healthwatch Suffolk

My Health, Our Future

Understanding Children and Young People's Mental Health - The State of Suffolk

November 2017
Prepared by Thomas Delaney

ACKNOWLEDGEMENTS

Healthwatch Suffolk would like to thank the pastoral staff, senior management and teachers who made My Health, Our Future possible. Without working in collaboration across Suffolk, this project would not have received such a positive response.

Above all, we thank the pupils at the following schools:

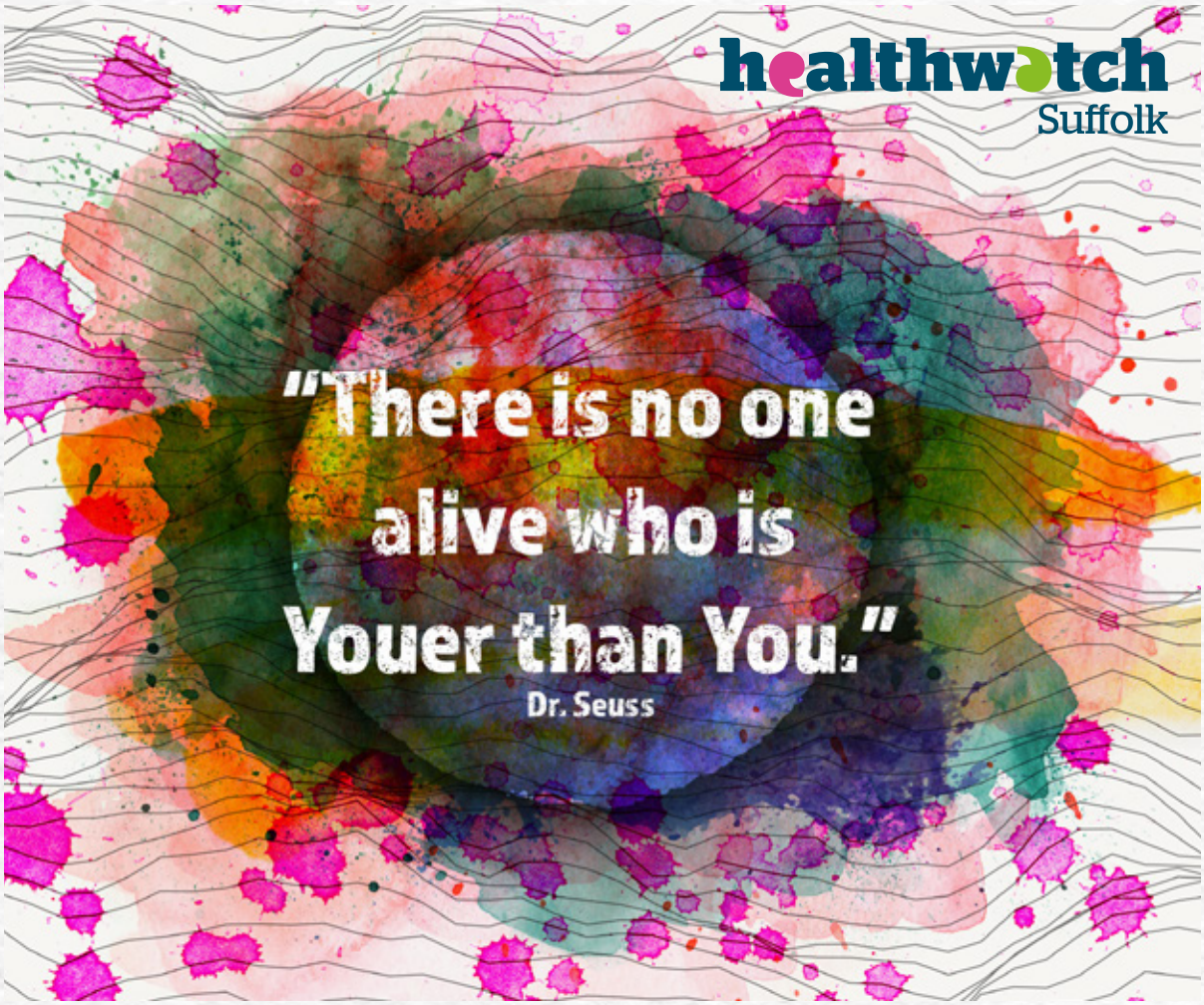
- Felixstowe Academy
- Farlingaye High School
- Northgate High School
- Ipswich Academy
- Stowupland High School
- Samuel Ward Academy
- Newmarket Academy
- Mildenhall College Academy

Important note:

Much of the data highlighted within this report is presented according to the differences that are evident between male and female respondents. Please note the below icons (and colours) that have been used to represent gender within many of the graphs and graphics that you will find throughout this document.

Female Male

CONTENTS



Getting creative about mental health and wellbeing

Healthwatch Suffolk encouraged young people to get creative about their understanding of mental health and wellbeing.

Students attending the schools that took part in "My Health, Our Future" were tasked with submitting something that is personal, powerful and that represents what mental health and wellbeing means to them. We have included a few of the submissions within this report.


HOPE
Hold on Pain ends

FOREWORD

Andy Yacoub
Chief Executive of Healthwatch Suffolk

"My Health, Our Future" is one of a growing number of influential reports by Healthwatch Suffolk, many of which have been designed, researched and completed with the help of partner agencies.

A combination of in-house expertise, knowledge, key resources and our extensive Suffolk wide network of partners, has led to this report being the most keenly awaited since Healthwatch Suffolk was launched in 2013.

In my opinion, "My Health, Our Future" is impactive, significant, co-produced and visually powerful. Let me explain why.

The report is impactive because it is distinct, challenging and offers achievable recommendations that will positively influence strategy and implementation, both at a county level and within individual schools. This State of Suffolk report is supported by 8 individual reports. The individual reports are to be shared directly with the 8 participating schools.

The report is significant because it is based on a particularly large sample size. In fact, we have been unable to identify any other equivalent research at county level, with over 6,800 respondents having taken part. The potential for eventually reaching 70-75% of secondary school pupils across all of Suffolk, numbering tens of thousands, is now plausible, thereby creating a unique county database of intelligence for commissioners, schools and providers.

The study, PHSE learning activity and our sign-posting posters/cards, have also already created opportunities for passing on critically important information to the pupils and their teachers. The report is wide reaching because the core essentials of the project were added to by the schools involved, allowing them to add factors that were relevant to them.

The report has been co-produced, with pupils, teachers and other school staff. Co-production is a priority for Healthwatch Suffolk and now also Suffolk's Health and Wellbeing Board. The value and strength of co-production cannot be underestimated when considering how much of an impact a researcher and commissioner, as in this case, aims to achieve.

The success of the project may also potentially lead to larger and broader 'mental & physical health' State of Suffolk initiative. Our activities with 9 secondary schools in Suffolk (inclusive of our innovative pilot with Thomas Gainsborough school, Sudbury, in 2016), is now also opening doors to other secondary schools. The basis upon which the data and intelligence has been gathered and analysed also lends this study to be compared nationally, because of the adoption of the Short Warwick Edinburgh Emotional Wellbeing Scale (SWEMWBS).

The report is visually powerful because of the stunning pupil artwork from our participating schools. A selection of the artwork has been appropriately interspersed throughout the text of the report. The art accentuates what pupils told us through the survey and we have also created a range of infographics in order to clearly and creatively carry our key messages.

We all have school in common from an early age. Actions taken in school can have a big impact on a student's wellbeing, not just in the short term but also throughout their lives. Secondary school spans a crucial juncture and often challenging transition into physical and social maturity. Our report therefore sets out why recognising the emotional health needs of young people and taking steps to meet those needs at this stage is of the utmost importance.

I sincerely hope you find the report interesting and helpful. You will, I believe, be surprised at some facts, shocked by others, and left feeling positive by some aspects, such as the recommendations. The fact these recommendations have been agreed with the commissioners involved leaves me to believe that they will be acted on, and that change of a positive nature will come about. My thanks to everyone involved, particularly our researcher Tom Delaney, other team members at Healthwatch Suffolk, the pupils, teachers and other school staff, our commissioners, and those who supported the project through other means.

Eugene Staunton
Chair of Children's Emotional Wellbeing Group, Associate Director of Transformation, Lead for Children and Young People, Mental Health, Maternity and Learning Disabilities for NHS Ipswich and East Suffolk Clinical Commissioning Group and NHS West Suffolk Clinical Commissioning Group (CCG)

In October 2015 CCG areas were required to develop a Local Transformation Plan (LTP) in response to the recommendations set out in the Future In Mind Report - promoting, protecting and improving our children and young people's mental health and wellbeing, the report of the Government's Children and Young People's Mental Health Taskforce.

Suffolk's plan sets out how over the next five years, it will improve children and young people's emotional wellbeing and mental health by transforming services.

The work is overseen by the Children's Emotional Wellbeing Group with representation from across our Health and Care system - NHS Ipswich & East Suffolk CCG, West Suffolk CCG, Suffolk County Council, health and care organisations, young people, Suffolk Parent Carer Network, charities and schools.

In our annual review of our Transformation Plan (October 2017), we celebrate progress made and consider areas for further focus over the next 12 months which include:

1. Working in partnership to develop a behaviour pathway for East and West Suffolk that will provide a clear, consistent pathway for all families and young people in Suffolk and will align with the requirements within the SEND Action Plan Priority 3 to review and develop pathways for ADHD and Autism.
2. The Emotional Wellbeing Hub (a new health and care single point of contact) will become operational in April 2018 and is key to our strategy and focus on prevention and early intervention.
3. Recruiting to a new pilot crisis service and monitoring the outcomes for Suffolk's young people and families.

We commissioned Healthwatch Suffolk to produce this report to support us in better understanding the specific needs of our young people in schools, we are both encouraged and challenged by the comprehensive findings of the My Health, Our Future report. In working together on

the recommendations, we have been able to reflect on how these are woven into the Transformation Plan and can see where there is significant progress, and where we will continue to work in co-production to deliver health and care, system-wide improvements that will benefit the children, young people and families of Suffolk.

TABLES

GRAPHS

FIGURES

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EXECUTIVE SUMMARY

Background

My Health, Our Future' has been an iterative process building on a pilot study in 2015/16.

The project was informed by the vision of Future in Mind, a report produced by Norman Lamb MP in 2015. It highlighted the need to move towards a children and adolescent mental health system focused on prevention and early intervention, as half of all diagnosable disorders establish by the age of 14.

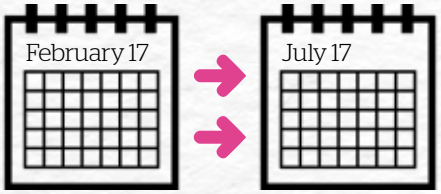
My Health, Our Future sought to establish clear patterns of need among children and young people across Suffolk. The findings are discussed in relation to the school's Tier One functions: mental health and wellbeing promotion and prevention.

Objectives

Our objective is simple: to engage children and young people via a whole-school approach, including their curriculum, local services and their understanding of mental health and wellbeing issues. The objectives are threefold:

1. The project forms part of Suffolk's Emotional Wellbeing Plan (CAMHS Transformation Plan);
2. The responses have been used to create bespoke reports for each school involved. This allows schools to truly understand the needs of their students, leading to new forms of engagement and changes to the curriculum; and
3. The students completing the online survey have been up-skilled on issues surrounding mental health and wellbeing.

My Health, Our Future is a part of the Children and Young People's Emotional Wellbeing Plan (EWB2020). See page 8 for more information.



Data was collected between **February** and **July 2017**.

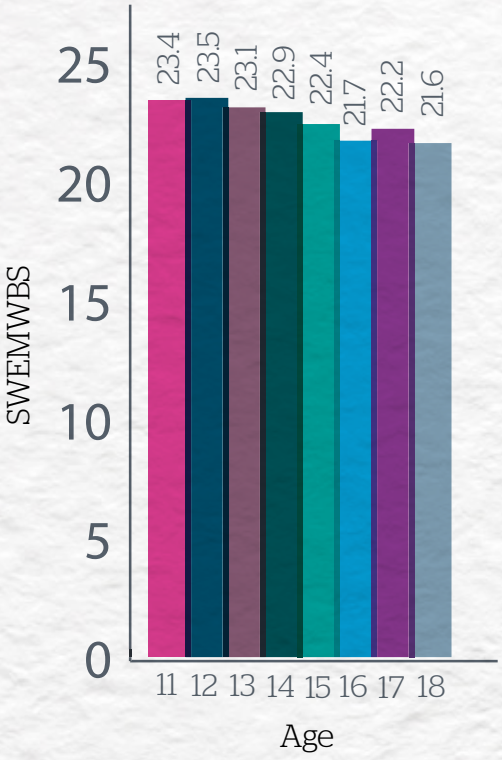
Over **6,800** responses were recorded from a total of **eight schools** across the county. The response rate is **79%,** which means our results can be generalised to the wider population of children and young people in Suffolk.

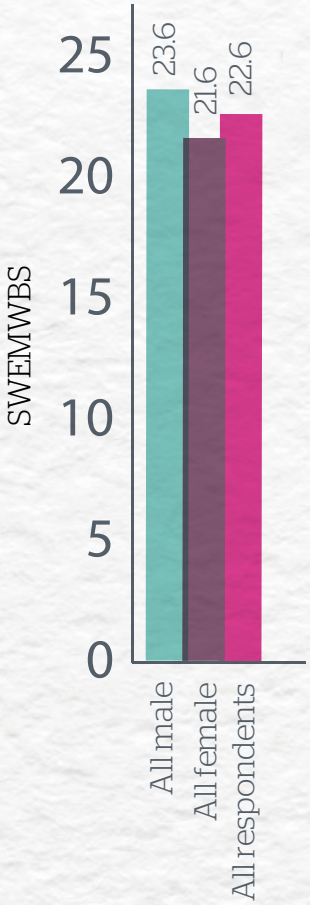
After checking for safeguarding issues (see page 40), low wellbeing scores, incomplete surveys and duplication, a total of 6,238 responses were analysed.

The Short Warwick-Edinburgh Mental Wellbeing Scale:
The survey used a measure of wellbeing called the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). Scores can range between 7 (lowest possible wellbeing) and 40 (highest possible wellbeing).

5,397 responded to the SWEMWBS. The average score was **22.6**. This is at the lower end of 'average' when compared to the Population Norms in Health Survey for England (23.6). The graph below shows average ratings for each SWEWBS item.

Graph 3: *All participants average score for each SWEMWBS item (out of a possible score of five). n = 5,397*





Graph 4 and 5: *Average SWEMWBS score by age and gender. n = 5,397*

When we look at the differences between male and female SWEMWBS scores, we see that the overall average is 'low' due to female respondents.

The average male score was **23.6** (slightly above average), while the average female score was **21.6** (almost in the lowest 25% of the population).

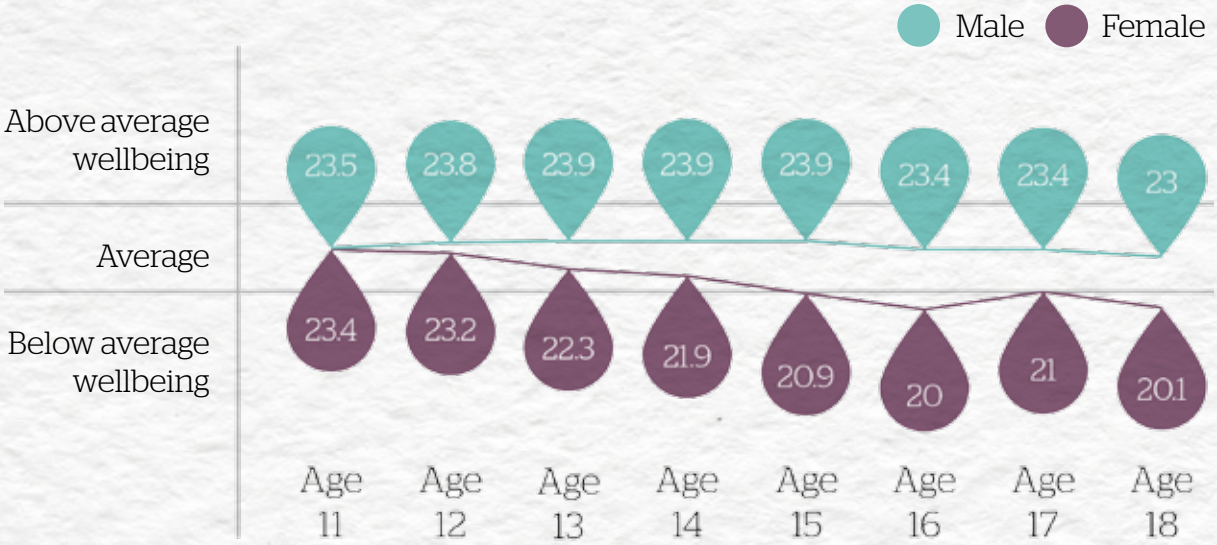


Figure 6: *Gender and age comparison of SWEMWBS score. Female participants experience poorer wellbeing with increasing age, falling below the 25th percentile when compared to the national average. n = 5,397*

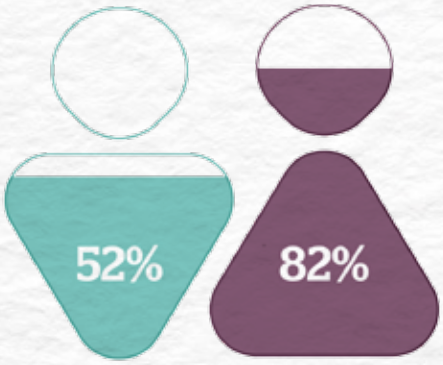


Figure 9: *Percentage of all students that want to be taught about mental health and wellbeing. n = 2,345*

- % of all age groups who said they had not been taught about mental health and wellbeing
- % of each age group who said they had not been taught about mental health and wellbeing

Prevalence of mental health and wellbeing education in Schools

45% of respondents said they are not taught about mental health and wellbeing in schools.

Respondents aged 15 onwards have lower levels of mental health and wellbeing provision in schools (this is due to exams etc). Older students (14+) are discontent with current PSHE curriculum as it does not reflect their life experiences.

The desire for mental health and wellbeing to be taught in school increases among female respondents from **age 12 (73%)** to **age 17 (89%)**.

On average, **52%** of male respondents wanted to be taught about mental health and wellbeing in schools (this percentage remained stable across all ages).

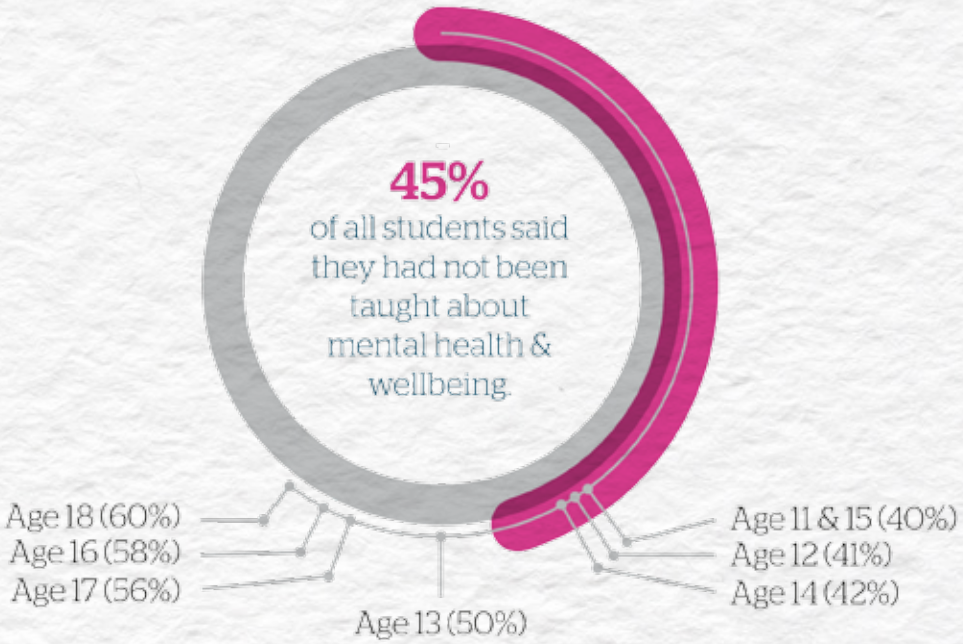
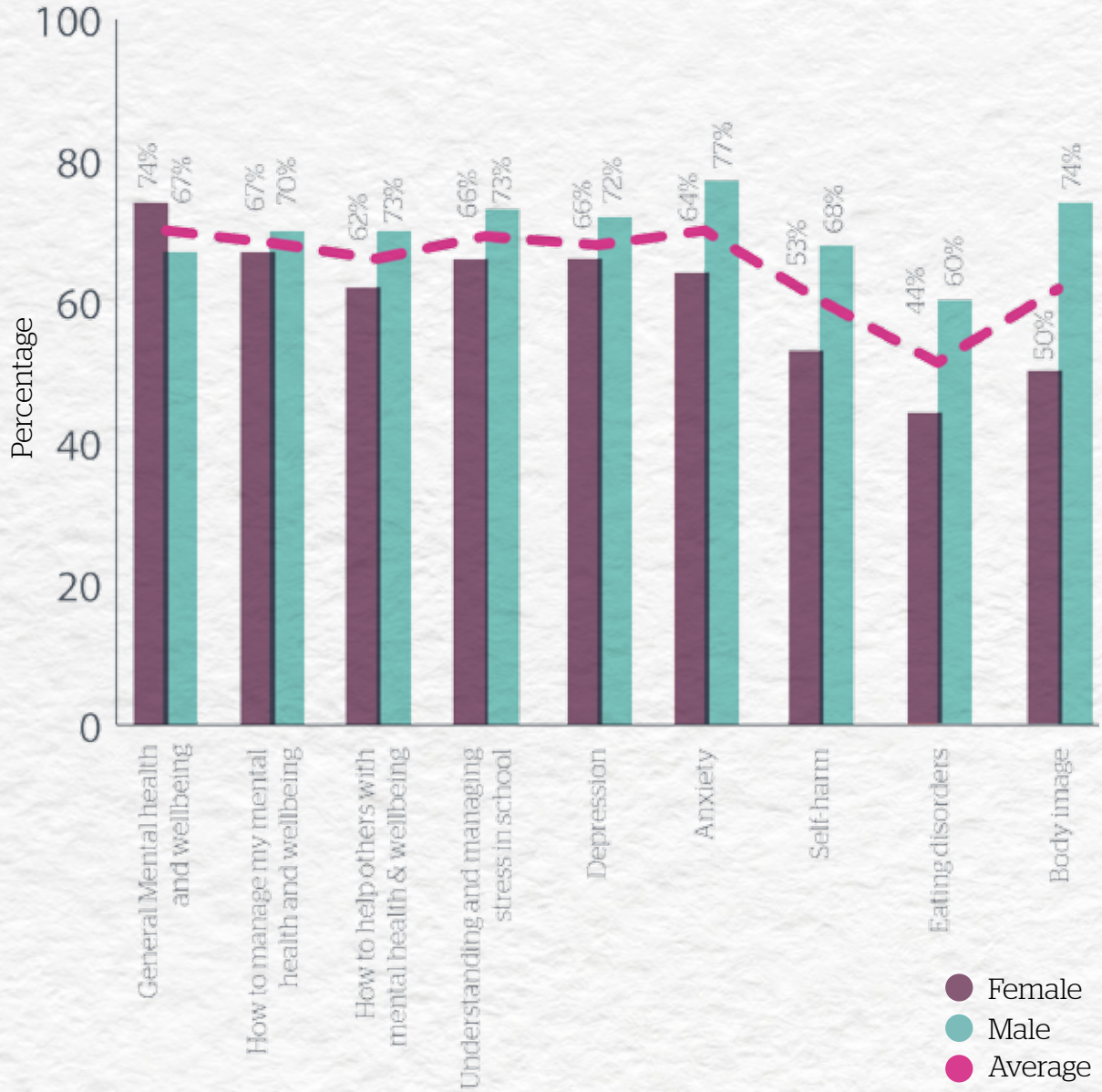


Figure 7: *Percentage of students who said they had not been taught about mental health and wellbeing (total and age group comparison). n = 5,119*

Graph 7: *Respondent's preference for what topics should be taught in school. n = 1,707*



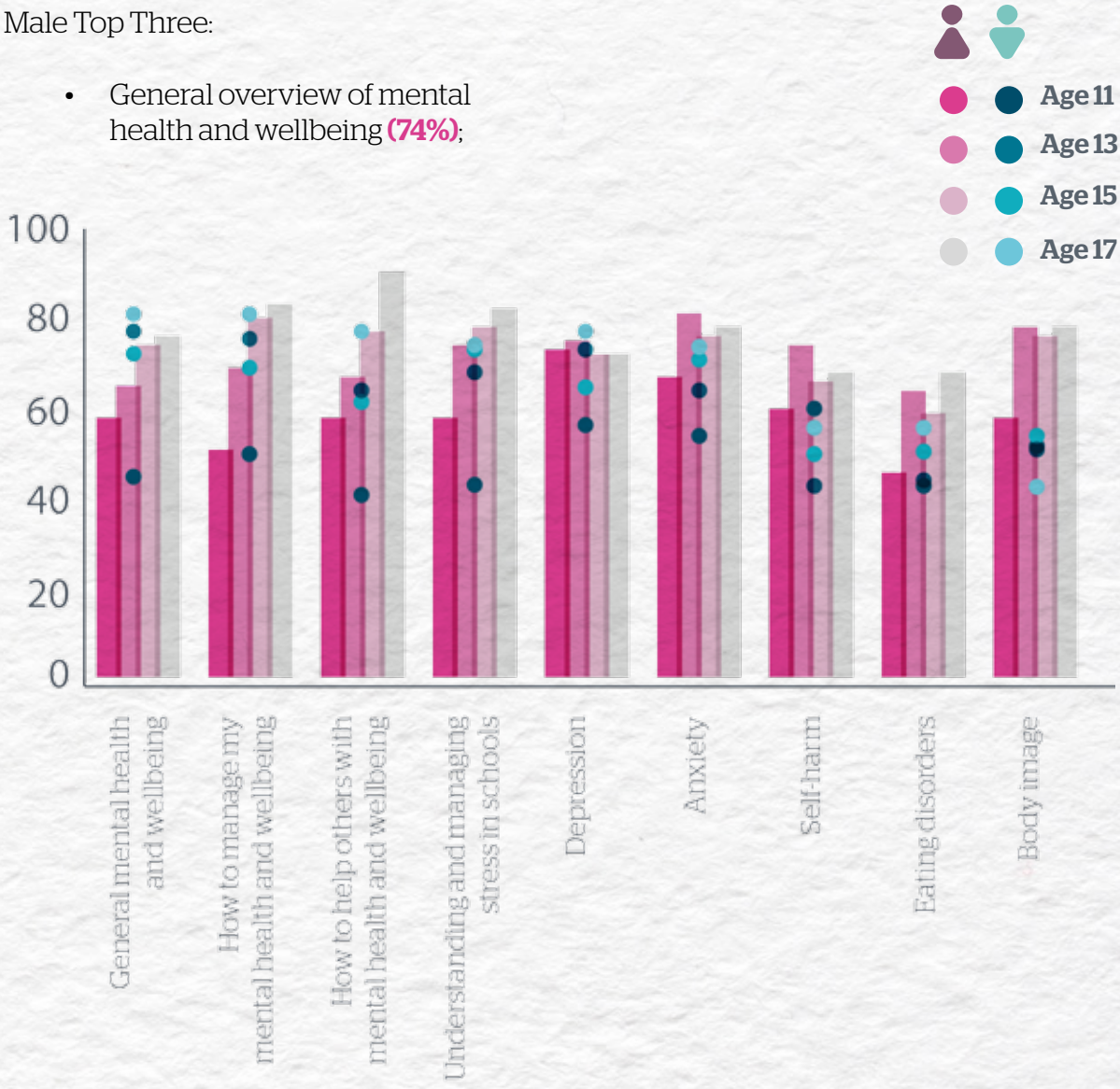
Topics students would like to see taught in school:

Female Top Three:

- Anxiety **(77%)**;
- Body image **(74%)**; and
- Understanding and managing stress in school **(73%)**.

Male Top Three:

- General overview of mental health and wellbeing **(74%)**;
- How to manage my mental health and wellbeing **(67%)**; and
- Understanding and managing stress in schools **(66%)**.



Graph 8: *Respondent's preference for what topics should be taught in school by age and gender. n = 1,707*

Figure 13: 68% said they could travel 0 - 19 miles to access services.

When visiting an NHS service, what's the most important thing?

Top three:

1. To be taken seriously (92%);
2. To be listened to and understood (91%); and
3. Confidentiality (83%).

This was the same across all age groups.

When visiting an NHS service, how far can you travel?

Although 'close to where you live' was the least important factor when visiting an NHS mental health Service, **68%** of respondents can't travel more than 20 miles to visit an NHS Service.

This was the same across all age groups.

This is due to public transport and issues around expressing mental health or low wellbeing to their parents.

What makes you feel stressed?

Revision, exams and managing a work-life balance were listed as the top three stressors for respondents. This increased from age eleven to seventeen.

Fears of being bullied and peer pressure decreased with age.

The young people's comments expressed that the reason adolescents like school less as they get older is because of the increasing pressures generated by exams and pressures on academic performance. They thought that girls were particularly affected by this partly because they care more than boys about doing well at school, and partly because girls were seen (by both genders) as internalising emotions more easily.

Boys were described as more laid back and caring less about what others thought of them.

Graph 16: *Gender differences between* responses to options about what makes respondents feel stressed (see page 72 for a detailed breakdown). n = 2,266

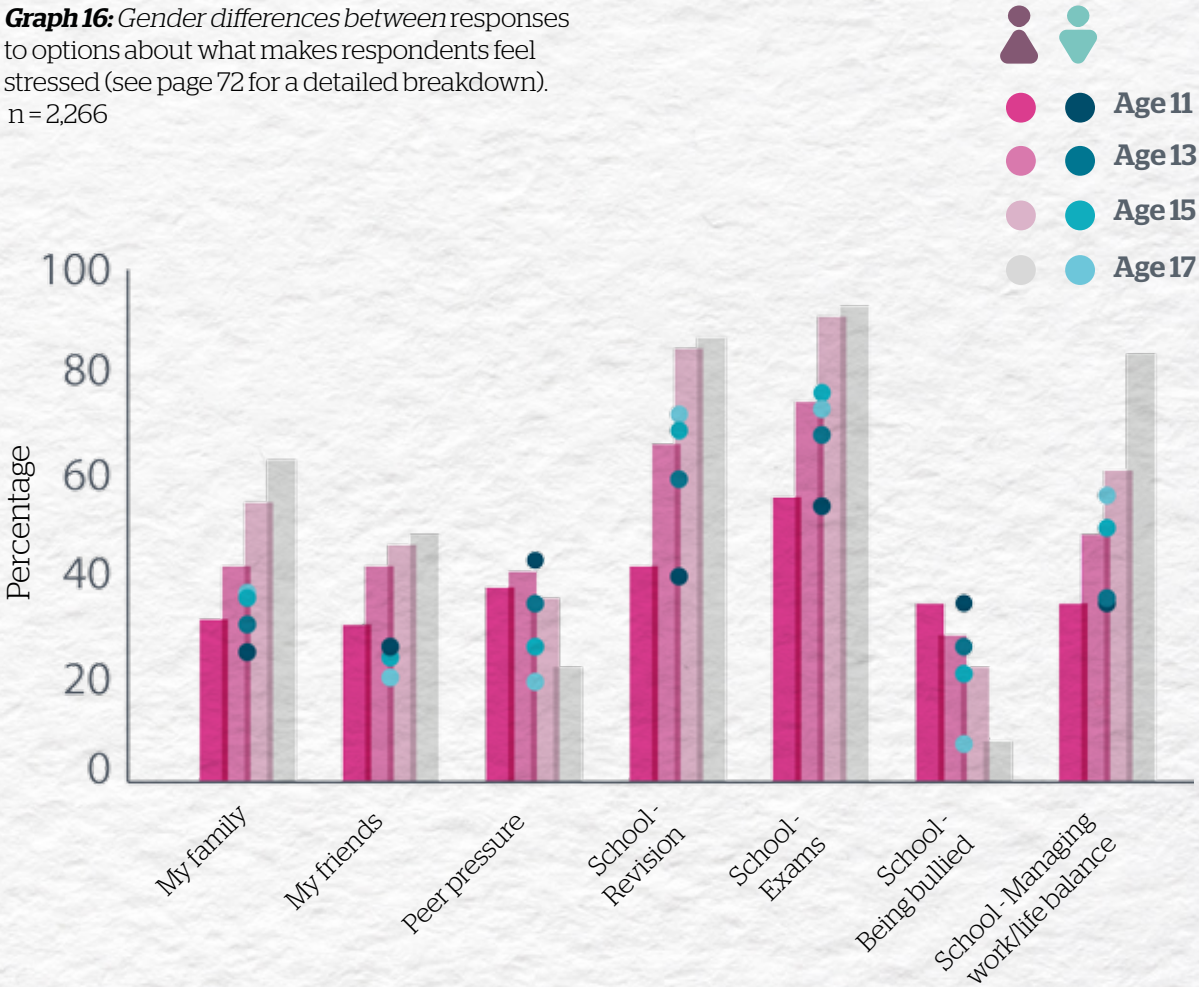


Figure 14: Accumulative school pressures (e.g. exams and revision) become an increasingly prominent source of stress in participant's lives.

The prevalence of school work as a stressor among female respondents is particularly worrying.

- Exams (**54%** at age eleven to **90%** at age seventeen)
- Revision (**41%** at age eleven to **82%** at age seventeen)
- Managing work-life balance (**34%** at age eleven to **81%** at age seventeen)

School related stressors (age 11) - **40%**
School related stressors (age 17) - **85%**

Coping: The young people felt that parents and family are an important source of support for adolescents but that it would become more difficult to discuss things with parents as they became older. This was partly because some things were felt to be more personal as young people age but respondents also spoke about wanting to feel independent and therefore discussing problems with parents less to feel autonomous.

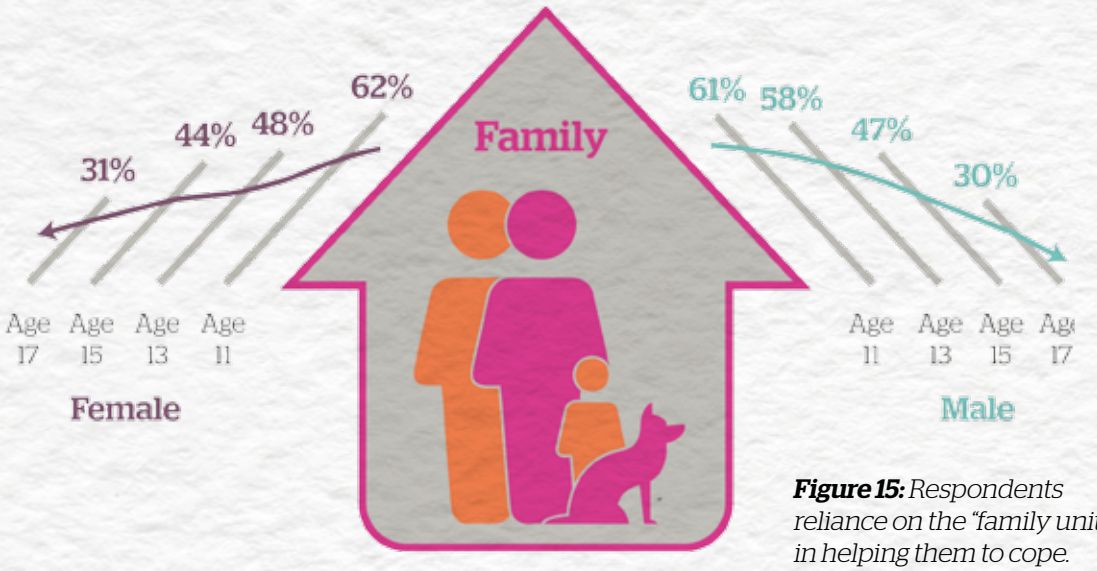


Figure 15: *Respondents reliance on the "family unit" in helping them to cope. n = 4,560*

Across both male and female students, reliance on the family unit falls with increasing age. At age 11 **2 out of 3** students said family are important in helping them to cope. This drops to less than **1 in 3** by age 17.

Body image and self-esteem

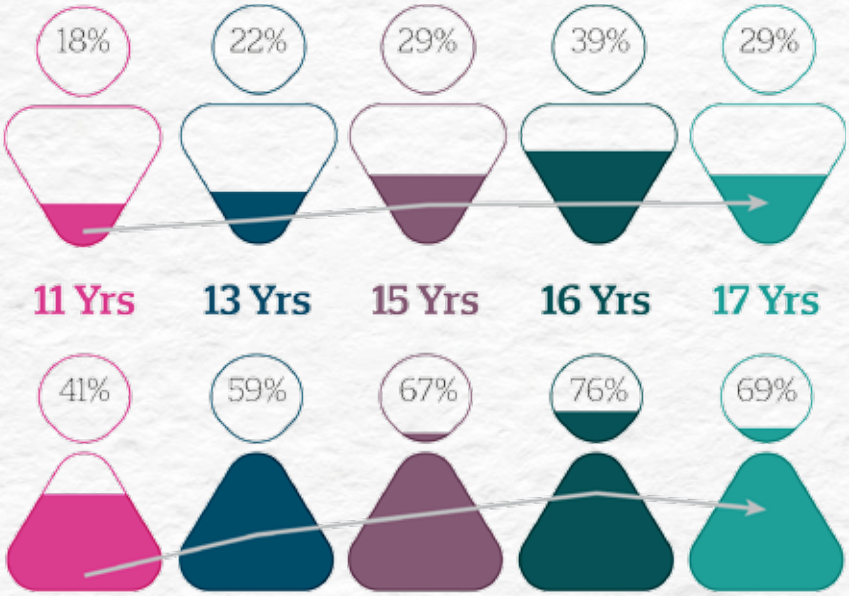
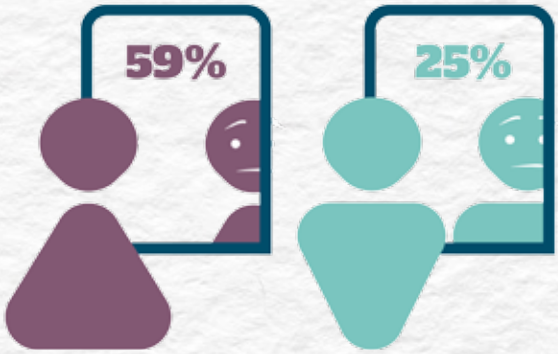


Figure 17: Levels of worry (most or all of the time) generally increase with age for both genders but is particularly noticeable amongst female respondents (based on 2,305 responses).

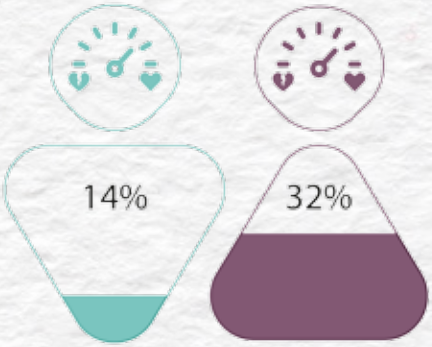


3 out of 5 females and **1 in 4** males worry about their appearance and/or body image most or all of the time (based on 4,609 responses).

Figure 16: Female and male respondents level of worry about their appearance (most or all of the time) n = 4,609

Female respondents had lower levels of self-esteem compared to their male counterparts. As with body image, age is positively correlated to lower levels of self-esteem.

1 in 3 female and just over **1 in 10** male respondents would rate their day-to-day self-esteem as either poor or very poor.



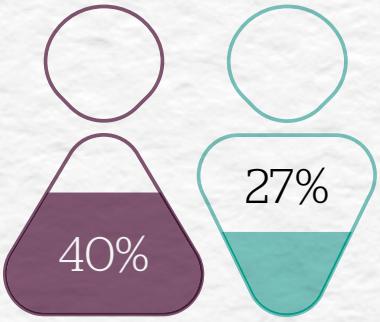
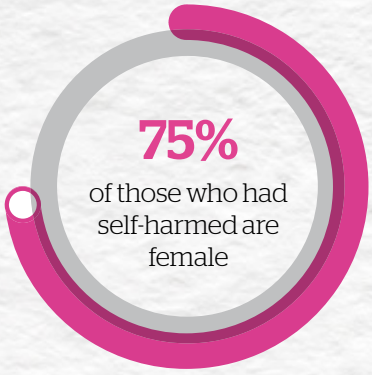
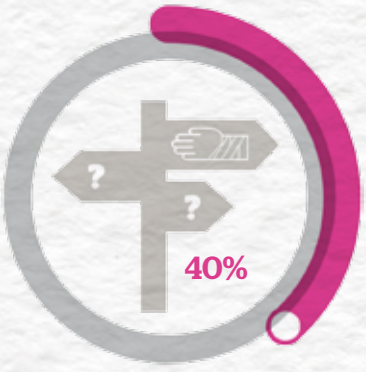


Figure 28: Percentage of male and female respondents who know of someone that is self-harming.
n = 921





Figures 32: 40% of respondents indicated that they do not know where to go for support with self-harming.
n = 918

Self-harm

Self-harm was classified under the following themes:

1. self-injury or self-poisoning intentionally to cause harm
2. an act with non-fatal outcome, in which an individual deliberately initiates a behaviour that, without intervention from others, will cause self-harm

Just over a fifth of 15-year old respondents reported that they had self-harmed, in line with other recent research.

