Nuffield Foundation

Grown up?

‘Higgledy piggledy’: Systems of support for young people aged 14–24 with poor mental health

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Grown up?

1. Introduction

1.1 Why we focus on the mental health of 14–24-year-olds

The *Grown up?* programme at the Nuffield Foundation is exploring the journeys to adulthood, for young people aged 14–24, part of Gen Z, to inform policy and practice. It focuses on different aspects of their lives including the markers of adulthood, transitions from education to employment and their digital lives. No picture about journeys to adulthood of this generation would be complete without shining a light on their mental health.

The World Health Organization explains mental health as a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community[1]. Mental health is as important as physical health but perhaps not as well understood yet or given the same priority. It is a continuum of fluctuating experiences, ranging from positive or challenging everyday emotional states to mental health conditions that are characterised by persistent and severe symptoms that impact cognitive or behavioural functioning and interfere with everyday life. Living with poor mental health[2] requires access to support across the whole continuum of needs, from interventions that help prevent or alleviate the symptoms to medication or hospitalisations in situations of crisis.

Young people's mental health is a priority issue for a number of reasons.

First, there has been a significant and concerning rise in the number of young people who require support with mental health conditions – 1 in 4 young people aged 16–24 years had a common mental health condition in in 2023/4 compared to 1 in 6 in 2007[3]. The precariousness of global and domestic events in recent years, the effects of COVID-19[4], financial worries due to the higher cost of living[5], changes in daily life rhythms brought about by an ever-present digital realm[6,7], and the thinning of social connections young people experience[8], have all undoubtedly contributed to the growing number of young people experiencing low well-being[9] and mental health conditions[10,11].

There has also been a lot of public, academic, and political discussion about the true scale of poor mental health among young people[12] and the rising number of young people being out of education or work due to poor mental health[13]. Are young people being over or under-diagnosed? Is poor mental health a result of challenges faced by young people in modern life or 'concept creep' resulting from greater awareness and greater prominence in media? Some of these questions are set to be explored in the reviews led by NHS national advisor Professor Peter Fonagy – looking into mental health conditions, attention deficit hyperactivity disorder (ADHD) and autism[14] – and by Alan Milburn – investigating causes of inactivity and unemployment among young people aged 16–24 (see Appendix 1).

Second, supporting mental health needs is particularly important during adolescence and early adulthood. Research shows that the brain continues to mature well into the 20s with many structural and neurodevelopmental changes that may heighten young people's behavioural and emotional vulnerabilities[15]. Indeed, around two thirds of all mental health

conditions emerge during adolescent years, making the provision of support during this time even more important[16]. Effective mental health support from birth and in adolescence can make a life-long difference, impacting future life satisfaction, employment prospects and even income levels[17]. However, the evidence on what works for young people is still limited[18].

Third, adolescence is also an age when a number of major life transitions are taking place – from secondary school to further education, A levels or apprenticeships, marked with rigorous GCSE exam regime; transitions to university or employment; and the transition from child to adult status and the many things that may come with that, including the first romantic relations, moving out of family home, and starting a family. All of these important life transitions impact on a young person's mental health and well-being and vice versa. Poor mental health during important life milestones can influence young people's ability to accomplish them successfully and can limit their future life chances.

Finally, turning 18 marks the legal transition from childhood to adulthood across the UK[19,20,21,22] in accordance with the United Nations Convention on the Rights of the Child[23,24]. It is not just a milestone determining new things young people can do, like getting married or being able to buy alcohol. It also determines what support services young people can or cannot access, including with their mental health needs. Reaching the age of 18 is often described as a 'cliff edge', when suddenly all the scaffolding of support offered by child-specific services – whether in education, social care or mental health – falls away and young people are left to navigate a complex and often less supportive landscape of adult services on their own. This sharp boundary in service provision is at odds with young people's later transitions to adulthood[25] and evidence on brain development extending into early adulthood. Therefore, support needs to be better aligned and attuned to the specific phase of the young person's development, rather than an arbitrary cut-off. The conceptualisation of transition points and age thresholds is an evolving issue within the mental health services landscape.

Over the last 10–15 years, mental health overall and the mental health of young people specifically have received greater focus in national policies, creating more opportunities for young people to access support, particularly under the age of 18. Some of the most significant policy and practice developments include: a goal of parity of esteem between mental and physical health; new evidence based approaches to mental health support overall as well as for specific conditions; an increase in early and preventative interventions; expansion of talking therapies' availability; establishment and ongoing expansion of mental health support in schools and colleges; and new integrated approaches – such as the community-located support hubs discussed later in this paper (see Appendix 1 for a list of policy and practice developments).

However, there remain major issues with support for young people with poor mental health – the level of need still outpacing provision[26], uneven funding allocations for mental health services across the country[27], and twists and turns in policy implementation all contribute to a postcode lottery of what is available in different locations as well as across the childhood/adulthood boundary[28,29].

1.2 Focus on prevalence and systems of support

This report is the third in a series of data commentaries under the *Grown up*? programme[30]. It is for anyone with an interest in mental health and young people aged 14–24, but will be particularly relevant for researchers, policymakers, and commissioners of services. It has two distinctive features: First, it brings together data on the prevalence of mental health conditions with *service use*, often considered separately. Second, it attempts to map the landscape of mental health support for young people across different components. In doing so, it highlights the extent of the gap between young people's mental health needs and the available support.

Informed by youth insight and engagement (see Box B in methodology section), this data commentary explores both **formal** and **informal** mental health support for 14–24-year-olds. **Formal** support is provided through designated child or adult health services or professionals commissioned by NHS (including GPs and specialist mental health professionals). This is usually in health settings, but may also be provided in education settings, community hubs or digitally. **Informal** support is provided by professionals or individuals with or without specific knowledge of mental health within different systems that young people interact with on a daily basis – such as family and friends, education, digital services, community, and employment – and is funded through a variety of sources. The second part of this report focuses specifically on those systems and discusses the formal and informal support provided within those systems.

Our focus on wider systems of support for young people's mental health is equally informed by the evidence that a holistic approach to a young person's mental health is important across the childhood/adulthood boundary[31] and by the important role mental health support provided through formal and informal systems plays in young people's lives[32].

We wanted to understand the whole continuum of support young people can access to address poor mental health where hospitalisation is **not** required – from early help and advice through to services that can provide tools, guidance, and signposting to clinical support, including in a crisis. Where we look at the formal support provided through mental health services, our focus is on community based and outpatient settings.

Through this work we aim to:

- Consider the need for mental health support not constrained by strict age or services boundaries, but driven by understanding of the evolving needs of young people aged 14–24 and recognition of the importance of holistic and young-person-centred approaches to mental health support (discussed throughout the document).
- Understand the scale and key trends in poor mental health in the 14–24 population in England (discussed in Chapter 2).
- Map the systems and, where data available, the scale of support within these systems for young people aged 14–24 with poor mental health, particularly around the childhood/adulthood transition point (discussed in Chapters 3 and 4).
- Identify key gaps in research and data (discussed throughout the documents).

This document draws on important surveys and administrative data collections for England to present a more comprehensive data picture and draws on insights from young people and professionals to paint more nuanced picture of how these systems work for young people. Young people who shared their insights were located in England, Scotland and Northern Ireland, and professionals' insights focused on practice in England. The next section explains how this data commentary was put together.

1.3 Methodology

To capture a broad overview of systems of support for young people with mental health needs, this data commentary has utilised the following:

- Curated review of themes from published academic research and grey literature on support for mental health needs and transitions to adulthood. This is not a synthesis of the evidence available on the subject, rather a thematic analysis of key publications to stimulate discussion and research.
- Examination of relevant data for England from **publicly available data tables** from prevalence surveys, administrative data sources and published research on mental health needs and access to support for young people aged 14–24. Box A presents three of the key data sources examined. Through the document we indicate where further analysis of the data would be useful.

Box A: Data sources on mental health used in this data commentary

Note: In this data commentary, terms are used in the same way as in the sources referenced, including sex/gender, sexuality, disability, and race/ethnicity.

