th>Wave</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wave 1</td>
<td>16/01/2017</td>
<td>05/03/2017</td>
</tr>
<tr>
<td>Wave 2</td>
<td>06/03/2017</td>
<td>16/04/2017</td>
</tr>
<tr>
<td>Wave 3</td>
<td>17/04/2017</td>
<td>28/05/2017</td>
</tr>
<tr>
<td>Wave 4</td>
<td>10/04/2017</td>
<td>28/05/2017</td>
</tr>
<tr>
<td>Wave 5</td>
<td>29/05/2017</td>
<td>17/07/2017</td>
</tr>
</tbody>
</table>

NB. Waves 1, 2 & 3 cover 5-16 year olds; Waves 4 & 5 cover 2-4 year olds and 17-19 year olds.

Sample

The sample design is as follows:

- The sample currently covers England only, though there may be some interviews in Scotland at a later point.
- We have selected children/young people in England from the Medical Research Information Service Integrated Database Administrative System (‘MIDAS’ – the NHS Patient Register). The register includes a range of information including the names, ages and addresses of people who have registered with a GP or visited an NHS Hospital.
- It is a named sample.
- As well as being a named sample, we also know the age of each child/young person. We drew the sample based on the child/young person’s ‘school year age’ – i.e. the age they will turn by the end of the school year (31st August 2017). By doing this, all children at reception through to Year 11 will be eligible for the teacher component of the survey. In addition, we’ll be conducting analysis based on school year. Therefore, some respondents may actually be younger when you interview them but they are ‘set’ on the ARF and in the CAPI as their sampled age. So although you will still collect their DOB, even if they are
a ‘year younger’ at interview, they will be set on the ARF and in the CAPI as the age when sampled.

- To get as full a picture from the data as possible we need a high response to all the different aspects of the survey – full parent and child interviews, full young people interviews (with a parent interview if possible), the self-completions (administered as Computer Assisted Self Interviewing), consent to data linkage, consent to contact for future studies and consent to teacher contact. This will help us to ensure the data collected is as high quality as possible, which will in turn enable local and national commissioners to plan appropriate support for children and young people.

2.2 Privacy

Parent interviews

It is very important that the only people present during the interview with the parent are you and the parent. Any children in the household, including the child who is the subject of the interview, should not be present during the interview. Most children aged 5-16 will not be home during school hours. If you interview the adult outside of school hours it could mean that the child will have to be left in another room on his/her own. If the parent is unhappy about this it may be necessary to re-arrange a time for the interview when another adult can be present to take care of the sampled child.

Child (11-16) interviews

Children aged 11-16 years will also be interviewed themselves, where appropriate, and will complete a self-completion (CASI) questionnaire as part of this. In order to work on this survey, all interviewers have completed an Enhanced DBS (Disclosure and Barring Service) check and are requested to conduct interviews with children without their parent in the room. Naturally, some parents may be uncomfortable about leaving you alone with their child. If the parent does express concern, try to reassure them. If they are insistent on being present during the child interview, then please continue on this basis, using the following technique:

- Please proceed by sitting side by side with the child so that they can see the computer screen and can either point to the answers or type in the answers themselves (in effect, doing the whole interview as a self-completion). If this is not possible; forego the child’s interview.

Young person (17-19) interviews

Young people aged 17-19 years can give their own consent for taking part. They will be interviewed face-to-face and will also complete a self-completion (CASI) questionnaire. It is essential that young adults aged 17-19 are interviewed on their own. If a parent does insist on being in the room, please
follow the same technique described above.

2.3 Significant problems

As part of the psychiatric assessment of children, we ask both parents and children/young people to describe ‘significant problems’ that the child/young person may have when they occur in the conversation. You may find that the parent or child/young person will talk about the problems when they are first mentioned in conversation, rather than at the place in the questionnaire designed to get more details about these. We have therefore created a parallel block for the significant problems section for both the parent and child/young person, which means you can access this section at any point in the interview. This will enable you to type in verbatim comments about specific problems whenever they occur in the interview. You need to make sure you have pressed the Save button before you exit the box, so that all the entries are retained. It would also be helpful if you could add the question label if you are writing comments on a specific question, so that we can identify which comments refer to which questions.

After each topic section within the DAWBA, there are 5 to 6 open-ended questions. Parents and children will be asked these questions if they have highlighted a mental health issue through their answers to the closed-ended questions within that topic section.

Please ensure that you never use the child’s name in your comments.

These comments are sent, along with the DAWBA response, to Robert Goodman and his team of clinicians for diagnostic work to take place. We cannot send potentially identifiable data outside of NatCen/ONS so it is extremely important that the child’s name is never used in your comments – you could instead use an initial/letter or just ‘the child’.

2.4 Language problems

In some households, the parents may have difficulty understanding English. The concepts of the interview are too difficult for the use of an interpreter and the subject matter too sensitive.

For respondents aged 2-16, if the parent/guardian you initially speak to does not speak enough English, your first step should be to see whether the other parent/guardian speaks sufficient English to do a face-to-face interview with you. If neither parent can speak sufficient English then you can use the translated screening card to find out which language they speak. This card has been translated into the ten most prevalent languages spoken in England. The card introduces the survey and lets the participant know what taking part will involve. If they consent to taking part they will be sent a short paper Strengths & Difficulties Questionnaire (SDQ) that has been translated into the relevant language. Please code in the admin block which language SDQ they will need.
The Brentwood office will then send the participant a translated SDQ in the post, with a pre-paid return envelope for the participant to send it back in.

There may be situations where the parent (who cannot speak sufficient English) gives permission for you to interview the child (aged 11-16) because they can speak sufficient English. We are not able to do this because we would not be obtaining the initial ‘factual’ part of the questionnaire from the parent interview (the household grid, relationship information etc.). In this situation, we would therefore forgo the child interview and just obtain the translated parent SDQ (if the parent agrees).

For respondents aged 17-19, as long as they themselves speak sufficient English to do a face-to-face interview with you, you can continue with the interview. If they do not speak sufficient English, please follow the same process outlined above – use the translated screening card so that an appropriate translated SDQ can be sent out. In these situations, you will not need to interview the parent or offer them a translated SDQ – you will only need to try and gain agreement for the young person to be sent an SDQ.
3 Interview Documents and Interviewing Procedure

3.1 Interviewer documents
Here is a list of all survey documents and tools that you will be using:

Doorstep documents:
- Advance letter laminate/reference copy
- Parent, child & young person information leaflets
- Translated screening card
- ‘Sorry I Missed You’ letter
- Address Record Form (ARF) (3 different versions)

Documents needed during the interview:
- Parent showcards
- Child/Young Person showcards
- Data linkage consent forms (parent and young person)
- Useful contacts leaflet
- Teacher contact card

Reference documents/tools:
- Project instructions
- Safeguarding training booklet
- Study webpage
  - Natcen: www.natcen.ac.uk/NSHW
  - ONS: www.ons.gov.uk/NSHW
3.2 Advance materials

Advance letter

The advance letters will be sent out to participants from NatCen’s Brentwood office ten days\(^1\) before your fieldwork is due to start. For children aged 2-16, the letter will be addressed to the parent/carer (not named) of the pre-selected, named child whom the interview will be about. For young people aged 17-19, the letter will be addressed directly to them. The letters include a £10 post office cash voucher. This incentive is not conditional on the household taking part in the study.

On the doorstep, when you have introduced yourself, tell the respondents a little bit about the National Study of Health and Wellbeing. You will receive an example letter (laminated) which you can show to remind respondents.

There are also some spare copies of the letter in your work pack in case someone who doesn’t remember receiving the letter, or who has lost it, would like a copy to keep.