15% of respondents reported previously self-harming. Of those who had self-harmed, three quarters were female.

40% of respondents indicated that they do not know where to go for support with self-harming.

Figure 24: Almost **one in ten** respondents stated that they had been a victim of cyberbullying in the last two months (8 per cent).
n = 1,432

Cyberbullying

The prevalence of cyberbullying increases with age – from 7% at age eleven to 16% at age sixteen.

Cyberbullying was more prevalent among female respondents. The comments provided attributed this to the judgements young people make of each other on looks and how social media was a catalyst to do this publicly.

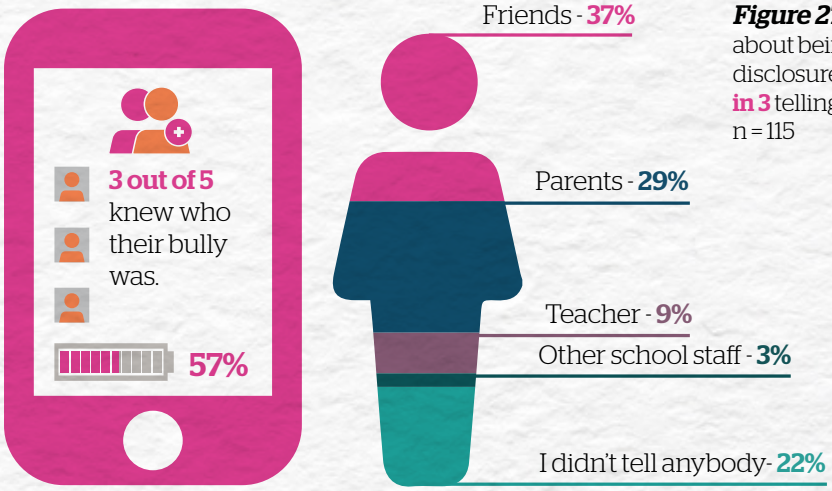
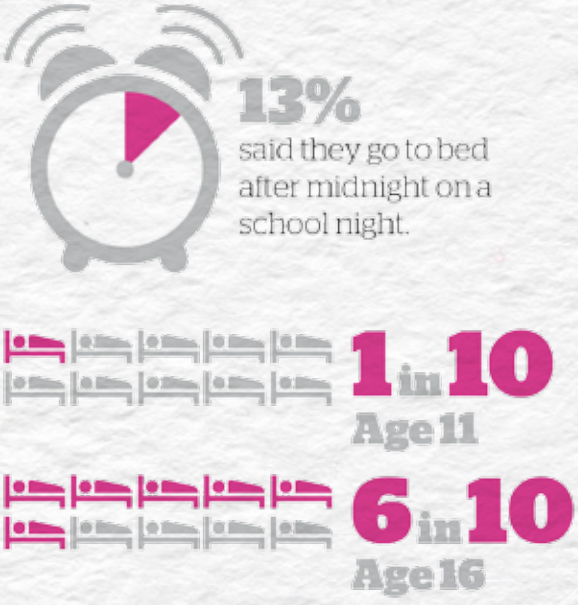


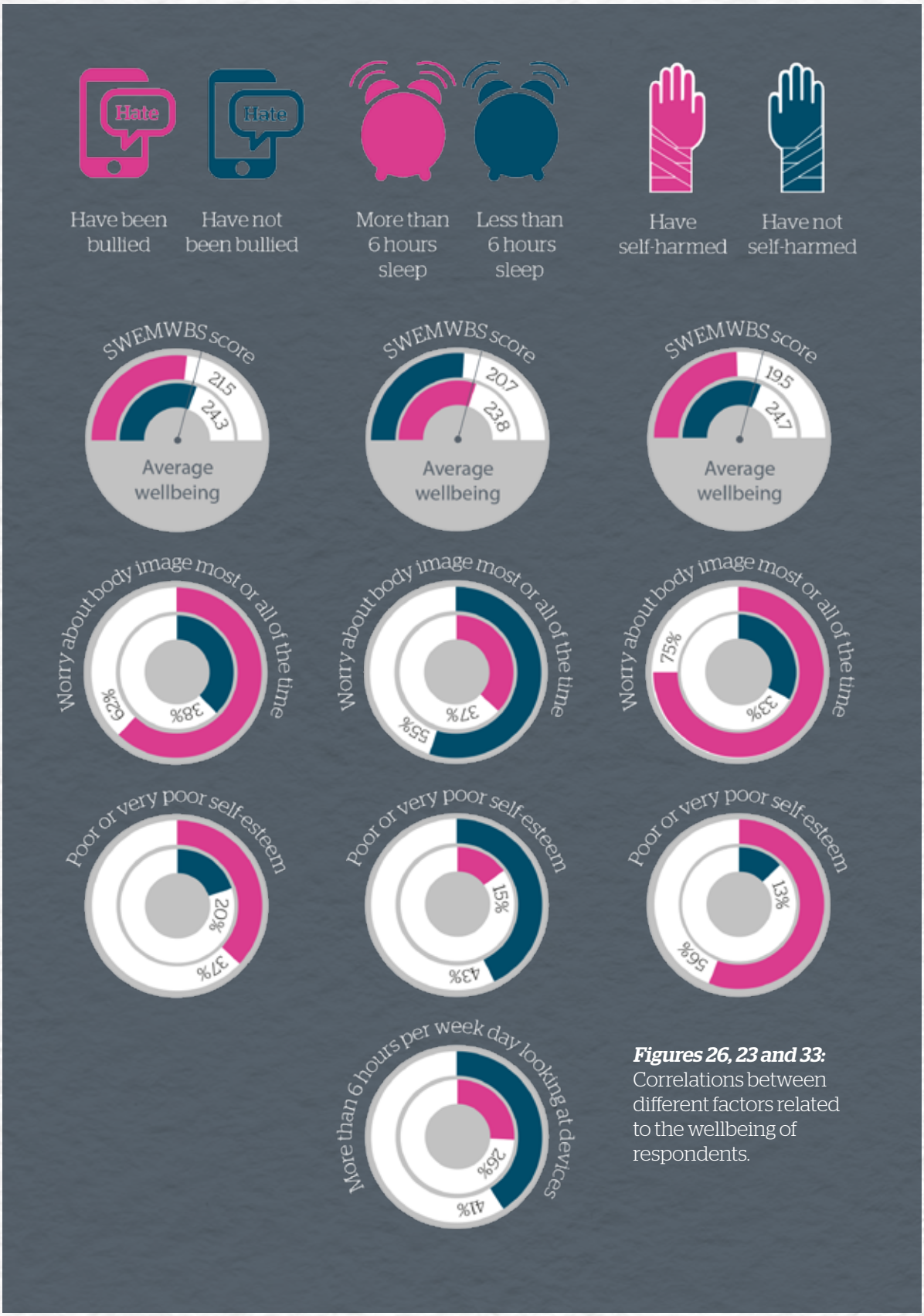
Figure 27: Respondents who told someone about being cyberbullied report making a disclosure to a number of individuals, with **1 in 3** telling their friends.
n = 115

Sleep duration on a school night

The number of respondents that get **less than six hours** of sleep on a school night increases with age from **one in ten** at age 11 to **six in ten** at age 16.

The findings indicated that those respondents getting less than six hours sleep on a school night experience higher levels of worry about their body image, poorer self-esteem and score lower on wellbeing than those who get more than six hours sleep (see page 93).





Figures 26, 23 and 33: Correlations between different factors related to the wellbeing of respondents.

Discussion

It should be clear from the range of issues discussed that there is considerable potential for improving children's subjective well-being. This over-arching goal will not be achieved through focusing on a single issue, nor can it be achieved by the actions of only one key stakeholder.

Some of the findings appear to be amenable to national and local policy initiatives, while others are more relevant to services and practitioners, to parents and to children themselves. In this section we provide a few selected examples of the relevance of the findings for different stakeholder groups.

Leadership and Management:

To ensure actions are integrated, sustained and monitored for impact it is important that a commitment to addressing social and emotional wellbeing is referenced within improvement plans and policies. This includes safeguarding; confidentiality; PSHE education; SMSC (Social, Moral, Spiritual and Cultural) education; behaviour and rewards and practice.

It is also important to involve pupils, staff and parents in developing these policies via coproduction so that they remain 'live' documents that are reviewed and responsive to the evolving needs of the school community.

Making children and young people's voices heard across health and education sectors:

Involving students in decisions that impact on them can benefit their emotional health and wellbeing by helping them to feel part of the school and wider community and to have some control over their lives. At an individual level, benefits include helping students to gain belief in their own capabilities, including building their knowledge and skills to make healthy choices and developing their independence. Collectively, students benefit through having opportunities to influence decisions, to express their views and to develop strong social networks.

Upskilling Suffolk's Workforce:

It is important for staff to access training to increase their knowledge of emotional wellbeing and to equip them to be able to identify mental health difficulties in their students. This includes being able to refer them to relevant support either within the school or from external services.

Promoting staff health and wellbeing is also an integral principle of the whole school approach to emotional health and wellbeing. Teaching and learning establishments can demonstrate a commitment to staff health and wellbeing in many ways. For example, by providing opportunities for assessing the emotional health and wellbeing needs of staff, by providing support to enable staff to reflect on and to take actions to enhance their own wellbeing and by promoting a work-life balance for staff.

Implementing a whole-school approach to mental health and wellbeing:

The findings from My Health, Our Future indicate that a shift towards a whole-school approach is warranted. Building resilience among Suffolk's children and young people should not be left to certain aspects of the curriculum, such as PSHE or RSE, as schools are a universal service, accessed five days a week by most children.

With such a huge amount of time spent in the classroom, schools provide an ideal environment for promoting good emotional wellbeing and identifying early behaviour changes and signs of mental distress. For children experiencing adversity at home, school can also provide a consistent, protective and therapeutic environment, which can help them to cope.

Digital literacy:

Schools and other educational settings should take proactive measures to help prevent cyberbullying from occurring, and to reduce the impact of any incidents that do happen.

All schools are required to follow anti-discrimination and equality laws. Staff must act to prevent discrimination, harassment and victimisation within the school. Cyberbullying prevention should build on these requirements, promoting and maintaining a safe and welcoming environment.

Recommendations:

1. The Emotional Wellbeing 2020's Workforce Development programme should proactively offer all secondary schools training and development.
2. Stakeholders should work collaboratively to provide a systematic approach to upskilling children and young people on issues regarding mental health and wellbeing across secondary schools in Suffolk.
3. Personal, Social, Health and Economic Education (PSHE) and Relationship and Sex Education (RSE) should include digital literacy and online safety.
4. EWB2020 stakeholders should work collectively to promote children and young people's voices throughout health and education systems, such as the Health and Wellbeing Board.
5. The EWB2020 should increase funding for Tier One support
6. Schools should be engaged on the forthcoming Emotional Wellbeing Hub and, where possible, should receive increased signposting material.
7. Healthwatch Suffolk will help My Health, Our Future schools to implement a Mental Health and Wellbeing Roadmap.


Perfect

INTRODUCTION

1.1 - My Health, Our Future

NHS England, the Department of Health and the Department for Education are now working together to administer the 'transformation' of Child and Adolescent Mental Health Services (CAMHS), using £1.25 billion in government funding over the course of the current parliament. Stakeholders in Suffolk have received £1.6 million, increasing to £2.3 million, per year until 2020.

Central to the approach of 'transformation' is the ambition that all local stakeholders will work together to understand the nature of local need and how best to meet it. There is a focus on the rejuvenation of early intervention services based in the community.

With the goal of improving the mental health and wellbeing of an entire population, one of the best places to start is at school. Each of us have school in common for 10 years of our lives during a critical stage of our early development. It is a place where you can reach an entire section of our growing population. Secondary school in particular spans a crucial and often challenging transition into physical and social maturity, and it is a time when some young people are vulnerable to stresses and in need of support.

Research has shown that protective factors developed in school can help all students and can offset risk factors from elsewhere in a student's life[iiiii]. This means

Research has shown that protective factors developed in school can help all students, and can offset risk factors from elsewhere in a student's life.

that, for some students, school can be a haven; a safe refuge from things that may otherwise cause them to feel stressed or isolated.

Actions taken in school can have a big impact on a student's wellbeing, not just in the short term but over their entire lives. Mental health is a foundation of school achievement. Positive mental health and wellbeing can translate into good behaviour, good habits, good attendance, positive community and good grades. If every school were producing students with good mental health and wellbeing, we would see a ripple effect across the entire nation, to everyone's benefit.

However, while schools have been granted greater autonomy to find their own ways to meet the mental health needs of pupils, this autonomy has not been accompanied by measures to strengthen their capacity in this area, or by a commitment to improve and develop the resources in the community that schools can draw upon. Furthermore, schools are struggling to have their voices

heard in the unfamiliar world of health commissioning as academisation has diminished the 'brokerage' role played by local authorities. As a result, too many pupils continue to be denied the option to access high-quality, school-based early intervention services for emerging mental health problems.

Schools have the potential to become a key part of the mental health infrastructure for children and young people. If they are to fulfil this potential, it will be necessary to take the important step of recognising them as centres of both education and health.

The 'My Health, Our Future' project seeks to ascertain the needs of children and young people in Suffolk. It sets out why it is important that schools do take on a greater role and how that role should be conceived of in practice. It also considers how local services can build on the 'transformation' agenda to provide schools with the mix of resources and incentives they need to meet pupils' emerging mental health needs, and hold them to account for doing so.

1.2 - Children and Young Peoples' Mental Health and Wellbeing: A National Picture

It is widely believed that there is a crisis in the mental health of children and young people. The scale of the problem is such that professionals have warned of a 'hidden epidemic'[iv], while a wide variety of other stakeholder groups, including young people themselves, have also voiced real concern[v]. Consider the following findings.

1. 1 in 10 children and young people aged between 5 and 16 had a clinically diagnosable mental health condition. That translates into roughly three children in every classroom[vi].
2. Half of all mental health problems are established by age 14 and 75% by age 24[vii].
3. In a 2015 survey of 1,180 headteachers, two-thirds named the mental health of pupils as their top concern[viii].
4. Mental health problems are one of the main causes of the burden of disease worldwide. In the UK, they are responsible for the largest burden of disease– 28%[ix]. However, mental health services only receive 13% of the overall NHS budget. Children and Adolescent Mental Health Services receive just 0.7% of the total NHS budget[x].

Despite the consistency of these reports' findings, the absence of official data on the topic makes it difficult to arrive at a firm understanding of the current levels of mental ill-health among children and young people. However, we can be sure that there is a significant and urgent need to bring about parity of esteem and tackle the growing mental health and wellbeing crisis seen among our children and young people.

1.3 - My Health, Our Future: the background

"My Health, Our Future" has been an iterative process building on a pilot study in 2015/16. The project was informed by the vision of Future in Mind, a report produced by Norman Lamb MP in 2015, which highlighted the need to move

towards a children and adolescent mental health system focused on prevention and early-intervention, as half of all diagnosable disorders establish by the age of 14.

In 2015/16 Healthwatch Suffolk completed a pilot study that engaged 500 secondary school students via a live interactive survey. This was followed by workshops with 100 Health and Social Care students. The data collected was used to inform a theatre production and community engagement event hosted by students at the Thomas Gainsborough School. The School Report informed the ongoing work of commissioners, as well as new policies and engagement at the school.

The Future in Mind report and the subsequent local Child and Adolescent Mental Health Services (CAMHS) Transformation Plans have coproduction at their core. This means that we (HWS) are well placed to help commissioners and schools understand the needs of Suffolk's children and young people. Due to the success of the pilot project, we have been funded to engage with eight more schools across Suffolk ('My Health, Our Future').

The 'My Health, Our Future' project serves to increase children and young people's knowledge of mental health and wellbeing issues, while simultaneously collecting data relating to their personal experience and perspective of mental health and wellbeing in relation to the curriculum.

My Health, Our Future sought to establish clear patterns of need among children and young people across Suffolk. The findings are discussed in relation to the school's Tier One functions: mental health and wellbeing promotion and prevention.

Before going any further it is important to clarify the Tier system used within schools. This report distinguishes between three broad categories of school-based provision that exist in practice (See figure 1).

- Tier One: promotion and prevention
- Tier Two: early identification, triage and referral
- Tier Three: early intervention

	Tier One		Tier Two			Tier Three
Function	**Promotion**	**Prevention**	**Early Identification**	**Triage**	**Referral**	**Early Intervention**
Teachers						
Pastoral Staff						
School Nurses						
CAMHS Professionals						

Figure 1: *Tiered approaches to health and wellbeing provision in schools.*

Primary responsibility
Secondary responsibility
Co-ordinated responsibility

1.4 - Objectives

Our objective is simple: to engage children and young people via a whole-school approach, including their curriculum, local services and their understanding of mental health and wellbeing issues. The objectives are three-fold:

1. The project forms a part of Suffolk's Emotional Wellbeing Plan (CAMHS Transformation Plan);
2. The responses have been used to create bespoke reports for each school involved. This allows schools to truly understand the needs of their students, leading to new forms of engagement and changes to the curriculum; and
3. The students completing the online survey have been up-skilled on issues surrounding mental health and wellbeing.

Where it all started...

My Health, Our future followed a pilot in partnership with the Thomas Gainsborough School in Sudbury and Unity and Diversity, through which Healthwatch Suffolk collected the views of over 400 pupils about their use of mental health and wellbeing services as well as the ambitions of the EWB2020.

Download the report from:
www.healthwatchsuffolk.co.uk/our-reports-2


HOPE
Hold on, pain ends
Hope is being able to see that there is light despite all of the darkness.
Education breeds confidence
Confidence breeds hope
Hope breeds peace.


Who I am
hope is being able to see that there is light despite all of the darkness
LOVE
PEACE
KINDNESS

METHODOLOGY

2.1 - Research Questions

My Health, Our Future sought to answer the following questions:

1. What is the current level of wellbeing among children and young people in Suffolk?
2. Regarding mental health and wellbeing, are children and young people satisfied with their school curriculum? If not, why?
3. How can schools and local services more effectively serve the children and young people of Suffolk?

2.2 - Research Design

The My Health, Our Future project opts for a conclusive research design. A conclusive research design, as the name implies, is applied to generate findings that are practically useful in reaching conclusions or decision-making.

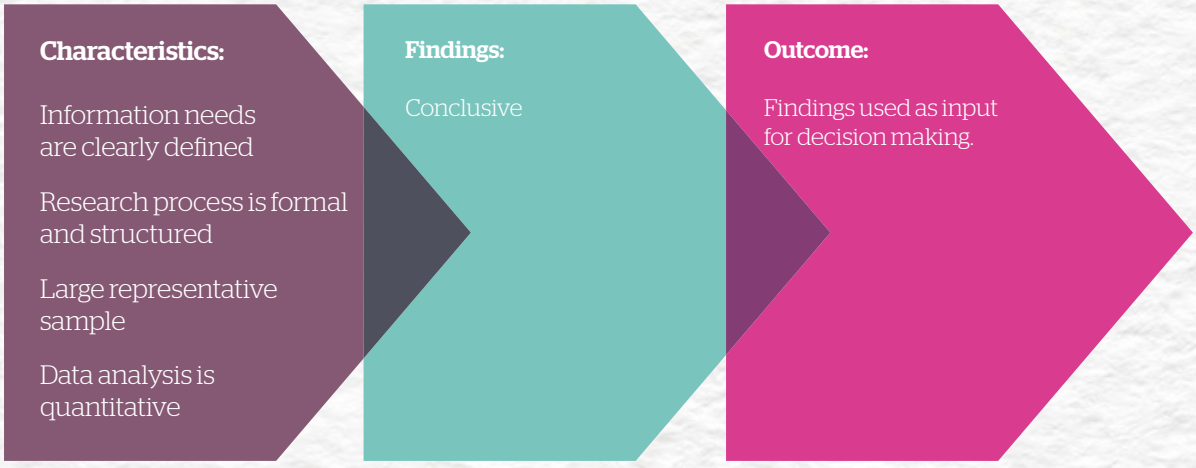
Conclusive research design usually involves the application of quantitative methods of data collection and data analysis.

2.3 - Instruments

Healthwatch Suffolk coproduced an interactive, online survey with local students over a period of three months. The survey was then used as a lesson plan and embedded into the curriculum from February 2017 to July 2017.

Each school involved in My Health, Our Future was given a bespoke survey link. The survey included six subsections on aspects relating to mental health and wellbeing. Each subsection included a short, informative video followed by several questions. Respondents were asked a minimum of twenty-seven questions.

Where possible, each school was given the opportunity to include additional



questions – schools often concentrated on new mental health and wellbeing policy or pertinent issues specific to the school.

Survey subsections:

1. Generalised information on mental health and wellbeing
2. Mental health and wellbeing: the school and the curriculum
3. Mental health and wellbeing services
4. Body image and self-esteem
5. Living with mental health and wellbeing issues
6. Self-awareness and Mindfulness

The My Health, Our Future survey also used the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS).

The SWEMWBS is a scale that measures mental wellbeing (as opposed to mental illness or disorder) and is suitable for use in the general population. Its strengths are that it is positively worded, represents positive attributes of wellbeing and covers both feeling and functioning. Evidence from a recent study suggests that users of mental health services and their carers prefer the SWEMWBS to other mental health outcome measures. Moreover, its psychometric properties are robust and it is sensitive to the changes that occur in wellbeing promotion projects.

All the validation studies have shown SWEMWBS to be easy to complete and to capture concepts of wellbeing familiar to general and minority populations.

Figure 2: *Survey response rate.*

2.4 - Sample

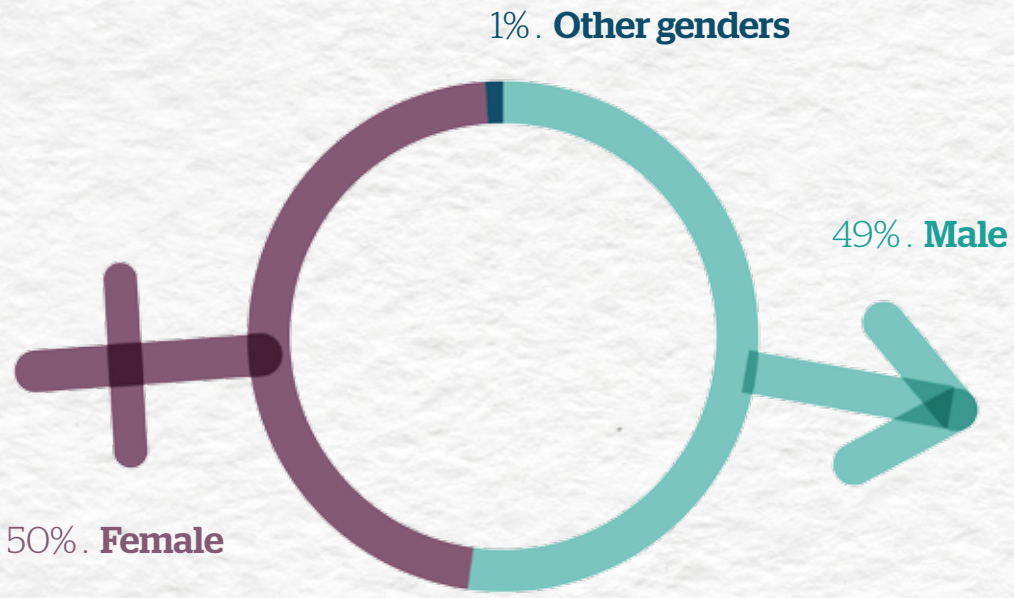
The survey was open from February 2017 to July 2017.

Over this period 6,803 responses were collected. After sifting for safeguarding issues, low SWEMWBS scores, incomplete surveys and duplication, 6,238 responses were analysed. The My Health, Our Future survey received a 79% response rate.

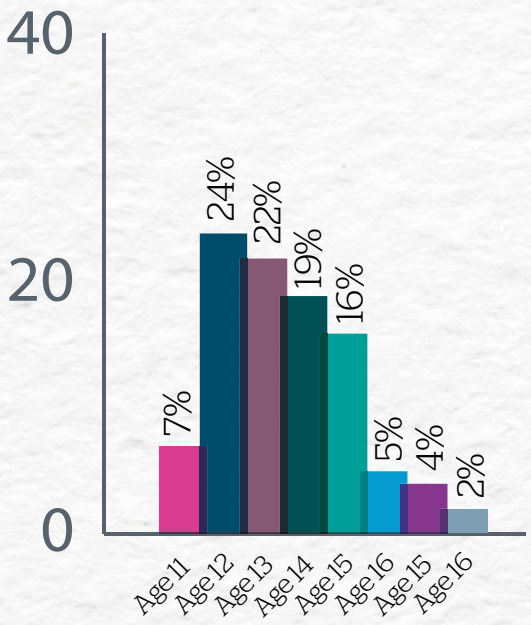
Table 1: *Number of respondents per year group.*

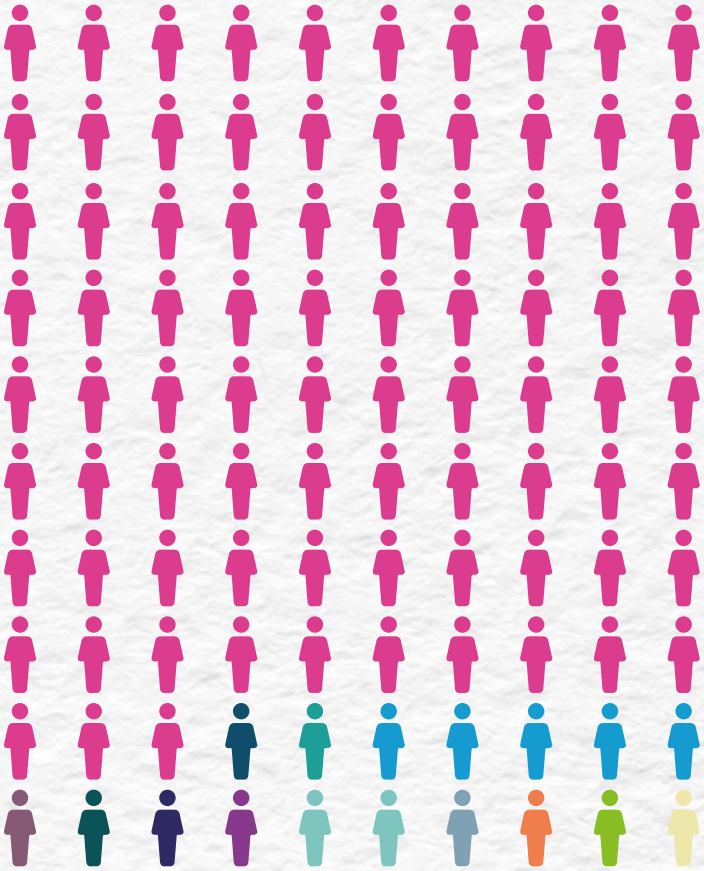
Number of respondents per year group								
	Year 7	**Year 8**	**Year 9**	**Year 10**	**Year 11**	**Year 12**	**Year 13**	**Total**
All schools (Actual)	1,577	1,580	1,485	1,410	1,051	408	386	7,897
All schools (Once filtered)	1,304	1,514	1,091	1,288	541	272	228	6,238
Response rate per cent	83%	96%	73%	91%	51%	67%	59%	79%

Figure 3: *Gender of participants (n=5,886)*



Graph 1: *Age (n=5,883)*





White English/ Welsh/Scottish/ Northern Irish/ British	83%	
White Irish	1%	
White Gypsy, Traveller or Irish Traveller	1%	
White other	5%	
Mixed/Multiple ethnic groups - White and Black Caribbean	1%	
Mixed/Multiple ethnic groups - White and Black African	1%	
Mixed/Multiple ethnic groups - White and Asian	1%	
Mixed/Multiple ethnic groups - Any other	1%	
Asian / Asian British - Indian	1%	
Asian/Asian British - Bangladeshi	2%	
Asian / Asian British - Any other Asian background	1%	
Black / African / Caribbean / Black British - African	1%	
Other ethnic group	1%	

Figure 4: *Ethnicity (n=5,836)*

2.5 - Data Collection

Teaching staff at each school were tasked with embedding the online survey into the curriculum and rolling it out across each year group. Five of the eight schools used the online survey as a lesson plan, dedicating additional time to discussing mental health and wellbeing after the survey was completed.

The online survey was hosted by Survey Monkey. Additional information and an opt-out form was sent to parents and/or guardians. Responses were anonymous.

2.6 - Data Analysis

The researcher at Healthwatch Suffolk analysed the data. The responses were analysed by gender and year group. The data was then cross-examined via multivariate analysis.

2.7 - Safeguarding

Safeguarding materials were made available to all participants. This included signposting to local and national mental health and wellbeing services.

Safeguarding is a term which relates to the action taken to promote the welfare of children and protect them from harm, and is defined in "Working Together to safeguard children 2013" as "protecting children from maltreatment; preventing impairment of children's health and development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes.

Healthwatch Suffolk raised **46** safeguarding cases during the course of the My Health, Our Future survey.

Respondents deemed a safeguarding issue were isolated by class, age, gender, and ethnicity, which allowed teachers and/or pastoral staff to locate the respondent.

School	General concerns	Cyberbullying	Self-harm	Total
1	6	0	0	6
2	2	0	0	2
3	3	8	0	11
4	6	0	11	17
5	0	3	0	3
6	1	0	0	1
7	3	2	0	5
8	1	0	0	1
			Total	**46**

Table 2: *The number of safeguarding alerts raised with schools.*

Monsters

There's a monster in my closet,
And one under my bed.
There's a few behind the curtain,
And one inside my head.
The monster in the closet,
Is red with glowing eyes.
It claims it's gonna eat me,
But I know it always lies.
The monster underneath my bed,
Has razor sharp teeth and scales.
It always tries to drag me down,
But everytime it fails.
The ones behind the curtain,
Leave messages on the wall.
But their threats are never scary,
Because they're ~~never~~ all so small.
The monster that's inside my head,
Follows me like a curse.
It has no fangs or claws or fur,
But it's by far the worse.
I can't escape my monsters,
I'll never be truly free.
But now I've learned to live with them,
Cause they're a part of me.

RESULTS

3.1 - Understanding the Data

Reading the Graphs:

Data is shown in bar charts and infographics, usually by age and gender with averages for girls and boys shown for comparison. Please note that not all students will have answered all the questions in the survey.

Where respondent numbers are lower than n=25 a white exclamation mark (!) will denote a warning. Where there is an exclamation mark, it is important to treat these data points with caution. This is because all the percentages in the charts are based on the total number of males or females who answered that question in the survey, not the total number of males or females who took part in the survey. This means that high percentages can potentially be misleading if only a small number of students answered the question.

Understanding the results: an example

Thirty boys take part in the survey but only eight answer the question on self-harm. Of these eight, five say that they have self-harmed. The chart therefore shows that 63% of boys (five out of eight) are self-harming. We cannot include the boys who did not answer because to do so we would have to make an assumption about what their answer would be. If we base the percentage on five out of 30 boys, we are assuming that those who did not answer are not engaged in self-harming.

Important note:

Much of the data highlighted within this report is presented according to the differences that are evident between male and female respondents. Please note the icons (and colours) right that have been used to represent gender within many of the graphs and graphics that you will find throughout this document.

Female Male

Children and Young People's Mental Wellbeing

3.2 - Question One: Warwick-Edinburgh Mental Wellbeing Scale Short (SWEMWBS)

Students were asked the SWEMWBS – a seven item scale used to ascertain mental wellbeing (see table 2).

The SWEMWBS involves seven questions, which correspond to a five-point Likert Scale. Respondents score between 7 (minimum) and 35 (maximum).

The SWEMWBS is scored by transforming the scores according to a raw score to a metric score conversion table. We have extrapolated the SWEMWBS responses and compared it to the results seen in the Population Norms in Health Survey for England (2011).

The results can be seen in graph 2 (page 43).

Below are some statements about feelings and thoughts. Please tick the box that best describes your experience of each over the last 2 weeks.						
	None of the time	Rarely	Some of the time	Often	All of the time	Total
I've been feeling optimistic about the future	1	2	3	4	5	
I've been feeling useful	1	2	3	4	5	
I've been feeling relaxed	1	2	3	4	5	
I've been dealing with problems well	1	2	3	4	5	
I've been thinking clearly	1	2	3	4	5	
I've been feeling close to other people	1	2	3	4	5	
I've been able to make up my own mind about things	1	2	3	4	5	

Table 3: *The SWEMWBS five point Likert Scale.*

Figure 5: *On average, all participants have a SWEMWBS score of 22.6. This falls into the "average" category when compared to national data.*

	None of the time	Rarely	Some of the time	Often	All of the time	Total	Weighted Average
I've been feeling optimistic about the future	423	971	2,000	1,541	462	5,397	3.1
I've been feeling useful	324	1,177	2,112	1,469	315	5,397	3.0
I've been feeling relaxed	369	1,159	1,761	1,580	528	5,397	3.1
I've been dealing with problems well	333	1,042	1,827	1,641	554	5,397	3.1
I've been thinking clearly	251	903	1,811	1,746	686	5,397	3.3
I've been feeling close to other people	291	816	1,502	1,789	999	5,397	3.4
I've been able to make up my own mind about things	182	556	1,342	1,946	1,371	5,397	3.7

Table 4: *Detailed breakdown of the responses to the SWEMWBS.*

Table Four provides a more detailed breakdown of the responses to the SWEMWBS.

The average SWEMWBS score across all respondents was 22.6. This is slightly lower than the 50th percentile presented in the Health Survey for England's (2011) SWEMWBS transformed score (23.6)[xi] .

When looking at Graph 2 we see that the bell curve indicates a comparable distribution of scores to the Health Survey for England (2011)[xii], albeit fractionally lower.

The data presented in Graph Six shows that students aged twelve to sixteen reported declining wellbeing scores (23.5 to 21.7, respectively), with those aged sixteen almost reaching the lowest 25 per

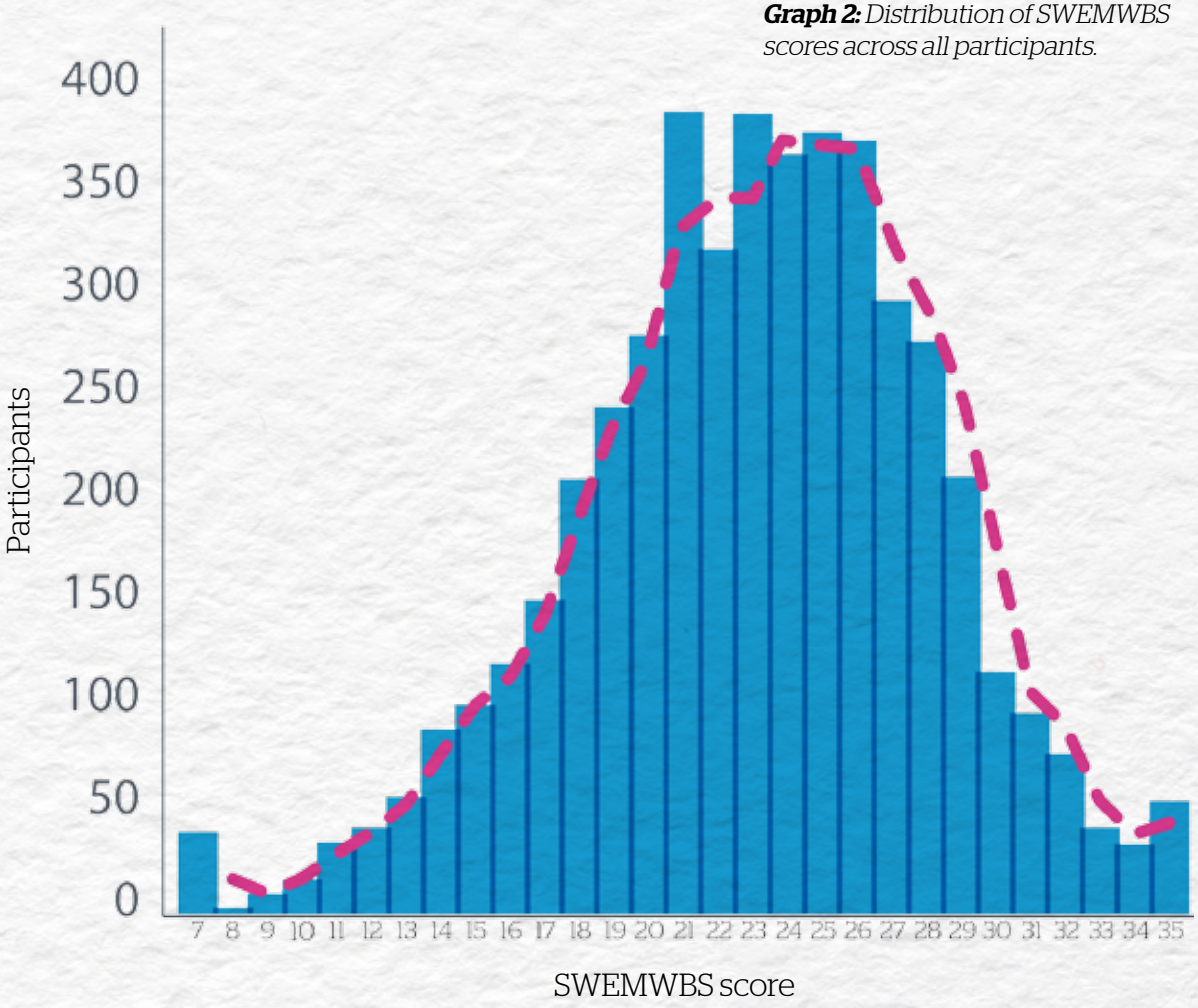
cent of wellbeing scores when compared to the Health Survey for England. The score for respondents aged eighteen was also markedly low.

The raw comments expressed that wellbeing decreased at age 16 and 18 due to GCSEs and A-Levels, and the additional pressures that come with the build-up to exams.

However, we see a clearer depiction of wellbeing when looking at the trends across the gender divide. Females reported distinctly lower wellbeing scores than their male counterparts. The SWEMWBS score for males remains relatively stable across the age range, with wellbeing increasing from the age of eleven to thirteen (23.5 to 23.9, respectively). From the age of thirteen to fifteen male wellbeing plateaus (23.9), before decreasing at age sixteen (23.4). Females, however, reported declining wellbeing scores from the age of eleven to sixteen (23.4 to 20, respectively).

When compared to the results from the Health Survey for England, female respondents aged fifteen to eighteen are in the lowest 25 per cent of the population, all scoring lower than 21.5 (see figure 5).

Graph 2: *Distribution of SWEMWBS scores across all participants.*



Graph 3: *All participant's average score for each SWEMWBS item (out of a possible score of five). n = 5,397*

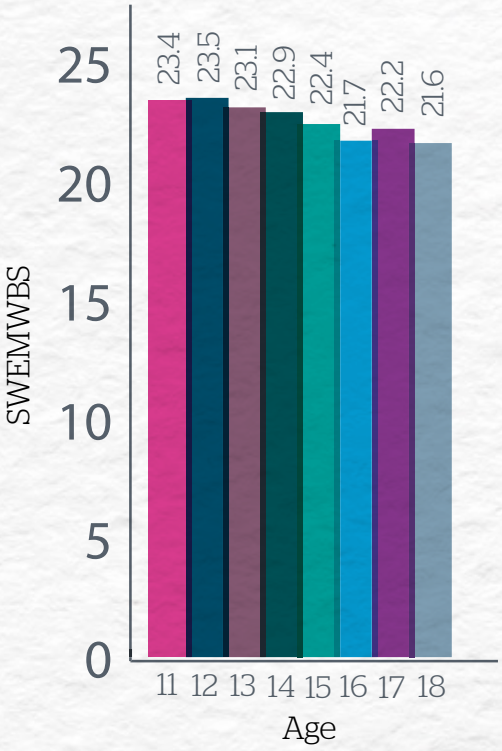
Figure 6: *Gender and age comparison of SWEMWBS score. Female participants experience poorer wellbeing with increasing age, falling below the national average after age 15. n = 5,397*

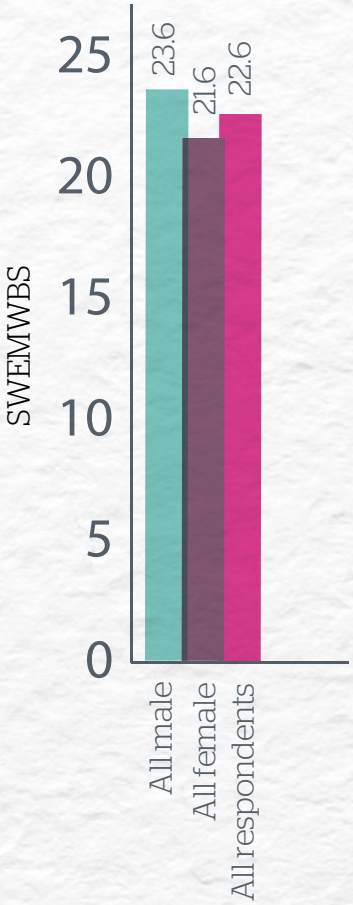
The seven statements seen in the SWEMWBS relate more to functioning than feelings compared to other wellbeing scales[xiii]. This indicates why levels of wellbeing fluctuate across age and gender, and how the indices interact with 'overall' wellbeing.

Across the respondent population, we can see that the majority of children and young people responded positively to 'feeling close to other people' and 'being able to make [their] own mind about things'.

Negative sentiment was more prevalent across four statements; 1 in 4 respondents reported that they felt 'optimistic about the future' and that they had been 'dealing with problems well' rarely or none of the time (26 per cent and 25 per cent, respectively). Twenty-eight per cent of respondents reported that they had been 'feeling useful' and 'feeling relaxed' rarely or none of the time in the last two weeks (see graph six).