Adult Psychiatric Morbidity Survey (2007, 2014, 2023/24)

This is a comprehensive publication on mental health needs in population 16+ in England, commissioned by NHS and the Department for Health and Social Care. This survey uses validated mental disorder screens and assessments for a range of mental health conditions, including common mental health conditions (using the CIS-R[33] – a structured interview examining the presence of symptoms of common mental disorders), attention deficit hyperactivity disorder (ASRS), posttraumatic stress disorder (PCL-C), signs of dependence on drugs and alcohol (AUDIT), gambling harms (PGSI), personality disorder (SAPAS and SCID-II Q) and bipolar disorder (MDQ). Clinical examinations assessed autism (ADOS), psychotic disorders (SCAN) and eating disorders (SCAN ED).

Mental Health of Children and Young People (MHCYP) survey

This major survey of the mental health of children and young people aged 8–25 in England was carried out in 1999, 2004, and 2017. The MHCYP survey (2017) and the subsequent waves of data collection (2020, 2021, 2022 and 2023) all used the Strengths and Difficulties Questionnaire (SDQ) as a main measure of mental health. Responses from parents, children, and young people are used to calculate the likelihood that the child had a probable or possible mental disorder at the time they completed the questionnaire. Important to note that although the SDQ was used in MHCYP 2017, the mental disorder prevalence estimates in the initial MHCYP 2017 survey report drew on a different and more detailed diagnostic assessment of mental disorder: the Development and Well-Being Assessment (DAWBA). In this data commentary the data presented is from the 2023 report.

NHS England annual reports on mental health (2020 to 2025)

These contain administrative data on people who used NHS-funded secondary mental health, learning disabilities and autism services.

Data from research reports and different organisations' annual reports as referenced

We report on the 14–24 group where possible. Where data for the 14–24 age grouping is not available we use the age grouping as per report or data collection referenced. There is no consistent approach to age grouping; therefore, there may be inconsistencies in data reported. The issue of inconsistent age groupings is recognised in research[34].

- Data from Freedom of Information (FOI) responses to our FOI request to 49 Mental Health Trusts in England[35], included in Section 4.4 Our FOI request focused on service arrangements for under-18s and young people aged 18–24.
- Discussion with 18 members of the Youth Insight Group for the *Grown up*? project and 24 young people with experience of mental health difficulties participating in online deep dive workshops in England, Scotland and Northern Ireland (see Box B for more information). Throughout this document, where views of young people are mentioned they are of those who took part in the Youth Insight Group and deep dives on mental health.

Box B: Youth engagement

The Nuffield Foundation commissioned specialist social research agency Hopkins Van Mil (HVM) to carry out a set of deep dive workshops (DDWs) exploring the journey of young people on the topics of education to work, digital lives, and mental health and well-being. In parallel, HVM was also asked by the Nuffield Foundation to convene a Youth Insight Group (YIG), made up of twenty 14–24-year-olds from across the four nations. YIG members helped to shape the content and format of the DDWs and reflected on the findings.

The Mental health and wellbeing deep dive workshop report – "pushed from pillar to post" report shares the detailed findings from the DDWs on mental health and well-being support. Across three online workshops, 24 young people from England, Scotland and Northern Ireland shared their lived experiences of seeking, receiving, and navigating support (see the report above for selection and recruitment detail). All participants had direct experience of mental health or well-being challenges. The workshops were designed in collaboration with the programme's YIG, ensuring that the process, framing, and interpretation of findings were shaped by young people themselves.

- Workshop and interviews with 18 professionals, who were recruited from organisations with extensive experience of supporting young people with mental health needs, have published research on the issue and were available to contact. They produced a map of systems of support for young people with mental health needs and low well-being, organised jointly by the *Grown up*? programme and the Nuffield Family Justice Observatory.
- Roundtable discussion with 20 representatives from organisations working on the issue of AI and young people's mental health, organised jointly with the Ada Lovelace Institute. Appendix 2 contains the list of organisations that took part in workshops, individual interviews and roundtable discussion. Throughout this document, where views of professionals are mentioned, they are of those professionals who took part in the roundtable, workshop, and individual interviews.
- In this data commentary we explore data for England; however, the youth insights were provided by young people from across the UK.

1.4 Mental health terminology

Despite an ever-growing focus on mental health, there is still a lot of confusion among young people themselves, as well as parents and professionals, about what it is. Professionals highlighted the absence of common language and a shared understanding of what mental health is, as well as differences in clinical thresholds of need across workforces within the

different systems in contact with young people. Both are key barriers to how support is provided and accessed by young people.

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community[36]. It represents a spectrum of needs, from positive psychological functioning and well-being at one end of the continuum, to mental health problems/conditions of differing degrees of severity at the other end. A person's mental health will change and fluctuate during the life course.

The terms 'mental health' and 'well-being' are often used together, sometimes interchangeably. However, they can be viewed as two independent concepts to be explored on their own or through intersections between them.

Well-being is how well we are doing as individuals. It can be objective (how someone's life looks from the outside, measured using externally observable indicators) and subjective (how the person feels about their life now and in the future – for example, satisfaction with different domains of their life: family, friends, choice, home, health, time use, future, money and things, appearance, schools, and other issues)[37]. Low well-being may impact negatively on mental health and many young people who have a diagnosable mental health condition have low well-being, but there is not always a direct connection[38]. **In this data commentary we do not explore the data on well-being.**

Mental health conditions are characterised by clinically significant disturbances in individuals' cognition, emotional regulation and/or behaviour. They include among others: common mental health conditions (CMHCs) such as anxiety, depression, phobias, obsessive compulsive disorders and panic disorders; psychotic disorders; post-traumatic stress disorder; and addictions and substance use disorders. Self-harm and attempting suicide are also included among mental health issues. Diagnosis of a mental health condition is complex and subject to changes; it is based on the duration of symptoms and the degree to which they impact on functioning, behaviour or cognition, using well established clinical assessment tools. As with physical health, mental ill health may have different levels of complexity and severity, and physical and mental conditions are often reported to occur at the same time.

'Probable mental health condition' is a term used in the Mental Health of Children and Young People survey. It indicates the likelihood of mental health condition calculated through the responses to the screening tools used in the survey (see Box A on data sources).

Neurodiverse conditions such as autism and attention deficit hyperactivity disorder (ADHD) are often measured in surveys and presented in statistics on services together with mental health conditions. There is a growing recognition that being neurodivergent does not equate to having a mental health condition. However, the appearance of neurodivergence and mental health conditions together is reported[39,40]. While issues related to neurodiverse conditions are touched on briefly, it isn't possible to do justice to the broad set of issues they raise within the scope of this report.

Mental health as a spectrum of need and diagnosable conditions is the focus of this data commentary.

List of abbreviations

APMS – Adult Psychiatric Morbidity Survey

ADHD – attention deficit hyperactivity disorder

CAMHS – Children and Adolescents Mental Health Services (also known as Children and Young People Mental Health Services) – a term used in relation to a range of support services available to children and young people aged under 18, usually delivered or funded by the NHS.

CBT – cognitive behavioural therapy

CMHC – common mental health condition

CMHC-NOS – common mental health condition, not otherwise specified

CNS – central nervous system

CYPMHS – see CAMHS

MHCYP survey – Mental Health of Children and Young People survey

GAD – generalised anxiety disorder

ICB – integrated care board

MHST – mental health support team

OCD – obsessive compulsive disorder

2. The state of poor mental health in young people

In this section we will consider the data on prevalence and trends in mental health in population of young people aged 14–24. To understand the prevalence rates of mental health conditions in the 14–24-year-old population in England we examined the data reported by prevalence surveys, as well as administrative data from mental health services. The data from services on people in contact[41] tell the story of how many people are seeking help from services, while the prevalence data paints a picture of how many may be in need of support, irrespective of whether they seek help or not. Data on contact with services does not equate to data on people receiving treatment as discussed further in this document (see section 4.1.3).