Information leaflets

There are three types of survey information leaflets that can be used, depending on the age of the participant. One for parents, one for children and one for young people aged 17-19. They are colour coded to help you differentiate between them – the parent leaflet has a blue tree design, the young person leaflet has a purple tree design and the child leaflet has a yellow tree design. Read these through before you start work as they will help you to answer some of the questions participants might have.

These information leaflets are not sent out with the advance letter.

Participants will not have seen these yet so you can use them on the doorstep to help gain cooperation. Once an appointment has been made, leave the appropriate leaflet with the respondent. This helps ensure informed consent.

\(^1\) This is slightly earlier than we might normally send out advance letters at NatCen but is a stipulated ethical requirement.
Showcards

There are two types of respondent showcards – one set is for use in the parent interview and one is for use in the child/young person interview. You will receive one of each in your workpack.

Useful Contacts leaflet

This leaflet lists useful contacts for participants to call or to find out more information about any of the issues that may come up during the interview, should they want to. Leave one copy with the parent and one copy with the child/young person; the CAPI will instruct you when to give them out.

Teacher contact card

If the parent and child (aged 5-16) give consent to one of the child’s teachers being contacted by us to complete a short questionnaire, please give the participant a teacher contact card and ask them to sign or print their name and their child’s name. The child can then give this card to their chosen teacher to make them aware of the survey and aware that they will receive an email and letter from us about the questionnaire (see section 5.5 Teacher questionnaire). There is no more you will need to do – the email and letter will be sent out from the office.

Translated screening card

The translated screening card can be used if a participant does not speak English. It contains a short paragraph that introduces the survey and tells them that if they consent, they (and their child) will be sent a short paper questionnaire to fill in. This has been translated into the ten most prevalent languages spoken in England.
‘Sorry I missed you’ letter

This is a letter for you to use if you are struggling to make contact at an address. It explains a little about the study and has space for you to write your name and telephone number so that the respondent can call you to arrange a convenient time for you to go back. You will receive several of these in your workpack, to use as and when you need them.

3.3 Interview process

The survey consists of:

- Face-to-face and self-completion (CASI) questionnaires with parents of children aged 2-16 (and where possible, parents of young people aged 17-19);
- Face-to-face and self-completion (CASI) questionnaires with children and young people aged 11-19;
- Self-completion questionnaires with teachers of children aged 5-16. (You will not need to administer this questionnaire – an email with a survey link, as well as a letter containing a paper version of the questionnaire, will be sent to teachers from the office)

Who you’ll be interviewing

The respondents (the 2-19 year olds) have been pre-selected and are already named on your ARFs. You will be interviewing different combinations of people at each address, depending on the age of the named child/young person. There are separate ARFs for each age group, and the CAPI program will guide you through who to interview. As an overview, you will be interviewing the following:

- For children aged 2-10:
  - A parent/legal guardian of the named child
- For children aged 11-16:
  - A parent/legal guardian of the named child
  - The named child, where possible
- For young people aged 17-19:
  - The named young person
  - A parent/legal guardian of the named young person, where possible

For each case, we only need to interview one parent/legal guardian and this can be the person who has more involvement with the child/young person or who is
simply most willing to take part. For 17-19 year olds, the named young person is the primary participant. However, we would still like parent interviews with this age group wherever possible as the information provided is extremely valuable, particularly for the clinical ratings. You will be prompted on the ARF and in the CAPI to ask the 17-19 year old for consent to interview their parent/guardian.

If the named child/young person (aged 11-19) does not want to take part, unfortunately we cannot interview any other children or young people in the household who might be within the relevant age range, only the sampled child. If another child or young person is keen to take part, explain that we can only use interviews from selected participants so that our data is representative and so that we don’t bias our sample and survey answers. Where possible, try to persuade the selected participant to take part.

Interview length

Based on the dress rehearsal, our best estimates for interview length are as follows:

- Parent interviews - an average of around **90-100 minutes**.
- Child/young person interviews - an average of around **45 minutes**.
- Teacher questionnaire - an average of around **15 minutes**.

There is likely to be quite a lot of variation in the timings given above as it will inevitably depend on the age of the child/young person, the answers they give and how much they have to say. Respondents with few health difficulties are likely to have a shorter interview, and respondents with a lot of problems could have an interview that is much longer. We anticipate around 10% of interviews to be longer and this has been accounted for in the fee structure. If you have a particularly long interview and if the respondent is getting tired, you may want to suggest that you take a break or continue the next day.

Administering the Self-Completion (CASI) Questionnaire

The CASI covers the most sensitive questions (e.g. smoking, drinking, and drugs, as well as questions on self-esteem and wellbeing) to help participants feel able to answer honestly.

The CASI has a locking function. When the participant comes to the end of the CASI it locks so that you can’t review any of their answers. You can tell the participant about this function before they start the CASI, to provide reassurance.

We expect most participants will complete the CASI independently. It is fairly long and may take around 30 minutes, depending on the age of the child and their answers. Bring something to do during this time, perhaps some work, a crossword or reading material. This may help the participant not to feel pressured to complete the CASI too quickly. As with overall interview length, self-completion length is also something we would like your feedback on after the dress rehearsal.
Before handing over the CASI, there is a practice question you should go through together. This question is designed to help the participant feel familiar with how to navigate, and help you assess whether they may need additional assistance.

Some participants may need assistance in completing the CASI. Younger participants in particular may have difficulty reading all the questions. In such circumstances it is ok for you to complete the CASI together with the participant. These questions are highly sensitive, so it will be important to re-emphasise that they do not have to answer any questions that they do not want to.

Assistance can take different forms, and it will be important to establish with the participant the best way for you to provide support, to make them feel comfortable. For example, you can read out the question and the response options – and then the participant may want to code their answer directly, for more privacy.

3.4 Tips for introducing the survey

- The key is to avoid too much detail too soon and keep your introduction brief.

- When introducing the survey, generally avoid terms such as ‘mental illness’. The information leaflets may help. In the leaflets, we talk about the ‘health, development and emotional wellbeing of children and young people’. The study covers many different aspects of physical and mental health as well as general wellbeing, life circumstances and experiences.

- Think about the kind of questions that people may ask, and have short answers ready. In particular consider some of the information about how the survey will be used so that you can engage people with a story about how it will make a difference (without obviously focusing on mental health!).

  *How long will it take?* On average we estimate the parent interview takes 90-100 minutes and the interview for the child/young person takes 45 minutes. This may be off putting for some people. Explain that the survey is very thorough because it was last carried out in 2004 and we need new, up-to-date data to help plan services.

  *What will you ask me?* There will be questions on a range of health, emotional wellbeing, experiences and lifestyle topics. Participants don’t have to answer any questions they don’t want to.

- If you make contact, but the resident is too busy to talk to you at that time, you could leave the information leaflet with them and say that you will call back at a more convenient time to discuss it further.
• It is obviously important to reassure participants about confidentiality and to make it clear that no information from the survey will be passed on to anyone in a way that would allow any individual to be identified.