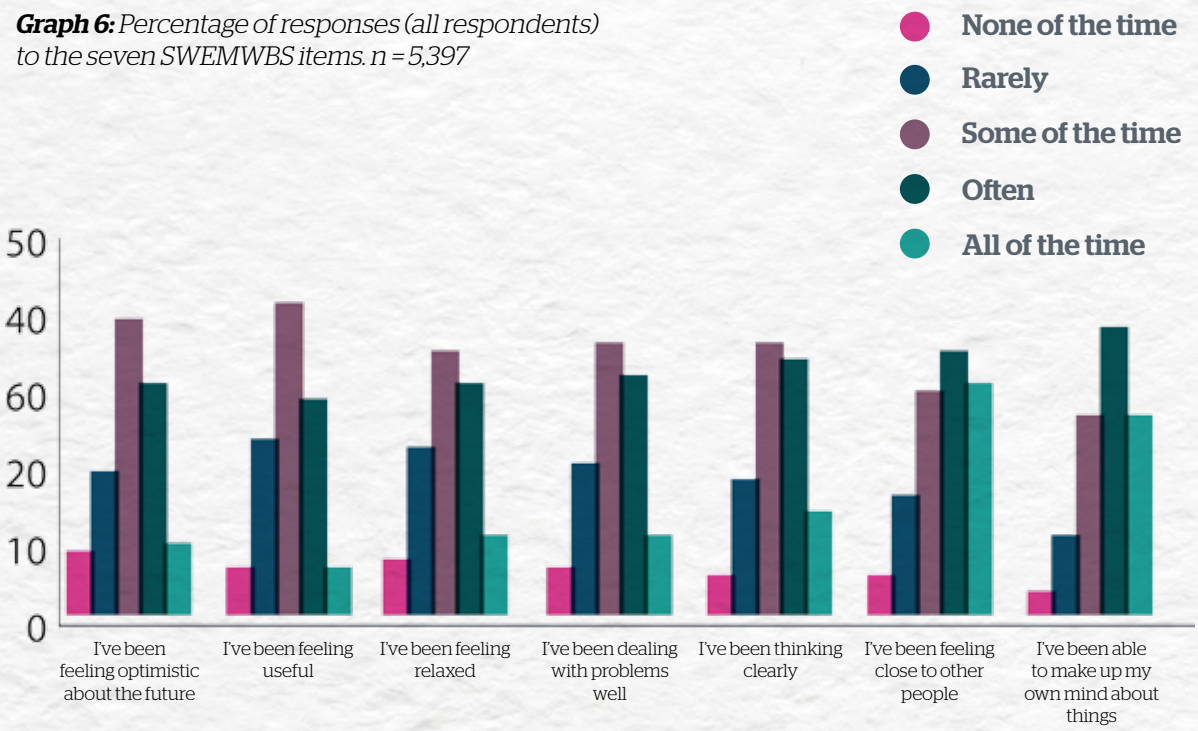
A detailed breakdown of SWEMWBS across age and gender can be seen in the appendices.





Graph 4 and 5: *Average SWEMWBS score by age and gender. n = 5,397*

Graph 6: *Percentage of responses (all respondents) to the seven SWEMWBS items. n = 5,397*



All respondents					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	8%	18%	37%	29%	9%
I've been feeling useful	6%	22%	39%	27%	6%
I've been feeling relaxed	7%	21%	33%	29%	10%
I've been dealing with problems well	6%	19%	34%	30%	10%
I've been thinking clearly	5%	17%	34%	32%	13%
I've been feeling close to other people	5%	15%	28%	33%	19%
I've been able to make up my own mind about things	3%	10%	25%	36%	25%

National comparable data

Gender: 79% of boys and 69% of girls rated their life satisfaction as high. Across all ages the proportion of girls who rated their life satisfaction as seven or above was lower than for boys and this gendered difference becomes more pronounced with age[xiv].

Age: Younger adolescents were more likely to rate their life satisfaction as seven and above. Generally, 15-year olds (remaining consistent with previous surveys) have the lowest life satisfaction among all groups with both boys and girls reporting a decrease since 2010[xv].

The Good Childhood Index found that there were significant downward age trends between the age of 10 and 14. There were also small differences in the percentage of children with low subjective well-being. Girls were significantly more likely to have low scores on all subjective well-being measures than boys[xvi] .

Young people who participated thought that students may rate their wellbeing lower as they got older because with age life becomes increasingly stressful; because there is more pressure from school and the responsibility of making decisions that will affect them in the future. Both boys and girls thought that the reason girls report lower life satisfaction is because there is more pressure on girls to do well in school and to be popular. The comments attributed to female respondents highlighted that they are subject to harsher judgement by their peers and in some cases teachers.

The children and young people also mentioned stress as a reason why health and wellbeing complaints are more prominent among girls and increase with age, as stress could lead to headaches, trouble sleeping etc (more on stress can be seen later in the report). Some of the boys felt that males were more likely to rate their health as good because they tend to do more sports and physical activity that provided a sense of body confidence and physical fitness.

The curriculum: promoting positive mental health and wellbeing

3.3 - Does your school teach you about mental health and wellbeing?

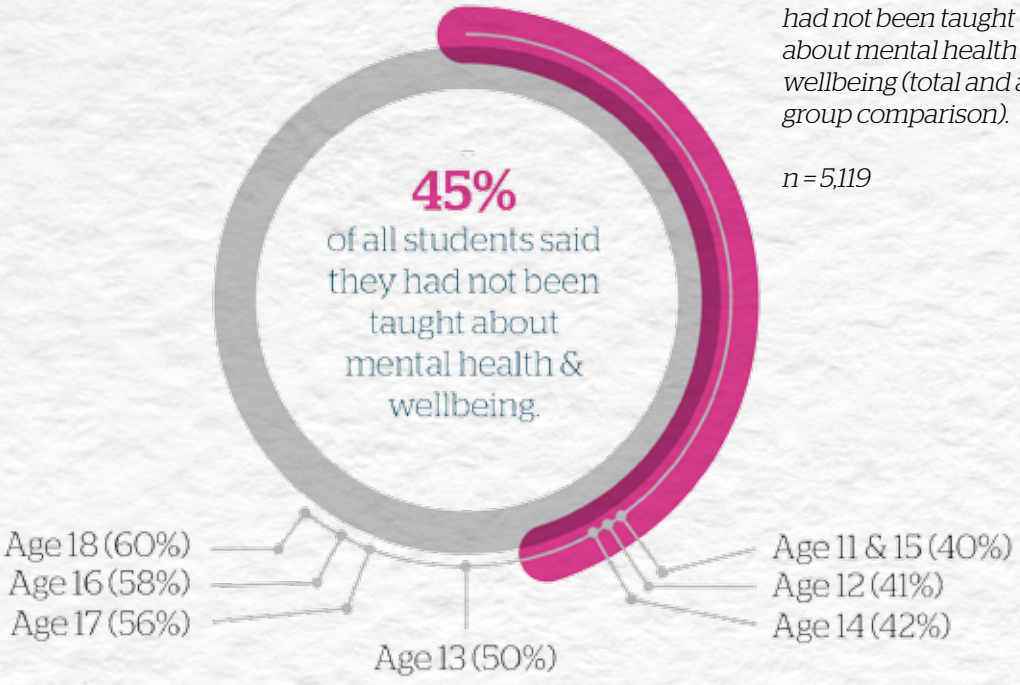
Figure six shows that the majority of students (55%) are taught about mental health and wellbeing at school. However, mental health and wellbeing provision within schools is not black and white. Responses differed between schools and ages. The responses indicate that although there may be a systematic approach to teaching mental health and wellbeing within a school, there is not a systematic approach across the county.

This, in part, is due to the academisation of secondary schools in Suffolk.

The provision for mental health and wellbeing within the curriculum decreased with age; six in ten respondents were taught about mental health and wellbeing at age eleven compared to four in ten at age sixteen. Furthermore, students commented that they were deprived of knowledge regarding mental health and wellbeing at crucial junctures, such as exam periods from age fifteen to sixteen (this is exemplified in figure 7).

Figure 7: *Percentage of students who said they had not been taught about mental health and wellbeing (total and age group comparison).*

n = 5,119



% of all age groups who said they had not been taught about mental health and wellbeing

% of each age group who said they had not been taught about mental health and wellbeing

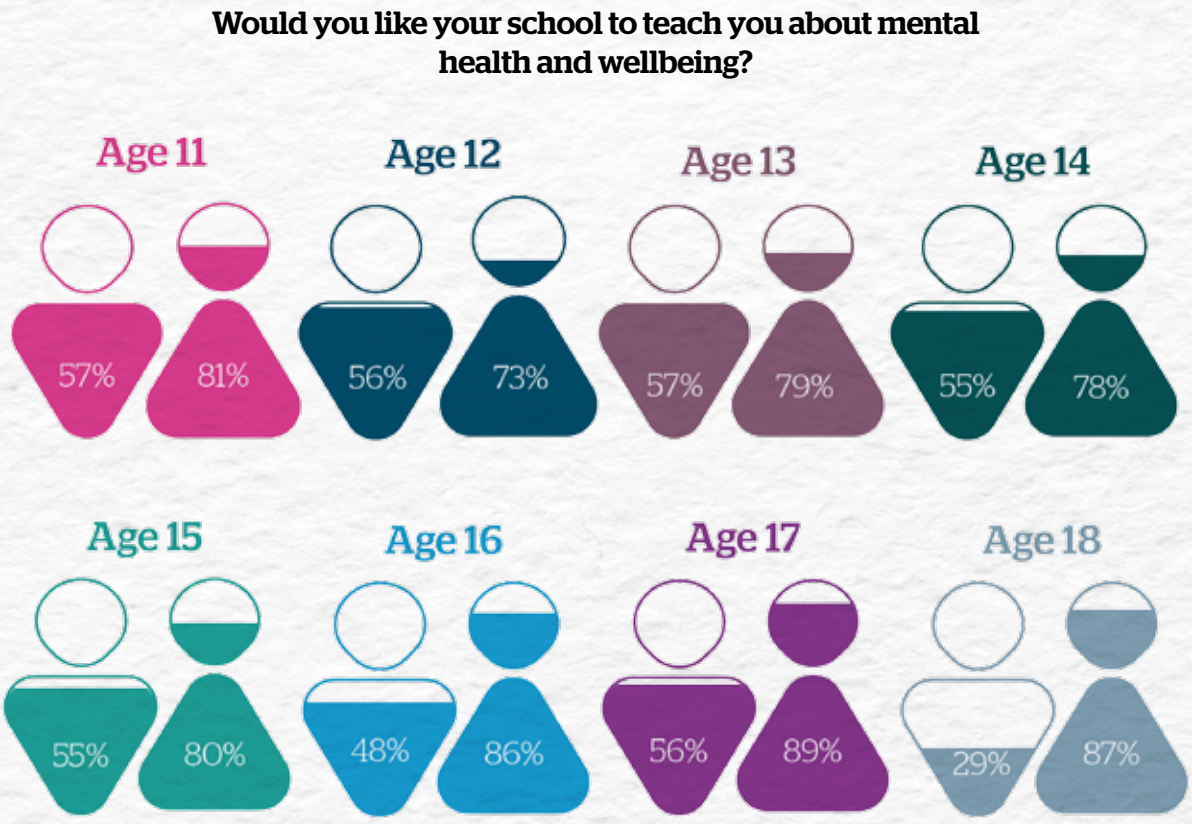


Figure 8: *Percentage of students that want to be taught about mental health and wellbeing. n = 1,286*

3.4 - Would you like your school to teach you about mental health and wellbeing?

Students who did not receive mental health and wellbeing education were asked if they would like their school to teach mental health and wellbeing in the future. There is a distinct differentiation in need between male and female respondents. On average, 82% of females and 52% of males answered 'yes' (See figure 8).

Female respondents need for mental health and wellbeing provision increases incrementally from the age of fourteen to seventeen (78 per cent to 89 per cent, respectively). The comments attributed to females highlighted that there is a need to talk about healthy relationships, sexual interactions and body image in relation to wellbeing.

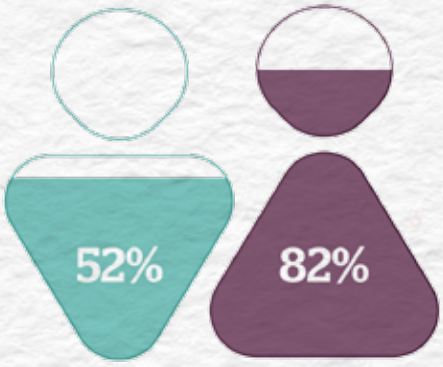


Figure 9: *Percentage of all students that want to be taught about mental health and wellbeing.*

n = 2,345

3.5 - You said that your school teaches you about mental health and wellbeing. Do you agree that the provisions for mental health and wellbeing teach you what you would like to know?

Students who said that they were receiving mental health and wellbeing education within school were asked if the current curriculum teaches them what they would like to know (see figure 9).

The majority of young people reported a favourable view of school PSHE lessons (55%). They seem to have a positive impact on young people's knowledge of health-related issues and on their personal values in relation to caring for others. The majority of young people who attend PSHE lessons thought that they help them to improve their skills and to look after their own health. However, a decrease in satisfaction with PSHE lessons was found as students get older. This was pertinent in relation to sexual health lessons.

This might indicate that the topics covered do not adapt according to the changing needs of young people over time. Also, specific topics on the curriculum for the older young people are needed. This has been cited in the wider literature[xvii].

Although relatively few respondents stated that their school did not teach them what they wanted to know (seven per cent), **almost two out of every five** students stated that they 'neither agreed nor disagreed' (38 per cent).

The majority of young people reported a favourable view of school PSHE lessons (55%).

This shows indifference towards the curriculum, which can be seen in the students' comments. Students that reported neutral sentiment towards mental health and wellbeing provision within the curriculum also reported that what they were being taught did not reflect the day-to-day experiences that children and young people face. This was a significant trend across respondents mentioning sexual relations.

Core to students' indifference towards a school's promotion of positive mental health and wellbeing – and pertinent topics, such as healthy relationships – was a lack of 'student voice'. Students felt that effective health and wellbeing promotion can only be achieved if students' voices are listened to and utilised. This is an area seen in national literature; reflecting real-world examples and other children and young people's narratives improve belonging, ownership, community, value, and esteem[xviii].

National comparable data

Over 50% said that personal and social issues, as well as issues of health & well-being, and 'staying safe' had been well covered by PSHE classes[xix].

HBSC England National Report, 2015

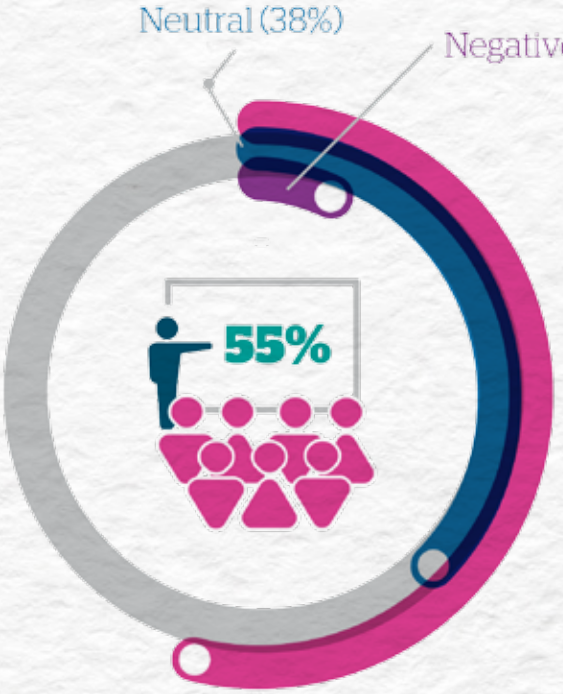
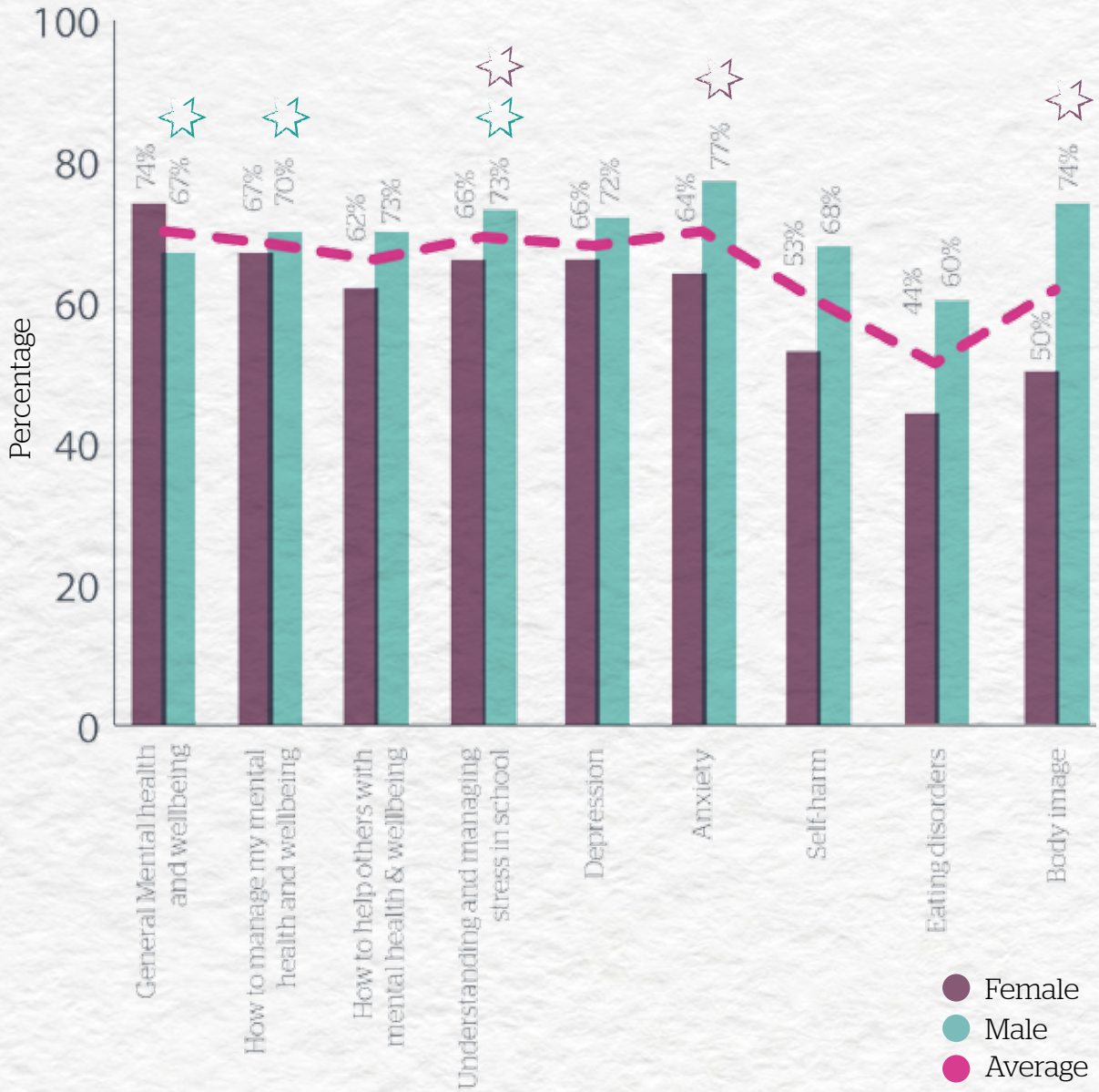


Figure 10: *Percentage of respondents who said their school taught them the things they would like to know about mental health and wellbeing and their sentiment about the subject. Based on the sample of respondents who had said they had been taught about mental health and wellbeing*

n = 2,646

55% of students said their school teaches them the things they would like to know about mental health and wellbeing.

Graph 7: *Respondents preference for what topics should be taught in school. n = 1,707*



3.6 - What topics should be taught in school?

Respondents were asked what mental health and wellbeing topics should be taught in school. The top three topics across male and female respondents are highlighted in the graph above with a star.

When looking at the difference in responses by gender and age, we see that females place more significance on each of the topics presented.

Females show an increased need correlated to age in four areas: general mental health and wellbeing (57 per cent at age eleven to 75 per cent at age

seventeen), managing their mental health and wellbeing (50 per cent at age eleven to 82 per cent at age seventeen), helping others with mental health and wellbeing (57 per cent at age eleven to 89 per cent at age seventeen), and understanding and managing stress in school (57 per cent at age eleven to 81 per cent at age seventeen).

Over three quarters of female respondents aged thirteen to eighteen thought that 'body image' should be taught in schools. Findings later in this report (see page 78) explore body image in more detail.

For male respondents, there were three areas of increased need correlated to age. These were: understanding and managing stress in schools (42 per cent at age eleven to 73 per cent at age seventeen), anxiety (53 per cent at age eleven to 73 per cent at age seventeen), and eating disorders (42 per cent at age eleven to 55 per cent at age seventeen).

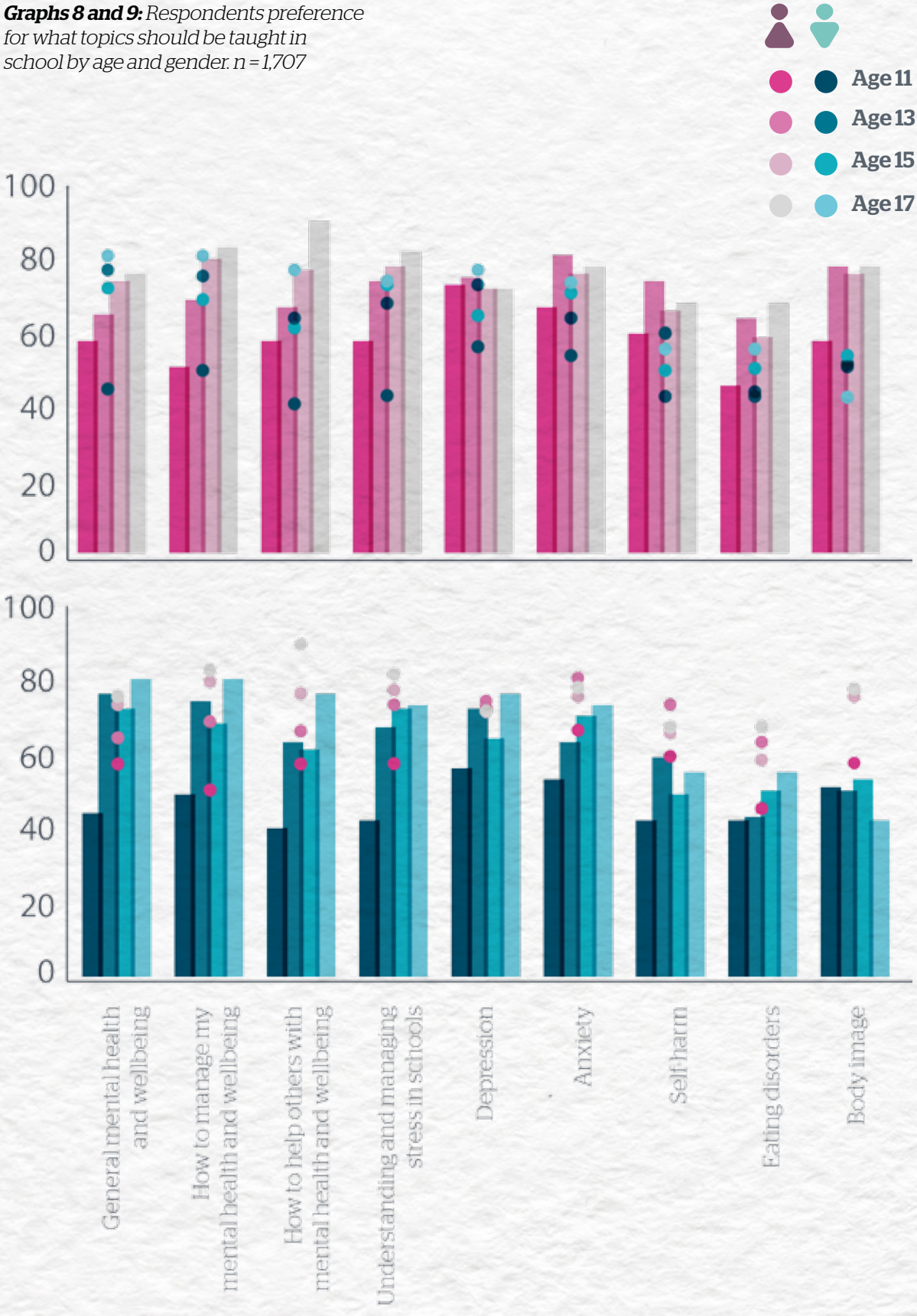
Students were given the opportunity to provide further comments. A thematic review of the comments highlighted several other common themes that should be discussed in schools.

These were:

- Stress and coping mechanisms
- Healthy relationships
- Sex education
- Emotional literacy
- Suicide and suicidal thoughts
- Symptoms of low mental health and wellbeing
- Bullying / cyberbullying
- Cyber literacy (interconnect with comments regarding safe internet usage and cyberbullying).

Over three quarters of female respondents aged thirteen to eighteen thought that 'body image' should be taught in schools.

Graphs 8 and 9: *Respondents preference for what topics should be taught in school by age and gender. n = 1,707*

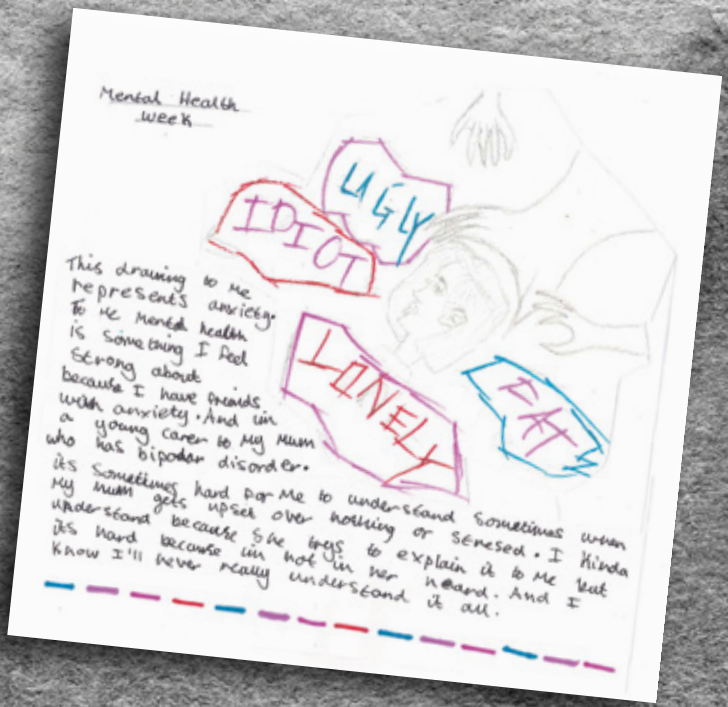


Which topics should be taught (Female)?				
	Age 11	Age 13	Age 15	Age 17
General mental health and wellbeing	57%	64%	73%	75%
How to manage my mental health and wellbeing	50%	78%	79%	82%
How to help others with mental health and wellbeing	57%	66%	76%	89%
Understanding and managing stress in school	57%	73%	77%	81%
Depression	72%	74%	71%	71%
Anxiety	66%	80%	75%	77%
Self-harm	59%	73%	65%	67%
Eating disorders	45%	63%	58%	67%
Body image	57%	77%	75%	77%

Which topics should be taught (Male)?				
	Age 11	Age 13	Age 15	Age 17
General mental health and wellbeing	44%	76%	72%	80%
How to manage my mental health and wellbeing	49%	74%	68%	80%
How to help others with mental health and wellbeing	40%	63%	61%	76%
Understanding and managing stress in school	42%	67%	72%	73%
Depression	56%	72%	64%	76%
Anxiety	53%	63%	70%	73%
Self-harm	42%	59%	49%	55%
Eating disorders	42%	43%	50%	55%
Body image	51%	50%	52%	42%

Tables 5 and 6: *Detailed responses to the question "Which topics should be taught?".*


hope
"hope is being able to see that there is light
despite all of the darkness"


Mental Health week
UGLY
IDIOT
LONELY
FAT
This drawing to me represents anxiety. To me mental health is something I feel strong about because I have friends with anxiety. And im a young carer to my mum who has bipolar disorder.
its sometimes hard for me to understand sometimes when my mum gets upset over nothing or stressed. I kinda understand because she tryes to explain it to me but its hard because im not in her head. And I know I'll never really understand it all.

3.7 - Where would you like to be taught about mental health and wellbeing?

Almost half of all students said that they would like to receive mental health and wellbeing education 'in the classroom' (49 per cent).

One in four students said that they would like to receive mental health and wellbeing education in PSHE lessons. PSHE lessons and 'in the classroom' were allocated different options as students during the survey pilot noted that mental health and wellbeing should be incorporated into all classrooms across the school, regardless of the lesson.

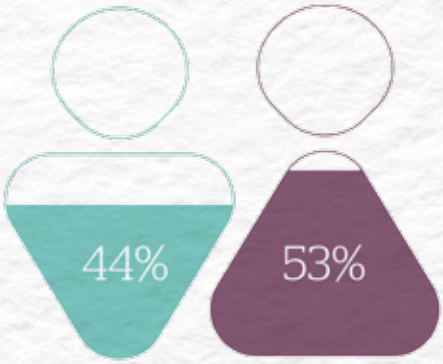
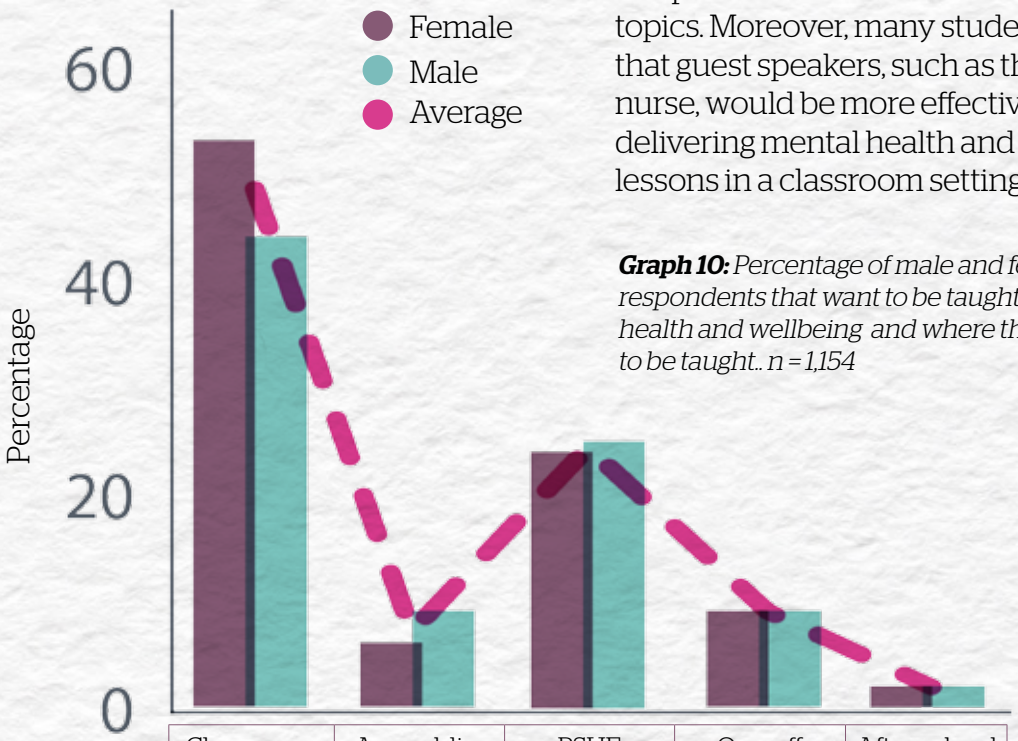


Figure 11: *Percentage of male and female respondents that want to be taught about mental health and wellbeing in the classroom.*

The comments received by the children and young people indicated that 'who' is just as important as 'where'. Many students assumed that teachers were not sufficiently trained to deliver lessons on specific mental health and wellbeing topics. Moreover, many students noted that guest speakers, such as the school nurse, would be more effective at delivering mental health and wellbeing lessons in a classroom setting.



Classrooms	Assemblies	PSHE lessons	One-off special events	After school
31%	18%	24%	42%	11%
35%	22%	25%	40%	11%

Graph 10: *Percentage of male and female respondents that want to be taught about mental health and wellbeing and where they would like to be taught.. n = 1,154*

Q. What would you like to learn about?

"Literally all of the above are **not covered in enough detail** to prevent much ignorance" - **Male (Age 14)**

"**Building self-worth**, and not based on abilities, but more focused on character." - **Female (Age 17)**

"**Ways in which to communicate** problems individuals might be feeling, if they are unwilling/scared about seeing school representatives." - **Male (Age 16)**

"I think that these **subjects need to be more widely discussed**, most people wouldn't know how to handle themselves in these situations." - **Female (Age 14)**

"I want something that is more about real-life and **how to handle stress**. This will help us more than triple maths a week." - **Male (Age 13)**

"**Knowing what to do when you are stressed** or angry." - **Male (Age 12)**

"**I want to learn about coping** with and staying mentally healthy with issues going on at home e.g. an ill family member etc." - **Female (Age 15)**

"I honestly feel that in some cases within school **Mental illness is almost promoted**, vulnerable and open young people could be convinced that they are mentally unstable or unwell and this could lead to a downward spiral which will eventually lead to them becoming mentally unwell. I also feel that some students (absolutely not all) treat mental illness as more of a fashion trend." - **Male (Age 18)**

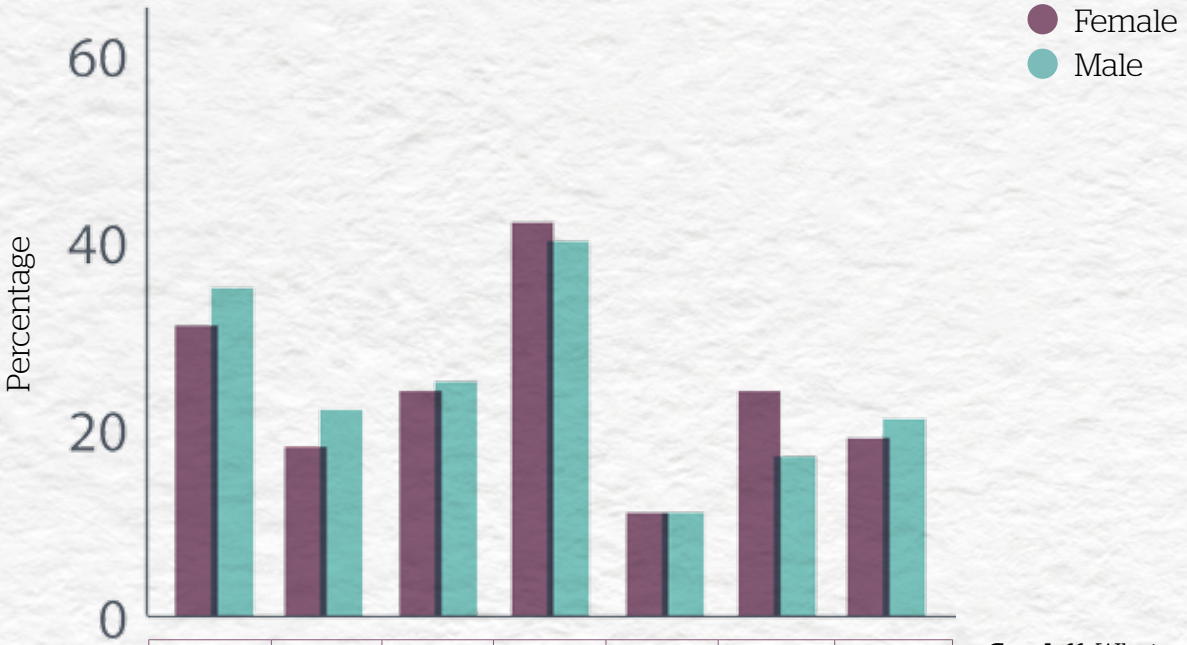
3.8 - Developing positive character traits among children and young people

Students were asked to think of effective ways that their school could promote positive characteristics in its pupils.

The top three results were the same across both male and female respondents:

1. Student subject reports (40 per cent and 42 per cent, respectively);
2. Praise postcards home (35 per cent and 31 per cent, respectively); and
3. Community engagement (25 per cent and 24 per cent, respectively)

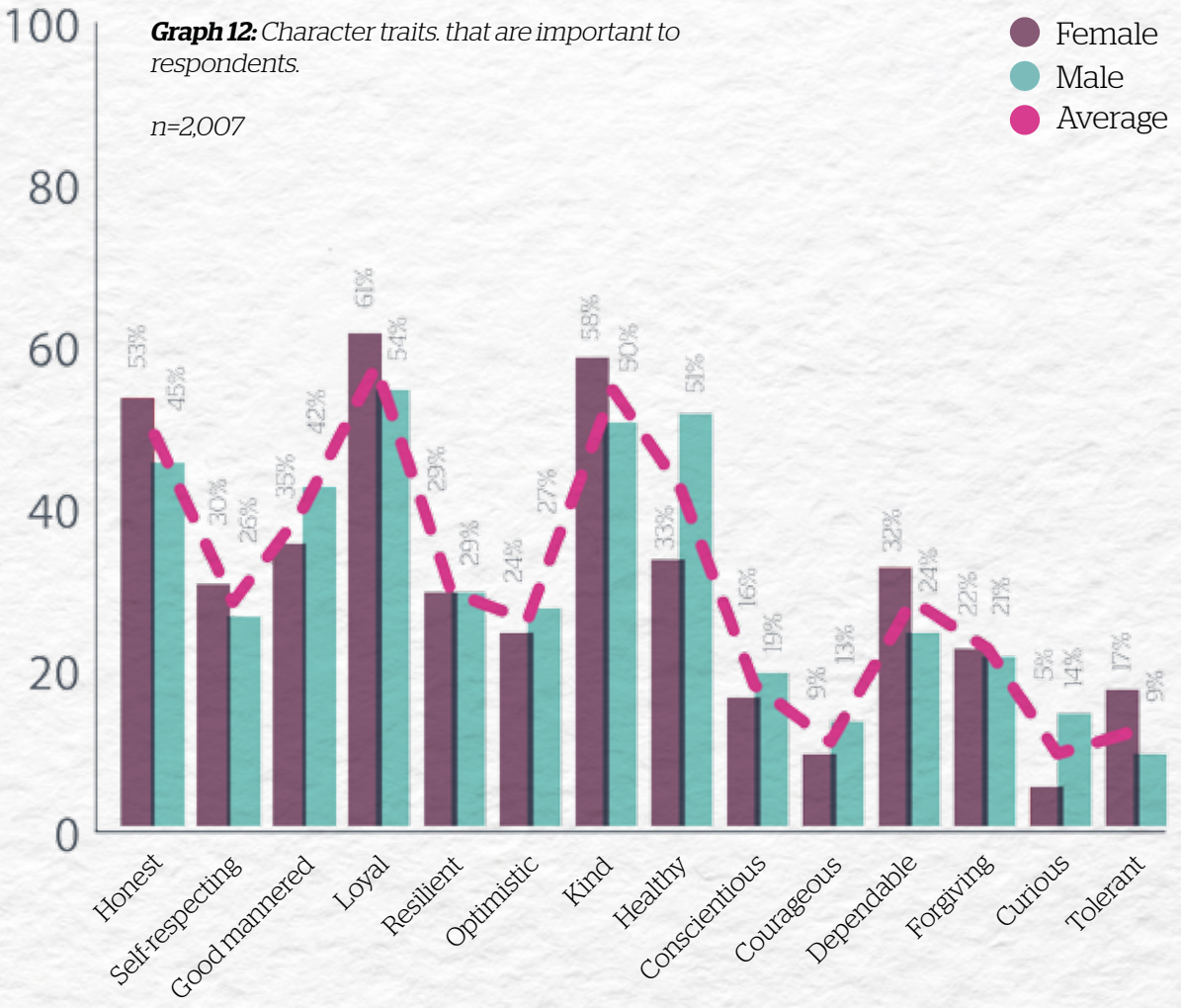
Older students (fourteen to eighteen) placed more emphasis on community engagement and motivational speakers.



	Praise postcards home	Assemblies	Community engagement	Student subject reports	Foyer displays	External motivational speakers	Student leadership programmes
Female	31%	18%	24%	42%	11%	24%	19%
Male	35%	22%	25%	40%	11%	17%	21%

Graph 11: *What respondents think are the best ways to encourage positive character traits.*

n=2,007



Graph 12: *Character traits. that are important to respondents.*

n=2,007

Students were also asked to rate character traits in order of importance. Although character traits across the board are ranked similarly in importance by both male and females, we see that the average top three for male and female are slightly different (see below).

Male top three:

1. Loyalty (54 per cent)
2. Healthy (51 per cent)
3. Kindness (50 per cent)

Female top three:

1. Loyalty (61 per cent)
2. Kindness (58 per cent)
3. Honesty (53 per cent)

Accessing NHS Services

3.9 - If you were to visit a service for mental health and wellbeing issues, what would you rate as important?