Around 6 out of 10 people with mental health conditions will first experience these conditions before the age of 25[42]. The age at onset[43] differs from one condition to another[44]:

- Those with anxiety- and fear-related conditions – 52% by age 18.
- Those with feeding- or eating-related disorders – 82% by age 25.
- Those with disorders due to substance use or addictive behaviours – 50% by age 25.

Just as with physical health, mental health problems can arise due to a variety of reasons: genetic predisposition[45]; experiences of trauma[46]; adverse childhood experiences[47]; environmental stressors[48]; poverty, housing, and socio-economic factors[49]; or a combination of those. The Youth Futures Foundation found that worsening sleep quality, employment precarity and affordability pressures, social media and smartphone use, and reduction in children and youth services are likely contributory factors to the rise in children and young people experiencing mental health problems[50].

While the age at onset or the factors behind poor mental health are not the focus of this report, alongside the data on prevalence and trends in mental health, they can inform effective responses for young people at different stages and with different conditions as they move from adolescence to adulthood.

2.1 Prevalence and trends

Survey data

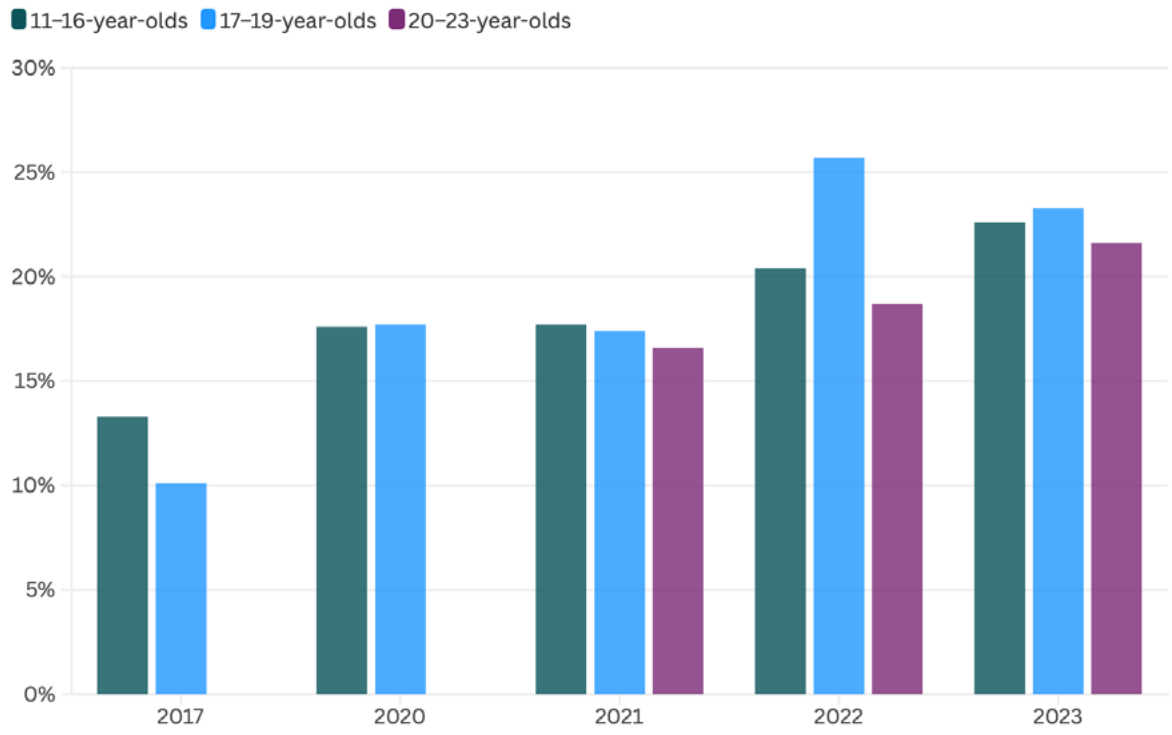
Diagnosis of mental health conditions is complex and reflects the duration and impact on functioning, behaviour, and/or cognition using well established assessment tools. The prevalence surveys used in this report (see Box A in methodology section) rely on the use of validated diagnostic and/or screening tools to estimate mental health needs in the population, and are not based on self-diagnosis. While mental health assessments in surveys are not as

robust as a clinical interview, they have been validated and are among the best available for the purpose in hand[51].

Both the Mental Health of Children and Young People (MHCYP) survey[52] and the Adult Psychiatric Morbidity Survey (APMS)[53] report on levels of mental health needs among young people and show an upward trend in poor mental health among young people.

Figure 1 draws on the MHCYP survey and shows the increase in the proportion of young people with probable mental health conditions from 2017 to 2023 for ages 11–23. It shows that the rise in mental health conditions was particularly marked for 17–19-year-olds from 2017, peaking in 2022[54].

Figure 1: Percentage of 11–23-year-olds with a probable mental health condition, by age, 2017 to 2023[55]



Note: Data on 20–23-year-olds only available for years 2021 to 2023.

Full description of Figure 1.

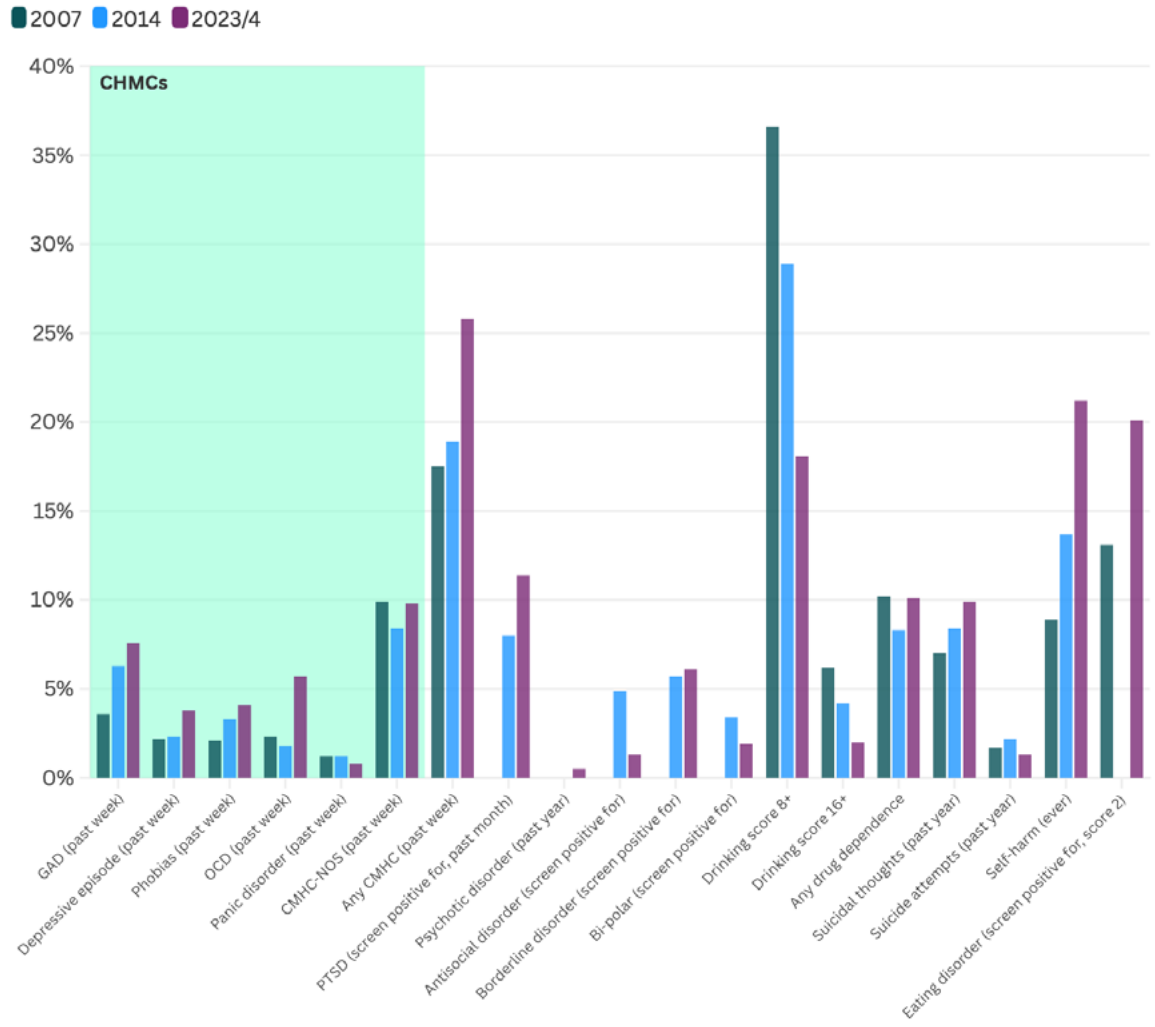
APMS shows that **1 in 4 young people aged 16–24 in England had a common mental health condition (CMHC) in 2023/24 compared with 1 in 6 in 2007**. It also shows that while mental health conditions have been increasing across all ages. The increase among young people has been the most notable, both in the UK and globally[56].