• The voluntary nature of the survey should also be covered, and the fact that individuals can refuse to answer particular questions or end the survey at any time.
4 The ARF

4.1 Introduction
You will receive a pre-labelled ARF for each of the addresses in your sample. There are three types of ARF, dependent on the sample age of the named child/young person:

- 2-10 year olds (pale yellow);
- 11-16 year olds (pale orange);
- 17-19 year olds (pale pink)

The ARF enables you to:

- record all attempts to make contact at the address, and keep track of the visits you make;
- establish whether the sampled child lives at the address;
- establish if parent gives consent for child (11-16) to take part;
- establish if young person (17-19) is willing for parent to take part;
- record the final outcome

4.2 Address label
The address information at the top of the ARF will show the serial number (including checkletter), plus the point number, field area and wave. It will also give the sampled child's name, address and age. **NB. Remember the child’s age is ‘set’ when they are sampled, and this is the age they will remain for the purpose of the interview.**

<table>
<thead>
<tr>
<th>ADDRESS AND RESPONDENT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN: 999911001P</td>
</tr>
<tr>
<td>Point number: 203  Field area: 8</td>
</tr>
<tr>
<td>Wave: 1</td>
</tr>
<tr>
<td>Child (2-10 year old) name: Joseph Carrie</td>
</tr>
<tr>
<td>53 Victoria Road</td>
</tr>
<tr>
<td>Bromley</td>
</tr>
<tr>
<td>Kent</td>
</tr>
<tr>
<td>BR2 9RP</td>
</tr>
<tr>
<td>Child (2-10 year old) age: 10</td>
</tr>
</tbody>
</table>
4.3 Final outcome

(*top right corner of the ARF*)

For addresses that are totally unproductive, this code will come from the ARF. For addresses which are fully or partially productive, this will come from the CAPI. It can only be coded when you have completed all interviewing for that address and will be computed by the CAPI, based on the respondent interview. Section 8 gives more detail about the outcome codes for this project.

4.4 Calls record

(*bottom half of front page of the ARF and p2 of the ARF*)

Keep a full record of all the visits you make to an address – include abortive visits as well as productive ones. Any notes about what happened at each call should be made in the notes box. Label the notes with the call number. There is also a grid (on page 2) where you can keep track of all telephone calls you make. All attempts and actual calls you make can be recorded here.

4.5 Completing the ARF

**SECTION A, Interviewer observation**, is where you record the standard observations that need to be made at all non-deadwood addresses.

**SECTION B, Establishing if named child/young person lives at the address** and if so identifies:
- For 11-16 year olds, whether a parent/guardian gives consent for the child to take part in an interview
- For 17-19 year olds who live with a parent/guardian, whether the named young person is willing for their parent to also take part in an interview

*Note for B1:* If the named child/young person is not resident, code the reason. If the named child/young person has moved, please establish the new address.

**SECTION C, Final Household Outcome**, is where you record the final outcome for the household.

**SECTION D, Unproductive outcome – further details**, is where you record further information (ready for transfer into CAPI) about an unproductive outcome. In particular, record information any information that you think might be useful to a reissue interviewer.

**SECTION E, Translations**, is where you record information (ready for transfer into CAPI) about any translations required (i.e. the number of SDQs required, for what ages, and in which language.)
5 Questionnaire content

The 2017 MHCYP has been designed to collect a range of household composition and demographic questions, alongside the key topics relating to the mental health of the sampled child.

The interview structure broadly comprises of the following:

- Household demographic questions
- Strengths and Difficulties Questionnaire:
- Development and Wellbeing Assessment
- Other topics of policy relevance related to mental health.

The type of interview you will be required to conduct will depend on the age of the sampled child / young person:

<table>
<thead>
<tr>
<th>2-10 year old</th>
<th>11-16 year old</th>
<th>17-19 year old</th>
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<tbody>
<tr>
<td>Parent interview only (Interviewer administered and self completion)</td>
<td>Parent interview (Interviewer administered and self completion) Child interview (Interviewer administered and self completion)</td>
<td>Young person interview (Interviewer administered and self completion) Parent interview optional if present at same address</td>
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</table>

The exact topics you will be asking will differ depending on the age of the sampled child / young person. Over the next 3 pages we provide a 1 page summary of the topics you will collect information on (based on the age of the sampled child / young person).
PARENT INTERVIEW

<table>
<thead>
<tr>
<th>2-4 year olds</th>
<th>5-10 year olds</th>
<th>11-16 year olds (11-17 for SDQ and DAWBA blocks)</th>
<th>17+ year olds (18+ for SDQ and DAWBA blocks)</th>
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</thead>
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**Sign In**

**DEMOGRAPHIC QUESTIONS**

Demographics and Household Composition

Accommodation / Tenure / Ethnicity

Select Parent / Child to interview

**PARENT INTERVIEW - INFORMATION ABOUT SAMPLED CHILD / YOUNG PERSON**

General health

**SDQ**

Eating, sleeping and toilet training (DAWBA)

Worries about separation from key 'attachment figures' such as parents (Separation Anxiety) (DAWBA)

Specific fears, e.g. spiders, blood, flying (DAWBA)

Social fears, e.g. speaking or eating in front of other people, meeting new people (Fear of social situations) (DAWBA)

Panic attacks or fears of crowds, public places, open spaces etc (DAWBA)

Stress after a very frightening event (PTSD) (DAWBA)

Obsessions and compulsions (OCD) (DAWBA)

Worry about physical appearance (DAWBA)

Worrying a lot about many different things (Generalised Anxiety) (DAWBA)

Depression (DAWBA)

Relationships with adults (Attachment disorder) (DAWBA)

Irritability, temper and anger control (DMDD) (DAWBA)

Hyperactivity and attention problems (ADHD) (DAWBA)

Difficult and troublesome behaviour (Behaviour Disorders) (DAWBA)

Development of language, routines, play, and social ability (Autism) (DAWBA)

Dieting, bingeing and concern about body shape (Eating Disorders) (DAWBA)

Tics (DAWBA)

Other concerns (DAWBA)

Stressful Life Event

School Exclusion and Social Services

Service Use

Strengths (including SEN) (DAWBA)

**PARENT INTERVIEW - INFORMATION ABOUT PARENTS / GUARDIANS**

Education, Employment and Armed Forces

Benefits and Income

**PARENT INTERVIEW - SELF COMPLETION SECTION**

General Health and Family Questions

**PARENT INTERVIEW – CONSENT FOR FUTURE CONTACT**

Teacher consent, data linkage consent and recontact consent
<table>
<thead>
<tr>
<th>11-16 year olds (11-17 for SDQ and DAWBA blocks)</th>
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<td>Social Support</td>
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<td>Service use</td>
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<td>Educational Attainment</td>
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<tr>
<td><strong>CHILD/YOUNG PERSON INTERVIEW</strong> - <strong>SELF COMPLETION SECTION</strong></td>
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<tr>
<td>Self-Esteem (General Feelings about yourself)</td>
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<td>Strengths</td>
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<tr>
<td>Recontact to future studies</td>
<td>Recontact to future studies, data linkage consent</td>
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### YOUNG PERSON INTERVIEW (without parent present)

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5.1 Parent interview

In most instances, you will be expected to conduct an interview with a parent / guardian of the sampled child. Specifically:

- a parent will always be interviewed first if the child is aged between 2-16 years old.
- a parent may also be interviewed of a sampled young person aged 17-19 years old, if they are present in the same household, and the parent / young person agrees for the parent to take part.

The parent interview contains the following sections:

Demographic Questions

Demographics and Household Composition

The parent will be asked some standard demographic information about their household (age, sex, relationship status).

Tenure / Accommodation / Ethnicity

This block is asked of the selected parent/guardian (or young person), collecting information on the accommodation, house type and tenure of the household. This block is also collects information on ethnicity of all household members.

Select Parent / Child to interview

This is where you will select the child to interview. Specifically:

- **ChosenChild**: Asks whether the sampled child is aged 17 or older. This question will only appear for the dress rehearsal. During mainstage this question will be populated by the sample.

- **ParentYP**: If Chosenchild = yes (sampled person is aged 17 or older), you’ll be asked “Are you happy for me to also interview your parent/guardian?”. Select yes if the parent is present in the household, and the parent is also to be interviewed.