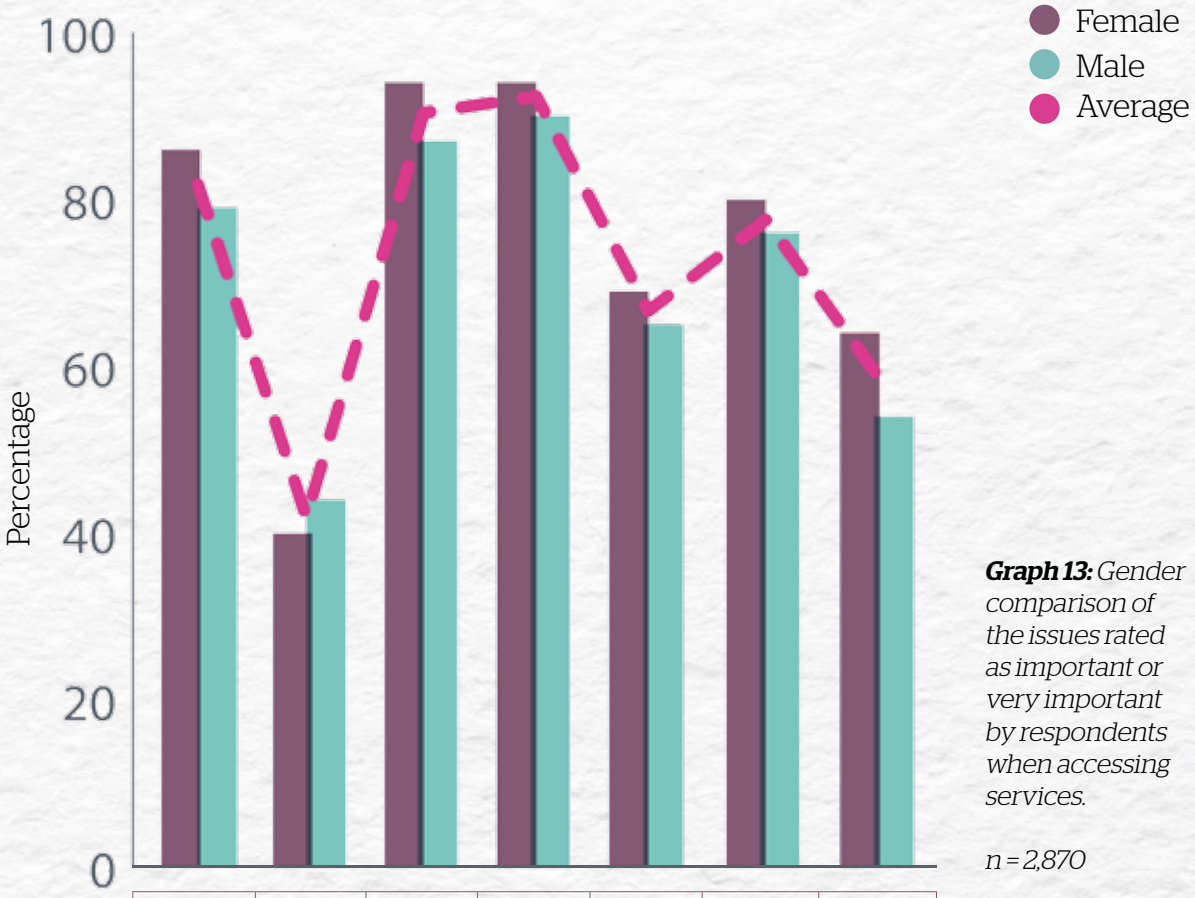
Students were asked 'what's the most important thing when visiting an NHS service?'.

The options presented in the question derive from previous focus groups with children and young people in the pilot stage of My Health, Our Future.

For the majority of students, being taken seriously and being listened to are more important than having an informed choice and a flexible service. This is in part due to students wanting to take ownership of their own voice.

Many students noted that parents, carers or guardians often speak on their behalf, and that oftentimes this does not allow them to express their precise emotions. This accounted for both mental health and physical health.

Figure 12: *Top three issues rated as important by young people with regard to accessing mental health support from a service. n = 2,870*



Confidentiality	Close to where you live	To be listened to and understood	To be taken seriously	To receive flexible services	To have information and choice	For health professionals to talk to me, not my parents
86%	40%	94%	94%	69%	80%	64%
79%	44%	87%	90%	65%	76%	54%
83%	42%	91%	92%	67%	78%	59%

Graph 13: *Gender comparison of the issues rated as important or very important by respondents when accessing services.*

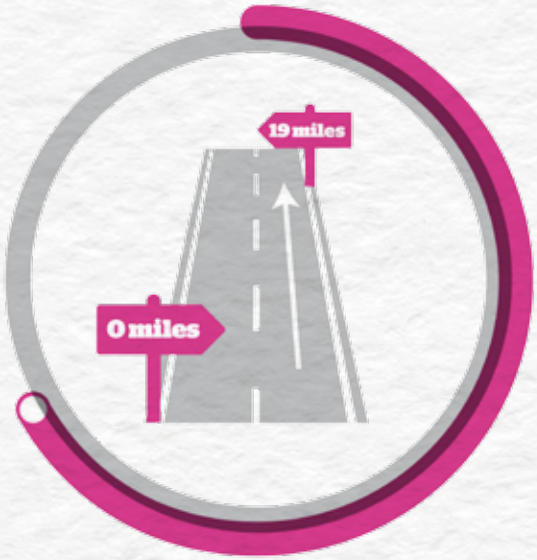
n = 2,870

3.10 - How far can you travel to get the support you need?

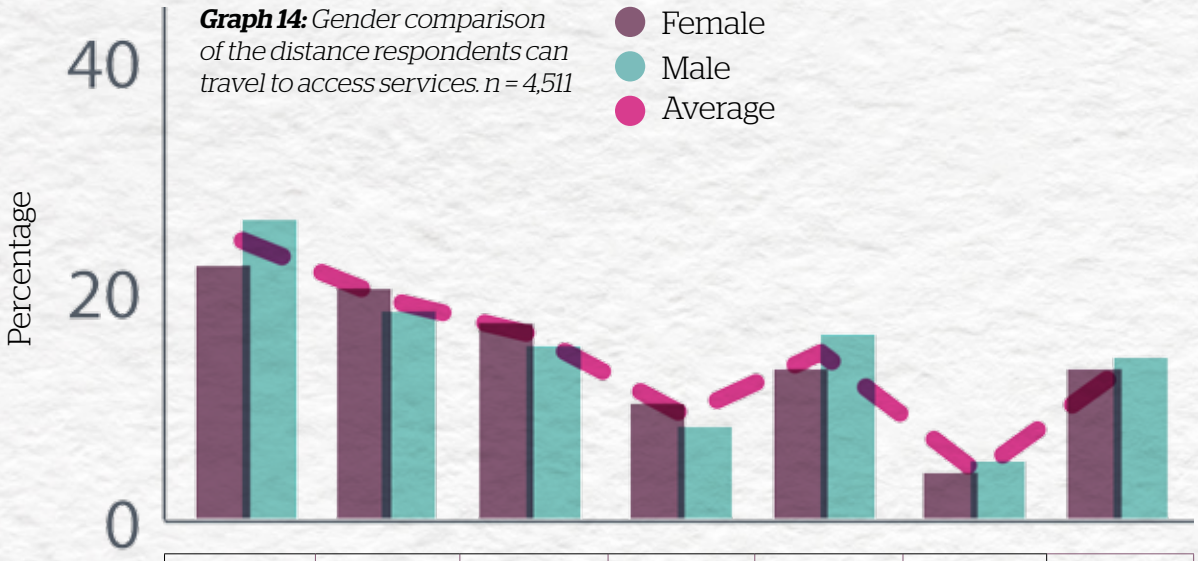
The least important aspect of NHS services for children and young people was being 'close to where [they] live' (42 per cent). A third of students cannot travel more than 20 miles to access the support they need.

This was due to students not being able to drive and not wanting to ask their parents for assistance. The comments indicated that older students would not be willing to tell parents about concerns. In turn, the avoidance of telling parents leads to children and young people not being able to access services.

Figure 13: 68% said they could travel 0 - 19 miles to access services.



Graph 14: *Gender comparison of the distance respondents can travel to access services. n = 4,511*



	0 - 2 miles	3 - 5 miles	6 - 10 miles	11 - 19 miles	20 miles or more	I can only access support on internet or by phone	I do not want to travel to access services
Female	22%	20%	17%	10%	13%	4%	13%
Male	26%	18%	15%	8%	16%	5%	14%
Average	24%	19%	16%	9%	14%	5%	14%

Stress

3.11 - What makes you feel stressed?

Please note: Respondents were asked to tick all that apply.

Responses indicate that accumulative school pressures are a stressful experience for children and young people from an early age.

Exams were the number one cause of stress for male and female respondents aged eleven (51 per cent and 54 per cent, respectively). Exam pressures remain the highest cause of stress for respondents across all ages, regardless of gender.

Accumulative school pressures, such as revision, exams and managing a work-life balance are positively correlated to age, across both male and

Figure 14: Accumulative school pressures (e.g. exams and revision) become an increasingly prominent source of stress in participants lives.

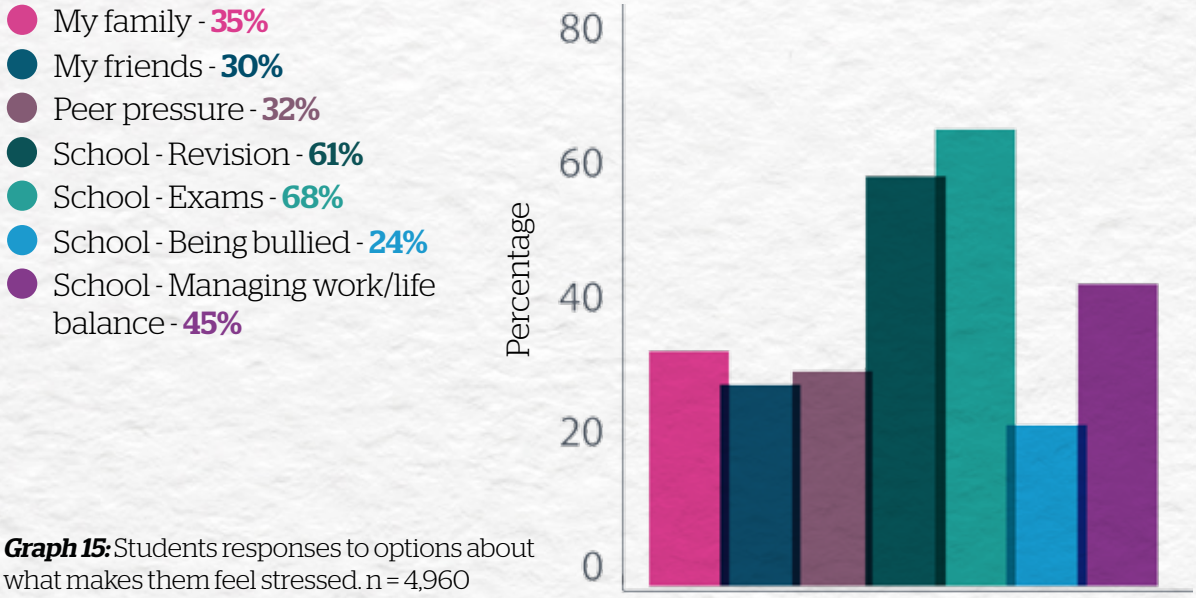
- School related stressors (age 11) - **40%**
- School related stressors (age 17) - **85%**

National comparable data

Overall, 17% of young people reported feeling pressured 'a lot' by school work. Girls were more likely than boys to report feeling pressured (21% v.13%), and both boys and girls reported feeling more pressured by school work the older they got[xx].

Perceived pressure from school work still remains high, especially among 15-year-old girls. Again, consistent with the survey 2010, older young people felt more pressure from school work than their younger peers. The proportion of boys who reported being pressurised by school work has decreased from 2002 to 2014, while the proportion of girls affected remained unchanged.

HBSC England National Report, 2015



Graph 15: Students responses to options about what makes them feel stressed. n = 4,960

female respondents. When aggregating the average of the three school-specific stressors, we see that they cause 2 out of 5 respondents stress at age eleven (40 per cent), rising to over 8 out of 10 at age seventeen (85 per cent).

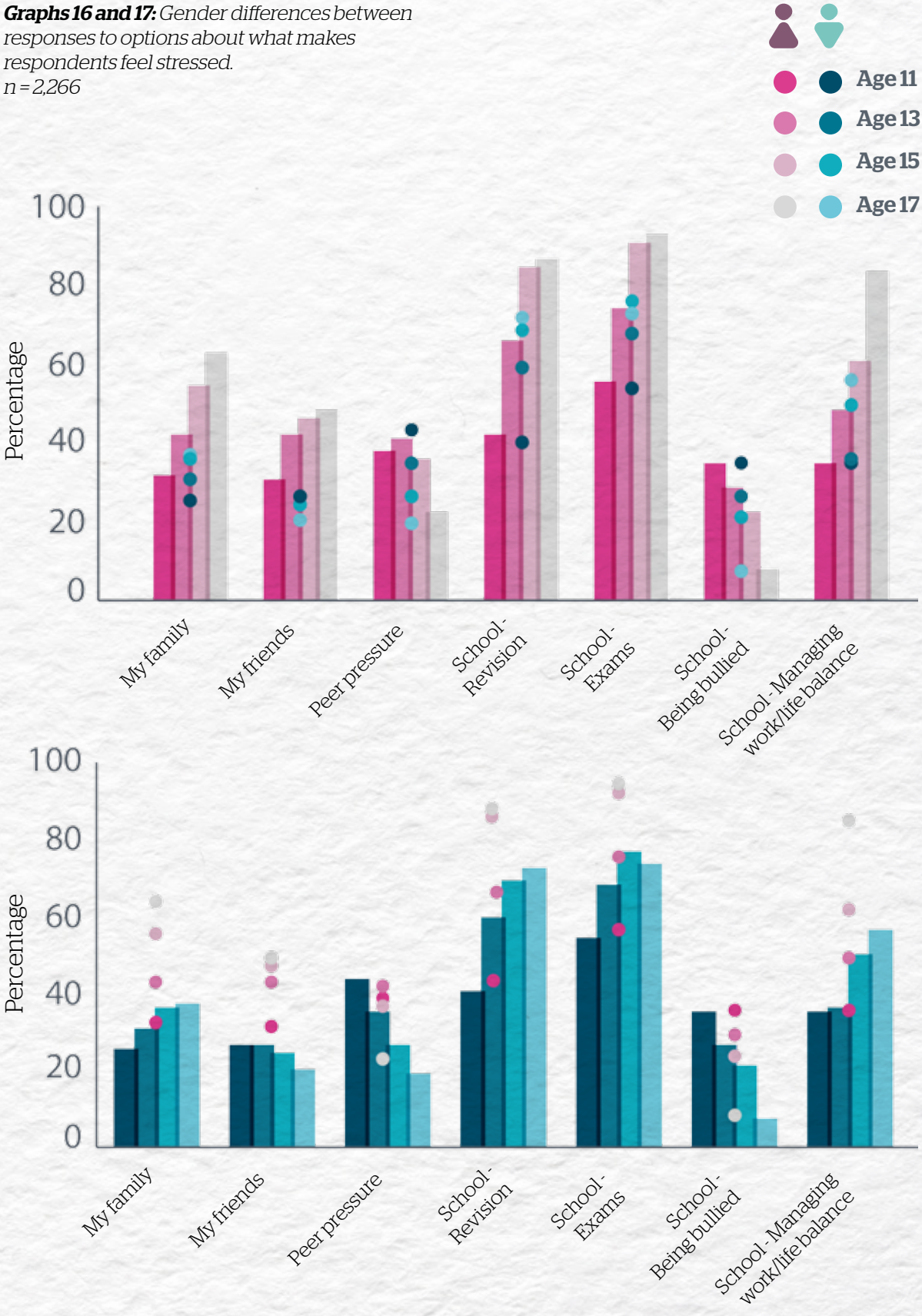
The pilot stage of My Health, Our Future found that friendship groups and relationships with peers were an important element of a young person's development. The responses to 3.11 indicate that friendships cause female respondents more stress as they get older (30 per cent at age eleven to 47 per cent at age seventeen), whereas male respondents see a reduction in stress in relation to friendships (25 per cent at age eleven to 19 per cent at age seventeen).

Conversely, family related stress increases with age across male and female respondents. When reviewing the comments provided, we see that much of this increased family stress can be seen through adolescent development and the need for children and young people to form their own identity.

Over one-third of students aged eleven attributed stress to peer pressure or being bullied (39 per cent and 34 per cent, respectively). Thankfully this decreases as respondents get older; 1 in 5 students at age 17 reported peer pressure as a stressor (20 per cent), while under 1 in 10 reported being bullied as a cause of stress (8 per cent).

The Good Childhood Report in 2015 highlights that a key theme for children in their survey was mental and physical health, especially the former, and the ways in which stress, worry and anxiety could have a negative impact on children and young people's well-being . In this survey, respondents also acknowledged that their own attitudes and behaviour could affect their well-being[xxi], and emphasised that they need to take responsibility for their own quality of life and stress management.

Graphs 16 and 17: *Gender differences between responses to options about what makes respondents feel stressed.*
n = 2,266



What makes you feel stressed (Female)?				
	Age 11	Age 13	Age 15	Age 17
My family	31%	41%	53%	61%
My friends	30%	41%	45%	47%
Peer pressure	37%	40%	35%	22%
School - Revision	41%	64%	82%	84%
School - Exams	54%	72%	88%	90%
School - Being bullied	34%	28%	22%	8%
School - Managing my work/life balance	34%	47%	59%	81%

What makes you feel stressed (Male)?				
	Age 11	Age 13	Age 15	Age 17
My family	24%	29%	34%	35%
My friends	25%	25%	23%	19%
Peer pressure	41%	33%	25%	18%
School - Revision	38%	56%	65%	68%
School - Exams	51%	64%	72%	69%
School - Being bullied	33%	25%	20%	7%
School - Managing my work/life balance	33%	34%	47%	53%

Tables 7 and 8: *Detailed responses to the question "What makes you feel stressed?".*


AUTISM
DEPRESSION
ADHD
PTSD
thank you
Be the light I'm mentally
Disabled person's Eye

Coping

3.12 - How important are the following in helping you when you feel like you can't cope?

Most of the young people thought that the family unit is the most important source of social support for young people. However, the data indicates that a young person's reliance on the family unit decreases with age (see figure 15).

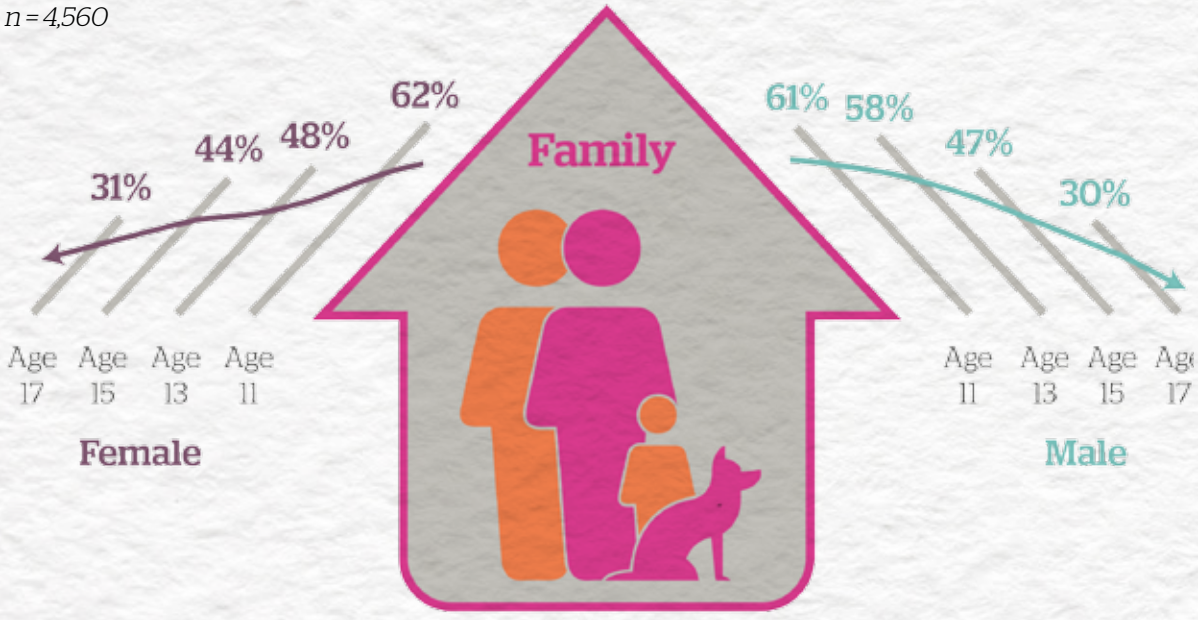
Friends were also seen as an important touchstone when children and young people feel that they cannot cope. The comments indicate that respondents over fourteen were more likely to confide in a friend as they're likely to be more understanding due to having the same 'lived experience'.

The young people felt that parents and family are an important source of support for adolescents, but that it would become more difficult to discuss things with parents as they became older.

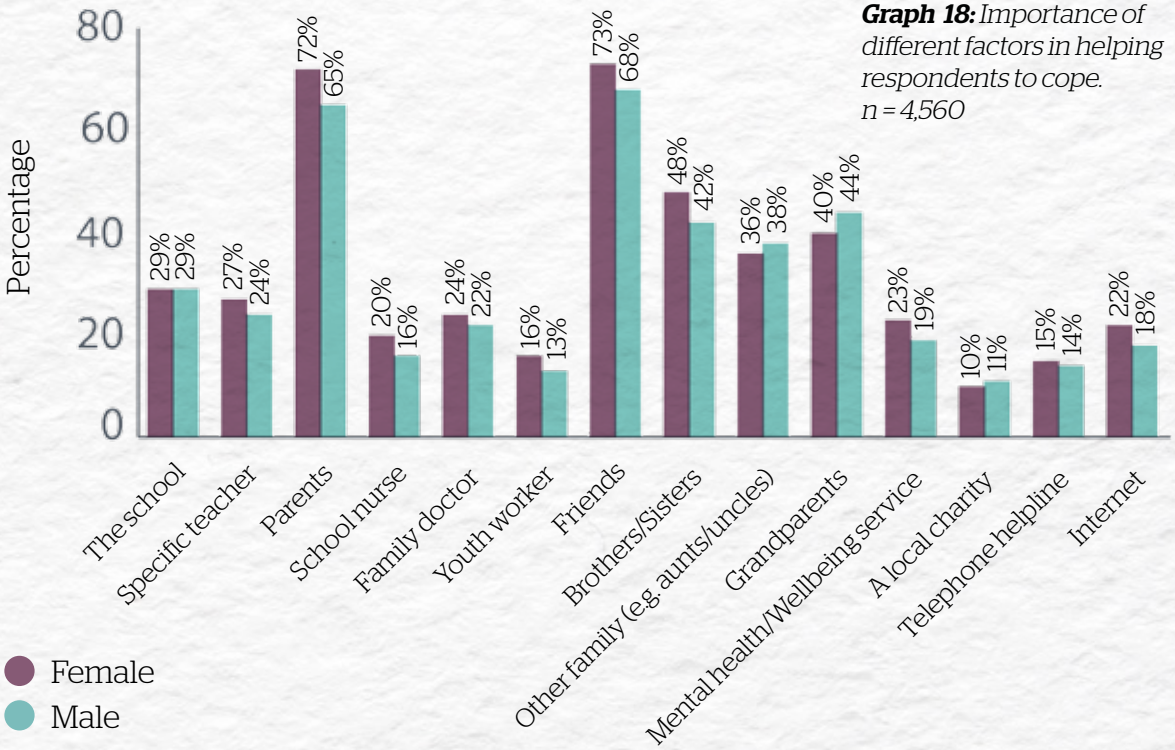
This was partly because some things were felt to be more personal as you got older, but young people also spoke a lot about wanting to feel independent and therefore discussing problems with parents less to feel autonomous. This desire for autonomy was also seen as an important reason for adolescents doing fewer activities with their families, including eating meals together as they got older.

These comments replicate wider literature[xxii xxiii].

Figure 15: *Respondents reliance on the "family unit" in helping them to cope. n = 4,560*



Across both male and female students, reliance on the family unit falls with increasing age. At age 11 **2 out of 3** students said family are important in helping them to cope. This drops to less than **1 in 3** by age 16.

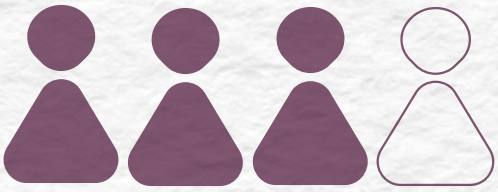


Graph 18: *Importance of different factors in helping respondents to cope. n = 4,560*

1 in 4 respondents said that they turn to a specific teacher when they feel they cannot cope (25 per cent). Teacher-pupil relations in regard to mental health and wellbeing management was a recurrent theme in the comments provided; many students felt that having a named teacher or teachers who were mental health and wellbeing contacts would be beneficial to all pupils.

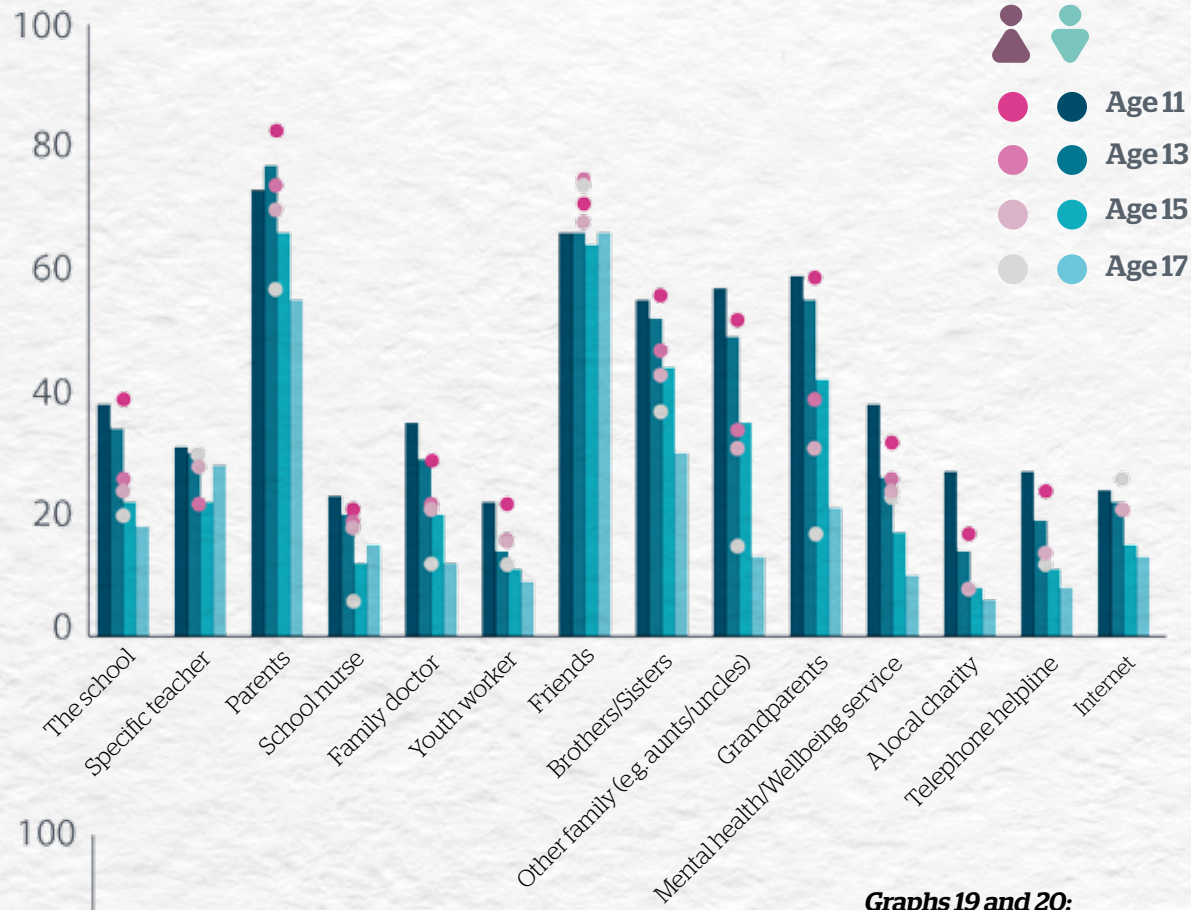
The data seen in graph 18 shows that children and young people are less likely to visit local services (e.g., family doctor, mental health and wellbeing service, a local charity or telephone helpline) as they get older. This again was related to wanting a sense of autonomy.

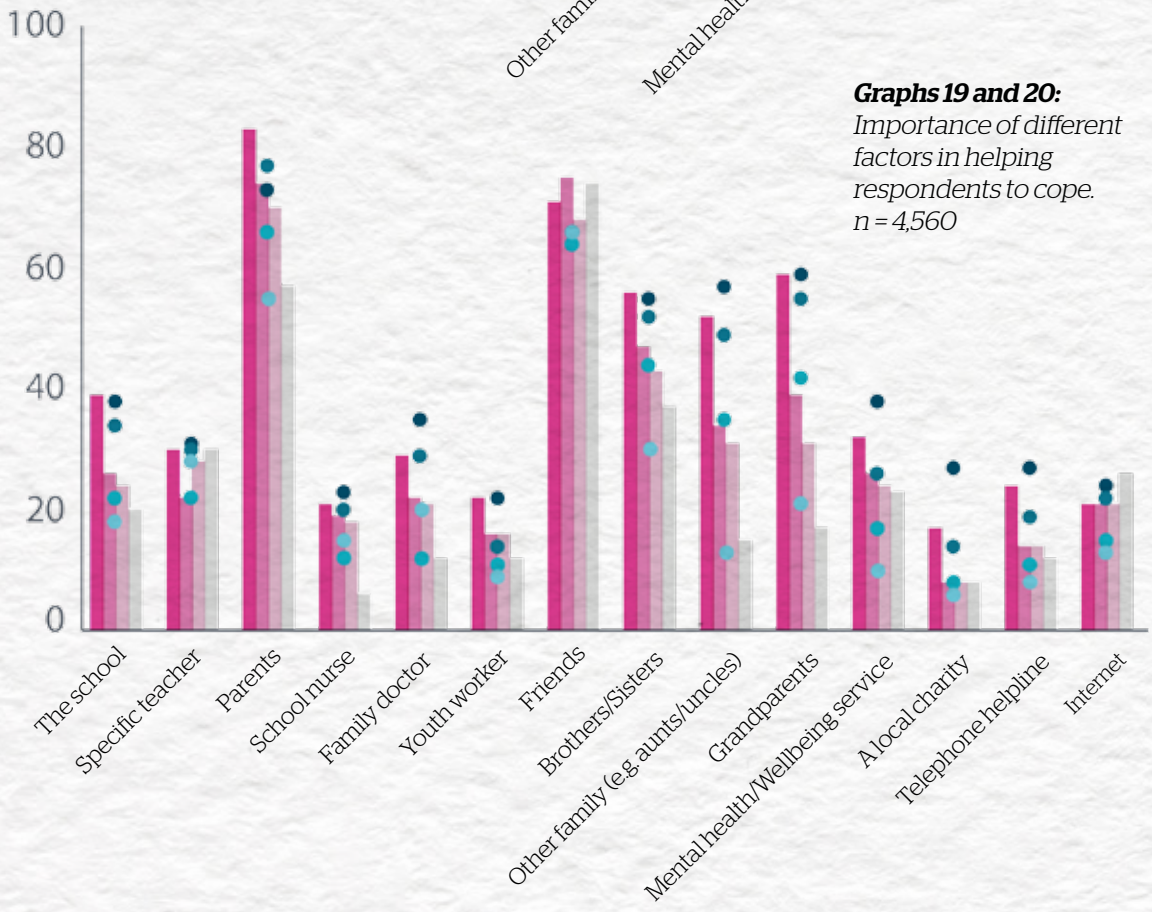
The data also shows that **less than 1 in 5** respondents would turn to a school nurse if they felt that they could not cope (18 per cent). For females aged seventeen this drops to just 6 per cent. Therefore, this is an area that warrants more in-depth analysis, as school nurses should be a key touchstone when promoting and preventing mental health and wellbeing in schools.



"Parents" were the most important factor in helping female respondents to cope ***(3 out of 4)****.*

"Friends" were the most important factor in helping female respondents to cope ***(2 out of 3)****.*





Graphs 19 and 20: *Importance of different factors in helping respondents to cope. n = 4,560*

How important are the following in helping you to cope (Male)?				
	Age 11	Age 13	Age 15	Age 17
The school	38%	34%	22%	18%
Specific teacher	31%	30%	22%	28%
Parents	73%	77%	66%	55%
School nurse	23%	20%	12%	15%
Family doctor	35%	29%	20%	12%
Youth worker	22%	14%	11%	9%
Friends	66%	66%	64%	66%
Brothers/Sisters	55%	52%	44%	30%
Other family (e.g. aunt or uncle)	57%	49%	35%	13%
Grandparents	59%	55%	42%	21%
Mental health/Wellbeing services	38%	26%	17%	10%
A local charity	27%	14%	8%	6%
Telephone helpline	27%	19%	11%	8%
Internet	24%	22%	15%	13%

How important are the following in helping you to cope (Female)?				
	Age 11	Age 13	Age 15	Age 17
The school	39%	26%	24%	20%
Specific teacher	30%	22%	28%	30%
Parents	83%	74%	70%	57%
School nurse	21%	19%	18%	6%
Family doctor	29%	22%	21%	12%
Youth worker	22%	16%	16%	12%
Friends	71%	75%	68%	74%
Brothers/Sisters	56%	47%	43%	37%
Other family (e.g. aunt or uncle)	52%	34%	31%	15%
Grandparents	59%	39%	31%	17%
Mental health/Wellbeing services	32%	26%	24%	23%
A local charity	17%	8%	8%	8%
Telephone helpline	24%	14%	14%	12%
Internet	21%	21%	21%	26%

Table 9 and 10: *Detailed responses to the question "Coping - How important are the following".*

Body Image and Self-esteem

3.13 - How often do you worry about your appearance or the way that you look?

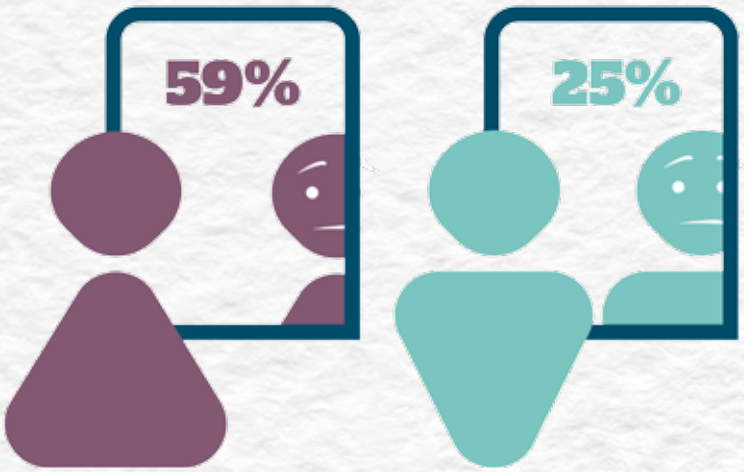
Body image, appearance and self-esteem were cited numerous times throughout the pilot stage of the project. For this reason we included them as two distinct categories within the survey.

The data highlights a shocking trend across male and female adolescents that should be addressed immediately. Three out of five females (59 per cent) and one in four males (25 per cent) reported feeling worried about their appearance and/or body image most or all the time.

When looking at male and female responses across the age range, we see a clear trend towards increased body dysmorphia and negative self-image as respondents get older, specifically among females. For example, 42 per cent of females at age eleven report worrying about their body and/or appearance, rising to three-quarters of female respondents at age sixteen (76 per cent).

This finding is comparable to wider literature[xxiv].

Qualitative comments highlight two clear trends that can be drawn across both genders. As the prevalence of body dysmorphia increases with age, there is an increase in males commenting that they feel 'too small' or 'not physically fit', while females feel 'too big', 'fat', or 'ugly'. A crosscutting theme was the feeling of 'being judged', as respondents felt pressured into meeting societies standards.



3 out of 5 females and **1 in 4** males worry about their appearance and/or body image most or all of the time (based on 4,609 responses.

Figure 16: Female and male respondents level of worry about their appearance (most or all of the time). n = 4,609

National comparable data

The Good Childhood Report in 2015 found that body image, appearance and confidence is of great significance to children in the UK, especially secondary school age girls, whose happiness with these aspects of life are markedly lower than their peers in other countries[xxv].

Good Childhood Report (2015)

The Suffolk Cybersurvey (2016) found that those who feel depressed are more likely to visit websites urging them to be 'very thin' (45% vs. 22%)[xxvi].

The Suffolk Cybersurvey (2016)

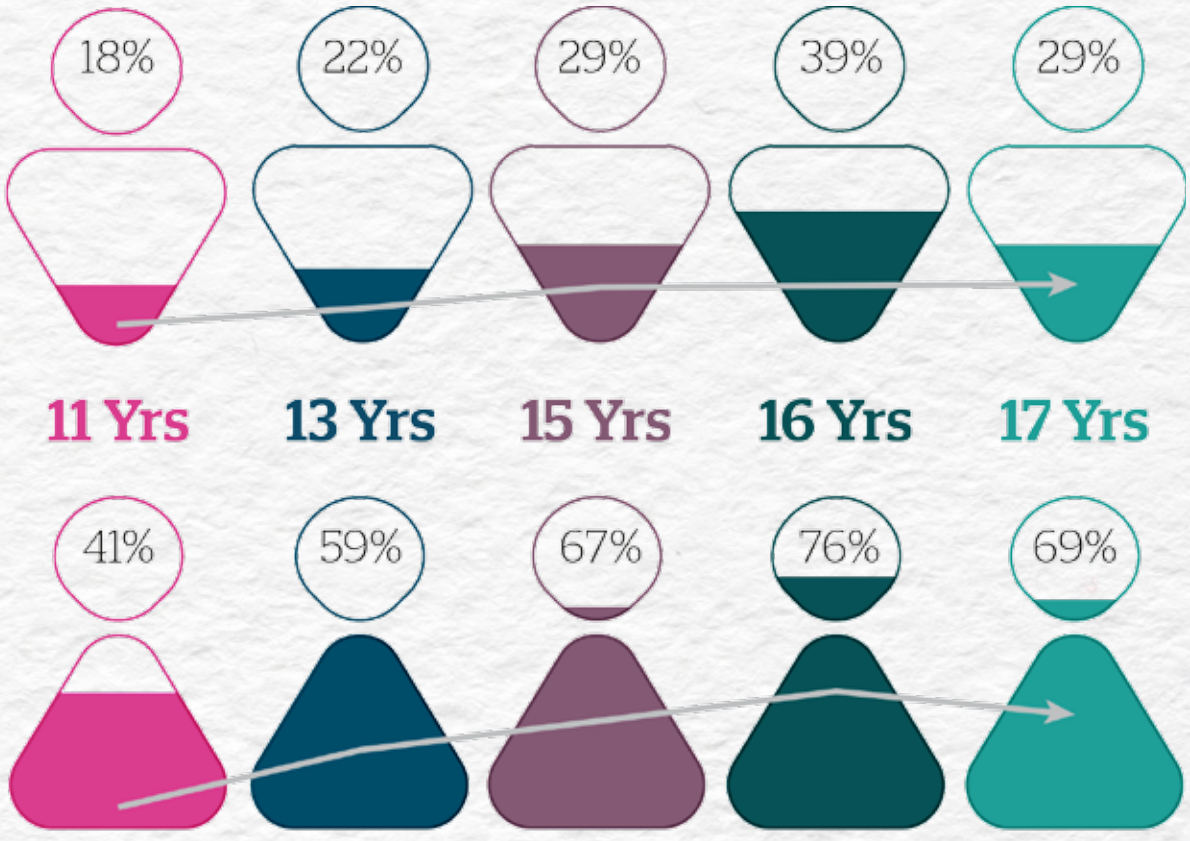


Figure 17: Levels of worry (most or all of the time) generally increase with age for both genders but is particularly noticeable amongst female respondents (based on 2,305 responses). n = 2,305

Why do you feel like you're not happy with your body or appearance?

"I get **jealous** of the way other people look." - **Male (Age 11)**

"Because I don't want others to make fun of what I wear and I do the same to my facial features because **I am scared** that others will make fun of me." - **Female (Age 12)**

"Because **society is putting lots of pressure** on girls that they have to look a certain way and it's hard to obtain those standards." - **Female (Age 12)**

"Because of people trying to find the smallest **flaws** in you." - **Male (Age 12)**

"To avoid things like peer pressure and people mocking you as this makes you feel **uncomfortable** in your own skin." - **Female (Age 13)**

"Every joke chips away at my sanity..."

"Because people **judge** you, and any imperfections will be a way to insult you or make you upset. There is **so much pressure** to be pretty and hourglass figure and skinny and people who don't have this feel ugly." - **Female (Age 14)**

"Because of the **media**, girls are expected to look like the models and fake people. if you don't have boobs or bum you're **judged.**" - **Female (Age 15)**

"Truly, **we all feel pressured** in one way or another to be perfect. Whether it be regurgitated by magazines or peers. Girls feel like they need to be slim and boys feel like they need to have an unrealistic physique. I sometimes feel pressured because of my peers and social media." - **Male (Age 15)**

"Being a female, you are being **judged constantly** on your looks or clothes and whether you are wearing too much makeup or not enough." - **Female (Age 16)**

"Comparison, seeing images in media and attitudes of male and female peers. - less being exposed to it at an older age, but instilled/ left over from early **exposure to media** and the attitude of peers when I was 11-15." - **Female (Age 17)**

"Society and what it considers beautiful, as a guy we are expected to be strong, muscular, masculine and dominate and the phrase **"be a man"** sums it up." - **Male (Age 17)**

"Because people always comment on how I look and **I hate it** because everyone **judges** me on how I look." - **Female (Age 11)**

"There is a lot of **pressure in society** at the moment to be 'perfect' and barely anyone can fit that criteria. People say stuff all the time and it's hard to ignore it." - **Female (Age 14)**

"Because I think if I don't look good **people wont like me**" - **Male (Age 11)**

"Because it seems this generation is provoked into thinking that the you **have to be perfect** in the sense that your face has to be a certain shape or even your body, so we as young people and maybe even older ones feel as if they have to act a certain way to be noticed or even look one way so you could also be 'noticed'. - **Female (Age 12)**

"Because everyone is so judgemental, and always **judge** you if you're different and judge you if you're not different and the same as everyone else." - **Female (Age 14)**

"Because I am **small and weak**." - **Male (Age 14)**

"...bullying is not dealt with at all..."

