Half of all lifetime cases of psychiatric disorders start by age 14 and three quarters by age 24. Some estimates suggest the majority start before age 18.

Surveys show that around 13% of boys and 10% of girls aged 11-15 have mental health problems.

The most common problems for boys are conduct problems. For girls they are emotional difficulties.

Over recent years there have been falls in physical fighting across countries including the UK.

Suicide rates for young men have fallen since 2001 to 7 per 100,000 in 2013 for 15-19 year olds, and to 14 among 20-24 year olds. There has been little change for young women, who generally have lower rates.

We lack representative data on recent trends in mental health for this age group. Some indications suggest there may be no rise in overall mental health problems for this age group. Others suggest there may be rises in some indicators, such as self-harm.

In 2014, there were 41,921 hospitalisations for self-harm by poisoning or other methods among 10-24 year olds in England.

The largest number of admissions to hospital for eating disorders is among young women aged 15.

Other mental health problems include attention deficit and hyperactivity disorder, affecting around two to four per cent of teenagers.

Four out of five young people report high life satisfaction.
Mental health

Mental health is a major part of young people’s general wellbeing, and is also closely bound up with their physical health. There is much debate about whether today’s generation of young people is more anxious, depressed and stressed than previous generations (Hagell, 2012; Collishaw et al, 2004), but there is no doubt that mental health disorders in young people are surprisingly common. Those most frequent in the teenage years include anxiety and depression, eating disorders, conduct disorder (serious antisocial behaviour), attention deficit and hyperactivity disorder (ADHD) and self-harm. At this age there can be early emergence of rarer psychotic disorders such as schizophrenia (Green et al, 2005). Half of all lifetime cases of psychiatric disorders start by age 14 and three quarters start by age 24 (Kessler et al, 2005). Other estimates suggest most of these problems start before the age of 18 (Kim-Cohen et al, 2003).

Mental health problems have important implications for every aspect of young people’s lives including their ability to engage with education, make and keep friends, engage in constructive family relationships and find their own way in the world. Detection, treatment and support for young people with mental health problems are all important parts of the services provided to this age group. Mental health problems are also a major contributor to the global burden of disease (Whiteford et al, 2013) and untreated problems are likely to be very expensive for health services as young people grow into adulthood. There is more on mental health services in Chapter 8, but it is worth noting that the mental health of young people is subject to considerable policy discussion in the UK at the time of writing, partly as a result of the House of Commons Health Committee report on the topic in October 2014, and the government report ‘Future in Mind’ published in 2015 following the work of the Children & Young Peoples Mental Health taskforce (Department of Heath, 2015).

Prevalence of mental health problems among young people

The prevalence of selected diagnosed mental health conditions in the UK youth population is not measured regularly and this shortage of good, recent data is an issue in understanding the picture. There are some measures in the British cohort studies but these are not repeated annually and the latest, the Millennium Cohort Study, only has data available on children in the primary school years. Two large scale and robust surveys by the Office for National Statistics (ONS) in 1999 (Meltzer et al, 2000) and 2004 (Green et al, 2005) are the source of most information about this topic but they have not been repeated since. Given that the Green data were collected in 2004, they are more than a decade out of date. Plans are underway to fund a new survey, but data will not be available for some time. It is critical to repeat these kinds of representative population surveys, particularly as there has been concern by academics and practitioners about the possible impact on this age group of the economic crisis of 2008, ongoing cuts to services and changes to the examination system in ways that may increase pressure and anxiety (Faculty of Public Health, 2010; Young Minds, 2015). Encouraging the regular collection of new survey data on the topic of adolescent mental health is critical.
Drawing on the older data from the last ONS survey of child and adolescent mental health in 2004, we can see (Chart 6.1) that the most common mental health problems in young men at that time were conduct disorders, with emotional problems most common in young women, although both were common in the opposite gender too. Overall, around 13% of boys and 10% of girls were rated as having some kind of disorder.