- **NmeAAsk**: This question identifies the name of the parent you will be interviewing. The response is pre-filled with the household reference person. Select no to change the parent / guardian to be interviewed.

- **NumA**: If NmeAAsk = no, then you can select the parent / guardian to be interviewed.

- **SexAAsk**: This question checks the sex of the chosen parent is correct. If incorrect, a check will prompt you to change response at the demographic questions.
• **NumC**: This question allows you to select the sampled child who will be the subject of the interview.

• **NmeCAsk**: This question allows you to enter an alternative / preferred name for the sampled child selected at NumC.

• **AgeAsk / DOBask**: These questions checks the age / DOB of the child is correct (pulling information from the demographic block). If incorrect, a check will prompt you to change response at relationship grid.

• **TransSDQ**: This question asks whether a translated SDQ will be completed by the parent. If the answer is ‘no’ then proceed with a full interview with the parent.

• **AdultInt**: This question is used to activate the relevant parent question blocks. Please set to 1 “yes, now / already interviewed”.

• **ChildInt**: This question is used to activate the relevant child / young person question blocks. Please set to 1 “yes, now / already interviewed”. You’ll only be routed to this block if the sampled child is aged 11 and older (as under 11’s are not eligible to be interviewed).

---

**PARENT INTERVIEW - Information about Sampled Child / Young Person**

Following the collection of demographic information about the household, you will move onto collecting the key topics associated with children’s mental health. The questionnaire is designed so that it doesn’t need to be administered by clinical child psychologists or psychiatrists. Researchers or survey interviewers who don’t have much (or any) prior experience of child mental health interviews can rapidly master the interviews.

**The basic structure of each section**

Nearly all of the sections in the questionnaire cover one type of mental health problem and have a similar structure:

• There is a brief introduction to give the respondent a mental picture of what the section is about.

• There are usually one or two screening questions to see if it is worth going any further. If the screening questions are positive, or if the respondent reported related problems in the Strengths and Difficulties Questionnaire, then the interview continues. If not, the rest of the section is skipped.

• The respondent is asked in detail about the presence and severity of symptoms in that domain. When symptoms are definitely present, the interview continues. When they are not, then the rest of the section is omitted.
Respondents may be asked about how long symptoms have been present, and when they started.

Each section ends by asking about the impact of symptoms on the child and the family.

**Free text sections**

For each section, where the parent has responded in a way that would suggest the sampled child/young person displays symptoms of a mental health disorder then you will be routed to a free text section.

The clinical raters who make the diagnoses do not meet the parents or young people. Whether they get the diagnoses right depends on the quality of the information they receive. You use these free text sections to help them by providing detailed transcripts of respondents’ accounts of the problems in their own words. You may find it easier to transcribe notes into a notepad as they speak and type these up after the interview closes. **Please ensure that you never use the child’s full name in your comments as we do not want to pass any identifiable information to the clinical raters.**

**General information on the interview sections**

Unless otherwise stated, in each section of the questionnaire it is important the parent knows we are interested in gathering information how the sampled child/young person is usually, not on the occasional ‘off day’. It may be worth stressing this point over the first few sections until you feel the parent understands this.

In these interviewer instructions, we have provided you with some background information on mental health disorders. The reason for this to give a good understanding of what disorders are covered in each section and also what types of behaviour may indicate mental health disorders. This is purely to provide background knowledge; you are in no way expected to make any judgements.

**General health of the sampled child/young person**

Prior to the full interview, a short number of general health questions are asked to ascertain the overall health condition, collect information on existing medication conditions and medication requirements.

**Strengths and Difficulties Questionnaire (SDQ)**

This section is asked for all ages of child/young person. For each of the 25 items in the strengths and difficulties questionnaire, the respondent is asked to state whether the statement you read out about the child is ‘Not True’, ‘Partly True’ or ‘Certainly True’, over the past 6 months.

The subsequent questions ask whether the child has difficulties with emotions, concentration, behaviour or getting on with people. If the parent does not think
the child has any such difficulties, they are routed to the next section of the questionnaire. If the parent states that the child has difficulties, they are asked if they interfere with their everyday life in terms of their home life, friendships, learning or leisure activities. Finally the respondent is asked if these difficulties put a burden on their family as a whole.

**Eating, sleeping and toilet training**

This section is asked for sampled children aged 2-4 years and collects information on the eating, sleeping and toilet habits of the child. Information is collected on whether the child eats too much or too little or is a picky eater for example. We are interested in how the child is usually and not just on the occasional ‘off day’ as children may go through periods where eating, sleeping and toilet training habits may change. If difficulties are expressed then questions on the impact of these difficulties are asked including free text questions.

**Worries about separation from key ‘attachment figures’ such as parents (Separation Anxiety)**

Most children have strong attachment bonds to key adults in their lives – parents, grandparents, teachers and so on. Technically, these adults are described as ‘attachment figures’. These bonds between children and their attachment figures provide the child with security and comfort particularly in times of stress. Close friendships with other young people are obviously important but we don’t count them as attachment bonds as far as this interview is concerned. Some children experience a lot of distress as a result of worries that something bad will happen to their attachment figures or that they will be separated from their attachment figures. This is what the section on separation anxiety is about.

Note that the reference period is the last 4 weeks. In subsequent questions, you will also need to emphasise that we are interested in how the child is usually and not in how she or he is on the occasional ‘off day’. This should be stressed every two or three questions until you are sure that the respondent knows.

**Specific fears, e.g. spiders, blood, flying**

This section of the interview is about some things or situations that young people are often scared of, even though they aren’t really a danger to them. Again, we are interested in how the sampled child is usually, not on the occasional ‘off day’. Not all fears are covered in this section; some are covered in other sections, e.g. fears of social situations, dirt, separation, crowds.

The list of potential phobias has been generated from those which are commonly known about plus those mentioned in previous mental health surveys.

Some fears are seasonal and if you just asked about the last few months, you might miss them. For example, some children are truly phobic of wasps or
daddy-long-legs but if you asked in March whether they are scared of them every day, the answer would probably be ‘No’. For these seasonal phobias, it is important to ask what the children’s fears and behaviors are like in the relevant season.

**Social fears, e.g. speaking or eating in front of other people, meeting new people (Fear of social situations)**

The aim of this section is to find out whether the sampled child/young person is particularly afraid of any social situations. As for specific phobias, we are trying to get the information we need to distinguish between mild fears (which are common) and a true phobia. Social fears and phobias are related to being with a lot of people, meeting new people etc. We are trying to identify children who have far more than ‘ordinary’ shyness, though social phobia might look like extreme shyness.

Again, we are interested in how the sampled child/young person is compared to other children of his/her age. Parents are asked about whether their child is afraid of particular social situations. Sometimes the parents won't know or the situation won't apply. For example, some parents don't know if their child is anxious about reading out loud in front of others at school - and in some cases, the child is not attending school.

**Panic attacks or fears of crowds, public places, open spaces etc**

This section asks if the sampled child has suddenly become panicky of no obvious reason in the past 4 weeks. Positive response then routes to further questions into potential triggers, while also giving the parent opportunity to give further details on the phobia triggering the panic and frequency with which the attacks occur.

**Stress after a very frightening event (PTSD)**

In this section we ask whether the sampled child/young adult has experienced an exceptionally stressful event or situation. We want to assess whether exceptionally stressful or traumatic events are likely to have been engraved on a child’s memory and liable to cause flashbacks and vivid nightmares which are symptoms of PTSD. Such events include abuse, being mugged at gun point or being caught in a burning house. We have provided you with a show card list of traumatic events so that you do not have to ask an open question and then make a judgement about whether or not it counts as a traumatic event.