"I worry sometimes because I feel like people won't accept me for who I am so **I have to change to become their friends.**" - **Male (age 16)**

"Because the people in this school are so horrible and judging they always have something mean to say about you and the **bullying is not dealt with at all.**" - **Male (Age 13)**

"If I don't look like the 'ideal body type' **people will judge me** and possibly not treat me the same in school. they will bully me and be rude ." - **Female (Age 12)**

"Sometimes I feel **too skinny**." - **Male (Age 13)**

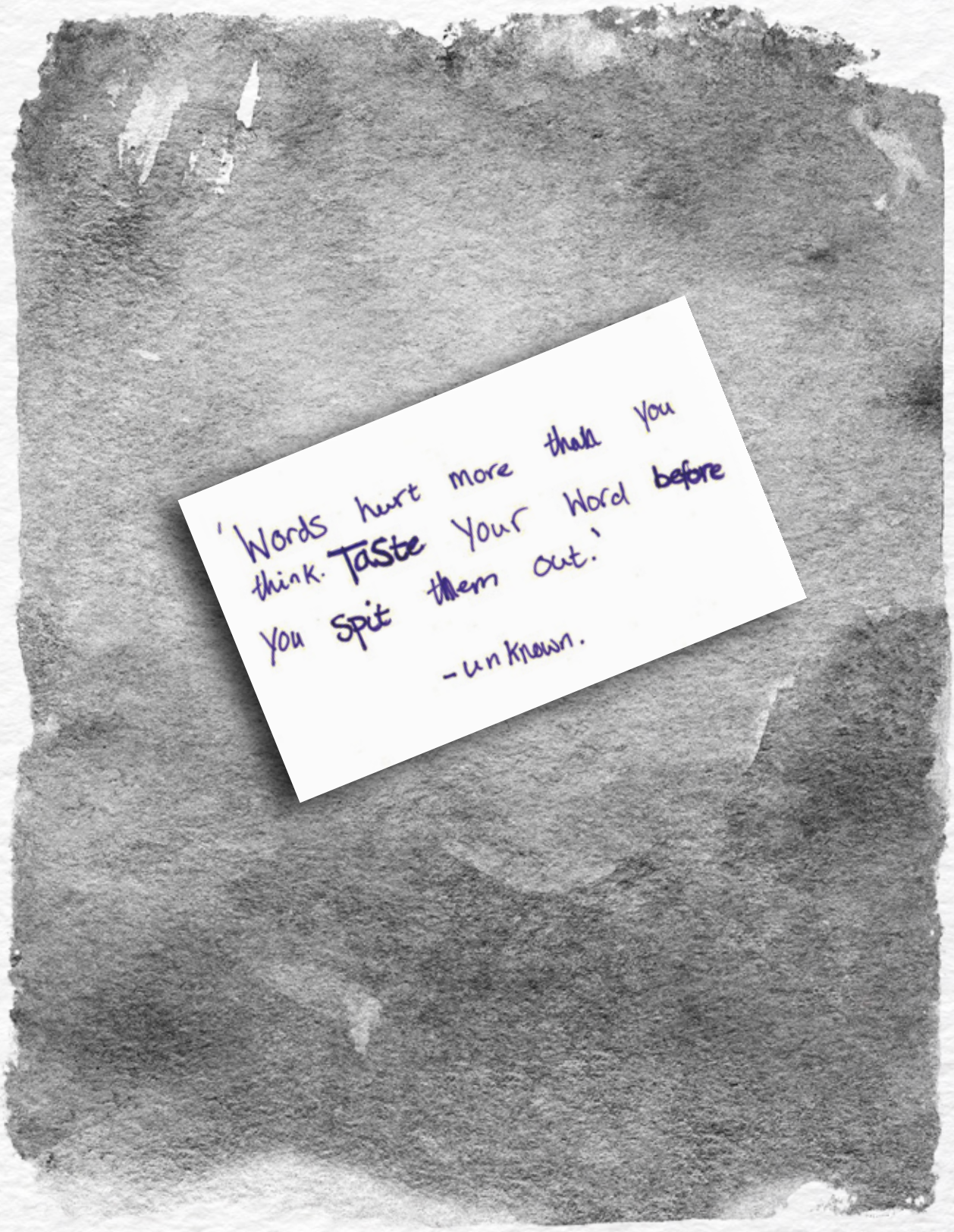
"There are **so many expectations** shown to us by models, magazines, celebrities and the internet that are unachievable that make us feel down about ourselves." - **Female (Age 13)**

"The way people look at me, it makes me uncomfortable also the way people joke about being bigger than other people. **every joke chips away at my sanity**." - **Male (Age 14)**

"My body **does not look as male as I would wish.** " - **Male (Age 14)**

"Because sometimes **people laugh at me**. I do not really mind, but sometimes it is upsetting coming from someone I like or admire." - **Female (Age 11)**

"Trying to keep up with fashion, **being pressured** into buying expensive clothing, people telling me that what I'm wearing suits a different type of person." - **Male (Age 14)**


'Words hurt more than you think. Taste your Word before you spit them out.'
-unknown.

3.14 - How would you rate your self-esteem from day to day?

An important key to promoting children's mental health is an understanding of the protective factors that enable children to be resilient when they encounter problems and challenges. Research suggests that there is a complex interplay between risk factors in children's lives and promoting their resilience and self-esteem.

As social disadvantage and the number of stressful life events accumulate for children or young people, more factors that are protective are needed to act as a counterbalance[xxvii].

'Resilience seems to involve several related elements. Firstly, a sense of self-esteem and confidence; secondly a belief in one's own self-efficacy and ability to deal with change and adaptation; and thirdly, a repertoire of social problem-solving approaches'[xxviii].

The role that schools play in promoting the resilience of their pupils is important, particularly so for some children where their home life is less supportive. School should be a safe and affirming place for children where they can develop a sense of belonging and feel able to trust and talk openly with adults about their problems.

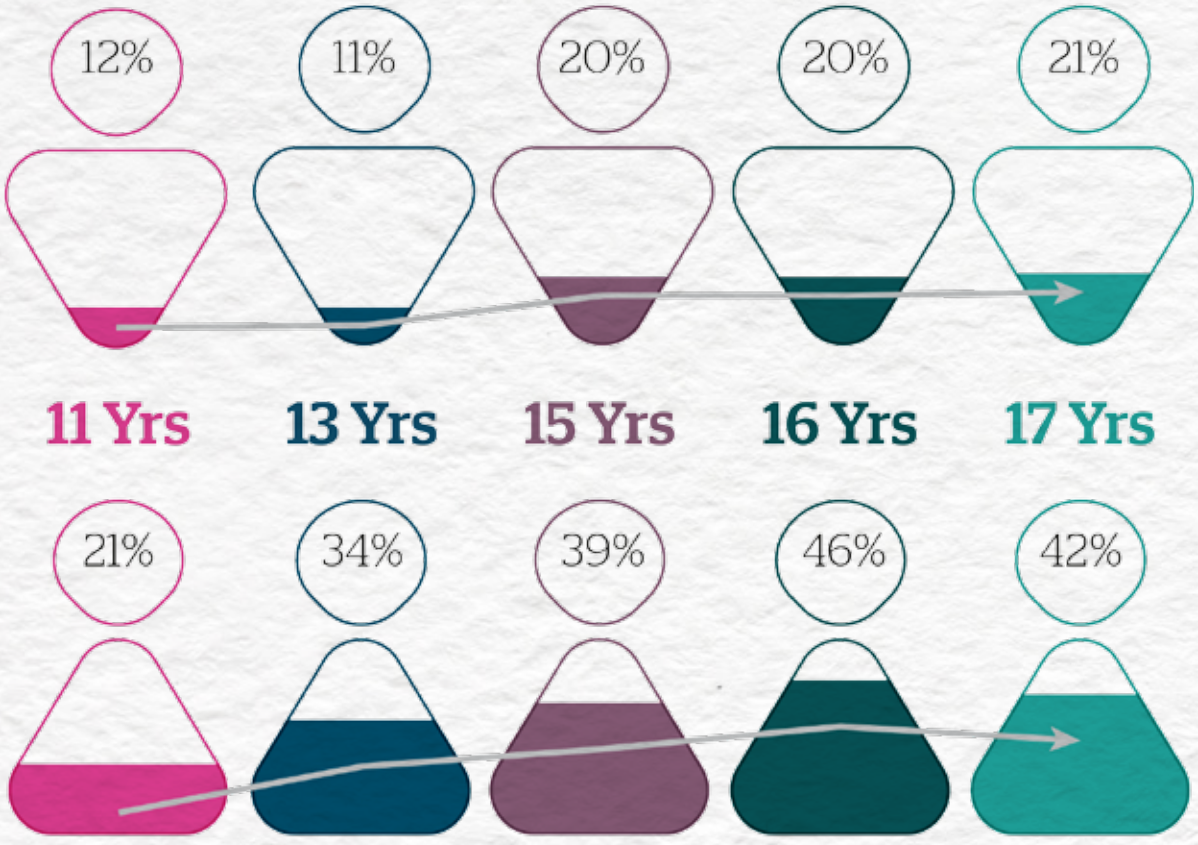


Figure 18: With increasing age, respondents are more likely to rate their self-esteem as either poor or very poor. This trend is particularly noticeable amongst female respondents. n = 2,289

The data highlights that there is a significant difference in male and female self-perception of day-to-day self-esteem.

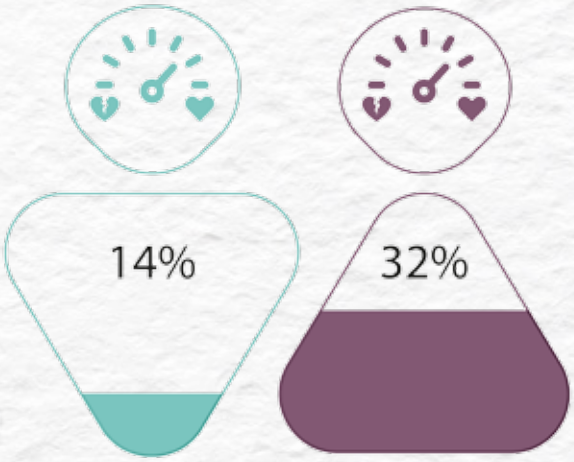
As seen in figure 19, on average **one third** of females rated their self-esteem poor or very poor (32 per cent), while just over **1 in 10** males rated their self-esteem poor or very poor (14 per cent).

As with body image, male and female rates of poor or very poor self-esteem rise with age (see figure 18). Specifically, females reported a rise of 25 percentage-points from the age of eleven to sixteen (21 per cent to 46 per cent). Although males reported an increase in poor or very poor self-esteem, it was not as significant as female respondents (12 per cent to 21 per cent).

The comments alluded to poor or very poor self-esteem being related to a many different aspects of adolescent development. Students noted that they lacked confidence when they were with their friends due to shifting friendship groups and trying to 'find' their identity.

This was compounded by a recurring theme of 'feeling lost'. Respondents were also very self-critical, often comparing themselves to 'prettier' or 'more intelligent' peers.

Figure 19: Female and male respondents who rated their day-to-day self-esteem as either poor or very poor. n = 4,579



1 in 3 female and just over **1 in 10** respondents would rate their day-to-day self-esteem as either poor or very poor.

"Respondents were very self-critical, often comparing themselves to 'prettier' or 'more intelligent' peers."

Why do you feel like you have low self-esteem?

"...they have groups about me on snapchat."

"People **make fun of me** and I don't like myself." - **Female (Age 12)**

"Because you can get nasty people who can say horrible things and **no matter how hard you try not to listen, you do.**" - **Female (Age 14)**

"**Society values people who are skinny** or toned and fit - not natural." - **Female (Age 17)**

"Because of **school pressure** and little attempts to try and mitigate this." - **Male (Age 17)**

"Because my 'friends' pretend there my friends but there not and **they have groups about me on snapchat.**" - **Female (Age 13)**

"Always feeling like whatever question I ask will be a stupid one, that every question I answer I will be told its wrong. When I sit alone **I can feel people looking and judging me**." - **Female (Age 16)**

"Don't really think I have any potential." - **Male (Age 17)**

"I never think good about myself because I don't like to and feel bad about it also **I don't think I am a good person.** I care about what others think about me." - **Female (Age 11)**

"I'm **worse than most people** at most things." - **Female (Age 12)**

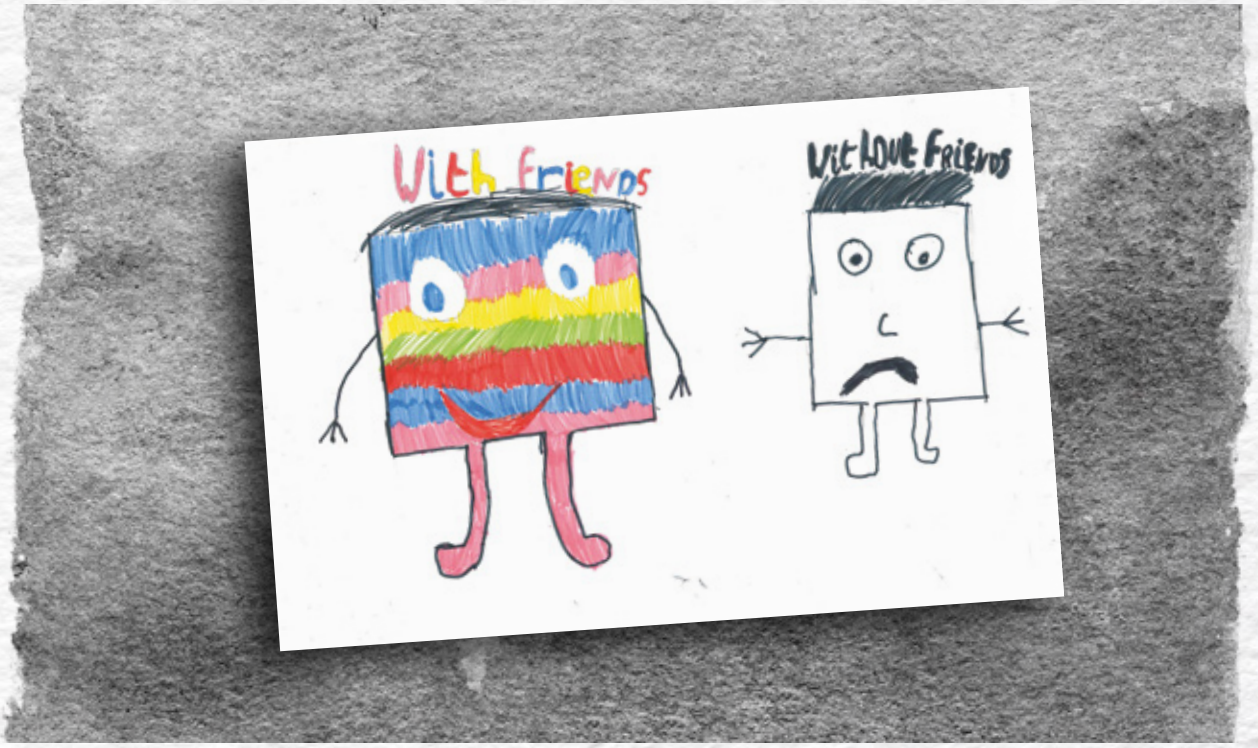
"Because when people say things or give you dirty looks that just makes you sad and makes me have **no confidence at all.**" - **Female (Age 13)**

"I always think that **I'm useless to my family and I feel lifeless** when I think about that and life in the school that I can't find the way to be my true self at school." - **Female (Age 16)**

"All my life I have had **people insult me because of my body image** and that's what I think of myself now, Ive heard it so much that its what I believe." - **Female (Age 13)**

"Because I've been put down quite a lot in the past and **don't have very much confidence in myself** and need people to help me believe that I do." - **Male (Age 14)**

"...all I am able to think about are the bad things."



Leisure time

3.15 - When you go home after school, what do you do?

Positive relationships and friendships with family and peers are crucial when fostering good emotional wellbeing[xxix]. Although a young person's emotional intelligence can be improved through a whole-school approach to mental health and wellbeing, social interactions and meaningful relationships begin in the home long before a person enters the education system.

Question 3.15 sought to ascertain what respondents did after school.

On average, almost one-third of respondents either spent time with their family or went out with friends after school (32 per cent aggregated). Over one-third of respondents went to their room (38 per cent). The other third of respondents selected 'other'.

The comments under 'other', accounting for 32 per cent of respondents, indicate that children and young people are involved in many different social activities after school. These included sports, walking pets and playing with siblings. However, there was also many responses that highlight engagement with peers via social media or online gaming platforms.

Respondents aged fifteen onwards tended to refer to homework and revision as their school-night social life.

There were over 900 comments collected regarding this question. The

Graph 21: *An indication of how respondents spend their time after school has finished for the day. n = 1,432*

overall sentiment highlighted that relationships, peers and friendships play a crucial role in young peoples' development, especially in helping a young person define their own identity. Also, as young people move from childhood through to adolescence, friendships become more affective and provide emotional support.

This is something that is reflected in the literature, as peers and friendship groups offer an arena in which new ideas and opinions can be discussed openly and new identities can be tried out[xxx]. These relationships influence a young person's social ability and can act as a feedback mechanism which guides young peoples' identity formation[xxxi]. Moreover, young peoples' social lives and quality of friendships has been associated with emotional wellbeing[xxxii].

Screen time and sleep

3.16 - On average, how many hours do you spend viewing an electronic screen on a week day?

"Screen time" is a somewhat contested concept with popular concerns approaching a moral panic relating to fears about young people's excessive use of computers and new communication technologies as well as television viewing.

Recent research has indicated screen time use should not be polarised as either negative or positive; for instance, young people's health and social outcomes have been shown to vary depending upon degree of video game playing[xxxiii xxxiv].

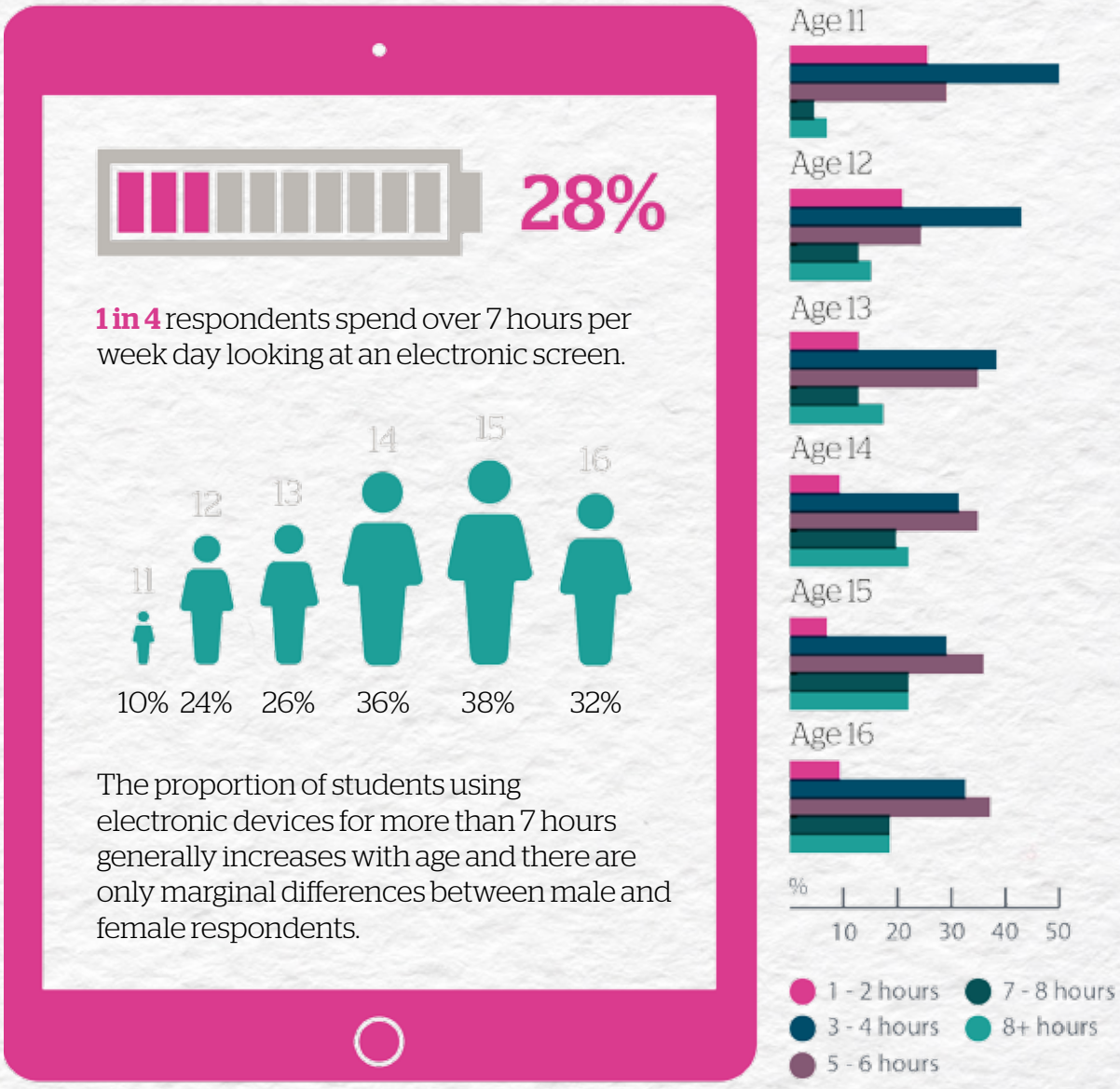


Figure 20 and graph 22 Reports of time spent using electronic devices. See table 11 for a detailed breakdown of responses. n = 1,435

Time spent on electronic devices (By age)					
	1 - 2 hours	3 - 4 hours	5 - 6 hours	7 - 8 hours	More than 8 hours
Age 11	22%	43%	25%	4%	6%
Age 12	18%	37%	21%	11%	13%
Age 13	11%	33%	30%	11%	15%
Age 14	8%	27%	30%	17%	19%
Age 15	6%	25%	31%	19%	19%
Age 16	8%	28%	32%	16%	16%

Table 11: Reports of time spent using electronic devices.

Recent literature has also correlated electronic device usage to the risk of short sleep duration, long sleep onset latency and increased sleep deficiency[xxxv]. In the last decade, we have witnessed a sharp increase in the availability and use of electronic devices such as smart phones, video game consoles, television, audio players, computers and tablets. Owing to this electronic devices have become an integral part of adolescent life, as exemplified by Ofcom reporting 88 per cent of children and young people owning a personal electronic device[xxxvi].

The data collected by the My Health, Our Future programme shows that more than one in four students spend over 7 hours per day looking at an electronic device (28 per cent). What's more, the usage of electronic devices increases with age, moving from 10 per cent using devices for over seven hours per week day at age 11 to 32 per cent at age sixteen.

Parallel with the increased use of electronic devices, there has been a shift towards poorer sleep over the past decades among adolescents[xxxvii].

Recent data on adolescent sleep shows that it is characterised on average by late bedtime, long sleep onset latency (SOL) and short sleep duration of approximately 6.5h on weekdays, contributing to daily sleep deficiency of about 2 hours.

The high rate of media use in adolescence may be one factor that is related to the short sleep duration and late bedtimes.

TV use has consistently and inversely been associated with sleep duration[xxxviii], as well as delayed bedtime and wake-up time in adolescents[xxxix]. A high level of computer use has been found to be related to sleep problems, reduced time in bed and increased SOL[xlxli].

Overall, electronic media use has been consistently linked with delayed bedtime and shortened sleep, according to a review of the literature.

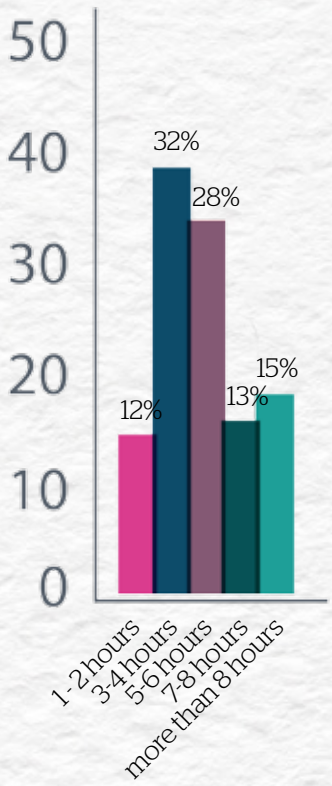
National comparable data

In a large population-based study in 2015, it was found that almost all adolescents reported using one or more electronic devices during the last hour before bedtime. Extensive use of these devices was significantly and positively associated with SOL and sleep deficiency, with an inverse dose-response relationship between sleep duration and media use[xlii].

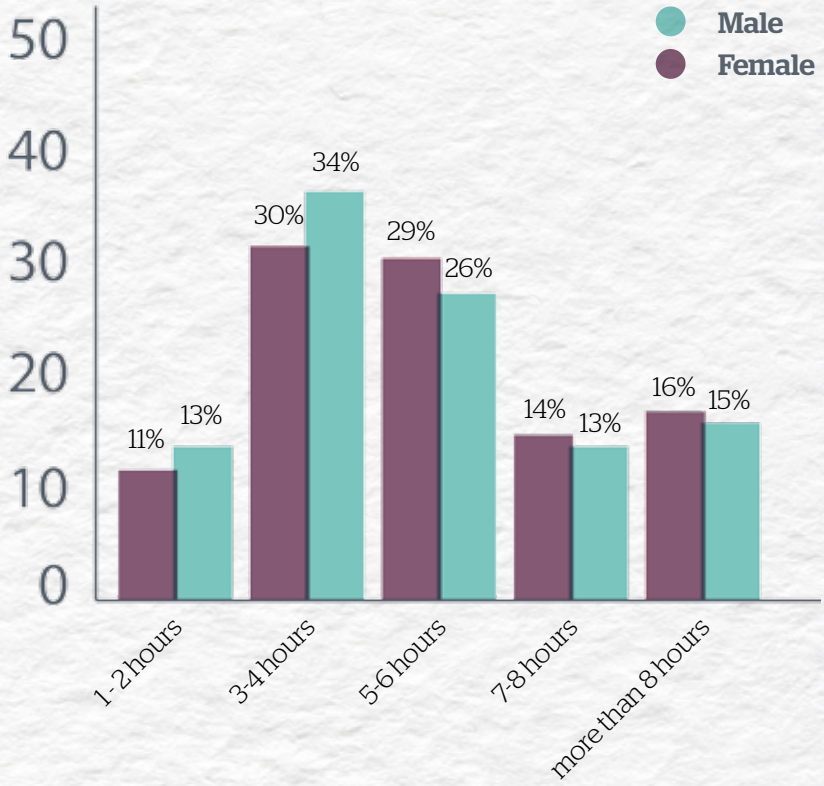
Hysing (2015)

One in ten children aged 8-11 who use the internet at home or elsewhere (8%) say they have seen something online in the past year that was worrying, nasty or offensive, with 12-15s being twice as likely to say this (18%)[xliii].

Ofcom (2015)



Graph 23: Time spent viewing an electronic screen on a week day.
n=1,435



Graph 24: Time spent viewing electronic devices on a week day (gender specific).
n=1,435

3.17 - On average, how many hours of sleep do you get on a school night?

Adolescents spend increasingly more time on electronic devices, while rising sleep deficiency in adolescents constitutes a major public health concern[xliv].

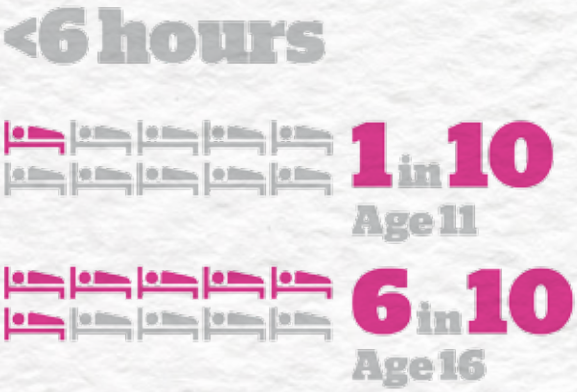
There are probably multiple pathways explaining the associations between sleep and electronic devices. Media use may directly affect sleep by replacing it due to its time-consuming nature, or may interfere with sleep through increased psychophysiological arousal. Alternatively, the bright light exposure inherent in most electronic media devices may interfere with sleep by delaying the circadian rhythm when exposure takes place in the evening and/or by causing an immediate activation.

We spend approximately a third of our lives asleep. Sleep is an essential and involuntary process without which we cannot function effectively. It is as important to our bodies as eating, drinking and breathing, and is vital for maintaining good mental and physical health. Sleeping helps to repair and restore our brains, not just our bodies.

Figure 21: Percentage of students who said they go to bed after midnight on a school night.

In humans, the amount of sleep a person needs depends upon their age. New born babies tend to sleep for an average of 16–18 hours per day, which decreases to about 13–14 hours after one year. Adolescents tend to require more sleep than adults, possibly due to the physiological changes that are happening in the body during this period. As the person reaches adulthood they tend to sleep 7–8 hours per day[xlv].

A mechanism called the circadian timer regulates the pattern of our sleep and waking, and interacts with the sleep homeostat. Most living things have internal circadian rhythms, meaning they are adapted to live in a cycle of day and night[xlvi].



The number of respondents that get **less than six hours** of sleep on a school night increases with age.

Figure 22: Respondents that get less than six hours sleep on a school night. n=1,455

Serotonin is another chemical that affects sleep. It is produced within brain, insufficient levels of serotonin are related to poor mental health experiences, for example, as depression and/or anxiety.

Levels of serotonin are highest in the brain when we are awake and active, and the brain produces more serotonin when it is lighter outside. Therefore, most people feel tired at night-time. The immune system also influences serotonin, and therefore influences sleep patterns[xlvii], which may explain why we need to sleep more if we are feeling ill.

My Health, Our Future's findings in relation to sleep are quite startling. On average, 1 in 10 young people aged eleven are getting less than six hours sleep per night, which dramatically rises to six out of ten young people at age sixteen (11 per cent and 60 per cent, respectively).

As previously discussed, this is contributing to a daily sleep deficiency of about 2 hours. This could lead to a myriad of negative physical and mental health outcomes, not to mention poor levels of concentration at school and poor attainment.

An example of the detrimental effects of under six hours sleep per night can be seen on the right-hand side of the page.

We can see that those respondents reporting the least amount of sleep on school nights exhibit poorer wellbeing (below average), heightened worry about their body image, poorer self-esteem and higher levels of electronic device use.

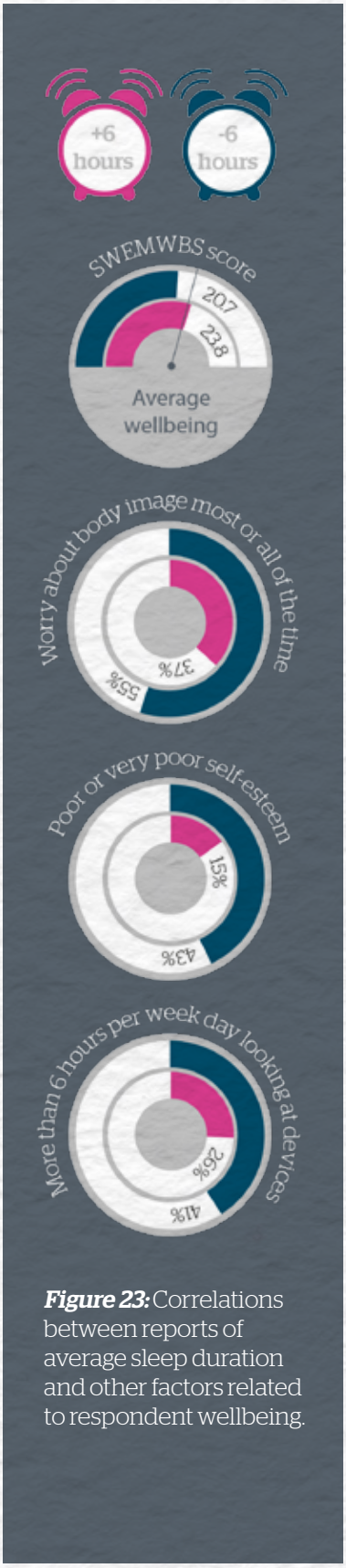
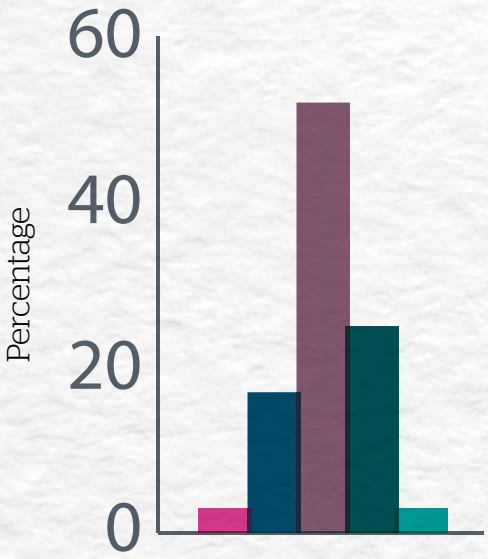


Figure 23: Correlations between reports of average sleep duration and other factors related to respondent wellbeing.



- Less than 5 hours - **3%**
- 5 - 6 hours - **17%**
- 7 - 8 hours - **52%**
- 9 - 10 hours - **25%**
- More than 10 hours - **3%**

Graph 25: Indicators of how much sleep respondents routinely get on a school night (all respondents). Based on 1,455 responses. n = 1,455

Cyberbullying

3.18 - Have you been a victim of online cyberbullying in the last two months?

Bullying describes intentional harmful behaviours repeated over time, against all individuals that are unable to defend themselves[xlviii].

It can be carried out in many ways including physical (hitting, kicking, theft), verbal (name-calling, threats), relational (social exclusion) and cyber (text messages, websites).

Research indicates bullying is associated with long-lasting negative outcomes, including a detrimental impact on the victim's physical health and emotional wellbeing[xlix], as well as school achievement[l].

Cyberbullying (or online bullying) is bullying using technologies, particularly over the internet or via mobile and gaming networks. Cyberbullying can be perpetrated by an individual or by a group of people to deliberately and repeatedly upset someone else. Any member of the school community – pupil, staff member, parent or carer – can be involved in or affected by cyberbullying.

Figure 24: Almost **one in ten** respondents stated that they had been a victim of cyberbullying in the last two months (8 per cent). n = 1,432

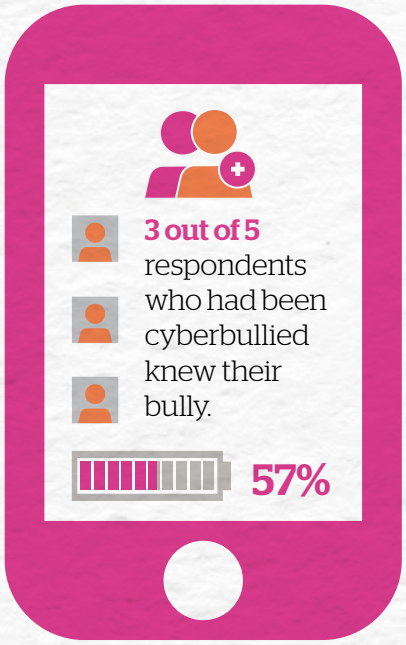


Figure 25: More than half of respondents who had been cyberbullied knew their bully. This indicates that the individual is likely to know their bully both online and within the school environment.
n = 115

Cyberbullying can include:

- intimidation and threats
- harassment and stalking
- vilification/ defamation
- exclusion or peer rejection
- impersonation
- unauthorised publication of personal information or images
- manipulation

Almost one in ten respondents stated that they had been a victim of cyberbullying in the last two months (8 per cent). As with findings from national literature sources, we see an increase in cyberbullying for those that are sixteen years of age (16 per cent).

When asked if the victim of cyberbullying knew the perpetrator, 59 per cent of females and 54 per cent of males said 'yes'. This indicates that the majority of victims engaged with the perpetrator not only online, but also at school.

This has the potential for catastrophic effects on the victims of cyberbullying. For example, the correlation between cyberbullying, poor emotional wellbeing, decreased self-esteem and body dysmorphia are evident from our findings (see right).

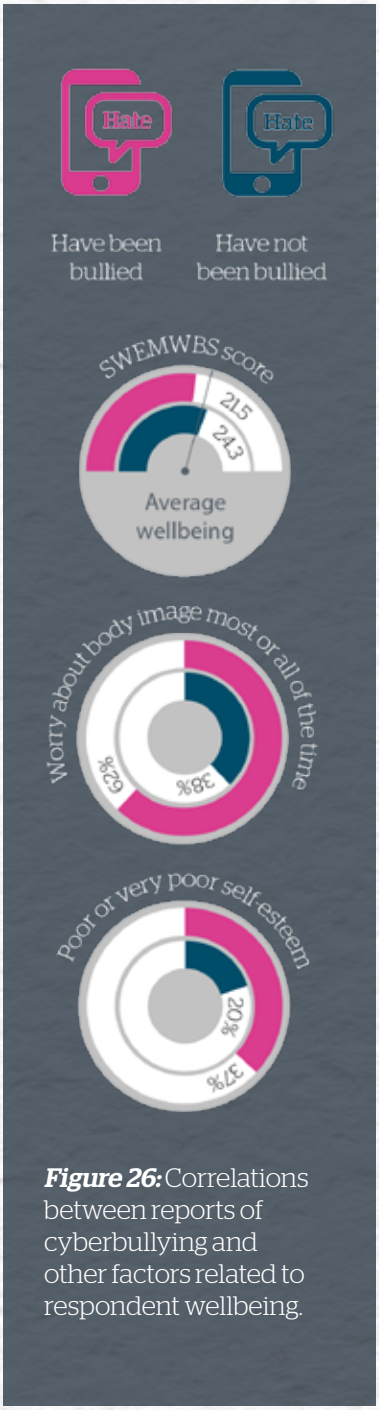
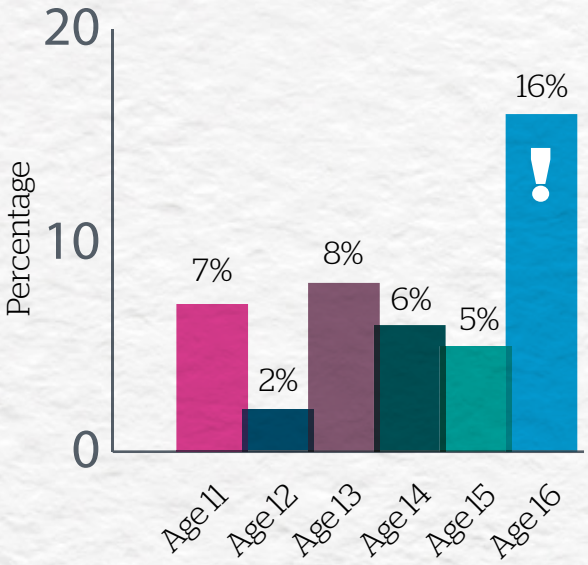


Figure 26: Correlations between reports of cyberbullying and other factors related to respondent wellbeing.

Graph 26: Proportion of respondents that report being cyberbullied by age groupings. n = 1,432



Those who were a victim of cyberbullying in the last two months were asked if they had discussed the issue with friends, parents or a member of staff at their school. The results show that over three-thirds of victims did talk to someone regarding the incident or incidents of cyberbullying. However, 22 per cent of respondents did not tell anyone.

Respondents who did not tell anyone about their incidents of cyberbullying were asked why they felt that they could not tell anyone. The majority of female respondents indicated that they were fearful of the repercussions, as many knew the person bullying them. A common theme among male respondents was that raising the issue 'wasn't worth it' or that they did not want to bother anyone.

As discussed previously, the young people saw their friends as being there for them and felt that they could sometimes relate more to peers than parents and other adults because they were the same age. Considering this, using friends as a coping mechanism was usually conducted via social media when outside of school.