Figure 2 paints a more nuanced picture by conditions and severity of symptoms. For example, it suggests:

- Around 1 in 5 (21.2%) young people aged 16–24 reported having self-harmed ever in 2023/24 compared to less than 1 in 10 (8.9%) in 2007.

- Other conditions such as problematic drinking declined, and drug dependence is fairly stable among young people.

Figure 2: Percentage of 16–24-year-olds with mental health conditions in 2023/24, by condition and comparison to years 2007 and 2014 where data available[57]



Note: 'Drinking score 8+' includes hazardous drinking (score 8–15), harmful drinking (score 16–19), and probable dependency (score 20+). 'Drinking score 16+' includes harmful drinking (score 16-19) and probable dependency (score 20+).

Full description of Figure 2.

APMS also reports on the severity of CMHC symptoms (CIS-R score[58]) by age (see Table 1). This is important for understanding the needs and availability of services across a spectrum as discussed in the next chapter. The data shows that in 2023/24:

- Around **1 in 12 (8.6 %)** young people **aged 16–24** had symptoms at a level likely to benefit from possible intervention (a CIS-R score 12–17).

- **1 in 7 (14.2%) young people had severe symptoms that would almost certainly benefit from intervention and treatment** (a CIS-R score 18+).
- The proportion of young people with more severe symptoms grew more compared to those with less severe symptoms.

Table 1: Severity of symptoms (CIS-R score) of CMHCs for young people aged 16–24 (%)[59]

CIS-R score	2007	2023/24
0–5	66.9%	58.9%
6–11	16.7%	18.3%
Under 12 total	**83.6%**	**77.2%**
12–17	7.2%	8.6%
18+	9.1%	14.2%
12+ total	**16.4%**	**22.8%**

The Youth Futures Foundation recently found that increases in common mental health disorders were not explained by increased reporting or identification, but reflected real rises in mental distress[60].

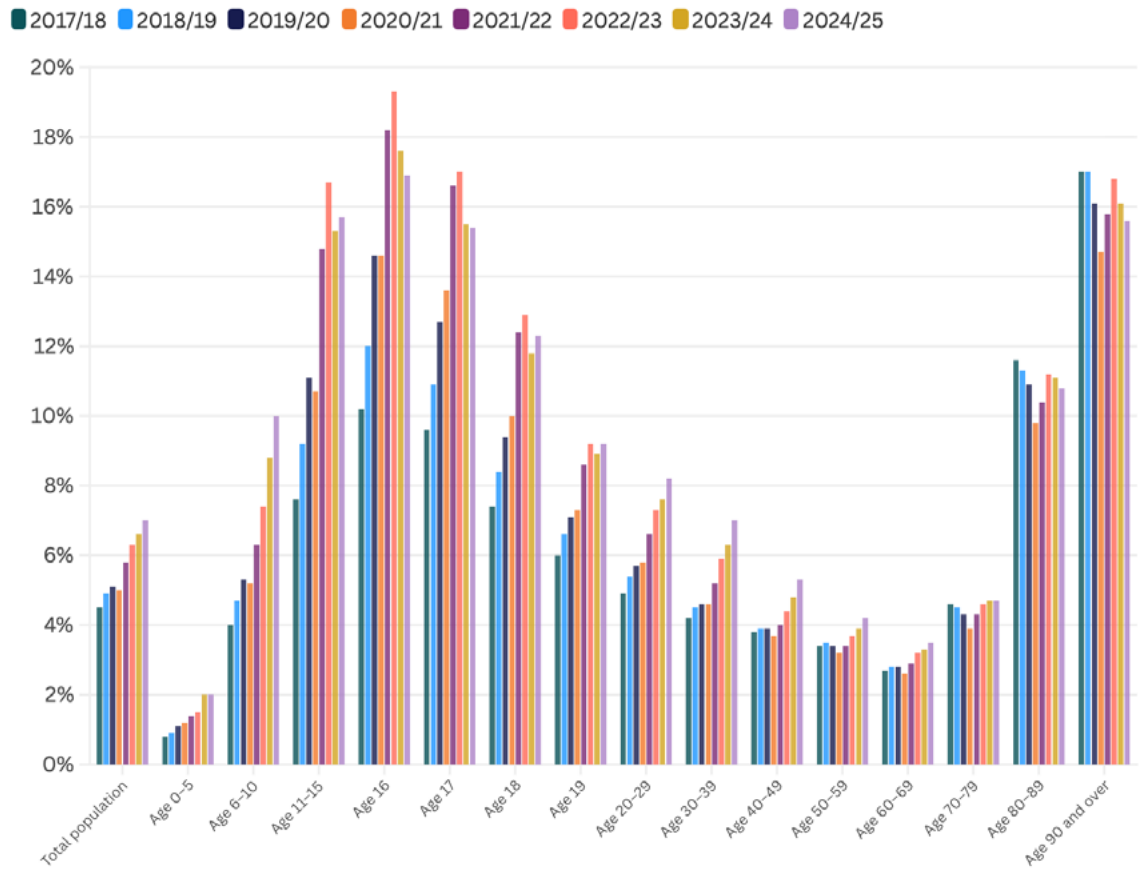
The rise in self-harm, suicidal thoughts and attempted suicides (as well as number of people dying by suicide, discussed later in this section) also suggests that there is a rise in the prevalence of mental health difficulties across a spectrum of conditions.

Contact with NHS-funded mental health services[61]

In 2024/25 around 1 in 10 (11%) young people aged 16–24 – 678,660 young people – have been in contact with NHS-funded mental health services.

Administrative data on the number of people in contact with NHS-funded mental health services shows an upward trend, peaking in 2022/23 before falling for some age groups (see Figure 3). Similar to prevalence data, the proportion of people in contact with mental health services grew for most age groups (apart from 70+) in recent years, but with higher rises for children and young people.

Figure 3: Percentage of population in contact with NHS-funded secondary mental health, learning disability and autism services, by age, 2017/18 to 2024/25[62]



Full description of Figure 3.