The events covered in this section are extreme and unusual. It is important to stress that this section does not cover ALL the events and occurrences that might have upset a child. Events such as divorce for example will be covered in the ‘Stressful life events’ section later. It is unusual for children to have experienced even one trauma of the sort needed to trigger off PTSD. Consequently, it is unlikely that the same child will have experienced several different traumas – but this does happen at times. When a child has had several severe traumas, treat them together when asking the remaining
questions about symptoms and their impact. For example, you would ask about flashbacks or numbing related to any or all of the traumas they have experienced.

**Obsessions and compulsions (OCD)**

Many children and young people have some rituals or superstitions, e.g. not stepping on the cracks in the pavement, having to go through a special goodnight ritual. It is also common for young people to go through phases when they seem obsessed by one particular subject or activity, e.g. a music group or a football team. With this section we aim to collect information on the small percentage of children/young people who display symptoms of OCD.

For a child with OCD, they are driven by an obsession which is an unwanted and unpleasant thought, image or urge that repeatedly enters the child's mind, causing feelings of anxiety, disgust or unease. This obsession leads a compulsion for the child to feel the need to perform a repetitive behaviour or mental act to temporarily relieve these unpleasant feelings brought on by the obsessive thought. A child with true obsessive-compulsive symptoms may need to shower or wash their hands dozens of times each day for example.

**Worry about physical appearance**

Most people worry about their physical appearance to some degree and for most, the extent of these worries change from time to time, e.g. Worsen when they develop a spot, start puberty. For some children/young people however, these worries over appearance can go beyond this, filling their thoughts, taking up a lot of their time and really upsetting them. Many people are worried about one of more aspects of their physical appearance, such as body hair, body shape, even if they don’t seem out of the ordinary to others.

This new section aims to provide insight into the degree to which the sampled child / young person worry over their physical appearance and how much of an affect these worries have on their everyday life. It will be asked of the 5 to 19 age group.

**Worrying a lot about many different things (Generalised Anxiety)**

Children with generalized anxiety have many different worries about many different things. In this section, you are trying to find out whether the child worries so much, and about so many things, that this really interferes with his or her life and leads to physical symptoms such as being tense or not being able to get to sleep. The worries (such as schoolwork, illness, the future) are present across different situations. So they may have one set of worries at home and a different set of worries at school.

These questions aim to gather information on whether the child has multiple worries after setting aside any worries or fears that have already been covered by the previous sections on separation anxiety, phobias and obsessions. We are looking to find exactly what they worry about, and how severe those worries are.
Depression

Just as in adults, depression in children and teenagers usually shows itself as severe and prolonged misery. Sometimes, though, the most obvious change in mood is not misery but increased irritability. This can be very tricky to judge since plenty of teenagers are irritable with their family! You need to focus on whether they have recently changed to being a lot more grumpy or irritable than in the past. In some cases, the most obvious clue to depression is neither misery nor irritability but a loss of interest in the things that the child used to enjoy doing. Perhaps the child has kept his or her misery secret, but the family may still have noticed that the child suddenly no longer wants to visit friends, go on outings, listen to music, and attend clubs. We ask questions on mood and frequency on moods, irritability and loss of interest. These are then followed by questions relating to self harm.

It is important to take your time over this section, to thank informants for answering the questions and to help them to orientate themselves back into the rest of the interview by explaining what the next few questions are about.

Relationships with adults (Attachment disorder)

This section is asked of the younger 2-4 year age group to gather information on potential attachment disorder by looking at the style by which the sampled child relates to adults. Usually bonds/attachments are formed from a very young age and are important for the child for becoming aware of other’s feelings, to help the child to loved and secure and to trust other people. When these bonds are not formed then children can develop attachment disorder where a child may feel they cannot come to depend on others which may then affect future social relationships. Questions are then asked on how the style of relating to adults affects relationships with others and everyday life events.

Irritability, temper and anger control (DMDD)

Most children/young people like adults are at times in a really irritable or angry mood and many young people have temper outbursts such as shouting or slamming doors on occasion. This section looks at the frequency of these angry moods and outbursts, what they involve (shouting, damaging things for e.g.), where they occur, what triggers them, if they affect/interfere with daily life (friendships, schooling etc.) and how these outbursts compare with other young people of the same age. Frequent chronic irritability and severe temper outbursts that seem over the top in relation to the trigger may indicate a relatively new disorder called Disruptive Mood Dysregulation Disorder (DMDD).

Hyperactivity and attention problems (ADHD)

This question section is about the level of attention and activity in the last 6 months. Nearly all children and young people are overactive or lose their concentration at times, we want to find out how the sampled child/young person compares with children of the same age. The responses needed here are how the sampled child/young person is usually. Where a parent responds with
definitely, it is worth checking the response until you are satisfied they are comparing the child with those of the same age.

**Difficult and troublesome behaviour (Behaviour Disorders)**

Nearly all children and young people are difficult and troublesome at times where they refuse to do as they are told, are irritable or annoying, have temper outbursts and so on. This section looks into difficult and troublesome behaviours displayed by the sampled child/young person in comparison with children of the same age. As in other sections, we are looking at how the sampled child/young person behaves usually and not on occasional ‘off days’. Some children are difficult with their brothers and sisters; however we are looking at whether the sampled child/young person is difficult with a range of adults.

The section on ‘behaviors which sometimes gets children into trouble’ is mostly fairly straightforward to ask about, although you may be embarrassed to ask parents whether their child has done such extreme things. In fact, it normally works fine, particularly if you mention that you have to ask parents all questions even if they are unlikely to apply. Instead of upsetting parents, this section sometimes cheers them up as they realise all the bad things their child is not doing! So even though these questions are quite sensitive, most parents are willing to answer them and understand why they are being asked. But do keep a careful eye on how respondents are reacting – if they are getting irritated, make a note and stop.

**Development of language, routines, play, and social ability (Autism)**

This section is about language, routines, play and social ability. In this section we are gathering information for clinician raters to make judgement on whether the sampled child/young person may have Autism Spectrum Disorder (ASD).

ASD is estimated to effect 1/100 people in the UK and is a disorder that affects social interaction, communication, interests and behaviour. Autism is a spectrum condition which includes Asperger syndrome and dyspraxia. It is wide-ranging – some people have accompanying learning disabilities while others have average or above average intelligence. With symptoms present from a young age, diagnoses can be made after 3 years.

Some of the questions are about how the sampled child/young person is now, whilst others are about how her/she developed in the first few years of life. The early years questions may be more difficult to answer in cases of adoption for example. The parent is asked to compare the sampled child/young person to others of the same age. This section covers;

- General development
- Play
- Hobbies
- Social interactions
- Chatting
• Speech
• Non-verbal communication
• Flexibility
• Movement
• Impact and burden

Dieting, bingeing and concern about body shape (Eating Disorders)

Only those who answer positively to 1 of the screening questions will be routed through the rest of the section. Questions are asked of the sampled child/young person’s current height and weight along with the lowest weight over the past 12 months and highest weight ever. Information is gathered on aspects of the child’s eating habits, attitudes towards food and their bodies and whether behaviours have interfered with daily life such as learning.

Tics

Tics are short sudden movements (motor) or sounds (vocal) that are made during otherwise normal behaviour. Both kinds are tic are often repetitive, following the same pattern every time and occur involuntary. Both motor and vocal tics are covered in this section.

Other concerns

This section allows the parent to mention any other aspects of the sampled child/young person’s psychological development that really concerns them and also their teachers.

