

Correspondence

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Prevalence: are two-fifths of young people really 'abnormal'?

We read with interest Deighton and colleagues' paper about mental health problems among 11- to 14-year-olds.¹ They stress the importance of understanding prevalence and report 'findings that indicate the scale of mental health problems in England is much higher than previous estimates'. The previous estimates referred to are from England's Mental Health of Children and Young People (MHCYP) survey, which recently identified 13.6% of 11- to 15-year-olds as meeting the diagnostic criteria for a mental disorder.² They do not explain why their estimate of 42.5% is more reliable.

Their survey was conducted in six of the most deprived local authorities in the country: Blackpool, Cornwall, Hull, Kent, Newham and Wolverhampton. The MHCYP survey was nationally representative. As expected, given the deprived areas sampled, children eligible for free school meals were overrepresented, as well as White pupils. These characteristics are associated with higher rates of disorder,³ but are not addressed with the use of survey weights. The MHCYP survey used a complex weighting strategy to correct for selection and non-response biases to ensure that the sample was representative.

Only the child self-report Strengths and Difficulties Questionnaire (SDQ) was used. The single-informant SDQ is a less reliable predictor of child mental disorder than the multi-informant SDQ, and the child self-report measure is less reliable than the parent or teacher measures.⁴ In contrast, the MHCYP used a multi-informant standardised diagnostic assessment; the Development and Wellbeing Assessment. This combines highly structured and semi-structured questions, as well as clinical rating to triangulate child, parent and teacher reports and assign ICD-10 diagnoses.⁵

Prevalence estimates rely on the thresholds applied. To identify pupils with problems in each of the four domains examined the authors have used a no longer recommended 'three band' approach and,⁶ crucially, do not appear to have taken account of impact.

Similarly, the overall threshold was derived by a score above the subscale cut-point on four of six possible subscales. This unusual approach was not explained, although we are sympathetic to the challenges of describing complex methodology within a short report. The standard approach would be to apply a threshold to the SDQ total difficulties score.⁴

We disagree, therefore that the authors' findings indicate that the MHCYP's rates are underestimates. Poor mental health can be conceptualised in a number of ways, and clarity about definitions, especially when making comparisons, is essential.

1 Deighton J, Lereya ST, Casey P, Patalay P, Humphrey N, Wolpert M. Prevalence of mental health problems in schools: poverty and other risk factors among 28 000 adolescents in England. *Br J Psychiatry* 2019; **215**: 565–7.

2 Government Statistical Service. *Mental Health of Children and Young People in England 2017*. NHS Digital, 2018 (<https://digital.nhs.uk/data-and-information/>

[publications/statistical/mental-health-of-children-and-young-people-in-england-2017/2017](https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england-2017/2017)).

- 3 HeadStart. *Evidence Briefing 1. Mental Health Problems in 11–14 year olds*. HeadStart, 2018 (<https://www.tnlcommunityfund.org.uk/media/documents/Headstart/Evidence-Briefing-1-Mental-Health-Problems-in-11-14-year-olds.pdf?mtime=20180802150808>).
- 4 Goodman R, Ford T, Simmons H, Gatward R, Meltzer H. Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *Int Rev Psychiatry* 2003; **15**: 166–72.
- 5 Goodman R, Ford T, Richards H, Gatward R, Meltzer H, et al. The Development and Wellbeing Assessment: description and initial validation of an integrated assessment of child and adolescent psychopathology. *J Child Psychol Psychiatry* 2000; **41**: 645–55.
- 6 Youth in Mind. *Scoring the SDQ*. Youth in Mind, 2016 (<https://sdqinfo.org/py/sdqinfo/c0.py>).

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Authors' reply

We thank Professor Ford and Ms McManus for raising some important questions and welcome extending the debate in this important area. We understand the questions raised by the author to be fourfold and respond to each in turn below.

First, whether estimates presented in our paper¹ are more reliable than the recent England's Mental Health of Children and Young People (MHCYP) study.² We would like to confirm that we did not claim our data are more reliable than the MHCYP data. Our paper draws on data collected as part of a large-scale, school-based study to explore the extent of mental health problems reported by children and young people and the factors that increase the odds of experiencing these problems. As we noted in the introduction to our paper, the national MHCYP study only reported after our paper was accepted for publication; however, we were able to add reference to the MHCYP survey at the point of revisions as we wanted to alert readers to this important work. We agree that both mental health and mental ill health 'can be conceptualised in a number of ways'. We would also want to note that there is much debate about how best to determine levels of need and much evidence of lack of precision even when using clinically experienced assessors.^{3,4} No cut-offs are perfect for estimating prevalences of children with mental health difficulties. In our paper we focus on raised levels of child-reported mental health difficulties in this school-based sample as likely indicators of level of difficulties that might be distressing for the child and potentially disruptive for the class and thus may be important in relation to potential early intervention.^{5,6}

Second, whether the more deprived sample contributes to higher levels of reported mental health difficulties. We highlight in the paper the slightly more deprived survey population relative to national figures and also explicitly note that deprivation is associated with mental health problems, so we feel comfortable that we have been very transparent about this potential limitation.

Third, whether the single-informant Strengths and Difficulties Questionnaire (SDQ) is a less reliable predictor of child mental disorder than the multi-informant SDQ. Relying only on self-report always has its limitations and this has been acknowledged in the paper. However, there is also much evidence of disagreement between different perspectives so it is not clear how best to determine whose view takes precedence. We think considering the child's perspective is a worthwhile endeavour.^{7,8}

Four, rationale around three-band versus four-band categorisation and use of subscale scores rather than total difficulties. The