2.2 Differences by gender/sex[63]

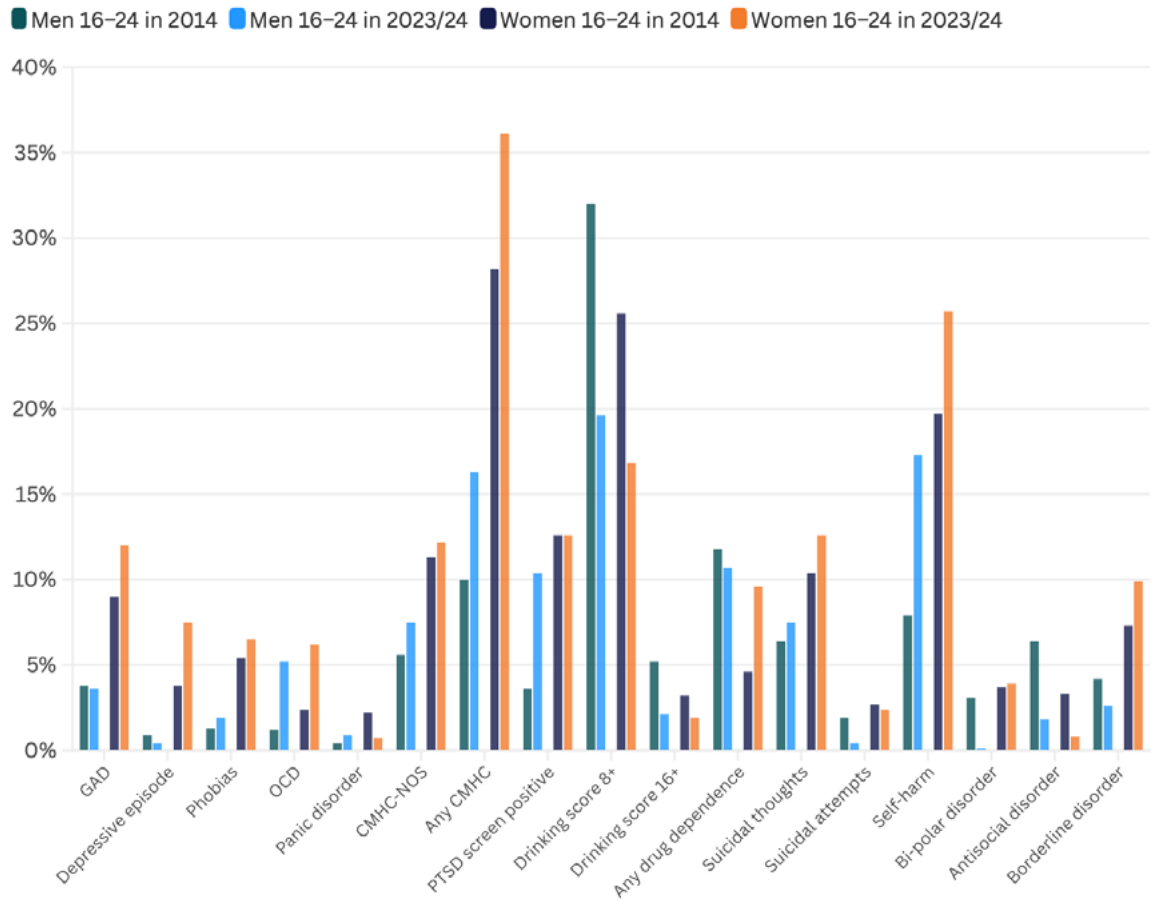
The proportion of young people experiencing worsening mental health has gone up in the last 15 years (although some recent Mental Health of Children and Young People (MHCYP) data suggest prevalence rates beginning to stabilise); however, there are differences between genders. More young females are experiencing poor mental health compared to young males (see Table 2). Furthermore, the proportion of young females who experience any common mental health conditions (CMHCs) and more severe symptoms of CMHCs is growing faster than that of males.

Table 2: Percentage point change between 2014 and 2023/24 in any CMHC in the past week and severity of symptoms, by gender among young people aged 16–24[64]

	2014		2023/24		Percentage point change (pp)	
	Male	Female	Male	Female	Male	Female
Any CMHC in the past week	10%	28.2%	16.3%	36.1%	+6.3pp	+7.9pp
Severity of symptoms: CIS-R score 12+ (inc. 18+)	9.1%	26%	14.9%	31.5%	+5.8pp	+5.5pp
CIS-R score 18+ only	4.2%	15.1%	8.2%	20.6%	+4pp	+5.5pp

The gap in prevalence rates of CMHC symptoms between young men and young women aged 16–24 is notable across many conditions (see Figure 4).

Figure 4: Trends in mental health conditions in 16–24-year-olds, by sex, 2014 and 2023/24 (%)[65]



Note: 'Drinking score 8+' includes hazardous drinking (score 8–15), harmful drinking (score 16–19), and probable dependency (score 20+). 'Drinking score 16+' includes harmful drinking (score 16-19) and probable dependency (score 20+).

Full description of Figure 4.

Figure 4 shows different trends for males and females depending on the condition. For example:

- The prevalence of generalised anxiety disorder (GAD) decreased in males but increased in females (-1.7 and +2.8 percentage points correspondingly).
- The prevalence of PTSD increased in males by 5.9 percentage points but did not change significantly in females.
- Drug dependence increased in females but decreased in males.

The previous two figures highlight the importance of considering data from a perspective of gender/sex and age to more fully understand the mental health needs and trajectories of this age group, as well as to inform support provision.

While data on the 16–24 age group is helpful, a more detailed analysis by age groups among children and young people is needed. For example, the latest MHCYP survey report states that among 8–16-year-olds, rates of probable mental disorder were similar for boys and girls, while among 17–25-year-olds, rates were twice as high for young women than young men. This warrants a question of what sparks that difference in the 17–25 population and what response is needed as young people transition to adulthood.

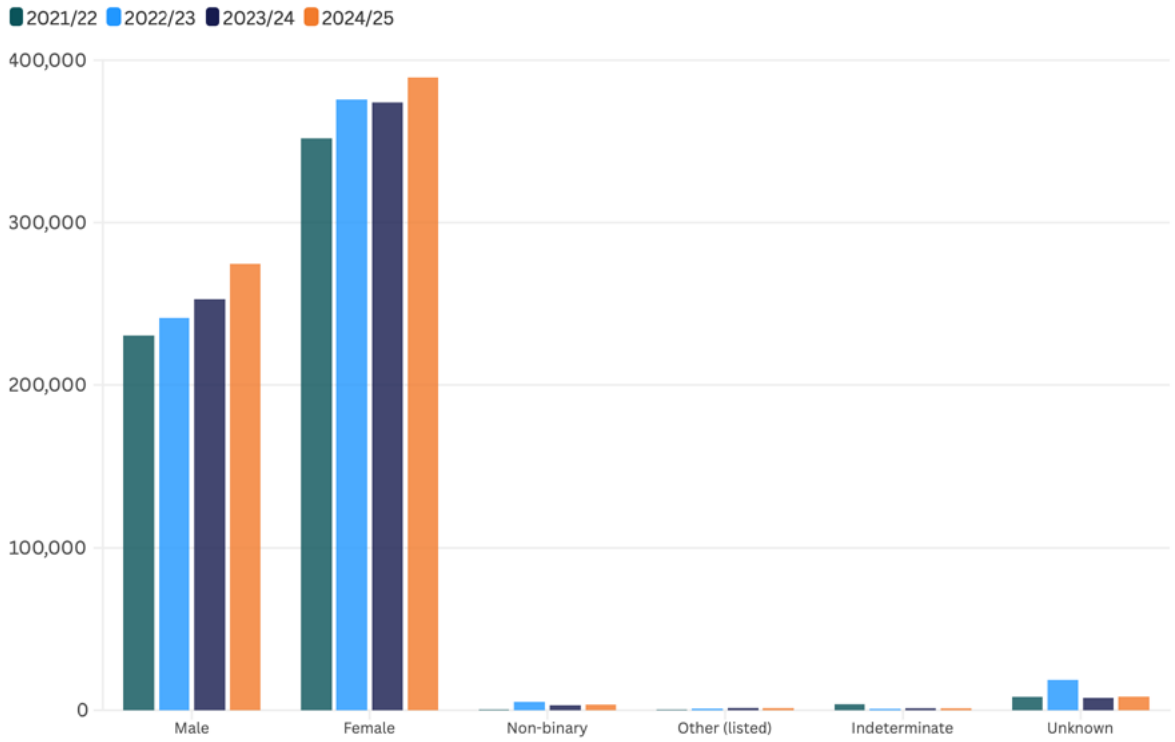
Data on suicide rates in population of 15–24-year-olds as reported by Office for National Statistics (ONS) shows that the rate of dying by suicide remains much higher for males, and that it has increased for both genders from 2014 to 2024 (see Table 3). This is despite the prevalence data in Figure 4 showing females having a higher rate of suicidal thoughts, and the reduction in suicidal attempts for both groups from 2014 to 2024. The suicide rate in males aged 20–24 is particularly concerning.