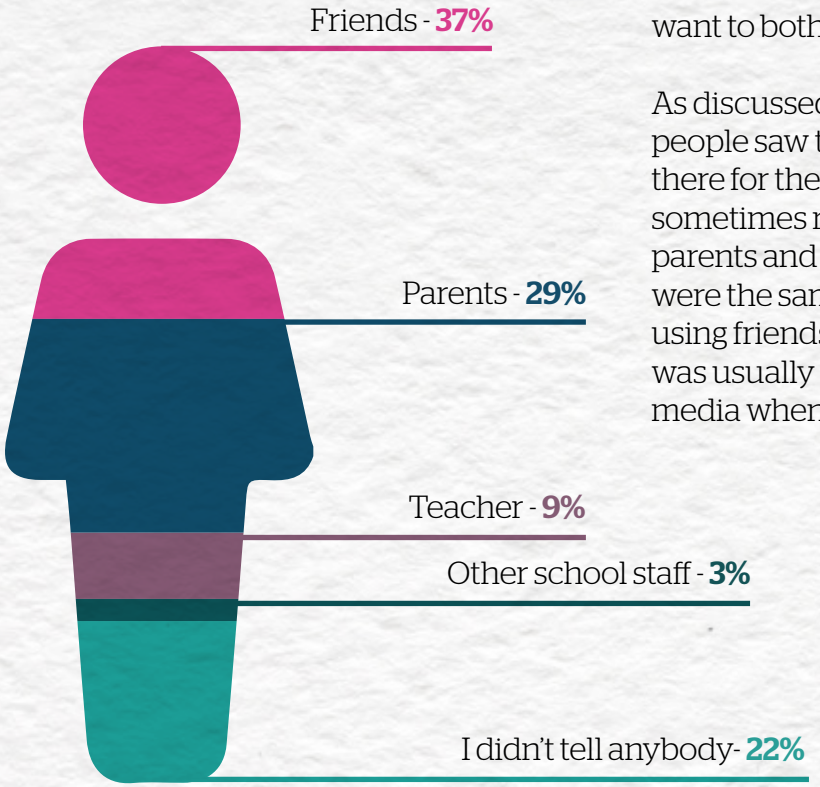


Figure 27: Respondents who told someone about being cyberbullied report making a disclosure to a number of individuals, with a majority telling their friends. n = 115

National comparable data

Overall, 18% of young people reported experiencing cyberbullying in the previous two months. 24% of girls reported being cyberbullied compared with 12% of boys. Girls were more likely to experience cyberbullying across all three age groups, and the risk of experiencing cyberbullying increases with age for both boys and girls[li].

HBSC England National Report (2015)

The likelihood of being cyber bullied appears to increase with age, whereas the more traditional forms of bullying decrease with age.

A survey of senior leaders and teachers in schools conducted by the Department for Education found that the most common form of bullying in schools is general verbal abuse, identified by 74 per cent of all respondents. This was followed by cyber bullying (45%) and physical abuse (26%). Racial and religious bullying was far less common. Cyber bullying was reported by far higher numbers of secondary than primary respondents (65% compared to 23% respectively)[lii].

Department for Education (2015)

Ofcom's findings state that 8% of respondents aged 12 to 15 have been a victim of cyberbullying in the last twelve months[liii].

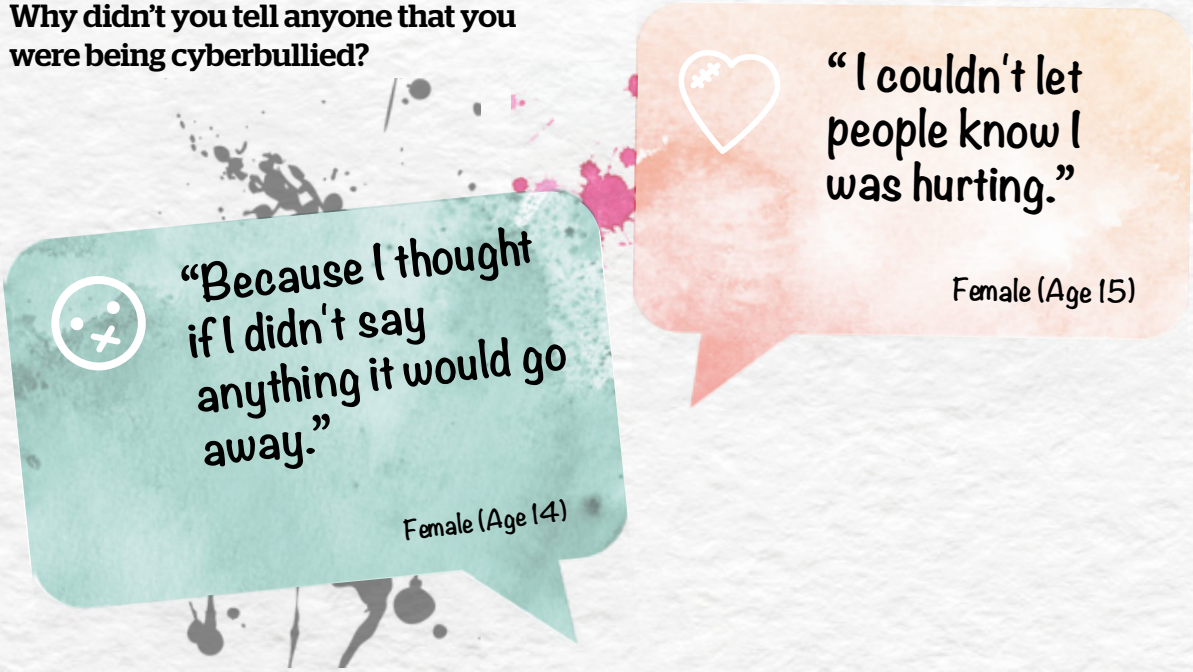
Ofcom (2015)

For female respondents specifically, it was noted that this could lead to victimisation and cyberbullying. In effect, their plea for help could oftentimes result in a new piece of gossip among friends and wider groups within school.

Male responses, on the other hand, indicated that peers are likely to make fun of each other if they try to discuss things they are worried about. However, the comments also highlighted that young males are expected to handle more teasing than girls and therefore may be less likely to report bullying than girls would be.

A minimal number of respondents commented that the greater access to, and use of, social media by older as compared to younger adolescents were considered possible reasons as to why cyberbullying became more common as they got older.

Why didn't you tell anyone that you were being cyberbullied?



"I don't want to bring people down and make them feel like me."

"**Don't want any other drama** to happen, and make it worse." - **Female (Age 12)**

"Because I'm **not a tell-tale**." - **Male (Age 12)**

" I was **scared**." - **Female (Age 16)**

" **I didn't want the people to bully me** anymore then they did." - **Female (Age 12)**

"I didn't want to get that person told off and **didn't want to start more drama**." - **Female (Age 12)**

" Because **I didn't want anyone else to get involved**." - **Male (Age 12)**

" It would **make it worse**." - **Female (Age 14)**

"Didn't want to **snitch** ." - **Male (Age 14)**

"I don't like to discuss my problems **I often feel like I'm bothering people** and I don't want to bring people down and make them feel like me." - **Male (Age 15)**

Self-harm

3.19 - Do you know anyone who is currently self-harming?

Over a third of students reported that they know someone who is currently self-harming.

Although this figure sounds high, it does not represent peer group relations in school. For example, if a young person is self-harming, it is likely that several of their friends will know. Therefore, each friend will select 'yes', which leads to a false narrative when quantifying the number of students currently self-harming.

The data does, however, indicate a prevalence of self-harm among secondary school students, which is reflective of national literature. Moreover, we see that there are more females than males who know someone who is currently self-harming.

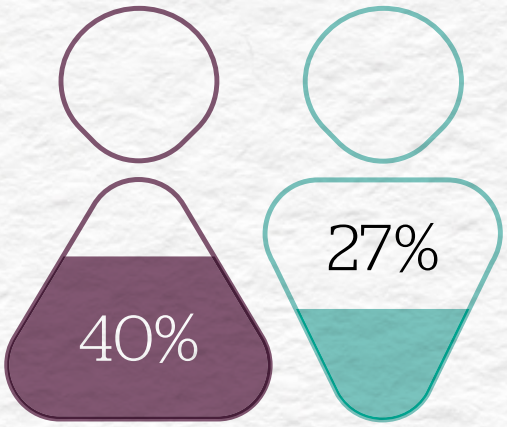


Figure 28: Percentage of male and female respondents who know of someone that is self-harming. n = 921

Figure 29: Proportion of respondents who reported knowing of someone currently self-harming (above).

3.20 - Have you ever self-harmed?

15 per cent of respondents reported previously self-harming, while almost three quarters said that they had not (72 per cent). Just over one in ten respondents said that they 'would rather not say' (13 per cent).

Figures 30: Percentage of respondents who said they had not self-harmed. 15% said 'yes' and 13% would rather not say (below).

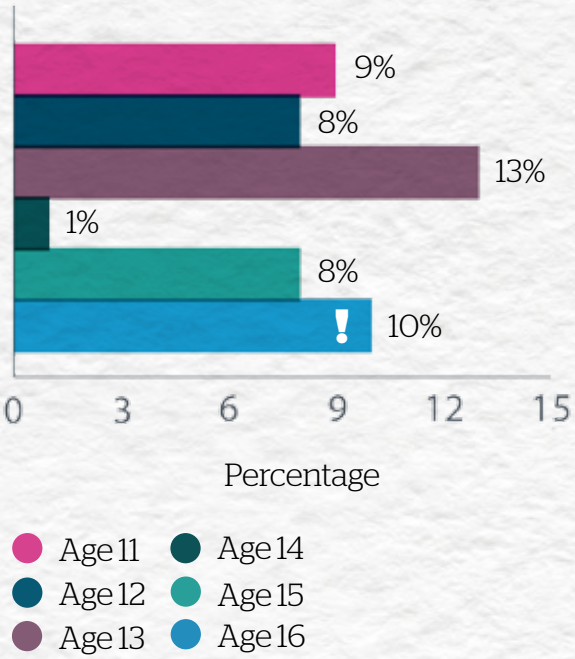
These figures, although shocking, are reflective of the national picture. The HBSC England National Report in 2015 found that when asking fifteen-year-old respondents, just over one fifth (22 per cent) reported that they had ever self-harmed. For those aged fifteen in the My Health, Our Future survey, the average was 18 per cent (4 percentage points lower than the national average).

What is self-harm?

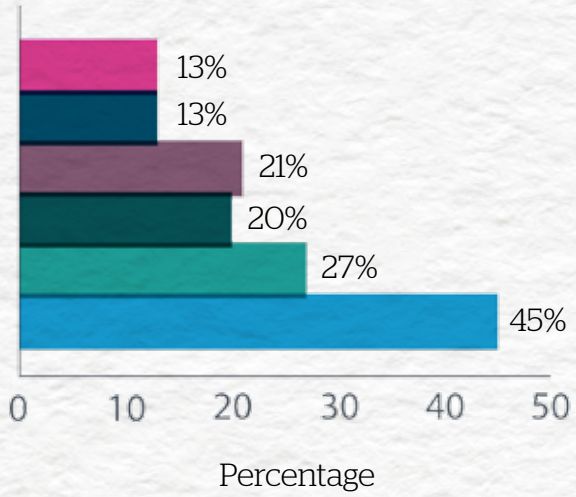
Self-harm can be defined as:

- Self-injury or self-poisoning intentionally to cause harm.
- An act with non-fatal outcome, in which an individual deliberately initiates a behaviour that, without intervention from others, will cause self-harm.

Graph 27: *Proportion of respondents who reported having self-harmed before by age (male respondents). Based on 389 responses.*



Graph 28: *Proportion of respondents who reported having self-harmed before by age (female respondents). Based on 466 responses.*



Young people identified both external and internal reasons as to why someone may self-harm. The external reasons covered factors such as family and relationships, which came up in the majority of young people's comments. Also, other influences such as stress, bullying, body dysmorphia, and social media were all mentioned in at least half of the comments collected.

Figure 31: In line with the HBSC England National Report (2015), our findings indicate that nearly three times as many girls as boys reported that they had self-harmed before. n =141

National comparable data

In the HBSC England National Report nearly three times as many girls as boys reported that they had self-harmed; 11% of boys compared to 32% of girls[liv].

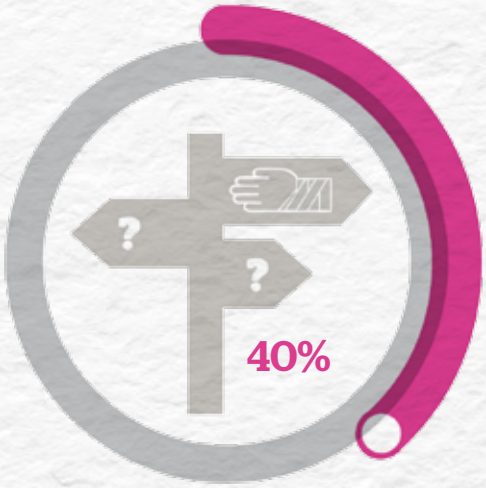
HBSC England National Report, 2015

3.21 - Do you know where to go for support regarding issues of self-harm?

40 per cent of participants said that they do not know where to go for support regarding self-harm. The services that young people were aware of were services available at school, such as the school nurse.

There was limited knowledge of where or how to access local services for mental health and wellbeing.

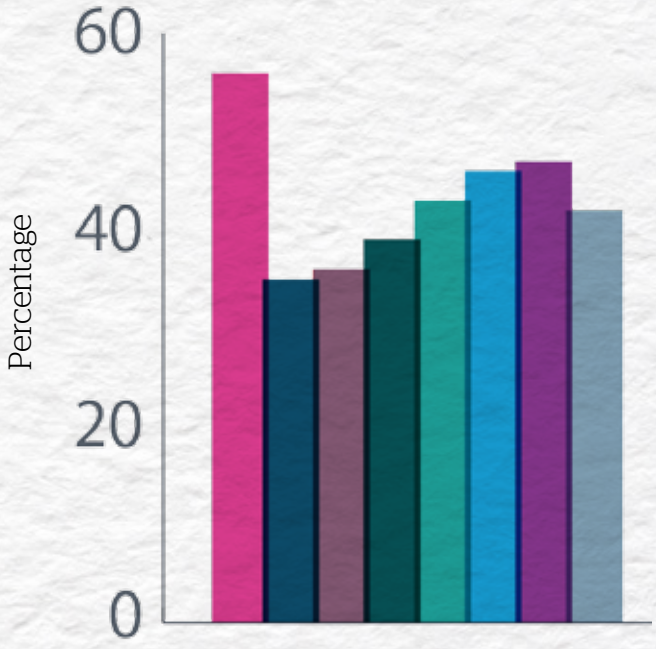
The services schools promoted included counselling and services promoted by information letters and word-of-mouth. They also discussed how the internet could be viewed as a useful tool or as a damaging influence.



Figures 32: 40% of respondents indicated that they do not know where to go for support with self-harming. n = 918

- Age 11 - **56%**
- Age 12 - **35%**
- Age 13- **36%**
- Age 14 - **39%**
- Age 15 - **43%**
- Age 16 - **46%**
- Age 17 - **47%**
- Age 18 - **42%**

Graph 29: Knowledge of where to go for support with stopping self-harming across age groups.



Local comparable data

The Suffolk Cybersurvey (2016) found that respondents who felt depressed most of the time were more likely to visit websites that encourage people to self-harm or talk about suicide (33 per cent vs. 9 per cent)[lix].

Suffolk Cybersurvey (2016)

Childline was one of the national services identified as a resource young people were aware of. There were opposing views between students who felt they would approach staff for advice and support and those who wanted to avoid any staff finding out.

Although Healthwatch Suffolk provided signposting materials to all participants, early work in the pilot stage found that students would benefit from signposting posters on the back of toilet doors. This was for two reasons; first, all pupils visit the toilets throughout a school day so it would raise awareness systematically. Second, students said that they would often excuse themselves from class and go to the toilet if they felt distressed.

Looking at the demographics for those reporting previously self-harming, we see that females are three times more likely to have previously self-harmed. This, again, reflects national findings. A detailed breakdown of respondents reporting previously self-harming can be seen in the appendices.

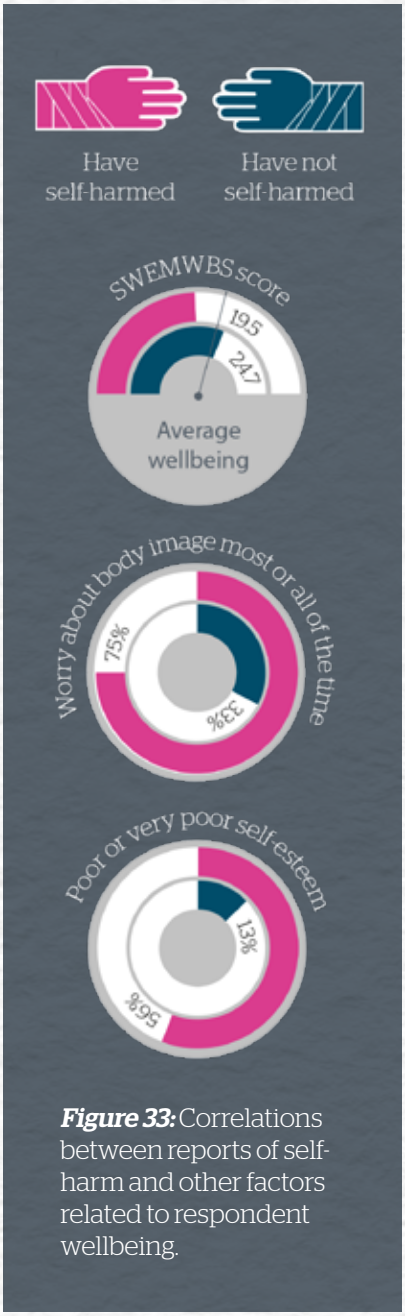


Figure 33: Correlations between reports of self-harm and other factors related to respondent wellbeing.


mental health and wellbeing
Anxious
tired
nervous
not talking
feeling upset
feeling Down
Stress
Being alone
never want to go anywhere
Dog
Things
Sunshine
love
Scooter
nice
Colours
clothes
Trampolining
cool
Shadows
rain
Skinny
nice
Death
Terrorism
Happy
Scared
Feelings
Stress
Parents
People
Social
Dead
family
life

DISCUSSION

It should be clear from the range of issues discussed that there is considerable potential for improving children's subjective wellbeing but also that this over-arching goal will not be achieved through focusing on a single issue Nor that it can be achieved by the actions of only one key stakeholder.

Some of the findings appear to be amenable to national and local policy initiatives, while others are more relevant to services and practitioners, to parents and to children themselves. In this section, we provide a few selected examples of the relevance of the findings for different stakeholder groups.

4.1 - Leadership and Management

To ensure actions are integrated, sustained and monitored for impact it is important that a commitment to addressing social and emotional wellbeing is referenced within improvement plans, policies (such as safeguarding; confidentiality; personal, social, health and economic (PSHE) education; social, moral, spiritual and cultural (SMSC) education; behaviour and rewards and practice[lx]).

It is also important to involve pupils, staff and parents in developing these policies coproductively so that they remain 'live' documents that are reviewed and responsive to the evolving needs of the school community.

In addition to leadership from senior management, feedback from practitioners highlights the importance of having a champion who will promote emotional health and wellbeing across the school. Such champions do not have to be senior managers, but they do need the support of the senior management team and governors to take work forward in a way that is embedded across the school.

School leaders have an important executive role in advocating for the needs of children and learners within the context of wider local strategic planning and in influencing local commissioning arrangements through Healthwatch Suffolk and the Health and Wellbeing Board[lxi]. All schools should work towards

4.1 - What do the National Institute for Health and Care Excellence (NICE) say?

NICE Guidance: Head teachers, Governors and teachers should demonstrate a commitment to the social and emotional well-being of young people. They should provide leadership in this area by ensuring social and emotional wellbeing features within improvement plans, policies, systems and activities. These should all be monitored and evaluated.

accessing the free national secondary school mental health 'first aid' training[lxii].

The Children and Young People's Mental Health and Wellbeing Taskforce[lxiii] recommends that schools assign a lead on mental health issues who would be responsible for linking schools with expertise, identifying issues and making referrals. It also recommends that local mental health commissioners and providers assign a point of contact in specialist children and young people's mental health services for schools as well as in GP practices who would be responsible for advising on the management of specific cases[lxiv]. This, in Suffolk, is progressing via the Emotional Wellbeing Hub under the umbrella of the Children and Young People's Emotional Wellbeing Transformation Plan 2020 (EWB2020).

4.2 - Making children and young people's voices heard across health and education sectors

Involving students in decisions that impact on them can benefit their emotional health and wellbeing by helping them to feel part of the school and wider community and to have some control over their lives.

At an individual level, benefits include helping students to gain belief in their own capabilities, including building their knowledge and skills to make healthy choices and developing their independence. Collectively, students benefit through having opportunities to influence decisions, to express their views and to develop strong social networks.

The voice of families and carers are also crucial in creating a cohesive and united system-wide approach to mental health

4.2 - What do the National Institute for Health and Care Excellence (NICE) say?

NICE recommend that secondary education providers:

1. Develop partnerships between young people and staff to formulate, implement and evaluate organisation-wide approaches to promoting social and emotional wellbeing;
2. Introduce a variety of mechanisms to ensure all young people have the opportunity to contribute to decisions that may impact on their social and emotional wellbeing;
3. Involve young people in the creation, delivery and evaluation of training and continuing professional development activities in relation to social and emotional wellbeing.

and wellbeing in Suffolk. The family plays a key role in influencing children and young people's emotional health and wellbeing[lxv].

There is strong evidence that well implemented universal and targeted interventions that support parenting and family life and that offer a combination of emotional, parenting and practical life circumstances (combining drug, alcohol and sex education, for example) have the potential to yield social and economic benefits[lxvi].

4.3 - Upskilling Suffolk's Workforce

It is important for staff to access training to increase their knowledge of emotional wellbeing and to equip them to be able to identify mental health difficulties in their students. This includes being able to refer them to relevant support either within the school or from external services. The report of the Children and Young People's Mental Health and Wellbeing Taskforce recommends that staff working with children and young people in universal settings, including schools, should receive training in children and young people's development and behaviours but should not be expected to replace specialist services[lxvii].

Promoting staff health and wellbeing is also an integral principle of the whole school approach to emotional health and wellbeing. Teaching and learning establishments can demonstrate a commitment to staff health and wellbeing in many ways. For example, by providing opportunities for assessing the emotional health and wellbeing needs of staff, by providing support to enable staff to reflect on and to take actions to enhance their own wellbeing and by promoting a work-life balance for staff. A good way of driving these changes is through the Workplace Wellbeing Charter National Standards or Suffolk Mind's Workplace Wellbeing Programme, for example.

4.3 - What do the National Institute for Health and Care Excellence (NICE) say?

Integrate social and emotional wellbeing within the training and continuing professional development of teaching staff and governors involved in secondary education, and to ensure teaching staff have the knowledge, understanding and skills they need to develop young people's social and emotional wellbeing

4.4 - Implementing the whole-school approach to mental health and wellbeing

The first category of school-based mental health provision is the facilitation and delivery of promotion and prevention services. This is what has traditionally been understood as 'Tier One" provision within the tiered model, and is primarily aimed at children and young people who are 'thriving' and 'coping' according to the THRIVE model (see figure 34).

As the majority of secondary schools in Suffolk are now academies, they have been granted the autonomy to design their own unique approaches to mental health provision in response to the levels and types of need among their pupils. This is reflective of the government's wider approach of granting schools the freedom to develop innovative solutions to boost pupils' performance.

While it is important for schools to have autonomy in this area, moves to increase that autonomy have not been accompanied by measures to boost their capacity to meet pupils' mental health and wellbeing needs.

The following paragraphs outline the three broad groups of staff who are involved in mental health and wellbeing provision in secondary schools in relation to Tier One: promotion and prevention. These are teachers, pastoral staff, and school nurses.

Teachers:

Teachers play a significant role in school based mental health and wellbeing provision and are integral to efforts to ensure that 'Tier One: promotion and prevention" is delivered effectively.

A key finding is that every school's needs are unique and as such issues and assumptions will vary for each school

Figure 34: The THRIVE model.

community, between teachers and frontline staff.

The following table highlights some of the shifts in thinking that underpin a whole-school approach, promotion and prevention. The table provides a stimulus for discussion to explore existing thinking and make the case for change with a more holistic approach (See the National Children's Bureau for more information[lxviii]).

Table 12: some of the shifts in thinking that underpin a whole-school approach, promotion and prevention.

Old assumptions	Why wellbeing matters	The whole school approach
Mental health problems are only of concern to specific groups of children and young people (CYP).	The nature of mental health (MH) is that it is a continuum and that CYP move up and down and that EWB impacts much more broadly than on those exhibiting specific problems.	Emotional wellbeing (EWB) is a key element in CYP's development and readiness to learn. Evidence shows that EWB dynamics will be impacting on ALL students and that readiness to respond early within the normal environment is the most effective.
These are issues that are clinical in nature and teaching staff cannot be expected to learn these skills as well.	Schools should not believe they are required to replicate specialist services or focus only on students with diagnosable mental health problems.	Many emotional issues are not clinical in nature and not best served by specialist interventions but social models offer broad based approaches that act preventatively.
Schools core business is education and OFSTED reflects this.	Regulation and inspection are increasingly reflecting the broader nature of development in anticipation of its impact on all educational outcomes.	Creating a school ethos that promotes wellbeing, resilience and positive skills has proven able to improve the individual and school performance.

Pastoral teams and specialist staff are the best response by schools.	Early intervention measures take place in every classroom every day, where young people can make sense of their own strengths and weaknesses and build resilience. When these are not sufficient then a high-quality system of care and support is important.	Undertaking a school mapping exercise to highlight the different settings, staff and interventions where young people are learning about themselves and their coping strategies will reveal in a school the wealth of opportunities to impact positively on your students.
These students are costly in time and resources	These students and their needs do need to be planned for but here schools can draw on a range of new interventions. There is an increasing number of CYP who have fallen under the radar who do need specialist help, and often schools find services are not accessible or appropriate.	Mental health awareness can assist schools develop a clear early intervention strategy, identification process and with support robust care pathways and protocols. Schools can be influential in shaping external services and negotiating agreements as well as enhancing their commissioning role as a school and with other schools.
Staff are reluctant to manage the emotional needs of their students and need to be able to rely on specialist staff within school.	Staff within many schools are themselves highly stressed and this will be impacting on the emotional climate within schools and undermines ability to provide positive support to CYP.	Staff wellbeing is increasingly becoming a priority for schools and the evidence building that taking care of staff and offering them positive skills impacts on the staff but also the school climate and the students.

Governors and senior teams need to ensure that mental health issues are managed well and outside services.	Schools without a strategic overview of how to promote wellbeing and how to use resources to intervene early will face increasing fire-fighting demands and rely on services managed elsewhere.	As a board and senior team knowing your assets and strengths and where within a school a strategic approach to EWB offers clear opportunities to gain in other areas of performance and overall quality of a school environment and ability to lead from the front. Department of Education & OFSTED are developing a stronger set of criteria in this arena.

Pastoral staff:

Pastoral staff play a significant role in school-based mental health provision. Schools can choose to construct a pastoral system involving a variety of different staff members with different roles. All schools are required to have a nominated special and educational needs co-ordinator, and will have form tutors with pastoral obligations to pupils. They may also choose to employ additional non-teaching staff, such as 'pastoral managers', with responsibilities of this kind.

Pastoral staff are necessary to ensure provision in Tier One and Tier Two, and can also play a 'co-ordination' role that oversees provision across all three Tiers. Within Tier One, pastoral staff can promote behaviours relating to positive mental health and wellbeing, and signpost pupils to universal services available in the community.

In summary, pastoral staff are well placed to perform the following tasks:

- Assume the role of 'mental health lead' within the school.
- Ensure the maintenance of appropriate levels of confidentiality between staff with mental health expertise and teachers.
- Feedback on the general mental health and wellbeing of pupils to the school's senior leadership.
- Assume line-management responsibilities for counsellors.
- Oversee the collection and analysis of data regarding pupil outcomes and the effectiveness of counselling interventions
- Oversee processes for triage and referral.

School Nurses:

School nurses' main role is to identify health problems and concerns as early as possible by conducting health needs assessments, and to promote healthy lifestyles. Public Health England has set out six 'high impact areas' for school nurses:

- building resilience and improving emotional health and wellbeing
- keeping pupils safe, managing risk and reducing harm
- improving lifestyles
- maximising learning and achievement
- supporting additional health and wellbeing needs
- seamless transition into, and preparing for, adulthood (PHE 2016).

School nurses have the potential to play an important role in school-based mental health provision, and the Future in Mind report specifically set out the need for them to build resilience and improve emotional health and wellbeing among pupils (DH and NHS England, 2015). They are well placed to take on responsibilities in the first two Tiers of provision.

Within the first Tier, school nurses can effectively fulfil many responsibilities with regards to promotion and prevention. These responsibilities are detailed in the guidance issued by the Department of Health and Public Health England on school nurses' role in promoting emotional wellbeing and positive mental health and they include:

- recognising and utilising opportunities to promote emotional health and wellbeing
- de-stigmatising mental illness and normalising emotional health and wellbeing
- providing non-judgemental support (DH and PHE 2014).

4.6 - Digital Literacy

Schools and other educational settings should take proactive measures to help prevent cyberbullying from occurring and to reduce the impact of any incidents that do happen. All schools are required to follow anti-discrimination and equality laws and staff must act to prevent discrimination, harassment and victimisation within the school. Cyberbullying prevention should build on these requirements, promoting and maintaining a safe and welcoming environment.

Effectively addressing cyberbullying is an ongoing commitment, as a whole-school community, to:

1. understand and talk about cyberbullying
2. keep policies and practices up to date
3. make reporting easier
4. promote the positive uses of technology
5. evaluate the impact of activities

Reporting any incident of bullying can be difficult for the person being bullied and for bystanders. It may be particularly difficult for young people to report

cyberbullying if reporting will reveal something about their online activities that they do not want to share.

Engagement with technology involves feelings as well as actions – above all it is a social activity that allows young people to feel connected to their peers. Telling a young person who has been cyberbullied to keep their mobile phone switched off, delete an account or to stay off the internet as a response to cyberbullying may be interpreted as a disruption of their social life and perceived as a punishment. In some cases, the knowledge that this is likely to be a response may prevent reporting.

All members of the community should recognise that asking for help is not a failing or a weakness, but a strength which shows courage and good judgement. All members of school staff should treat all disclosures of harm with respect and seriousness.

Setting up a pupil cyberbullying taskforce or peer support programme or focusing on cyberbullying within existing groups – such as the school student council or student digital leaders group – can be an effective way to raise awareness and engage learners.

Aside from digital literacy regarding cyberbullying, schools and wider systems throughout Suffolk should raise awareness of the detrimental effects excessive usage of electronic devices can have on their sleep and, in turn, their wellbeing.

Sleep is the foundation of health. Children and young people should be provided with ongoing promotion and engagement regarding electronic usage and healthy sleeping patterns. The blue light emitted by screens on mobile phones, computers, tablets, and televisions restrain the production of melatonin, the hormone that controls the sleep/wake cycle or circadian rhythm. Reducing melatonin makes it harder to fall and stay asleep.

The results from My Health, Our Future suggest that the majority of young people aged fifteen to eighteen are currently facing a daily sleep deficit of two hours, which is proven to have a myriad of negative effects on physical and emotional health[lxx lxxi].

RECOMMENDATIONS

5.1 - The Emotional Wellbeing 2020's Workforce Development Programme should proactively offer all secondary schools training and development

The My Health, Our Future workstream has highlighted that school workforces have a significant role to play in identifying mental health and wellbeing issues in their students and signposting them to support. Teachers and school staff have a role in intervening in cases where students feel anxious about work pressures, as well as in referral to professional psychological assessment and support for students who are showing signs of diagnosable mental health conditions. However, to be effective in this role teachers should be given adequate training and opportunities for continuing professional development.

Healthwatch Suffolk acknowledge the valuable work that has taken place to enable frontline staff, families and carers access to timely and relevant learning and development packages across Suffolk. However, many of the school-based training packages have been oversubscribed and the communications of such packages has not been targeted.

Healthwatch Suffolk recommend the following:

1. EWB2020's Workforce Development programme should consider penetration across the education sector since 2015. Where possible, training should be redirected to schools that have not yet had training and/or engagement.
2. Taking a proactive approach, the promotion of the Workforce Development packages among education leads is a crucial next step. Relying on Suffolk County Council's internal 'Headlines' portal is not a sufficient tool for promotion such workforce programmes, as the advertisement may not reach the right contact within a school. A systematic process for accessing schools should be developed to ensure the Workforce Development offer is rolled-out equally across schools in Suffolk.
3. Additionally, Healthwatch Suffolk recommend that the review of the Workforce Development programmes considers upskilling staff on the prevalent issues seen within the findings of this report. Tackling issues such as sleep, cyberbullying and social media, among others, will enable staff to better combat problems that are current and prevalent among children and young people in Suffolk.

5.2 - Stakeholders should work collaboratively to provide a systematic approach to upskilling children and young people on issues regarding mental health and wellbeing across secondary schools in Suffolk

The findings in this report demonstrate that there is a significant need for children and young people to learn about positive mental health and wellbeing. This includes issues surrounding digital literacy, emotional intelligence, coping mechanisms, meaningful relationships and sex education.

At present, the Workforce Development programme only engages with half of Suffolk's population – namely adults. The system leads are yet to establish a systematic approach to engaging Suffolk's population of children and young people. Although Healthwatch Suffolk acknowledge that there has been innovative and progressive work undertaken via Suffolk Community Foundation's 'Children and Young People's Emotional Health and Wellbeing Fund', schools cannot readily access engagement packages for pupils that are relevant and timely. Therefore, Healthwatch Suffolk recommend the following:

1. The EWB2020 leads should work with Schools' Choice and the Schools Coordination Group to develop a pupil orientated engagement package specifically for mental health and wellbeing. To make 'emotional wellbeing everyone's business in Suffolk Children and young people need to be included in training and engagement packages. Thereafter, schools should be able to access pupil-specific engagement via CPD Online.
2. The engagement package offered to schools should take into account the findings from My Health, Our Future. This report has taken a step towards highlighting the needs of Suffolk's children and young people. Collectively, we should work towards addressing the needs of our children and young people.

5.3 - Personal, Social, Health and Economic (PSHE) and Relationship and Sex Education (RSE) should include digital and online safety

Technology is being used in schools to support engaging, positive and effective learning and for differentiation. Embedding appropriate technologies can be used to enhance educational opportunities for all – making learning more flexible, creative, accessible and effective. However, this report has highlighted that many children and young people are using electronic devices for many hours per day. Respondents as young as twelve have ongoing issues with 'sexting' and online safety due to explicit content and interactions, and almost one in ten have been a victim of cyberbullying in the last two months.

These prevalent issues, coupled with the findings that many students are indifferent towards their current PSHE curriculum and 45 per cent think that they're not taught about mental health

and wellbeing, means that there is a lot still to be done. Schools and the curriculum are pivotal instruments when engaging and upskills children and young people.

Chapter four of the "Children and Social Work Act 2017" states that relationships and sex education (RSE) is to become mandatory from 2019. As part of RSE, pupils must learn about safety in forming and maintaining relationships, the characteristics of healthy relationships, and how relationships may affect physical and mental health and well-being. Additionally, the legislation states that PSHE must be taught to all pupils receiving secondary education. While Healthwatch Suffolk support the new legislation, we would like to see any reforms or changes to PSHE and RSE coproduced with the children and young people of Suffolk. The findings from this report are a testament to why coproduction is a necessity when talking to children and young people about the issues they face on a day-to-day basis.

Healthwatch Suffolk recommend the following:

1. Healthwatch Suffolk will work with key stakeholders to aid in the delivery of RSE. The ongoing My Health, Our Future workstream can be used as a tool of coproduction, and to gain a representative response to the current needs of children and young people regarding Relationship and Sex Education.
2. Healthwatch Suffolk will work with the current My Health, Our Future schools to evaluate their current PSHE offer. Where possible, we will help to advise schools on best practice in relation to our findings (see recommendation 5.7 for more information).

5.4 - EWB2020 stakeholders should work collectively to promote children and young people's voices throughout health and education systems, such as the Health and Wellbeing Board

The Health and Social Care Act 2012 established Health and Wellbeing Boards as a forum for local councillors, the NHS and local communities (including schools when invited) to work together to identify the local priorities for children and young people. The job of the Health and Wellbeing Board is to collect and analyse information about current and future health and social care needs and develop a strategy for commissioning the right balance of services. Schools can influence this process by feeding in what they know about the needs of their pupils.

Local authority Directors of Children's Services and local Healthwatch are statutory members on Health and Wellbeing Boards. They are critical in promoting the interests of all children and young people, including those with SEND . Schools, however, are not statutory members of Health and Wellbeing Boards. Therefore, schools should approach their Director of Children's Services (DCS) or their local Healthwatch organisation, who are responsible for engaging children and young people, professionals and other stakeholders in the work of the Board. In light of this, Healthwatch Suffolk would like to offer its services to schools who feel that they are seldom heard or who

feel that they lack representation.

Healthwatch Suffolk recommend the following:

1. Healthwatch Suffolk will work with the Schools Coordination Group and the Headteachers Forum to create a communication stream whereby schools' voices can be heard collectively at the Health and Wellbeing Board in Suffolk.

5.5 - The EWB2020 should increase funding for Tier One support

Since October 2015, the EWB2020 has worked tirelessly to achieve its five priorities. Healthwatch Suffolk commend the workforces involved in the Workforce Development programme, Crisis Response, Multi-Agency Emotional Wellbeing Hub and Digital Strategy amongst others.

Looking forward to 2020, Healthwatch Suffolk would like to see more funding redirected towards Tier One promotion and prevention. The findings from this report indicate that wellbeing among the wider population of children and young people needs to be addressed. This is a touchstone of the Future in Mind report and the EWB2020.

Healthwatch Suffolk recommend the following:

1. The EWB2020 should look to increase funding regarding Tier One services, specifically promotion and prevention of mental health and wellbeing.

5.6 - Schools should be engaged on the forthcoming Emotional Wellbeing Hub and, where possible, should receive increased signposting material

Much work has been done to introduce an Emotional Wellbeing Hub to Suffolk and a relevant online platform (The Source) to help young people access timely information and signposting regarding mental health and wellbeing. However, the work of My Health, Our Future has raised questions around the promotion and communications accompanying these initiatives.

Pastoral teams and teachers are currently unsure of what the Emotional Wellbeing Hub will offer, where is it, and how they can engage effectively with the service. Meanwhile, many students are unaware of The Source website and the benefit it affords them and their peers. Ensuring effective promotion and prevention of mental health and wellbeing requires clear communication with all stakeholders, including children and young people.

Students have stated that the best place for advertising an online platform is the back of toilet doors. This is where students go when they feel they can't cope or they need to escape; students also visit the toilet daily.

Healthwatch Suffolk recommend the following:

1. The EWB2020 should produce an A3 poster promoting and signposting to The Source and other relevant mental health and wellbeing organisations. These

posters should be put on the back of toilet doors in every secondary school in Suffolk.

2. Prior to the Emotional Wellbeing Hub, the EWB2020 should distribute an information letter and/or introductory video to every school in Suffolk. The letter and/or video should explain why the Emotional Wellbeing Hub has been created, what it offers, what it does not offer, and how it hopes to engage schools on an ongoing basis.

5.7 - Healthwatch Suffolk will help My Health, Our Future schools to implement a Mental Health and Wellbeing Roadmap

The National Institute for Health and Care Excellence (NICE) advises that primary schools and secondary schools should be supported to adopt a comprehensive, 'whole school' approach to promoting the social and emotional wellbeing of children and young people. Such an approach moves beyond learning and teaching to pervade all aspects of the life of a school, and has been found to be effective in bringing about and sustaining health benefits .

Healthwatch Suffolk agree that the whole-school approach to mental health and wellbeing is optimal when trying to prevent and promote mentally healthy children and young people. This can be seen throughout the data presented in this report. As such, we will be working with the My Health, Our Future schools to implement a mental health and wellbeing roadmap, and measuring the impact it has on the pupils at each school.
For the wider system, schools should look towards Public Health England's new 'Rise Above' initiative, which aims to delay and prevent young people (11-16's) from engaging in exploratory risky behaviours and promote good mental health.

Public Health England are developing lesson plans for secondary schools on a range of these topics for publication in the autumn term, 2017. The lesson plans will be accredited by the Personal, Social and Health Education Association (PSHEA).

The 'Rise Above' initiative tackles issues that are prevalent to the My Health, Our Future findings, such as bullying and cyberbullying; Online Stress and the Fear of Missing Out; Exam Stress; Body Image in a Digital World; and Forming Positive Relationships.