**Chart 6.2** shows that the prevalence of mental health problems in the 2004 ONS survey varied by ethnicity and **Chart 6.3** by parents’ educational backgrounds (as a proxy for socioeconomic status). Rates of mental health problems were higher in some ethnic minority groups (Black) and lower in others (Indian, Pakistani and Bangladeshi). The distribution of disorders also appeared to be associated with social background. Young people living in households with higher levels of parental educational qualifications had lower levels of mental disorders.
Analyses of parents’ reports of their 16 year old children’s symptoms (in successive British birth cohorts) have allowed comparisons of data on this age group from 1974, 1986 and 1999. Although parental report has limitations in terms of understanding young people’s mental health, the repetition of similar questions at these three time points offers a unique insight. Over this 25 year period it appeared that there was a significant increase in emotional problems such as depression and anxiety and a rise in adolescent behaviour problems (Collishaw et al, 2004). However in the beginning of the 21st century this trend seemed to have slowed down or stopped. Comparison of the two large scale ONS surveys in 1999 and 2004 mentioned above showed little change over this five year period, as illustrated in Chart 6.4.
A recent study compared mental health difficulties in early adolescence (11-13 years) in two cross-sectional studies from secondary schools in England from 2009 to 2014, using the Strengths and Difficulties Questionnaire (SDQ). The samples were not nationally representative as the second study had a larger than usual ethnic minority sample, and the first study was weighted to match. However, the results were interesting – there were no large differences between the cohorts but a change in pattern. The results suggested an increasing burden of emotional problems for girls, and indication of a decrease in overall difficulties for boys (Fink et al, 2015). In 2014, 24% of the boys showed symptoms of conduct problems, compared with 15% of the girls. Emotional problems were more common in the girls: 20% compared to seven per cent in the boys.

Data returns to the Higher Education Funding Council for England has shown the proportion of university students who formally identify themselves as having mental health problems doubled between 2008/9 and 2013/14 (Institute for Employment Studies, 2015).
Emotional disorders and low mood

Collishaw and colleagues undertook a comparison between representative surveys in 1986 and 2006, focusing particularly on depression and anxiety (Collishaw et al., 2010). Chart 6.5 shows parents’ reports of their children’s symptoms of depression or anxiety for one cohort in 1986 and then another cohort in 2006. The same questions were asked in both surveys. Over the 20 year intervening period, ratings of depressed and irritable mood, sleep disturbance, appetite problems and general worry increased in both boys and girls. Note that this study covered a longer time period than the Fink et al. (2015) study cited above, and the final data point was 2006 rather than 2014. Rates for all these problems in 1986 ranged from 1–12% of the age group; in 2006 they ranged from 3–17%. The reason for this is not clear (Hagell, 2012). The combination of this study, the Fink et al. (2015) survey and recent data on self-harm all suggest a possible rise in some emotional disorders, especially in young women.

Although not based on any representative sample, it is interesting to note that ChildLine (the UK’s free, 24-hour helpline for children and young people) reported 315,111 counselling sessions in 2011/12, with the primary concerns being family relationships, bullying, physical abuse and self-harm (Harker et al., 2013).
Self-harm

The majority of people who self-harm (usually through deliberate cutting or scratching) are aged between 11 and 25 (Mental Health Foundation, 2006; Association for Young People’s Health, 2013). However, self-harm is a very private behaviour and a very sensitive topic, which means that there is a shortage of reliable information unless young people present at accident and emergency services. A Scottish self-report survey in schools found 14% of pupils aged 15-16 years claimed to have self-harmed. It was over three times more common in girls than boys (O’Connor et al, 2009). Recent estimates from the Health Behaviour of School Aged Children survey (Brooks et al, 2015) were higher, suggesting that overall 22% of the 15 year olds in the study had self-harmed. Again, these rates were three times as high for girls (32% of girls compared to 11% of boys). The majority of those self-harming said they were doing so once a month or more.

A minority of people who are self-harming will end up in hospital, but these cases provide important information about this behaviour. Reducing hospital admissions caused by self-harm is a key public health outcome indicator (Department of Health, 2012). Chart 6.6 shows self-poisoning admissions. The majority of these episodes will be drug overdoses, but some will include methods such as swallowing bleach. Although the peak age for admissions is 15, with a total of 4,403 admissions, there is a long ‘tail’, with steady rates of admissions into the early 20s. In total there were 36,423 admissions of 10-24 year olds for self-poisoning in 2014. Some young people will be admitted several times over the course of a year. In addition, some incidents will be accidents. But this figure represents a huge number of young people in extreme distress, particularly considering the number who do not go to hospital. Self-poisoning is one of the most common acute medical presentations in the UK (Camidge, Wood and Bateman, 2003).

![Chart 6.6 Hospitalisations for self-harm by self-poisoning, 10-24 year olds, England, 2014](source: Hospital Episode Statistics)
Chart 6.7 presents self-harm statistics, showing the majority of these incidents involve “intentional self-harm by sharp object”. The age distribution is similar but more extreme; this is particularly a behaviour of 15 year olds. The numbers are lower, totalling 5,498 incidents. Combining these with the self-poisoning statistics, this results in a total of 41,921 hospitalisations for self-harm among 10-24 year olds in England in 2014. Researchers studying hospital statistics have noted that relationship issues were the main reported cause in adolescents. Younger adolescents report problems with friends, older adolescents report problems with boy/girlfriends (Hawton et al, 2014).