Stressful Life Events

These questions gather further information on things then may have happened or problems that the sampled child/young person may have faced. Questions include asking about divorce/separation, family bereavement, serious illnesses, worrying events such as court appearances.
School Exclusion and Social Services

This section gathers information on the sampled child/young person’s educational history, e.g. how many schools attended and whether he/she has been excluded. Questions are also asked on time spent being looked after by social services.

Service Use

This section gathers information on which services the sampled child/young person or the parent have used in the past year. Reasons for use include seeking advice or treatment about a young person’s emotions, behaviours, concentration or difficulties in getting along with people. There are some particularly sensitive topics covered in this section such as police convictions. This section also includes a question on whether the sampled child/young person is a young carer.

Strengths (including SEN)

While the other sections of the interview have focused mainly on possible difficulties and problems, this section allows the parent to share the strengths and good points of the sampled child/young person. We are looking to find out what sort of person he/she, in the sorts of things the sampled child/young person does that really pleases the parent. This section also includes a question on special educational needs (SEN).

PARENT INTERVIEW - COLLECTING INFORMATION ON SAMPLED CHILD / YOUNG PERSON

Income / Employment / Benefits / Ethnicity:

These questions are asked of the selected parent / guardian, and collected for the parents of the selected person (or just of the young person if applicable). The questions have been condensed to collect key information to allow the production of key analysis of these topics (including the production of standard occupational coding).

Armed Forces:

An armed forces question will be asked of the parent / guardian of the selected child/young person, in order to provide valuable information on the mental health of children in armed forces households. This question will provide evidence to support the Armed Forces Covenant.²

Self-completion questionnaires for parents

² See https://www.gov.uk/government/collections/armed-forces-covenant-supporting-information
The parent will self-complete this section themselves. Before passing the computer to them please remember to PRESS F2 to save the interview so far.

The questionnaire consists of the 12-item General Health Questionnaire (GHQ-12) and Family Activity Device - General Functioning Scale (FAD-GFS). There are also two new questions about family arguments that the parent will only be asked if they are living with their spouse or cohabiting.

Most of the questions which have been asked of the parent have referred to the sampled child/young person, therefore it is necessary to stress that this self-completion questionnaire is about how they feel and not about the sampled child/young person.

5.2 Child interview

You will only be interviewing children about mental health problems when they are aged at least eleven. Although some young people will be reluctant to talk with you, you will probably be surprised by how well they respond to your interest and attention. A lot of children do not often get one-to-one attention from an adult who is interested in them and how they feel. Even if they tell you about distressing symptoms or problems in their life, they are very likely to feel better for having told you. Just being listened to may have been helpful to them, and if they do need professional help, they are more likely to seek it after they have had the experience of telling you without being criticised, ridiculed or ignored.

Questions about the child

The interview with the child (aged 11-16) follows a very similar format to the main part of the parent’s interview although there are a couple of sections that appear here that aren’t in the parent interview and vice versa.

Instructions for the sections that are unique to the child interview are outlined below. For the remainder of this section please refer back to the instructions for the parent interview.

ChildNow

The first question in the child’s face to face interview is for you to code whether you want to interview the child now.

ExitRat

There is an exit rating at the end of the interview that also asks you to say how well the child understood the questions. This will help the clinical raters in deciding how much weight to give to the data from the child’s interview.

Less common disorders

The child’s less common disorders section differs slightly from that of the adults.
Instead of a whole section on tics and twitches the child is only asked one question about these; “Do you have any tics or twitches that you can’t seem to control?” You may need to explain to the child what a tic or twitch is. They are also asked whether they have had any frightening or unusual experiences such as hearing voices or seeing things.

The section ends by asking if there is anything about the child’s feelings or behaviour, apart from the things that have already been discussed, that really concern the child or anyone else.

**Social support**

This section aims to find out what sort of social support network the child has, or feels they have. Does the child feel like they have lots of people they can turn to, or do they feel alone in the world?

The section starts by asking the child how many relatives and friends they have that they feel close to. It then provides a list of statements about the sort of support a young person may feel, for example ‘There are people I know who make me feel loved’, and asks them to say whether these statements are not true, partly true or certainly true for them.

**Social life**

This section on social life is new for 2017 and replaces the social life section in the 2004 and 1999 surveys. Topics covered in this section include:

- Caring for others
- Social Media
- Bullying, including cyberbullying

The section starts with one question about caring that determines if the child regularly looks after or helps others, in order to provide valuable information about the mental health of young carers.

Social media has grown in popularity since the launch of Facebook in 2004. Very little data has been collected about social media usage in relation to mental health, and was not collected at all in previous waves of this survey. The new social media questions will provide valuable information on this – they will determine what types of social media sites the child uses, what types of activities they engage in, how often they use them and who they are interacting with. There is also a set of attitude statements to determine how social media may influence mood. If the child/young person plays games on social media, they are also asked a set of questions that focus specifically about their frequency of gaming. This is because there have been recent concerns about how much time young people spend gaming and if it adversely affects their lives.

Linked to the growth of social media, there has also been a rise in what is known as ‘cyberbullying’ – being bullied via the internet. The new set of questions identifies the type of bullying experienced (both online and in person),
the frequency of bullying, who is doing the bullying and whether the participant has bullied others.

**Educational attainment**

The two main aims of this section are to find out what qualifications the child has passed or been entered for, and to find out whether the child left school ‘early’, and if so why and what are they doing now.

**Self-completion blocks**

The self-completion schedule covers the following areas:

- Self-esteem
- Strengths
- Troublesome behaviour
- Cigarettes
- Alcohol
- Experience with drugs
- Relationships with teacher
- Service use
- Feelings and thoughts

Before the participant starts to complete the self-completion questionnaire there are a number of points which you should cover:

- assure the participant of confidentiality;
- go through the practice question at the beginning of the self-completion with the participant so that they know how to answer the questions, and so that you can assess if they need any assistance;
- tell them that if they have any queries whilst they’re completing the questionnaire to let you know

**Self-esteem**

This is a standardised question (the Rosenberg self-esteem scale) that contains 10 statements about general feelings which respondents can agree or disagree with. This is new for 2017 and will allow us to measure levels of self-esteem against other aspects of mental health.
**Strengths**

The strengths section is similar to that in the adult interview, but has been added to the self-completion part of the interview so that children are less likely to feel inhibited when answering. Asking about their good points face-to-face may lead to over-reporting due to shame or under-reporting due to modesty.

**Troublesome behaviour**

Again, this is similar to the section on troublesome behaviour in the adult interview but, as with the strengths section, is included as part of the self-completion section to encourage truthful responding and to avoid over- and under-reporting.

**Cigarettes, alcohol, drugs**

This set of questions is about current and past use, frequency of use, accessing help, desire to quit or reduce usage, and the social situation in which they smoke, drink or use drugs.

**Relationships with teacher**

This set of questions establishes if the child/young person has experienced a difficult relationship with a teacher, and if it has interfered with their learning and attendance.

**Service use (asked of children aged 13+)**

This question asks whether they have contacted anyone (and if so who) because of worries about their emotions, behaviour, concentration or difficulties in getting along with people. There are also some questions on whether, in the past year, they have had to go to hospital due to their emotions or behaviour, and if they have received a police caution or conviction.