Table 3: Rates of suicide by age and sex in England in 2014 and 2024, per 100,000 population[66]

Age groups	Sex	2014	2024
Age 10 and over	All persons	10.3	11.1
	Males	15.9	17
	Females	4.9	5.6
Age 15-19	All persons	4.4	5.8
	Males	6.2	7.8
	Females	2.5	3.7
Age 20-24	All persons	8.5	10
	Males	13	14.2
	Females	4	5.5

NHS data on people in contact with secondary mental health services confirms the picture of uneven gender split along with rising contact growing across gender groups (see Figure 5).

Figure 5: Number of 16–24-year-olds in contact with secondary mental health services, by gender, 2021/22 to 2024/25[67]



Full description of Figure 5.

There is a recognition in the public debate and research that gender may play a role in how poor mental health manifests and develops under different stressors, with females more likely to internalise emotions and males to externalise[68]. This may explain the data, particularly in prevalence surveys, on problematic drug and alcohol use, addictions, and dependency,

which shows that males are more affected than females. There are also differences in social media use by gender that may be a contributing factor to a widening gender gap[69], but further research is needed.

There is very little data about non-binary and transgender young people, so trends for these groups cannot be reported.

A specific focus on age and gender in mental health is important to help build a more nuanced picture of needs and to inform support services.

2.3 Differences by other individual characteristics

The limited data on differences across a range of individual characteristics discussed in this section is largely focused on prevalence. To understand the prevalence and any trends in poor mental health for specific groups of young people, we looked at published research reports as the surveys reported in previous sections do not report on the young people from these specific groups.

Ethnicity and race[70]

Race and ethnicity are very important when it comes to mental health needs as racism and racialised inequalities negatively impact on mental health, as well as the level of trust in and access to services for young people (access to services is discussed later)[71,72].

The Children's Commissioner reported that that children (under-18s) from ethnic groups other than White are more likely to be referred to mental health services for being in crisis, while children of White ethnicity were more likely to be referred for conditions such as anxiety[73]. While the reasons for this may be complex, factors such as fear of racism and discrimination and distrust in services are likely to be a key contributing factor in this, limiting access to early intervention services. This was discussed by participants in the youth engagement we conducted (see section 4.5).

Youth Futures Foundation reported, based on data from the Understanding Society Survey, that between 2009 and 2023 there was a greater deterioration in mental health for young people from White British backgrounds compared to other groups. Their analysis showed that the average yearly mental distress symptom score[74] for ages 16–24 increased by 0.24 per year for White British young people and 0.16 for those from mixed ethnic backgrounds. Smaller increases were observed for South Asian (0.10) and Black (0.06) young people[75].

Their analysis on young people in contact with primary health services (such as GPs) due to mental health concerns between 2000 and 2023 also highlighted ethnic differences in mental-health-related presentations. It reported that between 2000 and 2019 there was 8.8 percentage point increase in White British young people presenting to primary care for a mental health problem (from 2.9% in 2000 to 11.7% in 2019). Whereas the percentage point increase for Black young people, while still substantial, was considerably smaller at 2.9 percentage points (from 1.4% to 4.3%). Following the pandemic, in 2023 there was a negligible

reduction reported in presentations to primary care for Black young people, whereas the reduction was marked for White British young people[76].

The very limited data on prevalence of poor mental health among different ethnic groups does not allow us to draw clear conclusions, but the data illustrates why closer attention needs to be paid to the subject to inform the development of support services.

Socio-economic status

The Adult Psychiatric Morbidity Survey (APMS) provides analysis across all age groups, showing that poverty, economic hardship and having multiple health conditions are associated with the prevalence of common mental health conditions (CMHCs). CMHCs were higher in those living in the most deprived fifth of areas (26.2%) compared to 16.0% in least deprived areas. Based on all population data there are also some regional differences in CMHCs according to APMS, with people in the North East (24.6%) and East Midlands (24.6%) more likely to have a CMHC than those in the South East (16.3%) and South West (18.7%). These regional differences align with average earnings/wealth of people living in the respective regions. For future research 16–24-group specific analysis would be helpful.

The Mental Health of Children and Young People survey shows that children aged 8–16 years with a probable mental disorder were more than twice as likely to live in a household that had fallen behind with rent, bills or mortgage payments (18.7%) than those unlikely to have a mental disorder (6.8%). They were also more than twice as likely to not be able to afford to keep the home warm enough (19.9% compared with 7.6%)[77]. Other research also confirms the link between adolescent mental health and socio-economic inequalities[78].

Gender identity and sexual orientation

LGBTQ+ young people in the UK are particularly vulnerable to high mental health difficulties[79]. Both the Millennium Cohort Study and the Cosmo study reported that LGBTQ+ young people were more likely to have signs of poor mental health. For instance, at ages 17–18, 47% of bisexual young people, 37% of gay/lesbian young people, and 44% of those with other sexualities reported having self-harmed, compared to 9% of heterosexuals in the Cosmo study. Those identifying as female or "non-binary+" were more likely to be classified as having high psychological distress, at 56% and 74% respectively compared to 32% of males[80].

Neurodiversity

Evidence suggests that that neurodivergent children and young people may have more frequent and complex physical and mental healthcare needs compared with their neurotypical peers[81]. Around 70% of autistic children experience depression or anxiety.[82] Similarly, children with attention deficit hyperactivity disorder (ADHD) are more than five times more likely to experience depression than those without[83]. Due to diagnostic overshadowing – where only a primary condition is identified – mental health needs may remain unmet[84]. Diagnosis of both conditions are rising, alongside mental health needs, which is why the Peter Fonagy review is looking at these three conditions and the drivers behind prevalence, particularly among young people.

Care experience

81,700 young people (under 18) in England were in care on 31 March 2025[85]. The vast majority of them have lived through some trauma, whether it was abuse or neglect in their birth families, negative experiences in care, or frequent moves. Over half of looked after children (55%) had 'borderline' or cause for concern' scores in 2024/25 based on their answers to the Strengths and Difficulties Questionnaire, a measure of mental health and well-being[86]. Care-experienced young people are more likely to have higher levels of behaviour and emotional problems, suffer symptoms associated with depression, to have recently self-harmed (in the past year), and to have ever attempted suicide than their peers. Stark findings from a Nuffield Foundation-funded report found 1 in 4 (26%) with foster or residential care experience and 1 in 5 (21%) with kinship care experience have tried to end their own life, compared to the 1 in 14 (7%) with no care experience[87].

Young people not in education, employment or training (NEET)

Around 1 in 7 young people aged 16–24 are classified as NEET[88]. Between 2018 and 2022, 1 in 5 (21 per cent) 18–24-year-olds with mental health problems were workless compared to 13% without mental health problems. Young people who are workless and have mental health problems are much more likely to have lower qualifications (GCSE and below)[89]. The Labour Force Survey shows that in 2023, 28% of economically inactive young men who were classed as NEET reported ill health as the cause, up from 13% in 2010. Ill health is also the primary reason for young women classed as NEET, where 26% cited this as the cause, compared with just 7% in 2010[90]. Studies have linked being NEET with the emergence of symptoms of depression, anxiety, substance use and suicidality[91]. Young people with social, emotional and mental health needs and an Education, Health and Care Plan (EHCP) are at a substantially higher risk of becoming NEET in Year 12 than their peers – including those with EHCPs for other needs[92].

2.4. Key questions and further research

The data on prevalence and trends of mental health conditions in young people aged 14–24 shows that the prevalence of poor mental health has increased in recent years across a spectrum of conditions. Recent rises have been linked to a combination of factors – including economic precarity, cost of living pressures, poor sleep quality, social media and the decline in youth provision. Understanding the bigger picture is important for the planning of support services discussed in the next chapter. However, there remain many data gaps, particularly in relation to the mental health of specific groups of young people, limiting the ability of service providers to attune their provision to them.