The hospital admissions data can also be used to look at time trends. Chart 6.8 shows the rate of hospital admissions for all kinds of self-harm per 100,000 population aged 10-24. This allows us to compare year on year allowing for changes to the numbers of 10-24 year olds in the population, so it is a more accurate way of reporting trends than absolute numbers. The chart shows a rise from a rate of 330 per 100,000 in 2007/8, to 367 in 2013/14.
Finally, rates of self-harm are particularly high amongst groups of vulnerable young people, such as those in the youth justice system. In 2014 there were 157 incidents reported for 15-17 year olds in prison, 1,081 among 18-20 year olds and 1,615 in the older age group of 21-24 year olds. These figures represent a fall in absolute numbers, but they represent a rise if we look at rates per 100 young people, because numbers in custody have fallen over this period. For example, reported rates of self-harm per 100 young people aged 10-17 in custody increased from 4.1 in 2010/11 to 6.6 in 2013/14 (Ministry of Justice / Youth Justice Board, 2015).
Suicide

Suicide is rare among young people but reducing all suicide is a Public Health England outcome indicator (PHE 2012). Reducing suicide by 20% is also a target of the Scottish Government (Scottish Government 2013). Chart 6.9 shows rates are higher in the older age group, and higher among young men than young women, a different gender pattern to self-harm. In addition, the chart shows a peak in suicide in the mid-1990s, but a decline in rates from then until around 2005. After this, rates seem to have been fairly stable. In 2013 the rates for young women were 1.6 per 100,000 for 15-19 year olds and 3.5 for 20-24 year olds, and for young men were 7 for 15-19 and 14.3 for 20-24.

Comparing suicide rates between the countries of the UK is difficult, as they vary in terms of definition and how the statistics are presented. Overall, the rates are similar in England, Wales and Scotland, with reductions in suicides by young people over recent years, but reflecting consistently higher rates among young men (ONS, 2015a). The trends in Northern Ireland are less clear but the absolute numbers are very small so the rates can fluctuate quite substantially.
Conduct disorder and behaviour problems

At some point, almost everyone gets involved in antisocial behaviour. Some risk taking in adolescence is normal and what is defined as antisocial is to some extent culturally and generationally specific. At any time, there are all sorts of different ways to be antisocial, some more concerning than others.

However, serious violent behaviour in this age group is relatively rare and can be associated with long-term negative outcomes. ‘Conduct disorder’ is the official, psychiatric term for serious antisocial behaviour (e.g., American Psychiatric Association, 1994), including the extremes of aggressive behaviour (fighting, being cruel to others or animals), destructive behaviour (arson or vandalism), deceitful behaviour (lying, stealing) and violation of rules (running away, truanting). As we have seen above in Chart 6.1, prevalence estimates for conduct disorder from the 2004 ONS survey suggested a rate of around 6.5% for young people aged 11-15%, with a higher rate in young men than young women.

Another measure of behaviour problems is the rate of first time entrants to the youth justice system. This is not a completely objective rating as it is affected by processing by the police and courts, which are themselves controlled by policy changes. Reducing first time entrants is currently a Youth Justice Board key performance target for Youth Offending Teams in England. The number of young people aged 10-17 receiving their first substantive outcomes (reprimand, final warning or court disposal) in 2013/14 was 22,393. This was down 75% from 2003/4. Overall there were 90,769 proven offences by young people under 18 leading to a caution or conviction in 2013/4, down eight per cent on the previous year and down 68% since 2003/4, ten years previously (Ministry of Justice/Youth Justice Board, 2015). Reasons for the fall include reductions in crime levels as a whole and changes in the way children are dealt with, including the development of more informal and constructive approaches within the youth justice system (Allen, 2011).

The Health Behaviour in School Aged Children (HBSC) study looked at trends in adolescent physical fighting across 30 countries using the 2002-2010 data. These have also shown that there were declines over time in two thirds of the countries involved (Pickett et al, 2013), including the UK and the USA. Chart 6.10 presents the comparisons for a selection of these countries. Rises were seen particularly in countries that had suffered severe economic crises during the intervening years (Greece and Spain, for example).
Unfortunately there are very few data on victims of violence in this age group. Some of the few data we have derive from the Crime Survey for England and Wales, which focused on violent crime and sexual offences in 2013/14 (ONS, 2015b). However, incidents against 10-15 year olds in 2013/14 were recorded for just a few hundred young people, which may not give a representative picture of the country.
Attention Deficit and Hyperactivity Disorder (ADHD and hyperkinetic disorders)

Key symptoms of ADHD are inattention, impulsiveness and hyperactivity. It has been estimated that ADHD affects around two to four per cent of teenagers in the UK, with rates consistently higher in boys than girls (AYPH, 2012). It can affect educational attainment, peer relationships, self-esteem and can contribute to youth offending. Chart 6.11 demonstrates the higher rates in young men, but until there is a new representative survey we cannot tell whether there has been an increase in prevalence in recent years.