**Feelings and thoughts**

This section contains the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) which is a set of 14 statements about general feelings and thoughts – respondents report how often they have experienced each feeling/thought over the previous two weeks. There is a final set of equality questions that ask about sexuality (of those aged 14+), impairments/illnesses, national identity, religion and ethnicity.
5.3 Young Person Interview (aged 17-19)

Questions about the young person

The interview with the young person (aged 17-19) follows a very similar format to the main part of the parent’s interview although again there are a couple of sections that appear here that aren’t in the parent interview and vice versa. The young person interview is almost exactly the same as the child interview, with just a few discrepancies:

- The young person (aged 17-19) is asked the whole section on tics and twitches, instead of the shortened version included in the child (11-16) interview.
- Young people are asked about service use – this section is longer than its equivalent in the child interview (it is more similar to the parent interview).
- Young people are asked if their parent is currently serving, or has ever served, in the UK Armed Forces. This matches the question that is asked of the parent so that we can collect the information should they not have a parent interview.
- If the young person consents, one of their parents can also be interviewed. If so, the parent will answer household grid questions and questions on income and benefits. If the parent does not have an interview, these questions will instead be part of the young person’s interview.

Self-completion blocks

The young person self-completion section is identical to the child self-completion section, apart from an additional set of three questions that ask about special educational needs. These questions are asked in the parent interview but we want to collect the information from the young person as well, in case they do not consent to their parent being interviewed.

5.4 Consent

In this study, we are asking for three consents:

- Consent to contact for possible future studies (asked of parents and young people aged 17-19)
- Consent to data linkage to health records and education records (asked of parents and young people aged 17-19)
- Consent to contacting a teacher (asked of parents of children aged 5-16)
**Future contact**

We do not yet know if there will be a follow up of this survey (in 2007 there was a follow up to the 2004 survey) but we need to be prepared in case there is. We are therefore asking for permission to re-contact parents and young people if we decide to undertake a follow-up in the future, or if other research studies (not related to this one) are carried out in the future. We are keen not to lose touch with people – this is why we are asking you to collect information about a close relative or friend who would know where to contact them if we do lose touch with them. We are also asking for email addresses since someone may move house and change their telephone number but still keep the same email address.

**Data linkage**

Participants (parents and young people age 17-19) are asked if they will consent to link their anonymised survey answer with government held health and education information. Examples of the datasets we would like to link to are:

- NHS Central Register;
- Hospital Episode Statistics Register;
- National Pupil Dataset
- ONS Mortality Data
- Mental Health Services Dataset

No answers given during the survey will be attached to their name on the register. You can reassure people that no one else will know that their name has been flagged in this way and it does not mean that they will be contacted again in the future. If they give consent to do this they need to read and sign the consent form provided.

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**Important Note – Completing the Consent Form**

We cannot use consent forms that are not correctly completed. Please take the time to make sure it’s correct. To complete the consent form:

1) Respondent reads the information section at the top of the form.

2) Respondent reads, adds their name, signs, initials and dates the consent section at the bottom of the form.

4) You add your name, sign and date at the bottom of the form.

5) Leave the bottom copy with respondents (labelled ‘Respondent Copy’).
6) Send the top copy (labelled ‘Office Copy’ to the office in your return of work envelopes. This can be done in batches of up to 9 consent forms (please do not include more than 9 consent forms in one envelope for information security purposes).

Please check:

- The correct date has been used;
- Respondent and you have both signed, initialled and written your name correctly.

A signature on a consent form is only valid where the respondent is properly informed and capable of understanding. It is important that you allow respondents time to read the consent form and that you are confident they understand what they are agreeing to. You should also be prepared to answer any questions they might have.

Gaining consent to data linkage is a really important part of the National Study of Health and Wellbeing so please do all you can to gain consent.

**Teacher contact**

Towards the end of the parent interview, we ask parents of children aged 5-16 for permission to contacting a teacher of their or their child’s choice (a teacher they feel knows their child the most).

The teacher questionnaire can be completed either online or on paper. We will be sending teachers an email with a link to complete an online questionnaire, as well as a letter containing a paper version of the questionnaire for them to send back to the office. We will also be sending a letter to the head teacher so that we can inform them of the survey and make them aware that one of their teachers has been invited to take part. We hope this will help to increase teacher response rates. Therefore, we need to know the teacher’s name and email address, head teacher’s name, school name and school address - you will be prompted to collect this information from the respondent at the end of the CAPI interview.

The CAPI contains a look-up file called Edubase that, providing you know the name of the school, will automatically fill in the school name, school address and head teacher name. If the school is not listed in Edubase, there is a function to enter the details manually. You will still need to collect the teacher name and email address from the respondent. As many respondents may not know this information, there are also questions in the CAPI to enable you to collect a general enquiries/reception email address for the school instead. If the respondent does not know any email address for the school or the teacher, you will be prompted in the admin block to look up the school website and find an email address that we could use. Preferably this would be the chosen teacher’s email address, but we know this isn’t always possible so a general email
address used for contacting the school could be recorded instead. Please note that recording the email address correctly is vital here – if we do not have a correct email address, we have no way of contacting the teacher and valuable information from the teacher therefore won’t be collected. Please do double check the information you have recorded!

All parents of children aged 5-16 should be asked for consent to contact the child’s teacher (unless the child has left school). CAPI will prompt you to do this. We will not be contacting teachers for young people aged 17-19. The varying types of educational establishments that this age group could be attending would make this element too complicated as well as costly.

In cases where the child has a home tutor – please ask for permission to contact them.

You may encounter children who have been excluded from school. If the child has not been excluded for very long (a few months) we would like you to ask for consent to contact the teacher. If the parent objects to this, do not take it any further.

It is important to reassure participants of confidentiality. The teacher will not see any of the parent’s or child’s survey answers, they will simply know that the child took part and that we would now like them to complete a short questionnaire about that child. The questionnaire is completed in confidence and the answers won’t be linked anywhere to the child’s name.

5.5 Teacher questionnaire

We estimate that the teacher questionnaire will take around 15 minutes to complete.

The teacher questionnaire is specifically about the named child and covers the following topics:

- Ability level of the child
- Any special educational needs
- Strengths and difficulties
- Emotions
- Attention, activity and impulsiveness
- Awkward and troublesome behaviour
- Any other concerns they may have about the child
- If the child has received any help from the school
6 Safeguarding

On this study, you will be asking participants about a variety of different topics, many of which relate to their emotional wellbeing and mental health. Some questions are very sensitive. Most of the particularly sensitive questions are administered via self-completion (CASI) but there is a chance that participants may disclose information to interviewers that might give cause for concern (i.e. possible signs of abuse). Whilst it is unlikely that this will happen, it is important to learn about safeguarding and child protection, so that you feel confident to recognise possible signs of abuse, and know how to respond appropriately and who to report any concerns to.

You will have received a short safeguarding guidance booklet – please read through this as part of your homework. We will also cover safeguarding during the briefing.
7 Planning work and Coding out

Planning the work

Due to the distribution of the sample, points will differ in size – they will contain around 15 ‘addresses’ (named children/young people) but will vary from a minimum of 7 up to a maximum of 20 (please note, there are few very small or very large points). Field periods for each Wave are around 6 or 7 weeks (see section 2.1 for specific dates for each Wave) and, because of the importance of meeting deadlines and response targets, we recommend that you start work on your points as soon as possible after receiving the addresses.

As mentioned in section 3, the length of the interview will also be variable. On average, the parent interviews are likely to take approximately 90-100 minutes and the young person/child interviews are likely to take about 45 minutes. However, if you have parents with children experiencing multiple problems, interviews may turn out to be considerably longer than this. Despite this, at the previous survey and during the dress rehearsal, parents of children who had problems were only too relieved to have someone to talk to. It does mean, however, that you need to be wary of making appointments too close to one another, in case an interview does turn out to be longer than expected. Where possible, you could, of course, make rather more flexible appointments, if this is acceptable to your respondents.

You also need to think carefully about the logistics of arranging to see parents and children. Where possible, interviews with the parent should be done without the child/young person being there. Please also remember, interviews with the child must not have a parent present.