Key research questions

How can we improve data collection to provide a more detailed picture about the prevalence of mental health needs in the 14–24 population and about access to mental health services, including age sub-groups, gender, race, sexual orientation and the wider environment?

3. Young people's journeys to mental health support

3.1 A young-person-centred perspective

Over the last two decades, the landscape of mental health support has been undergoing significant changes. This process is ongoing, characterised by fresh approaches being piloted, new services, and new systems of oversight and commissioning being introduced. This has affected how mental health advice and services are accessed by young people.

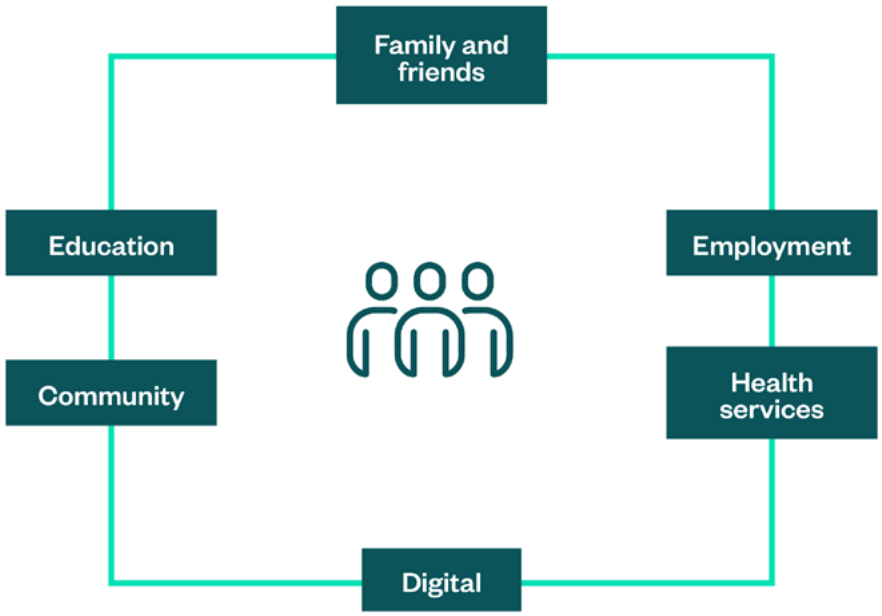
A young person's journey through mental health support systems and the starting point for that journey differs a lot from one person to another depending on their age, personal circumstances, availability of services locally, socio-economic status and many other things. It may also be affected by the intensity and persistence of symptoms, and the impact they have on a young person's daily life.

For many young people, access to mental health support takes a traditional route – through primary health services, like GPs, and referrals to secondary specialist mental health services. However, increasing numbers of young people today are seeking help for mental health not within professional health settings but online, through social media channels, anonymous chats, helplines or seeking advice from AI chatbots. This is due to the ease in accessing these resources but also is likely influenced by long waiting times for professional in-person services. The Royal College of Psychiatrists identified that at end of November 2025 there were 550,610 children and young people under 18 who had been referred to and were on waiting lists for mental health services in England – of these, 30% had been waiting for over two years and 53% for over one year[93].

Young people in education settings may access support through mental health support teams or through specialised or pastoral staff in schools, colleges or universities. A range of hubs in the community may also be a place to seek help (see section 4.2.1 for more information).

To better understand what these journeys may look like and how much support is available to young people, we undertook a mapping exercise. It drew on three sources: i) the Youth Insight Group; ii) three deep dive workshops with young people in England (Ealing, London), Scotland and Northern Ireland (see Box B); and iii) a group of professionals from organisations working directly with young people (see Appendix 2). The mapping identified six key systems young people turn to for mental health support as they transition from childhood to adulthood: families and friends, education, employment, community, digital, and health services (Figure 6). This is not intended to show formal pathways, nor is it an exhaustive list – for example, some mental health support is available for young people in the youth justice system, which is not included here.

Figure 6: Key systems young people turn to for mental health support as identified by young people in the Youth Insight Group and deep dive workshops



Within each system a range of key players/services were added based on discussions with young people and professionals to provide greater detail of what is available (see Figure 7). The map is not intended to be a definitive mapping exercise as it will vary depending on the group and place; however, it illustrates the complexity of the mental health support that young people can access and the differences between under and over 18s.

Once the map had been compiled, we looked for available data on the scale of support within each system. Building a comprehensive picture on access within these systems is not possible but the numbers presented in the chapter illustrate the limitations of data and fragmentation of the systems.

Barriers and enablers of access to mental health support for young people aged 14–24 were discussed with both young people and professionals and are summarised in Chapter 4.

3.2 Mapping the systems of support

Figure 7: Example map of systems of support for young people aged 14–24 years with poor mental health

Light blue – mostly available for young people under 18
Dark blue – mostly available for adults 18+
Purple – available across 18 birthday boundary
Yellow – age range depends on commissioning arrangements in areas
Dashed line – indicates where the same service mapped in more than one system

Full description of Figure 7.

4. Access to support for young people

4.1 Formal mental health support is insufficient and overstretched

> *"There's also been times where I need help and I'll call my mental health team and they'll say, 'No, you need to call these people instead.' You're pushed from pillar to post sometimes. I can't find where the buck ends."*
>
> **Young person, Deep dive workshop on mental health**

In the last two decades there have been some important developments in the provision of NHS-funded mental health services:

- Establishment of care pathways for certain conditions, such as:
  - Talking Therapies for anxiety and depression.
  - Early intervention for psychosis.
  - Eating disorders services.
- Bringing services closer to young people through:
  - Early Support Hubs in communities.
  - Mental health support teams in schools and colleges.
- Changes in commissioning:
  - The introduction of clinical commissioning groups in 2012.
  - And then replacing them with Integrated Care Boards (ICBs).
- Commitment for longer-term funding for services.

All of these changes prompted different approaches in how services are being commissioned and delivered, and the level of investment needed (see Appendix 1).

The Darzi Review highlighted that mental health only receives around 10% of NHS spending, despite accounting for 20% of the UK's morbidity burden[94]. In 2024/25, mental health spending amounted to £14.9 billion[95] and it was reported that ICBs spent 14.6% of their base funding allocation on mental health services.[96] Spending on children and young people mental health services (CYPMHS) continues to represent a very small proportion of total ICB spending. ICBs spent £1.1 billion on CYPMHS in 2023/24, which is equal to 1.04% of their total spend[97].

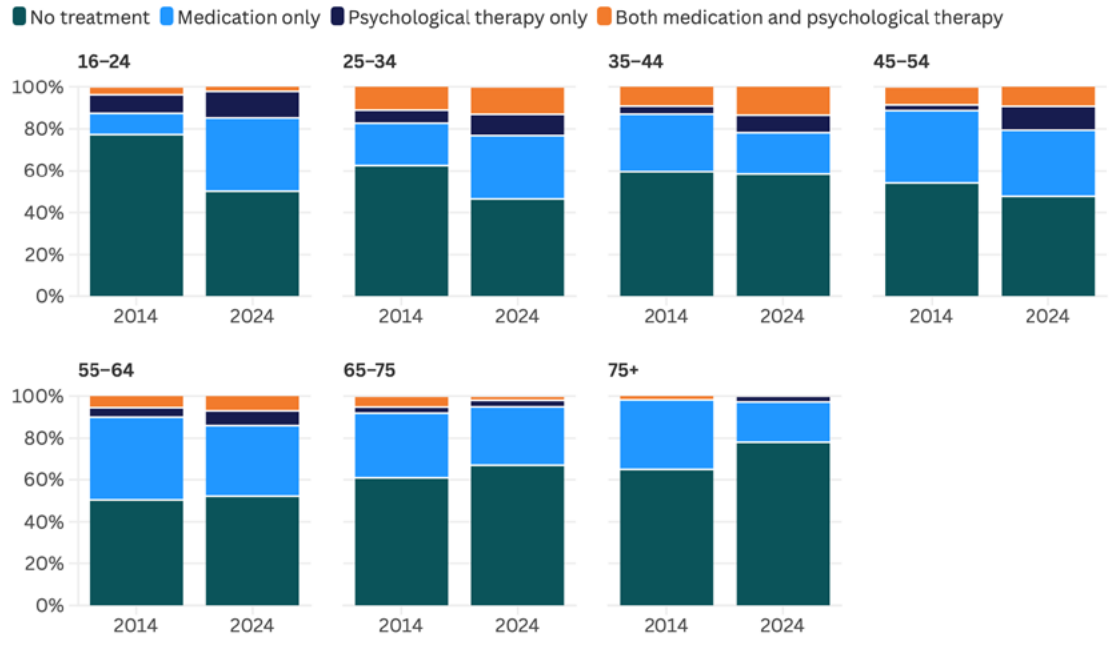
As part of the NHS Long Term Plan (2019), the government committed to ensuring mental health services continue to receive a growing share of the NHS budget, with requirements for ICBs to reflect this. However, this requirement has not been included in the more recent Medium Term planning framework for 2026/27 to 2028/29[98]. While investment in children's mental health grew over this time in real terms[99], this growth is accompanied by reductions to other services important for young people[100]. And the spending on mental health within the health budget is far from sufficient to meet the demand[101].