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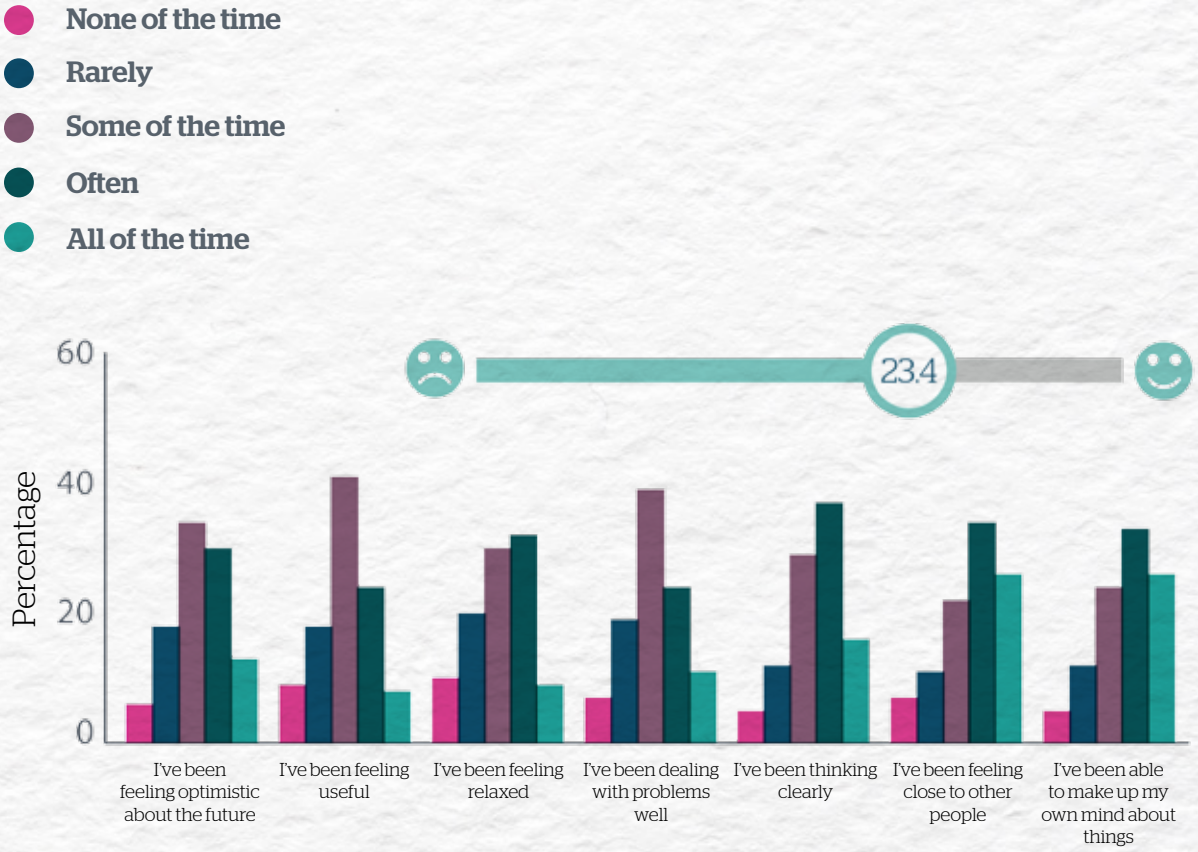
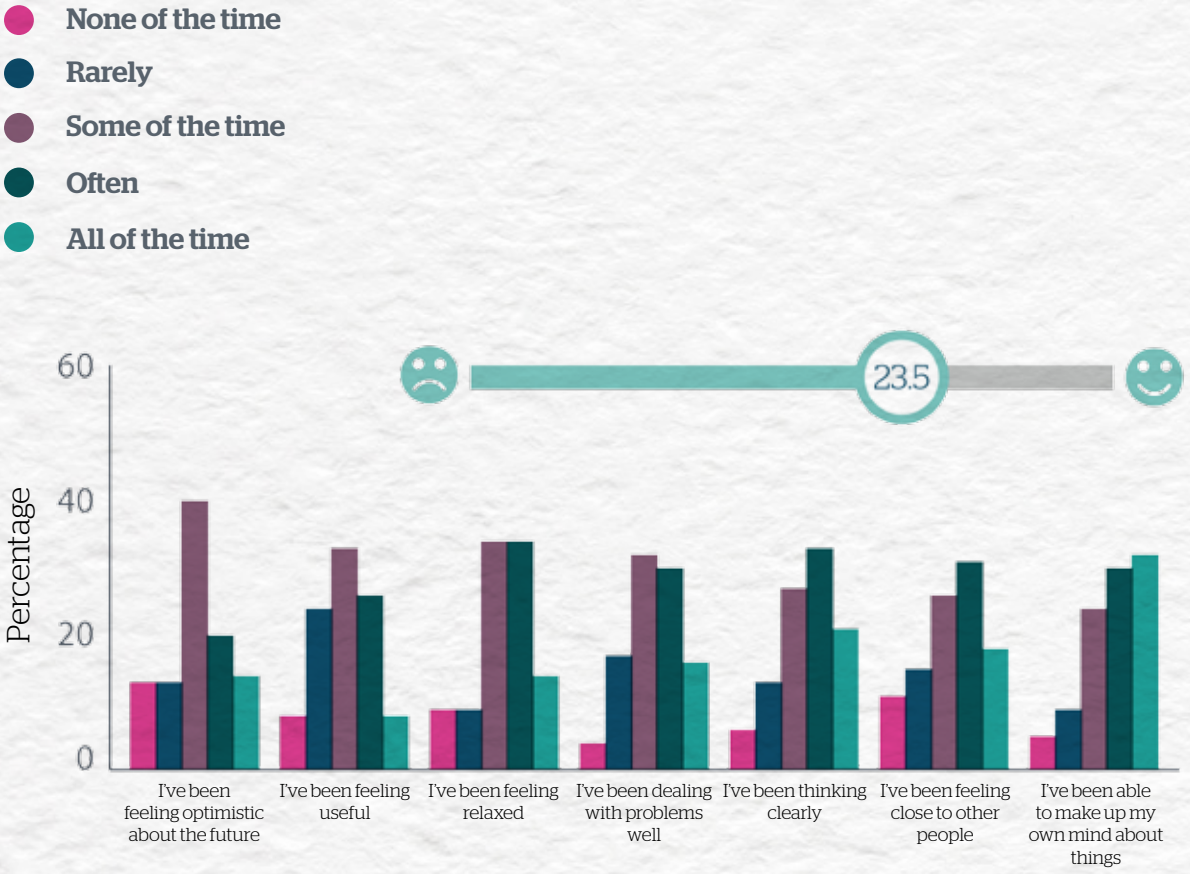
Appendix 1 (A)

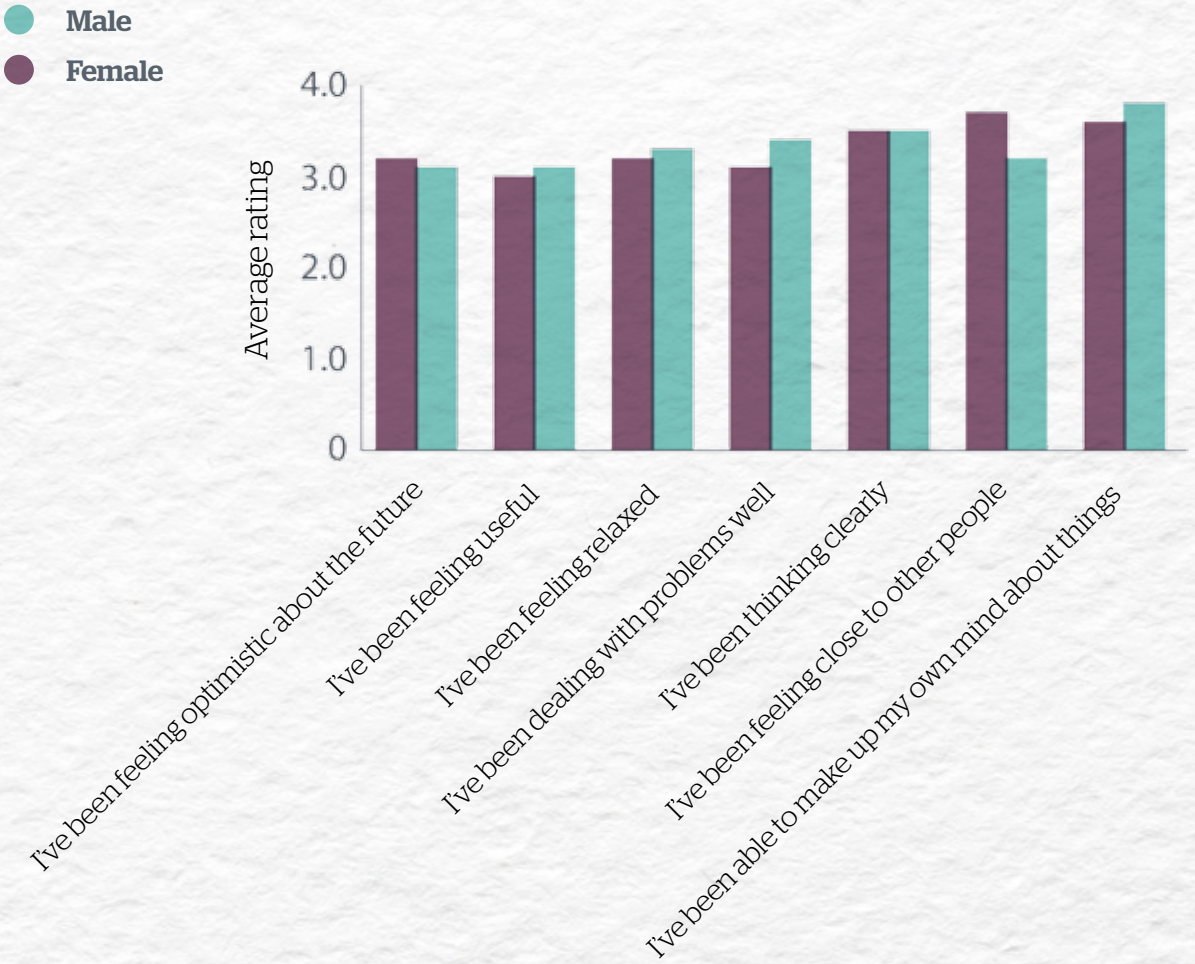
Short Warwick-Edinburgh Mental Wellbeing Scale (Age 11) - Graphs 30 - 32



Female respondents (Age 11)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	6%	18%	34%	30%	13%
I've been feeling useful	9%	18%	41%	24%	8%
I've been feeling relaxed	10%	20%	30%	32%	9%
I've been dealing with problems well	7%	19%	39%	24%	11%
I've been thinking clearly	5%	12%	29%	37%	16%
I've been feeling close to other people	7%	11%	22%	34%	26%
I've been able to make up my own mind about things	5%	12%	24%	33%	26%



Male respondents (Age 11)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	13%	13%	40%	20%	14%
I've been feeling useful	8%	24%	33%	26%	8%
I've been feeling relaxed	9%	9%	34%	34%	14%
I've been dealing with problems well	4%	17%	32%	30%	16%
I've been thinking clearly	6%	13%	27%	33%	21%
I've been feeling close to other people	11%	15%	26%	31%	18%
I've been able to make up my own mind about things	5%	9%	24%	30%	32%



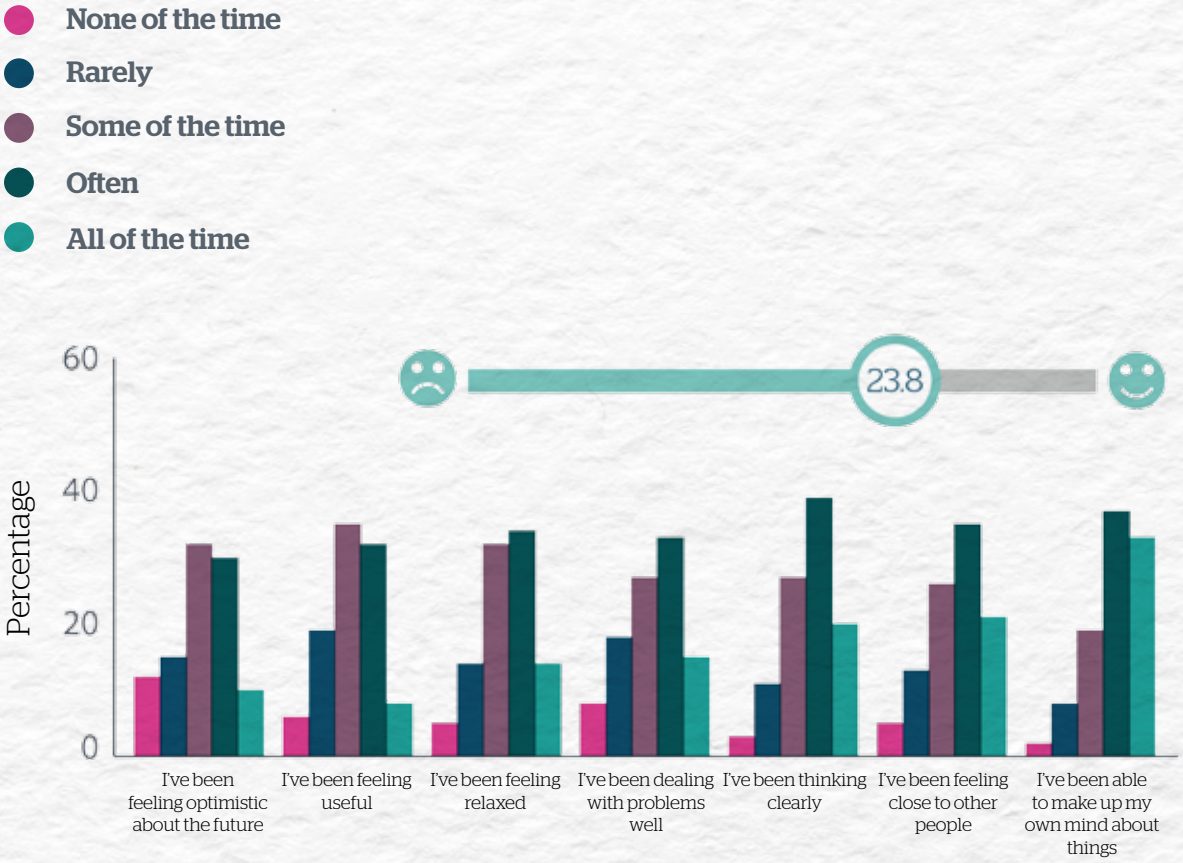
Ratings (out of 5) by gender (Age 11)		
	Female	Male
I've been feeling optimistic about the future	3.2	3.1
I've been feeling useful	3.0	3.1
I've been feeling relaxed	3.2	3.3
I've been dealing with problems well	3.1	3.4
I've been thinking clearly	3.5	3.5
I've been feeling close to other people	3.7	3.2
I've been able to make up my own mind about things	3.6	3.8

Appendix 1 (B)

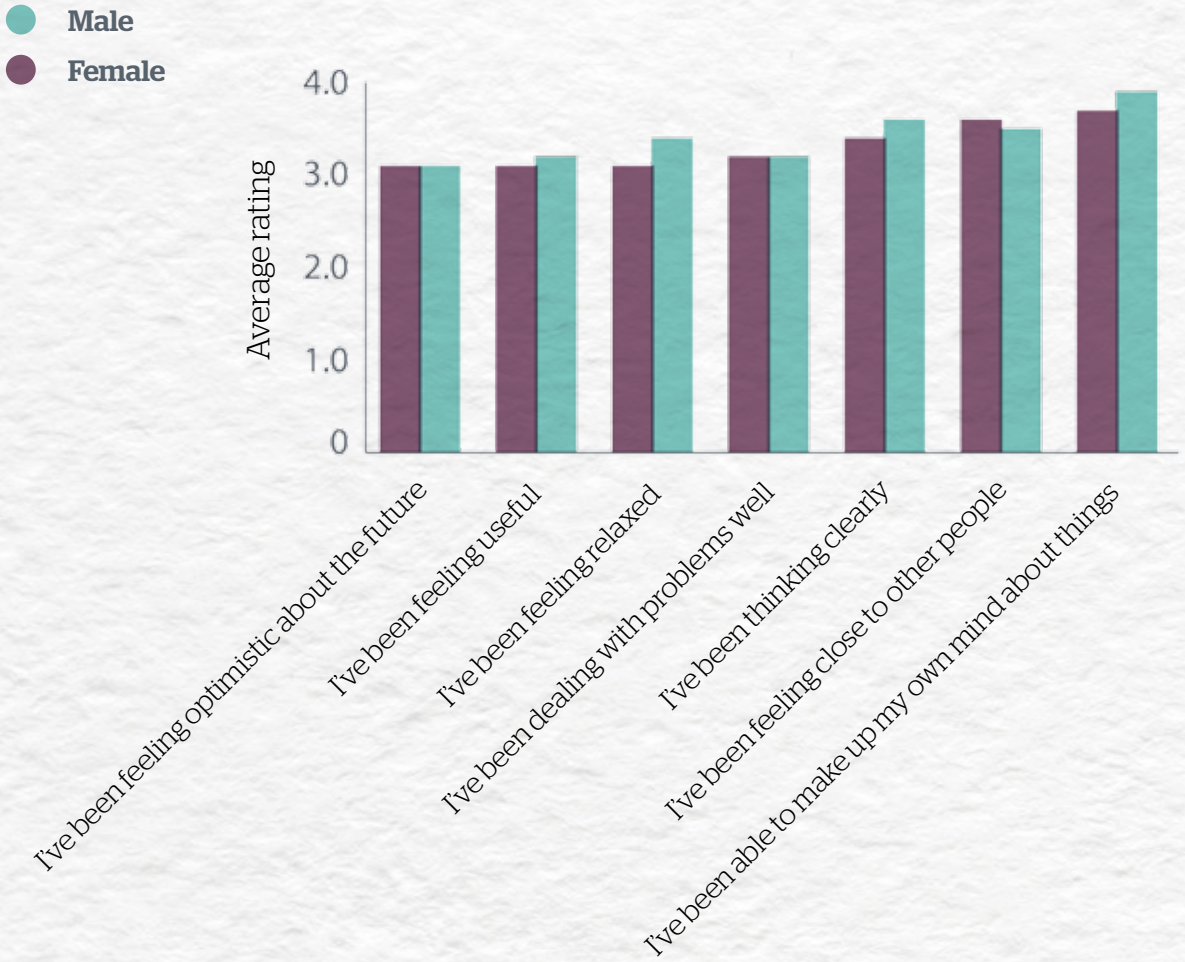
Short Warwick-Edinburgh Mental Wellbeing Scale (Age 12) - Graphs 33 - 35

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

Female respondents (Age 12)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	9%	16%	37%	29%	9%
I've been feeling useful	7%	21%	36%	32%	5%
I've been feeling relaxed	6%	23%	34%	29%	9%
I've been dealing with problems well	6%	17%	34%	32%	11%
I've been thinking clearly	5%	15%	31%	34%	15%
I've been feeling close to other people	3%	14%	25%	35%	22%
I've been able to make up my own mind about things	3%	9%	26%	37%	25%



Male respondents (Age 12)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	12%	15%	32%	30%	10%
I've been feeling useful	6%	19%	35%	32%	8%
I've been feeling relaxed	5%	14%	32%	34%	14%
I've been dealing with problems well	8%	18%	27%	33%	15%
I've been thinking clearly	3%	11%	27%	39%	20%
I've been feeling close to other people	5%	13%	26%	35%	21%
I've been able to make up my own mind about things	2%	8%	19%	37%	33%



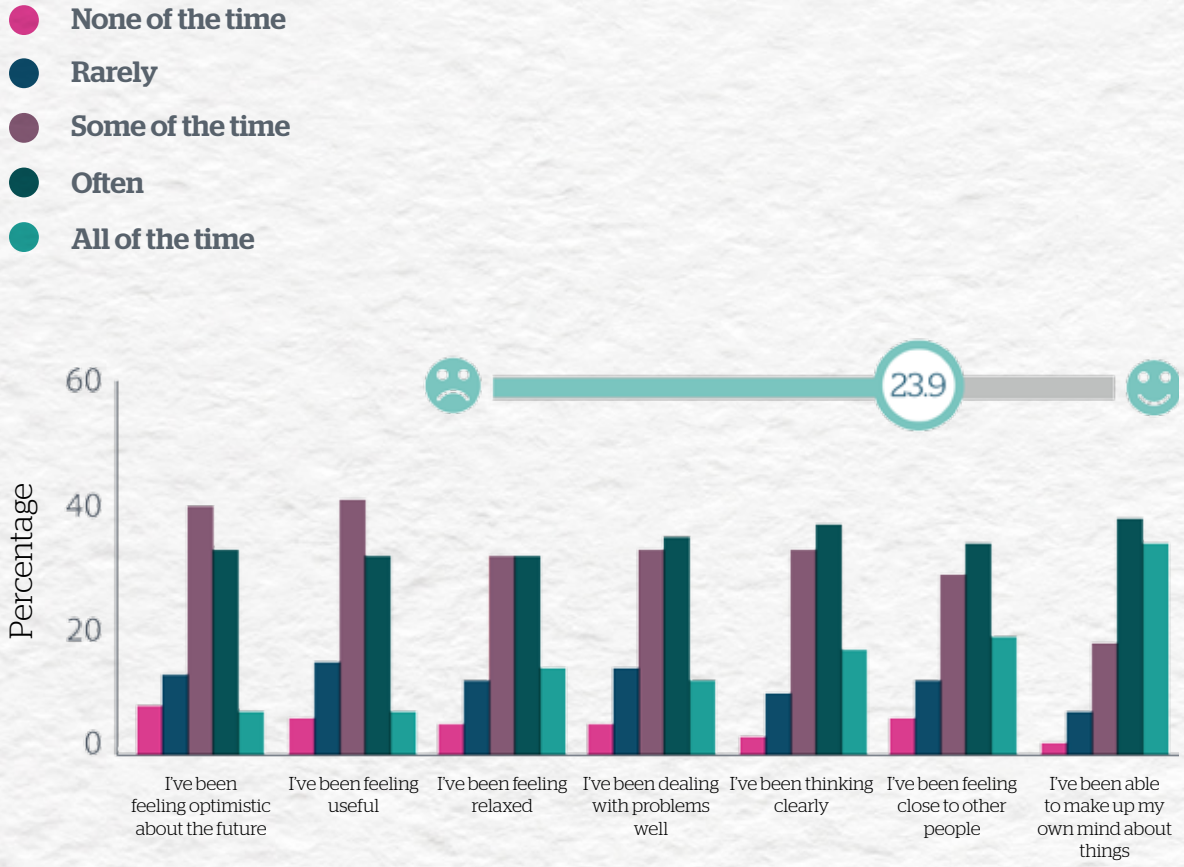
Ratings (out of 5) by gender (Age 12)		
	Female	Male
I've been feeling optimistic about the future	3.1	3.1
I've been feeling useful	3.1	3.2
I've been feeling relaxed	3.1	3.4
I've been dealing with problems well	3.2	3.2
I've been thinking clearly	3.4	3.6
I've been feeling close to other people	3.6	3.5
I've been able to make up my own mind about things	3.7	3.9

Appendix 1 (C)

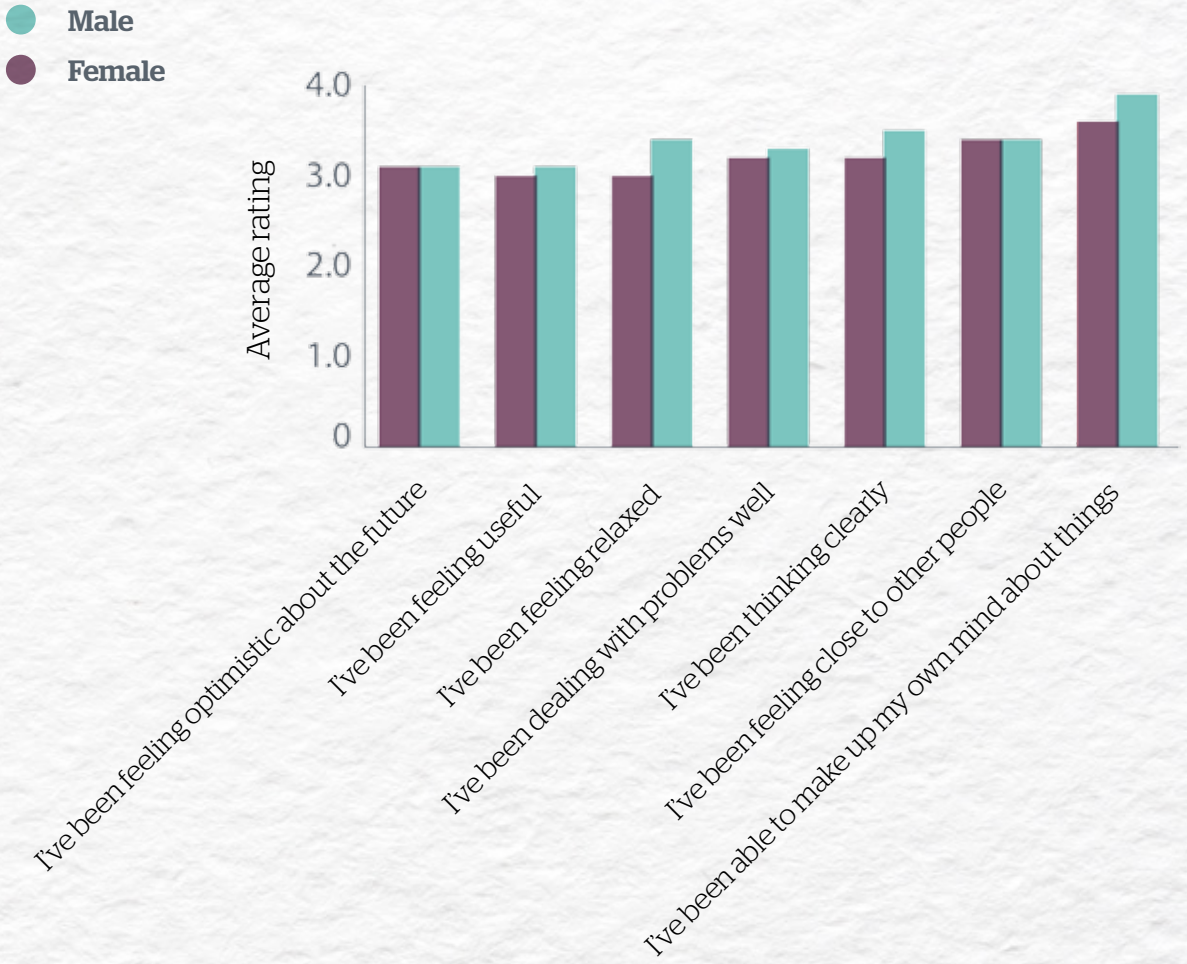
Short Warwick-Edinburgh Mental Wellbeing Scale (Age 13) - Graphs 36 - 38

- None of the time
- Rarely
- Some of the time
- Often
- All of the time

Female respondents (Age 13)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	7%	19%	40%	26%	8%
I've been feeling useful	6%	25%	38%	25%	5%
I've been feeling relaxed	8%	24%	38%	25%	5%
I've been dealing with problems well	5%	22%	35%	29%	9%
I've been thinking clearly	5%	19%	36%	31%	10%
I've been feeling close to other people	5%	15%	32%	33%	16%
I've been able to make up my own mind about things	4%	12%	28%	35%	21%



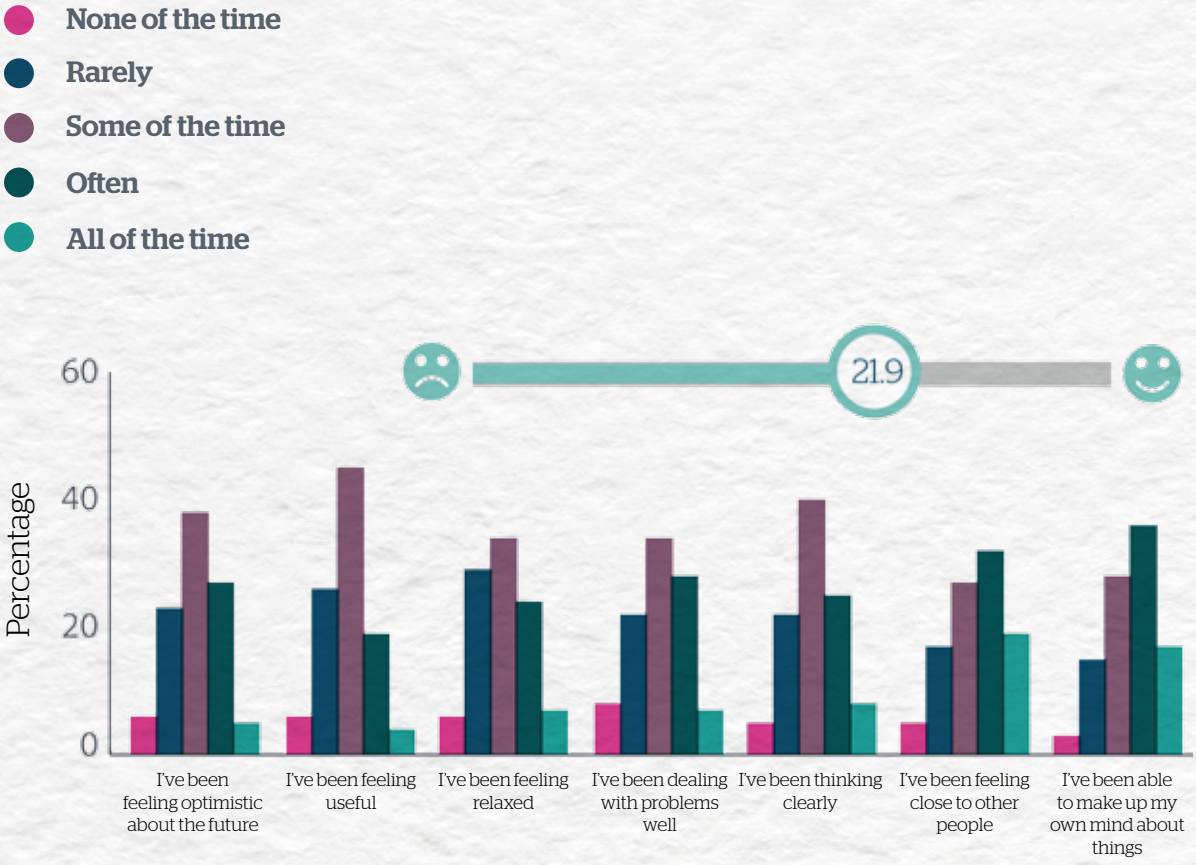
Male respondents (Age 13)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	8%	13%	40%	33%	7%
I've been feeling useful	6%	15%	41%	32%	7%
I've been feeling relaxed	5%	12%	32%	38%	14%
I've been dealing with problems well	5%	14%	33%	35%	12%
I've been thinking clearly	3%	10%	33%	37%	17%
I've been feeling close to other people	6%	12%	29%	34%	19%
I've been able to make up my own mind about things	2%	7%	18%	38%	34%



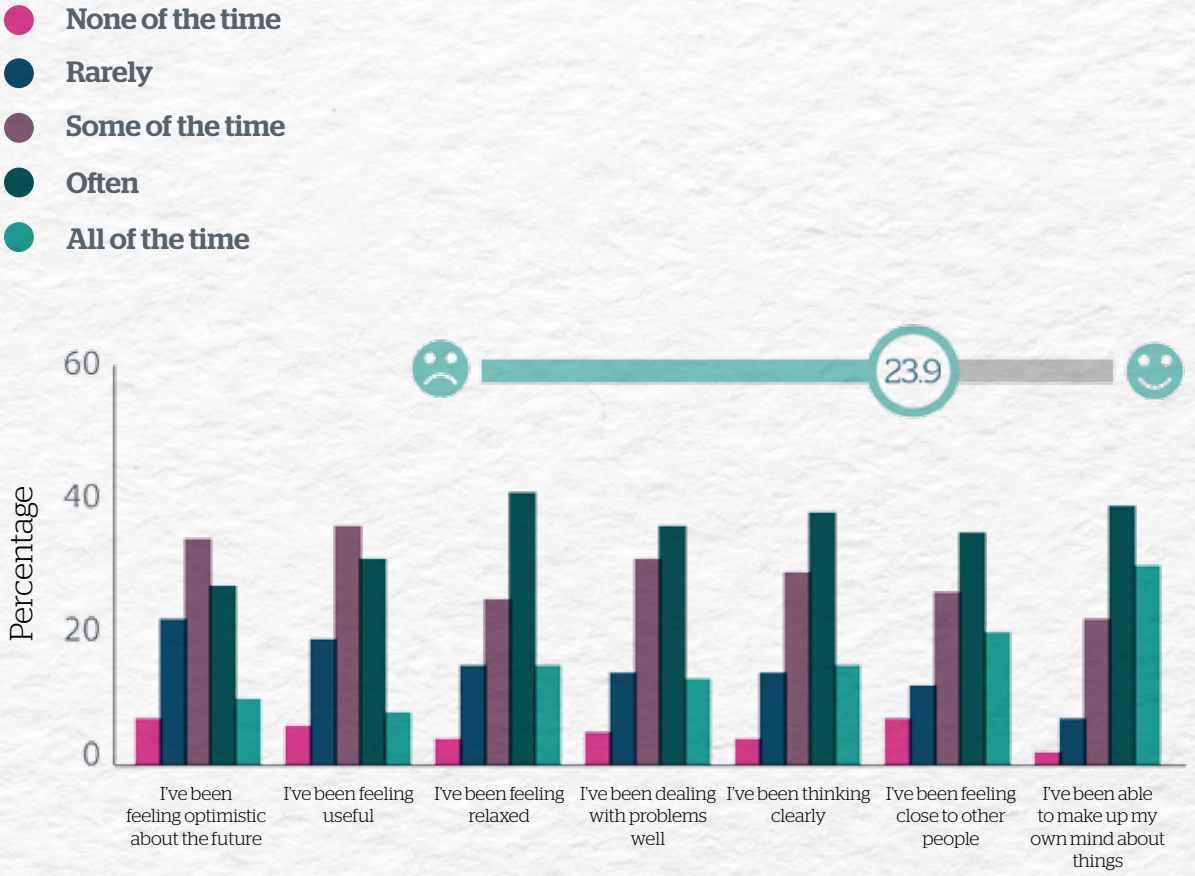
Ratings (out of 5) by gender (Age 13)		
	Female	Male
I've been feeling optimistic about the future	3.1	3.1
I've been feeling useful	3.0	3.1
I've been feeling relaxed	3.0	3.4
I've been dealing with problems well	3.2	3.3
I've been thinking clearly	3.2	3.5
I've been feeling close to other people	3.4	3.4
I've been able to make up my own mind about things	3.6	3.9

Appendix 1 (D)

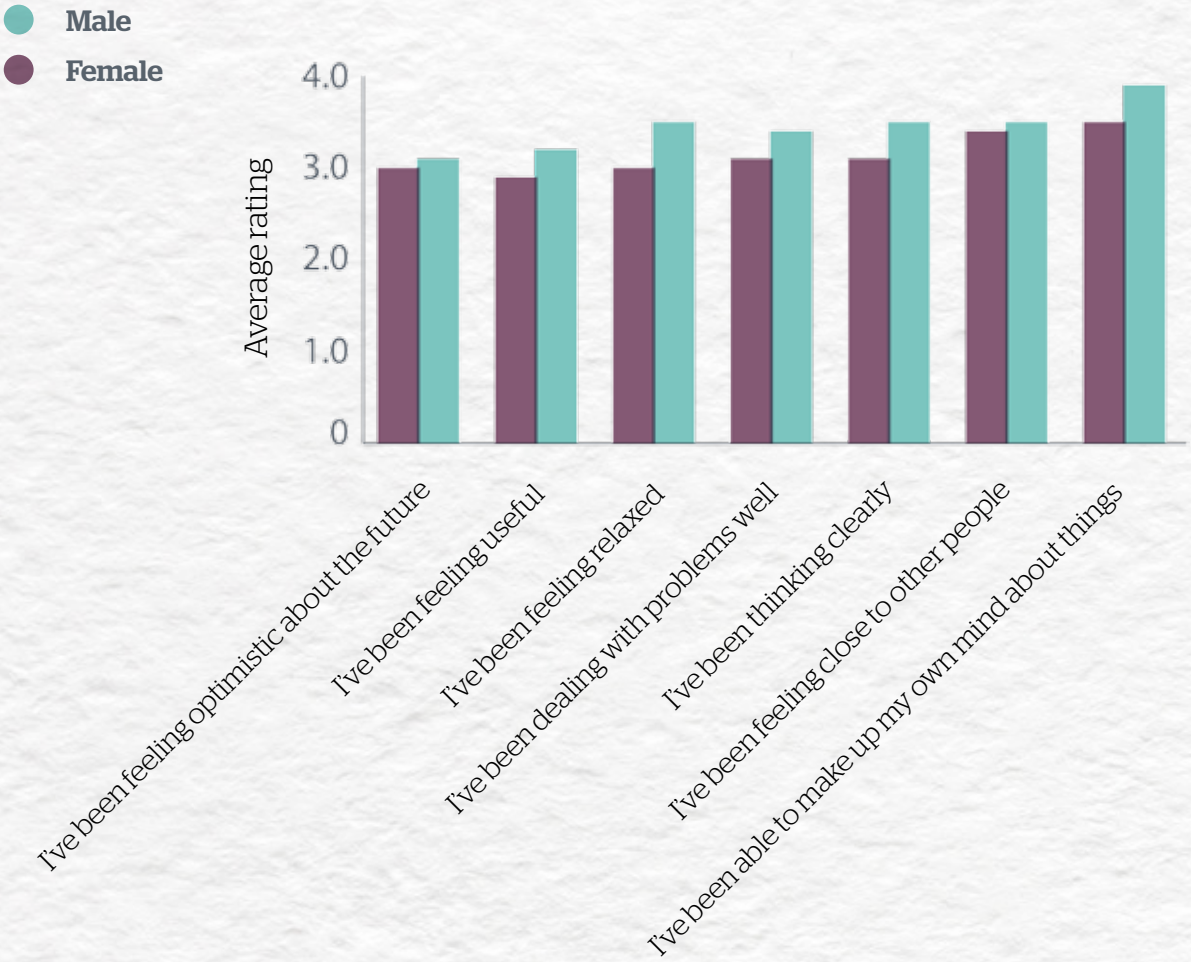
Short Warwick-Edinburgh Mental Wellbeing Scale (Age 14) - Graphs 39 - 41



Female respondents (Age 14)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	6%	23%	38%	27%	5%
I've been feeling useful	6%	26%	45%	19%	4%
I've been feeling relaxed	6%	29%	34%	24%	7%
I've been dealing with problems well	8%	22%	34%	28%	7%
I've been thinking clearly	5%	22%	40%	25%	8%
I've been feeling close to other people	5%	17%	27%	32%	19%
I've been able to make up my own mind about things	3%	15%	28%	36%	17%



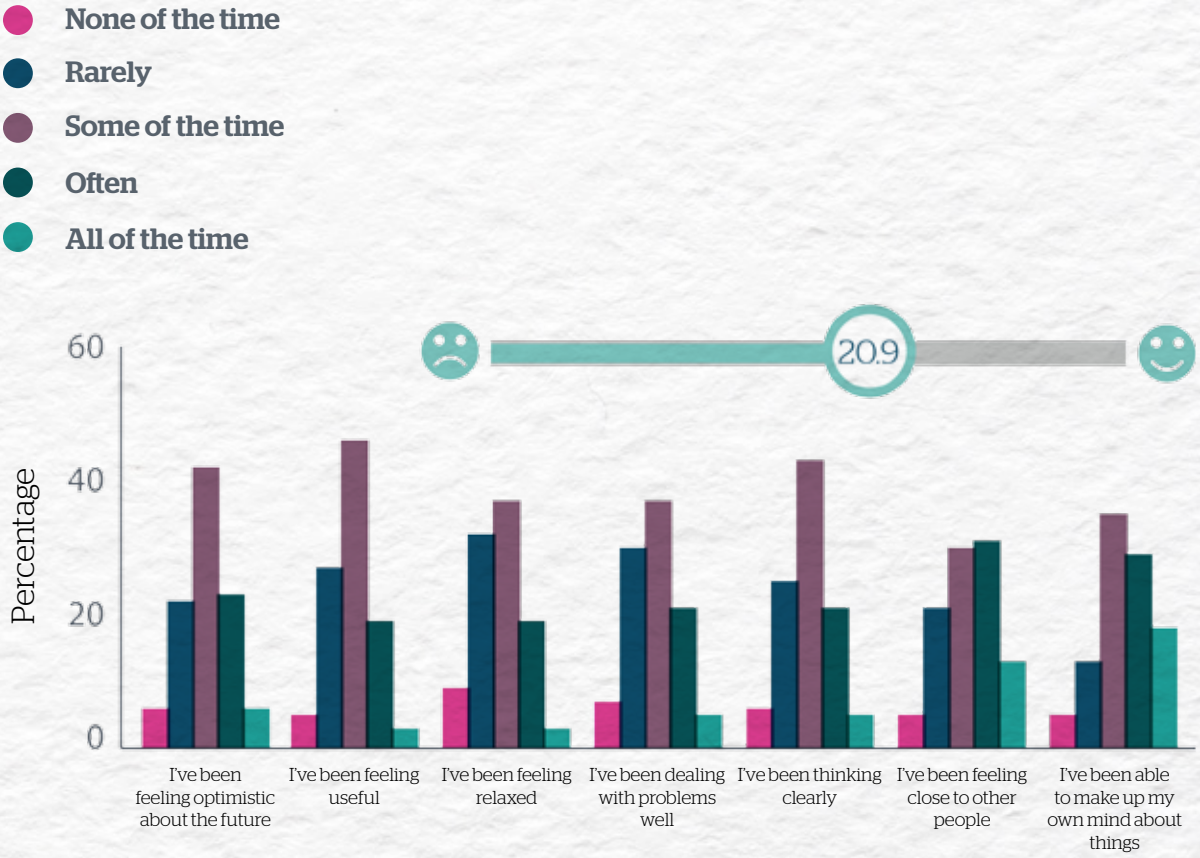
Male respondents (Age 14)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	7%	22%	34%	27%	10%
I've been feeling useful	6%	19%	36%	31%	8%
I've been feeling relaxed	4%	15%	25%	41%	15%
I've been dealing with problems well	5%	14%	31%	36%	13%
I've been thinking clearly	4%	14%	29%	38%	15%
I've been feeling close to other people	7%	12%	26%	35%	20%
I've been able to make up my own mind about things	2%	7%	22%	39%	30%