Apart from working parents, there are also those parents with several children of different ages whose day is very much broken up by needing to collect different offspring from school, nursery, playgroup etc. You will need to be as flexible as possible when arranging appointments to maximise your chances of achieving interviews. If an interview does turn out to be a lot longer than expected, you may occasionally need to split it over more than one visit, although this shouldn’t happen too often.

Please remember that these interviews can be draining, not just for the respondent but you the interviewer. With this in mind and taking into consideration the variable length of the interview it would prudent not to attempt more than two interviews in one day. Once you are familiar with the questionnaire you may feel able to do more.
Giving advice

If parents are having problems with their children, they may ask you for advice. As with all our surveys, your options are obviously limited. We suggest you advise them to speak to their GP who would be able to refer them on for further help if necessary. It might also be worth asking if they have discussed the problems with the child’s teachers. You can also give the respondent a Useful Contacts leaflet, listing a number of organisations that offer help and advice.

If you are asked for advice when you are interviewing the young person, again you can suggest that teachers might be able to help. You can also give young people a copy of the Useful Contacts leaflet.

As noted above, these interviews can be draining – if the parent or child/young person wishes to stop the interview (for whatever reason), you can exit the CAPI as you usually would in such circumstances.

Admin block and coding out

The admin block used for the survey is similar to other NatCen surveys. The outcome codes for full interviews and partial interviews will be automated, the other outcome codes will need to be entered.

Household Outcome Codes

As with other surveys, you have a large number of outcome codes available to you for coding out each case. Outcome codes for productive cases (those with a 3 digit code less than 300) will automatically generate an outcome code. Unproductive cases (outcome codes greater than 300) will require a manual coding for the reason of non-interview. Annex 1 contains the full list of outcome codes, however for simplicity we have presented the most common outcome codes below to help with coding out:

**Complete Interview**

110 Complete interview – Parent of Child under 11 years old (2-10s)
111 Complete interview – Parent and Child (11-16s)
112 Complete interview – Parent and Child (partial) (11-16s)
113 Complete interview – Parent only / no Child interview achieved (11-16s)
114 Complete interview – Young Person and Parent (17-19s)
115 Complete interview – Young Person and Parent (partial) (17-19s)
116 Complete interview – Young Person only / no Parent interview achieved (17-19s)

**Partial Interview**

210 Partial interview – Parent of Child under 11 years old (2-10s)
211 Partial interview – Parent (partial) and Child (11-16s)
212 Partial interview – Parent (partial) and Child (partial) (11-16s)
213 Partial interview – Parent only (partial) / no Child interview achieved (11-16s)
214 Partial interview – YP (partial) and Parent (17-19s)
215 Partial interview – YP (partial) and Parent (partial) (17-19s)
216 Partial interview – YP only (partial) / no Parent interview achieved (17-19s)

No contact
310 No contact with anyone at the address
312 Inaccessible
313 Unable to locate address
320 Contact made – but not with a responsible resident
323 No contact with any eligible respondent

Refusal
410 Office refusal
430 Refusal by parent/legal guardian before interview
431 Refusal by named child before interview
432 Proxy refusal
440 Refusal during interview (unproductive partial)
450 Broken appointment – no re-contact

Transmission of Cases
All cases should be transmitted back as normal. Completed cases should be transmitted on a daily basis.

Contact points
If you have any queries, please contact your Field Performance Manager in the first instance. They will then pass you on to a Researcher if they cannot answer your question.

Other contacts:

Program related queries 01277 200600
Ask for “Data Unit”

Briefings, allocations or incentives 01277 200600
Ask for “Logistics”

Support 01277 690200

Pay Query Line 01277 690219
## Annex 1: Household Outcome Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>110</td>
<td>Complete interview – Parent of Child under 11 years old (2-10s)</td>
</tr>
<tr>
<td>111</td>
<td>Complete interview – Parent and Child (11-16s)</td>
</tr>
<tr>
<td>112</td>
<td>Complete interview – Parent and Child (partial) (11-16s)</td>
</tr>
<tr>
<td>113</td>
<td>Complete interview – Parent only / no Child interview achieved (11-16s)</td>
</tr>
<tr>
<td>114</td>
<td>Complete interview – Young Person and Parent (17-19s)</td>
</tr>
<tr>
<td>115</td>
<td>Complete interview – Young Person and Parent (partial) (17-19s)</td>
</tr>
<tr>
<td>116</td>
<td>Complete interview – Young Person only / no Parent interview achieved (17-19s)</td>
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<td>210</td>
<td>Partial interview – Parent of Child under 11 years old (2-10s)</td>
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<td>212</td>
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<td>Partial interview – Parent only (partial) / no Child interview achieved (11-16s)</td>
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<td>214</td>
<td>Partial interview – YP (partial) and Parent (17-19s)</td>
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<td>215</td>
<td>Partial interview – YP (partial) and Parent (partial) (17-19s)</td>
</tr>
<tr>
<td>216</td>
<td>Partial interview – YP only (partial) / no Parent interview achieved (17-19s)</td>
</tr>
<tr>
<td>310</td>
<td>No contact with anyone at the address</td>
</tr>
<tr>
<td>312</td>
<td>Inaccessible</td>
</tr>
<tr>
<td>313</td>
<td>Unable to locate address</td>
</tr>
<tr>
<td>320</td>
<td>Contact made – but not with a responsible resident</td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>430</td>
<td>Refusal by parent/legal guardian before interview</td>
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<td>Refusal by named child before interview</td>
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<td>432</td>
<td>Proxy refusal</td>
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<tr>
<td>440</td>
<td>Refusal during interview (unproductive partial)</td>
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<td>450</td>
<td>Broken appointment. No re-contact.</td>
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<tr>
<td>510</td>
<td>Ill at home during field period</td>
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<td>520</td>
<td>Away / in hospital throughout field period</td>
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<tr>
<td>521</td>
<td>Named Child now living in an institute</td>
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<tr>
<td>522</td>
<td>Named Child now looked after by Local Authority</td>
</tr>
<tr>
<td>530</td>
<td>Physically or mentally unable / incompetent</td>
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<tr>
<td>541</td>
<td>Language difficulties with address as a whole</td>
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<tr>
<td>542</td>
<td>Language difficulties with parent/legal guardian</td>
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<tr>
<td>543</td>
<td>Language difficulties with named child</td>
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<tr>
<td>599</td>
<td>Other non-response (give details)</td>
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<tr>
<td>612</td>
<td>Issued but not attempted</td>
</tr>
<tr>
<td>672</td>
<td>Child moved, follow up address obtained, but outside of interviewers Area (relocation required)</td>
</tr>
<tr>
<td>674</td>
<td>Child moved, follow up address not known/not given</td>
</tr>
<tr>
<td>690</td>
<td>Other unknown eligibility (due to non-contact)</td>
</tr>
<tr>
<td>781</td>
<td>Named child deceased</td>
</tr>
<tr>
<td>782</td>
<td>Named child moved, follow-up address obtained but is overseas (including Scotland &amp; Wales)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<td>------</td>
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<tr>
<td>789</td>
<td>Duplicate</td>
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<tr>
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<td>Other ineligible (details to be recorded)</td>
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<td>830</td>
<td>Information refused about eligibility</td>
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<tr>
<td>840</td>
<td>Contact made but no-one knows if any residents are eligible</td>
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<tr>
<td>850</td>
<td>Unable to confirm if any residents are eligible due to a language barrier</td>
</tr>
<tr>
<td>890</td>
<td>Other unknown eligibility</td>
</tr>
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</table>