![Chart 6.11](source: Green et al (2005), Mental health of children and young people in Great Britain, 2004)

**Eating disorders**

The average age for the start of eating disorders is in the mid-teens and understanding these complex and distressing disorders is important when thinking about this age group. Overall, it is estimated that around one in 250 females and one in 2,000 males will experience anorexia nervosa, usually as an adolescent or young adult, and that around five times this number will suffer from bulimia nervosa (National Collaborating Centre for Mental Health, 2012). A study of the incidence of eating disorders in the UK from 2000 to 2009, using a primary care register, reported an age standardised annual incidence rate of 164.5 per 100,000 for girls aged 15-19 years, more than double the rate for other ages (Micali et al, 2015). However, like self-harm, eating disorders may be underestimated in the general population. Significant proportions will not seek help and good representative community surveys are rare. On the basis of routine Hospital Episode Statistics, the Health and Social Care Information Centre has reported that young people aged 10-19 years account for more than half of hospital admissions for eating disorders (HSCIC, 2014). As Chart 6.12 shows, the largest number of admissions in 2013/14 was for 15 year old girls. Although bulimia is more common, anorexia accounts for a larger proportion of the hospital admissions.
On the basis of the hospital admission data, HSCIC has estimated that these figures are rising; there was an eight per cent rise between 2011/12 and 2012/13, for example, and across that period the biggest rise was in young people in the 15-19 age group (HSCIC, 2014).

**Autistic spectrum disorders**

The majority of young people become increasingly focused on their peer groups and social interaction during adolescence. So this can be a very difficult time for young people who find it hard to manage their relationships with others. Those with autistic spectrum disorders (such as Asperger’s) may find this a particularly challenging life stage. The new Diagnostic and Statistical Manual version V was published in 2013, drawing together the various diagnoses of autism, autistic spectrum disorder and Asperger’s under one umbrella diagnosis of ‘autistic spectrum disorder’. This has three levels of severity and there is also a related diagnosis of social communication disorder (American Psychiatric Association, 2013). The defining characteristics of autistic spectrum disorders are impairments of social interaction, communication and imagination and often a reliance on repetitive, habitual activities and behaviours.

The only national survey data relating to prevalence derive from the 2004 ONS survey by Green and colleagues. This suggested a prevalence rate of approximately one percent for autistic spectrum disorders (Green et al, 2005). A prevalence study involving a total population cohort of 56,000 children aged nine to ten in south London, (Baird et al, 2006) estimated a total prevalence rate of all autistic spectrum disorders as 116 per 10,000. Extrapolating from available figures, there could be approximately 133,500 young people under 18 in the UK with an autistic spectrum disorder (National Autistic Society, 2012).
There is a strong gender differential in autistic spectrum disorders, with around five times as many boys as girls, and on average half of the children diagnosed with autistic spectrum disorders have learning disabilities (Frombonne et al, 2011).

**Young people’s reports of their wellbeing**

There is a wide range of measures of young people’s wellbeing and different surveys use different approaches (ONS, 2014), making it difficult to compare. The 2014 Health Behaviour in School Aged Children survey asked 11, 13 and 15 year olds to report their life satisfaction using a device called the Cantril ladder (Cantril Self-Anchoring Life Satisfaction Scale). Respondents had to place themselves on a 10 step ladder, where the top rung indicates they have the best possible life and the bottom rung indicates the worst. **Chart 6.13** shows the proportion of young people in England reporting high life satisfaction using this method. Four out of five young people reported high life satisfaction, although rates are lower in the older age group and lower in girls than boys. Comparable country rates from the HBSC are not available for the 2014 data at the time of writing but in the 2010 survey the rates were similar in England, Scotland and Wales.
High levels of life satisfaction were reported in the latest ONS wellbeing survey, although the method used was slightly different. Chart 6.14 shows the proportions reporting that they were satisfied with their life, felt they were doing worthwhile things with their lives, and felt happy yesterday.

Finally, the widely cited Unicef Office of Research produces the Innocenti Report Card (which is based in part on HBSC data), assessing child wellbeing in rich countries, with the most recent report published in 2013 (Unicef Office of Research, 2013). Chart 6.15 presents the rankings of children’s reported life satisfaction in 29 countries. The UK came 16th out of 29. Scandinavian countries are overrepresented in the top half of the table and Eastern European countries in the bottom half.
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