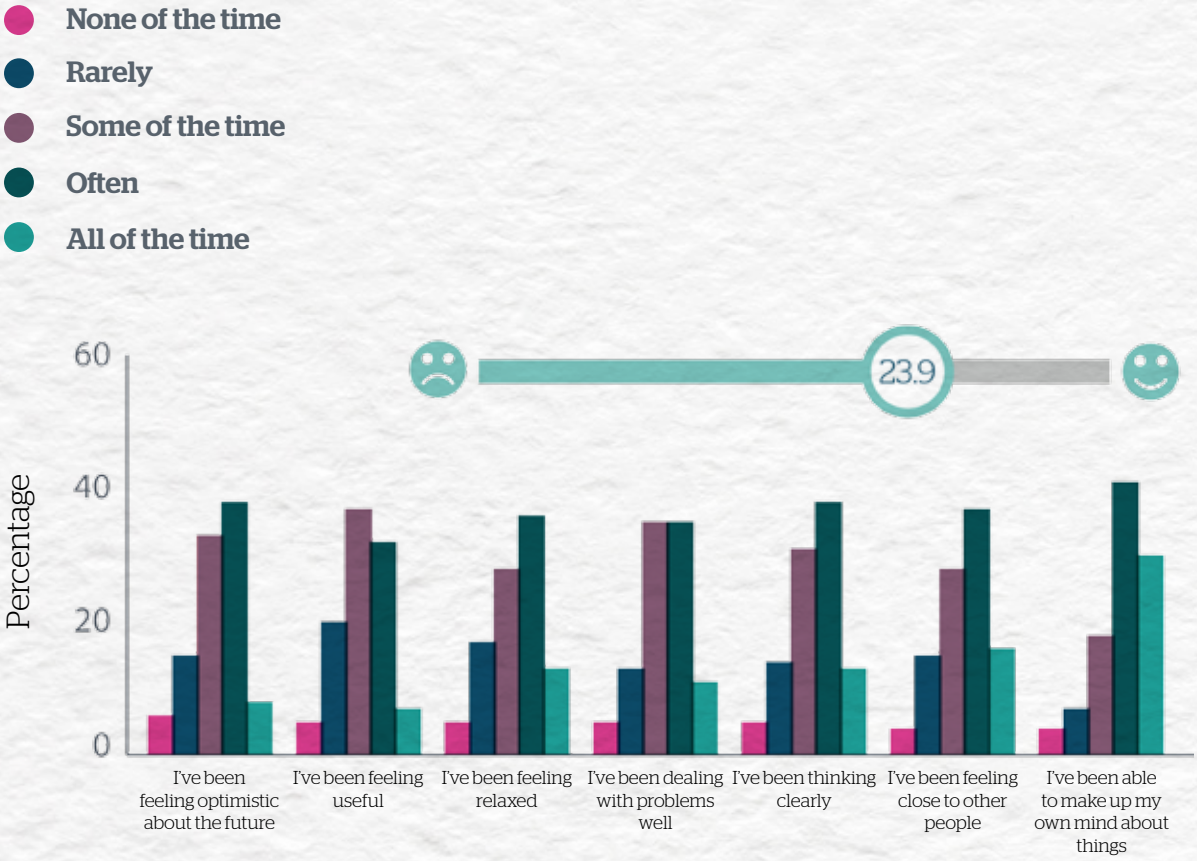
Ratings (out of 5) by gender (Age 14)		
	Female	Male
I've been feeling optimistic about the future	3.0	3.1
I've been feeling useful	2.9	3.2
I've been feeling relaxed	3.0	3.5
I've been dealing with problems well	3.1	3.4
I've been thinking clearly	3.1	3.5
I've been feeling close to other people	3.4	3.5
I've been able to make up my own mind about things	3.5	3.9

Appendix 1 (E)

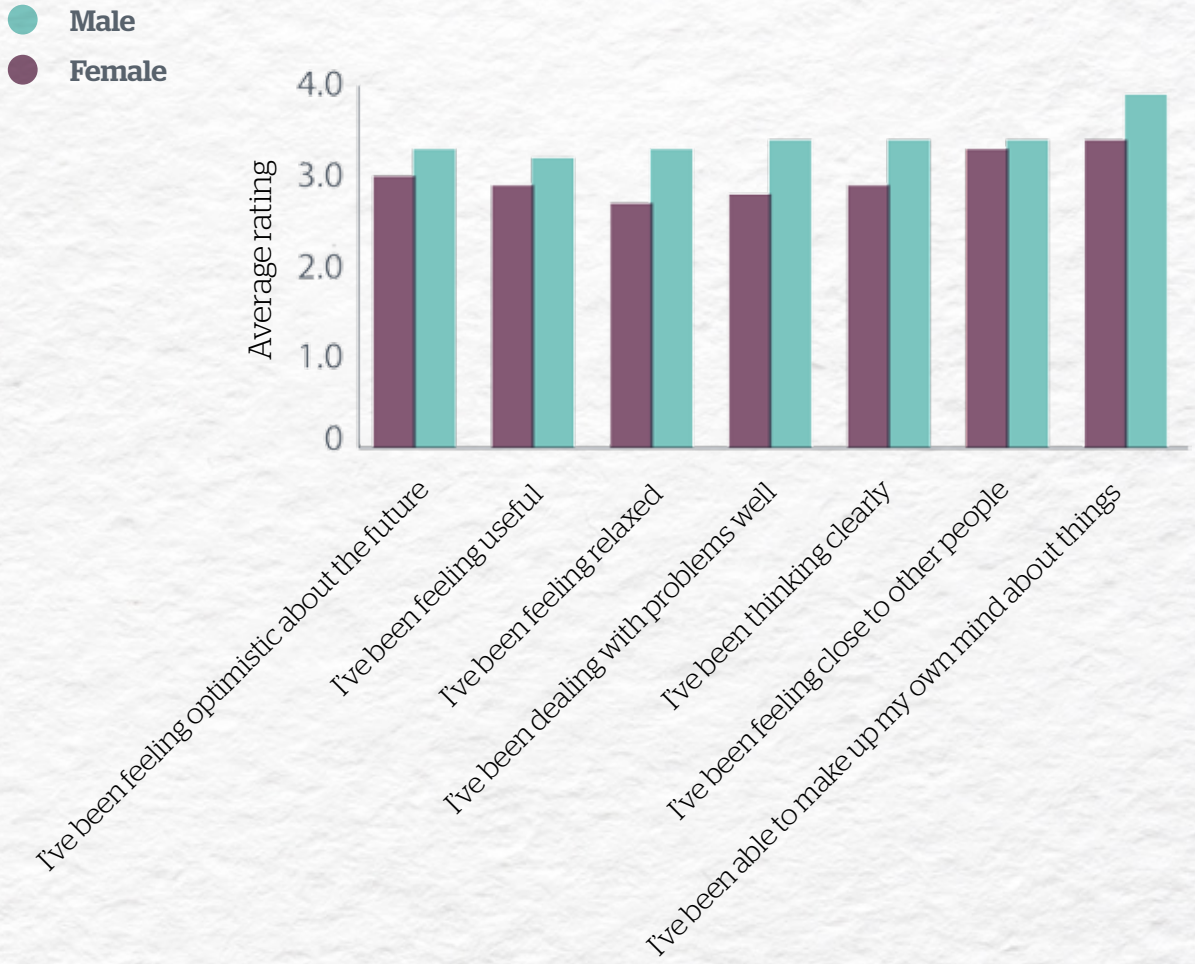
Short Warwick-Edinburgh Mental Wellbeing Scale (Age 15) - Graphs 42 - 44



Female respondents (Age 15)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	6%	22%	42%	23%	6%
I've been feeling useful	5%	27%	46%	19%	3%
I've been feeling relaxed	9%	32%	37%	19%	3%
I've been dealing with problems well	7%	30%	37%	21%	5%
I've been thinking clearly	6%	25%	43%	21%	5%
I've been feeling close to other people	5%	21%	30%	34%	13%
I've been able to make up my own mind about things	5%	13%	35%	29%	18%



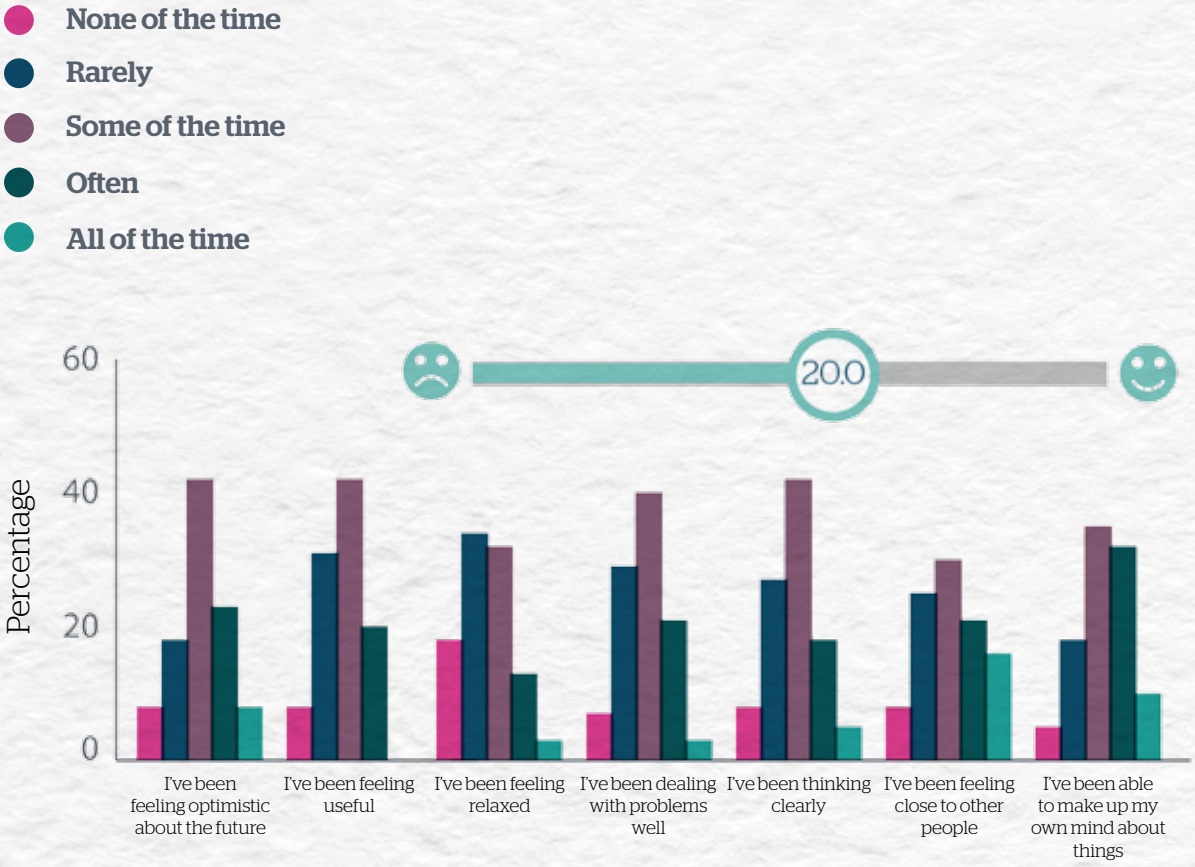
Male respondents (Age 15)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	6%	15%	33%	38%	8%
I've been feeling useful	5%	20%	37%	32%	7%
I've been feeling relaxed	5%	17%	28%	36%	13%
I've been dealing with problems well	5%	13%	35%	35%	11%
I've been thinking clearly	5%	14%	31%	38%	30%
I've been feeling close to other people	4%	15%	28%	37%	16%
I've been able to make up my own mind about things	4%	7%	18%	41%	30%



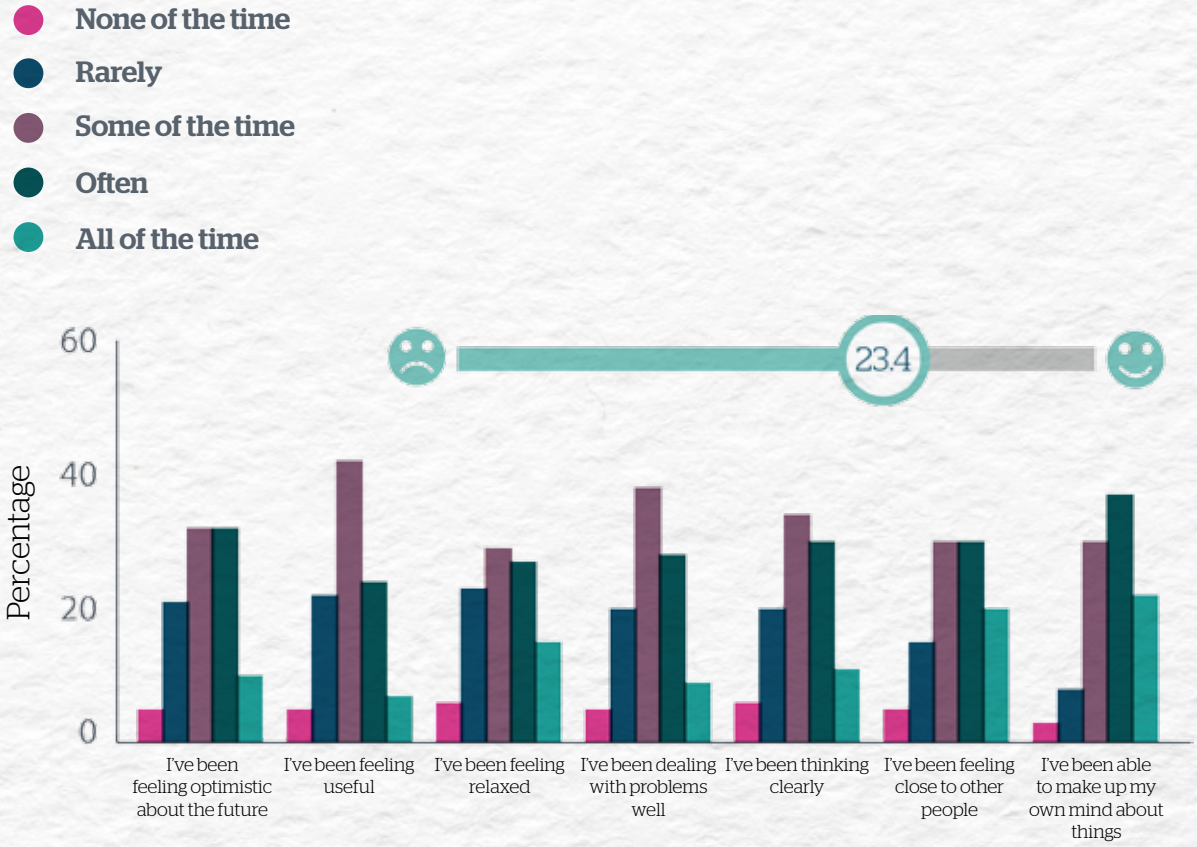
Ratings (out of 5) by gender (Age 15)		
	Female	Male
I've been feeling optimistic about the future	3.0	3.3
I've been feeling useful	2.9	3.2
I've been feeling relaxed	2.7	3.3
I've been dealing with problems well	2.8	3.4
I've been thinking clearly	2.9	3.4
I've been feeling close to other people	3.3	3.4
I've been able to make up my own mind about things	3.4	3.9

Appendix 1 (F)

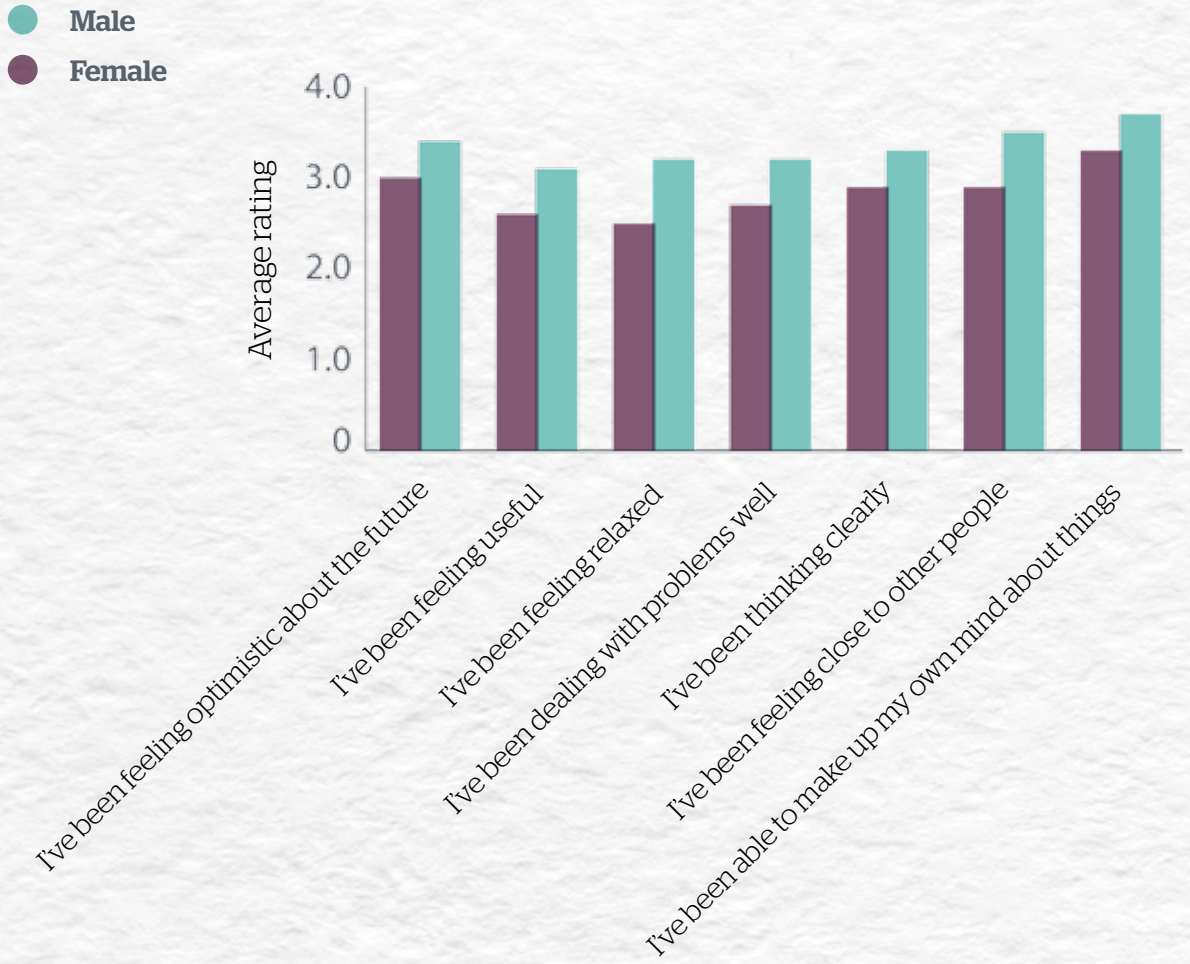
Short Warwick-Edinburgh Mental Wellbeing Scale (Age 16) - Graphs 45 - 47



Female respondents (Age 16)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	8%	18%	42%	23%	8%
I've been feeling useful	8%	31%	42%	20%	0%
I've been feeling relaxed	18%	34%	32%	13%	3%
I've been dealing with problems well	7%	29%	40%	21%	3%
I've been thinking clearly	8%	27%	42%	18%	5%
I've been feeling close to other people	8%	25%	30%	21%	16%
I've been able to make up my own mind about things	5%	18%	35%	32%	10%



Male respondents (Age 16)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	5%	21%	32%	32%	10%
I've been feeling useful	5%	22%	42%	24%	7%
I've been feeling relaxed	6%	23%	29%	27%	15%
I've been dealing with problems well	5%	20%	38%	28%	9%
I've been thinking clearly	6%	20%	34%	30%	11%
I've been feeling close to other people	5%	15%	30%	30%	20%
I've been able to make up my own mind about things	3%	8%	30%	37%	22%

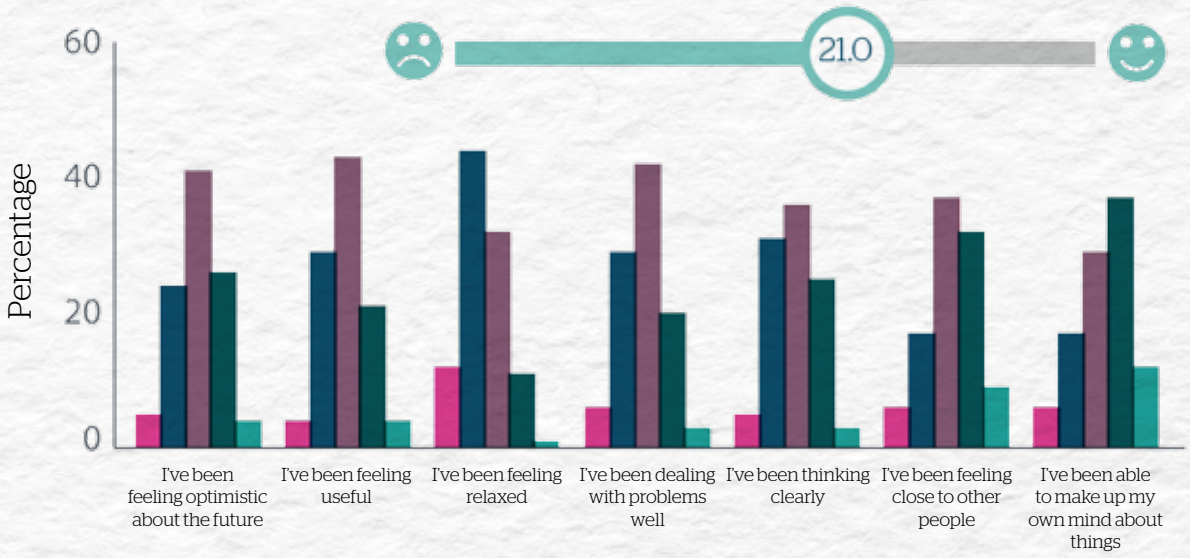


Ratings (out of 5) by gender (Age 16)		
	Female	Male
I've been feeling optimistic about the future	3.0	3.4
I've been feeling useful	2.6	3.1
I've been feeling relaxed	2.5	3.2
I've been dealing with problems well	2.7	3.2
I've been thinking clearly	2.9	3.3
I've been feeling close to other people	2.9	3.5
I've been able to make up my own mind about things	3.3	3.7

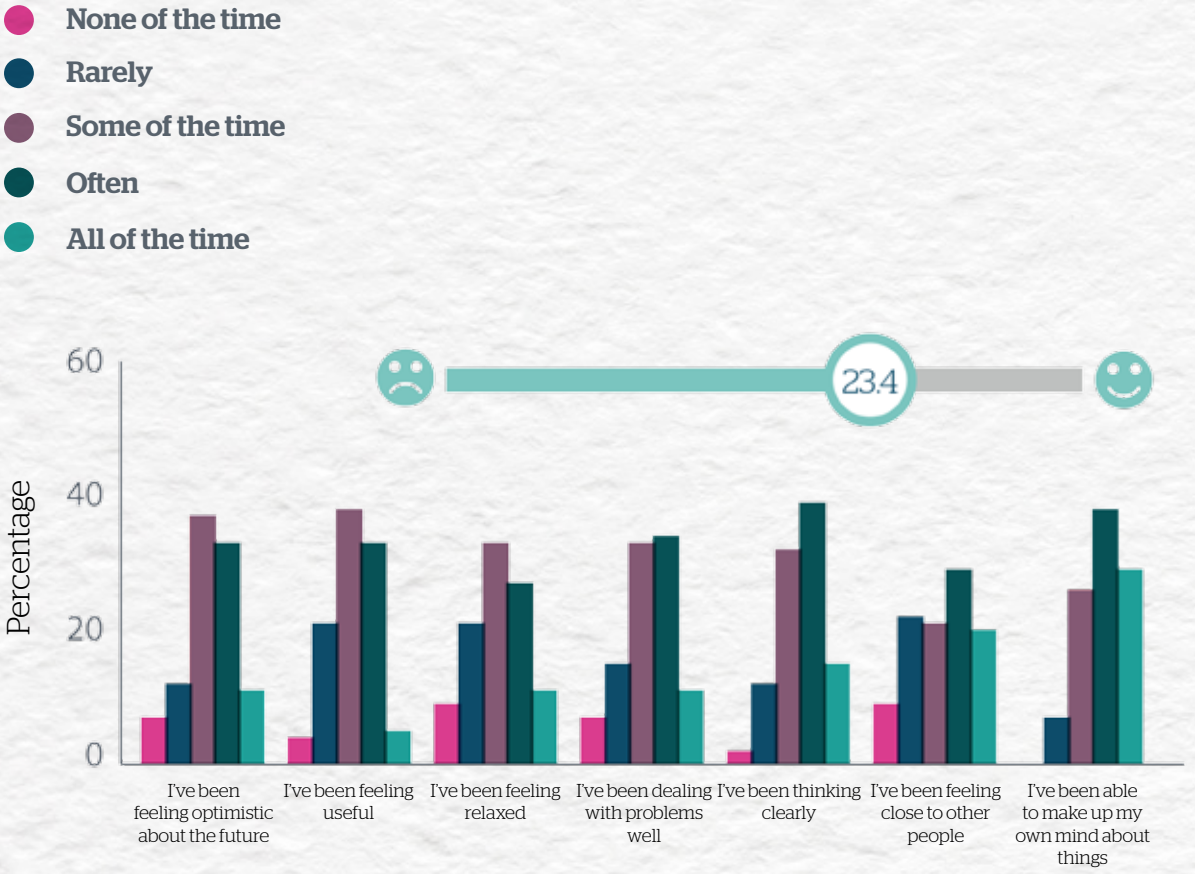
Appendix 1 (G)

Short Warwick-Edinburgh Mental Wellbeing Scale (Age 17) - Graphs 48 - 50

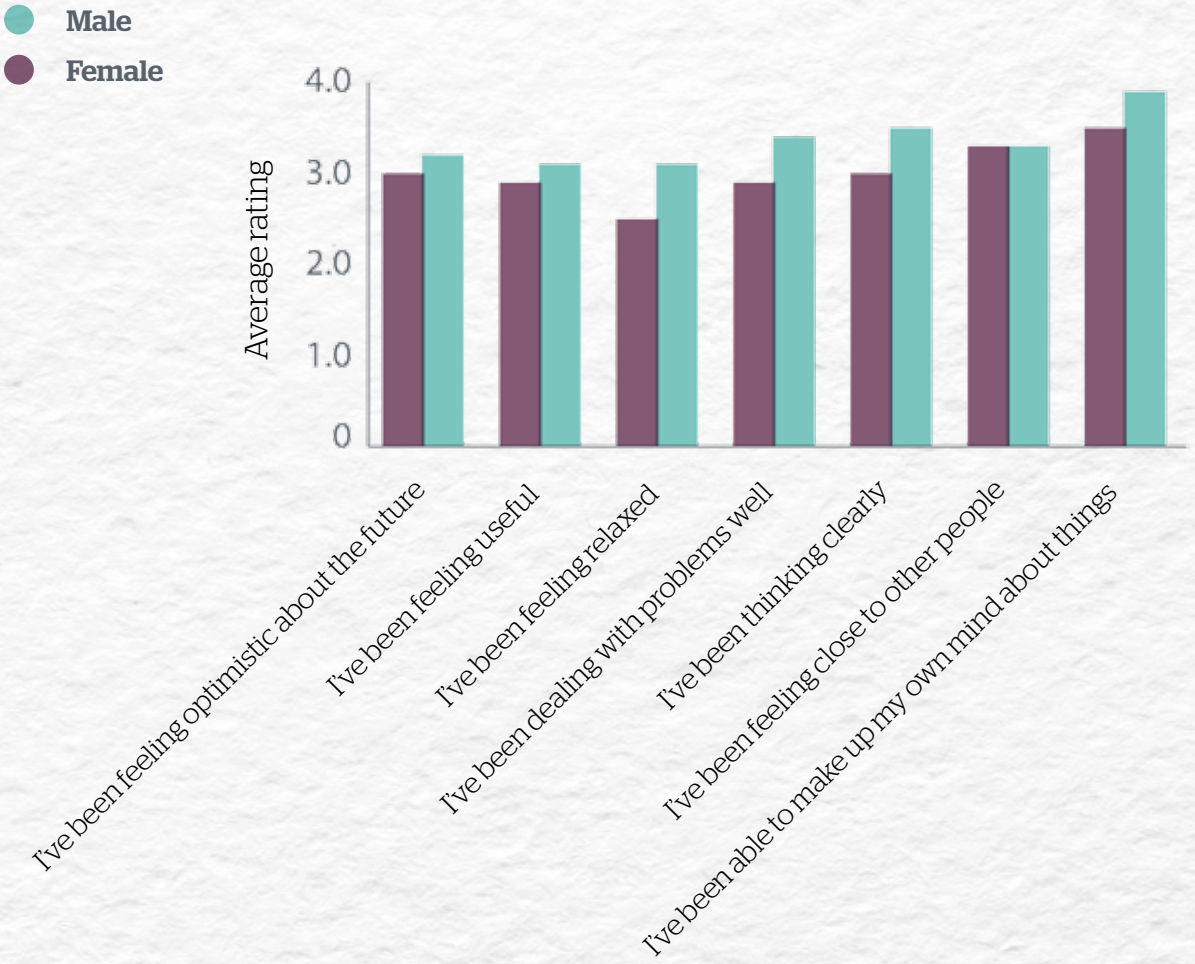
- None of the time
- Rarely
- Some of the time
- Often
- All of the time



Female respondents (Age 17)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	5%	24%	41%	26%	4%
I've been feeling useful	4%	29%	42%	21%	4%
I've been feeling relaxed	12%	44%	32%	11%	1%
I've been dealing with problems well	6%	29%	42%	20%	3%
I've been thinking clearly	5%	31%	36%	25%	3%
I've been feeling close to other people	6%	17%	37%	32%	9%
I've been able to make up my own mind about things	6%	17%	29%	37%	12%



Male respondents (Age 17)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	7%	12%	37%	33%	11%
I've been feeling useful	4%	21%	38%	33%	5%
I've been feeling relaxed	9%	21%	33%	27%	11%
I've been dealing with problems well	7%	15%	33%	34%	11%
I've been thinking clearly	2%	12%	32%	39%	15%
I've been feeling close to other people	9%	22%	21%	29%	20%
I've been able to make up my own mind about things	0%	7%	26%	38%	29%

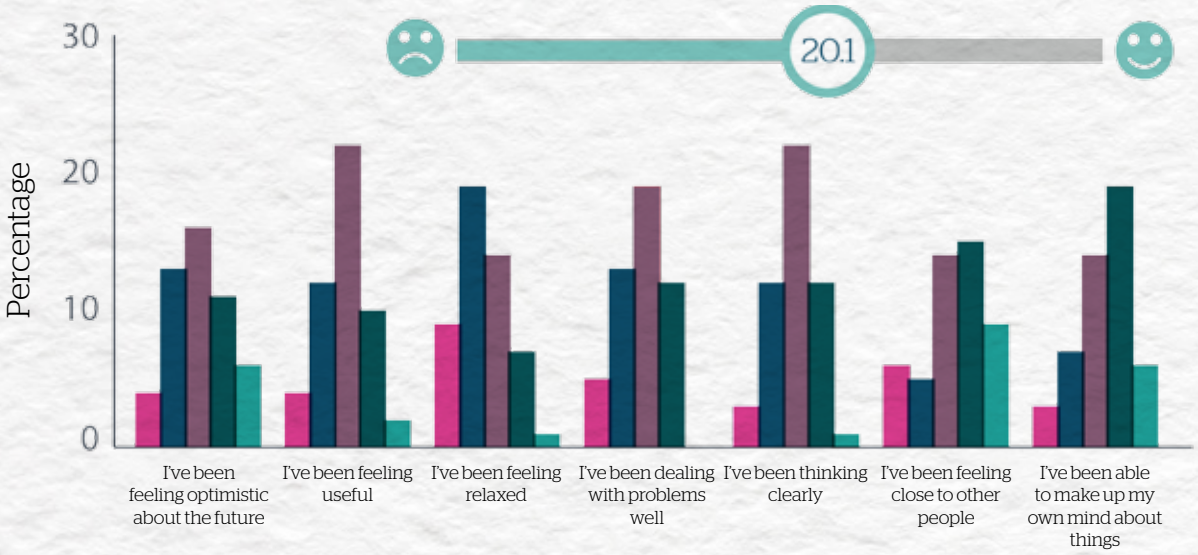


Ratings (out of 5) by gender (Age 17)		
	Female	Male
I've been feeling optimistic about the future	3.0	3.2
I've been feeling useful	2.9	3.1
I've been feeling relaxed	2.5	3.1
I've been dealing with problems well	2.9	3.4
I've been thinking clearly	3.0	3.5
I've been feeling close to other people	3.3	3.3
I've been able to make up my own mind about things	3.5	3.9

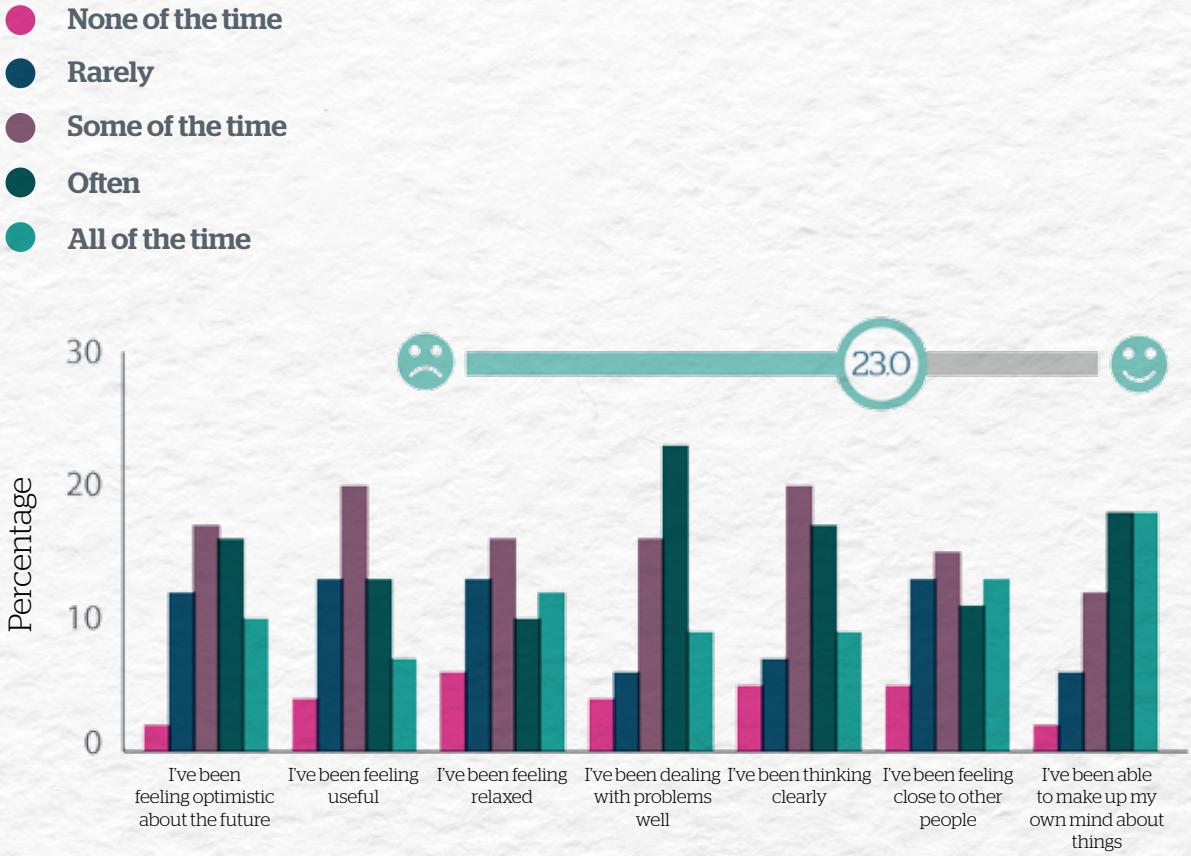
Appendix 1 (H)

Short Warwick-Edinburgh Mental Wellbeing Scale (Age 18) - Graphs 51 - 53

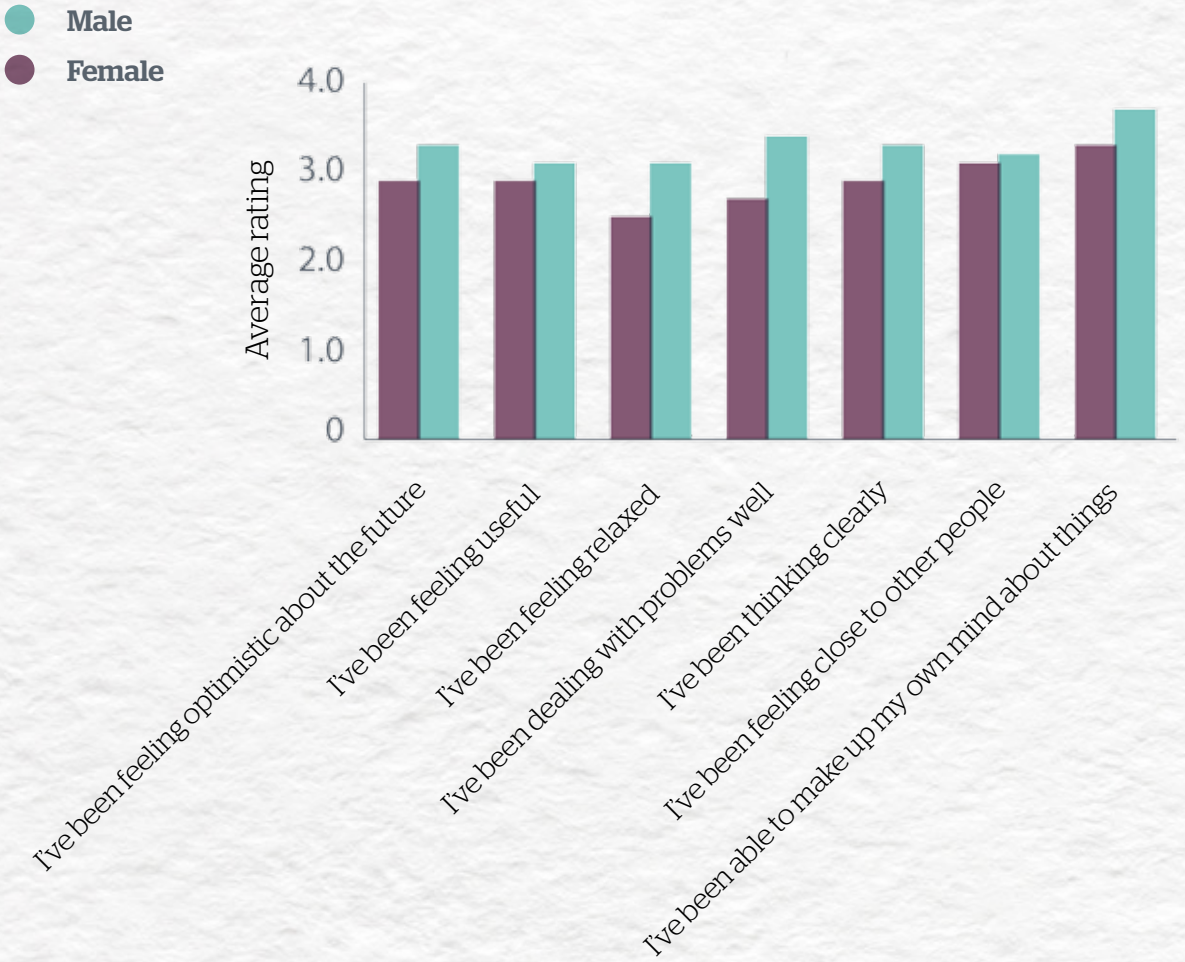
- None of the time
- Rarely
- Some of the time
- Often
- All of the time



Female respondents (Age 18)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	4%	13%	16%	11%	6%
I've been feeling useful	4%	12%	22%	10%	2%
I've been feeling relaxed	9%	19%	14%	7%	1%
I've been dealing with problems well	5%	13%	19%	12%	0%
I've been thinking clearly	3%	12%	22%	12%	1%
I've been feeling close to other people	6%	5%	14%	15%	9%
I've been able to make up my own mind about things	3%	7%	14%	19%	6%



Male respondents (Age 18)					
	None of the time	Rarely	Some of the time	Often	All of the time
I've been feeling optimistic about the future	2%	12%	17%	16%	10%
I've been feeling useful	4%	13%	20%	13%	7%
I've been feeling relaxed	6%	13%	16%	10%	12%
I've been dealing with problems well	4%	6%	16%	23%	9%
I've been thinking clearly	5%	7%	20%	17%	9%
I've been feeling close to other people	5%	13%	15%	11%	13%
I've been able to make up my own mind about things	2%	6%	12%	18%	18%



Ratings (out of 5) by gender (Age 18)		
	Female	Male
I've been feeling optimistic about the future	2.9	3.3
I've been feeling useful	2.9	3.1
I've been feeling relaxed	2.5	3.1
I've been dealing with problems well	2.7	3.4
I've been thinking clearly	2.9	3.3
I've been feeling close to other people	3.1	3.2
I've been able to make up my own mind about things	3.3	3.7

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healthwatch Suffolk

This report has been produced to support the ongoing development and implementation of the Suffolk Children and Young People's Emotional and Wellbeing Transformation Plan (EWB2020).

It will be publicly available on the Healthwatch Suffolk website. It will also be made available to Healthwatch England and bodies responsible for the commissioning, scrutiny or delivery of children and young people's services in Suffolk.

This may include Suffolk Clinical Commissioning Groups, the Suffolk Health and Overview Scrutiny Committee, the Suffolk Health and Wellbeing Board and Suffolk County Council.

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Report design, layout and infographics created by the Healthwatch Suffolk Information Team.

Published October 2017