Proportion of young people accessing clinical treatment

> *"I think with long-term conditions as well, they're not great because I don't know, that they're always, oh, you know, you got 10 sessions, you got this amount of time, we'll fix you with it, and that's done. And it's like, that's kind of not how I feel. Not how it works. And you always kind of feel disposable."*
>
> **Young person, Deep dive workshop on mental health**

Around 1 in 2 young people aged 16–24 with common mental health conditions (CMHC) (CIS-R score of 12+ which indicates a level of symptoms that would likely or very likely benefit from intervention) **are accessing some clinical treatment** (includes medication and therapies) according to the Adult Psychiatric Morbidity Survey (APMS). Access to treatment has increased over the last 10 years for all 16–24-year-olds and a greater proportion of those who would benefit from treatment are now accessing it. (see Figure 8).

Figure 8: Proportion of people (%) with a CIS-R score of 12+ receiving treatment for a mental or emotional problem, by age, 2014 and 2024[102]



Full description of Figure 8.

According to APMS, across the whole adult population (16–75+) the data show that those with the most severe symptoms of common mental health disorders (CIS-R score 18+) are the group most likely to report receiving treatment, suggesting an association between treatment use and severity of symptoms. For further research it would be useful to understand access to treatment by severity of needs for the 14–24 population specifically.

The survey reports an association between unmet treatment requests and age among people with CMHC symptoms (CIS-R 12+). 2.8% of participants of all ages reported having asked for, but not received, a particular mental health treatment in the past 12 months. Among adults with CMHC symptoms (CIS-R 12+) there was an association between unmet treatment requests and age: this ranged from 19.6% of 16–34-year-olds to 2.3% of those aged 75 and over. Those aged 16–34 were more likely to report not receiving a treatment they asked for compared to older groups.

Prescription of medication to young people

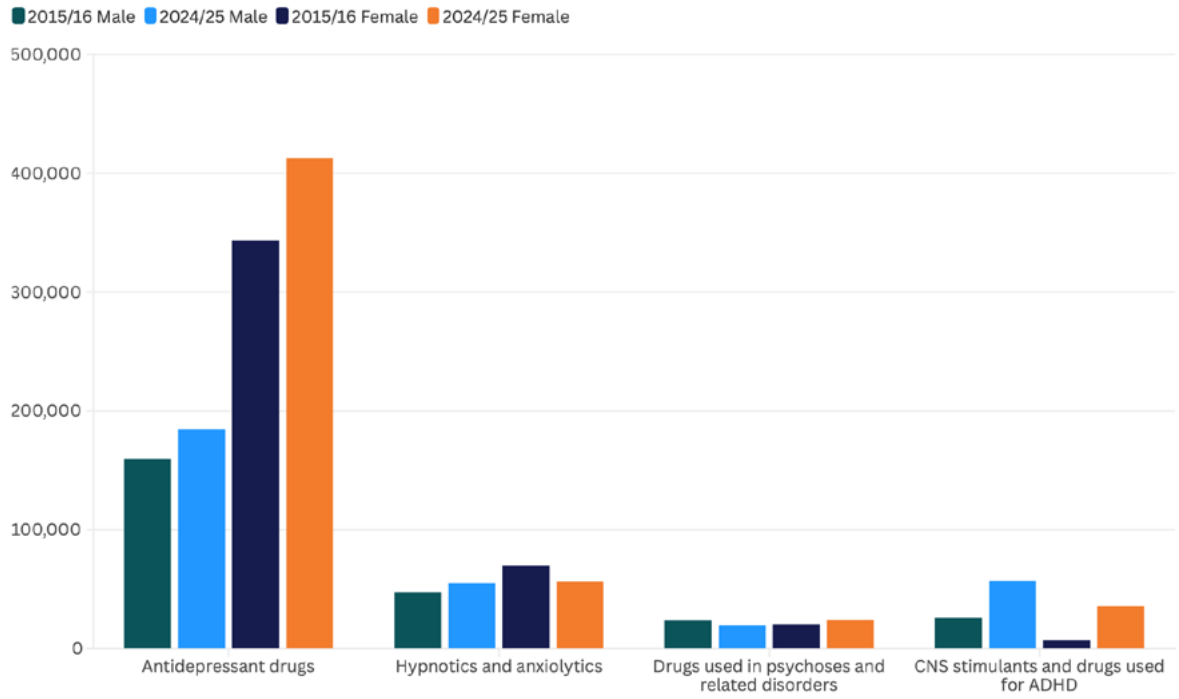
> *"I got put on antidepressants when I was freshly turned 19 and they were like, 'We're going to put you on this amount and then you up it when you feel right.' and it's like, 'Why am I in charge of this? I don't know the side effects, I don't know what could happen if I up it by accident.' You're putting teenagers in charge of their own medication."*
>
> **Young person, Deep dive workshop on mental health**

According to APMS, **medication-only** treatment represents the biggest proportion of types of treatment accessed. This picture of access to treatment is reflected in what we heard from some young people in our deep dive workshops on mental health. Their experience was of a formal mental health system that is over-reliant on medication, with the availability of therapeutic support being determined by postcode and limited to a higher level of need.

Data from the NHS Business Services Authority on the number of patients who are prescribed medication for mental health needs shows that in 2024/25 the total of 844,882 young people aged 15–24 were prescribed medication for mental health in England – this is around **1 in 8** of young people in this age group[103].

Figure 9 shows the number of young people in this age group, separated by type of medication, gender and changes from 2015/16 to 2024/25. The increase over time and differences in medication prescribed between males and females can be seen – with more females prescribed antidepressants and more males prescribed central nervous system (CNS) stimulants and drugs for attention deficit hyperactivity disorder (ADHD). Overall, the number of young people who were prescribed medication for mental health increased by 22%, largely driven by the rise in prescription of antidepressant drugs and ADHD drugs to females and some increase in CNS stimulants and ADHD drugs for males[104].

Figure 9: Number of patients aged 15–24 who were prescribed medicine for mental health, by type of medicine and gender, 2015/16 and 2024/25[105]



Full description of Figure 9.

Some of the concerns young people shared in relation to overreliance on medication were about the lack of information and communication about side effects of medication, and the difficulties they face when they need to wean off the medication. They also raised concerns about the ease with which the dosage may be upped when it does not appear to be working and the lack of information about long-term impacts on young people's health and functioning.

Young people in contact and accessing treatment based on NHS data

> *"I think another barrier can simply just be where you live. At secondary school, don't necessarily live in the same borough as other pupils. And I had friends who lived in different boroughs than me that got counselling or got referrals like that simply because they lived in a different borough. Same age, same problems, but they got quicker and better help just because they lived in like Westminster Council, for example, rather than Brent."*
>
> **Young person, Deep dive workshop on mental health**

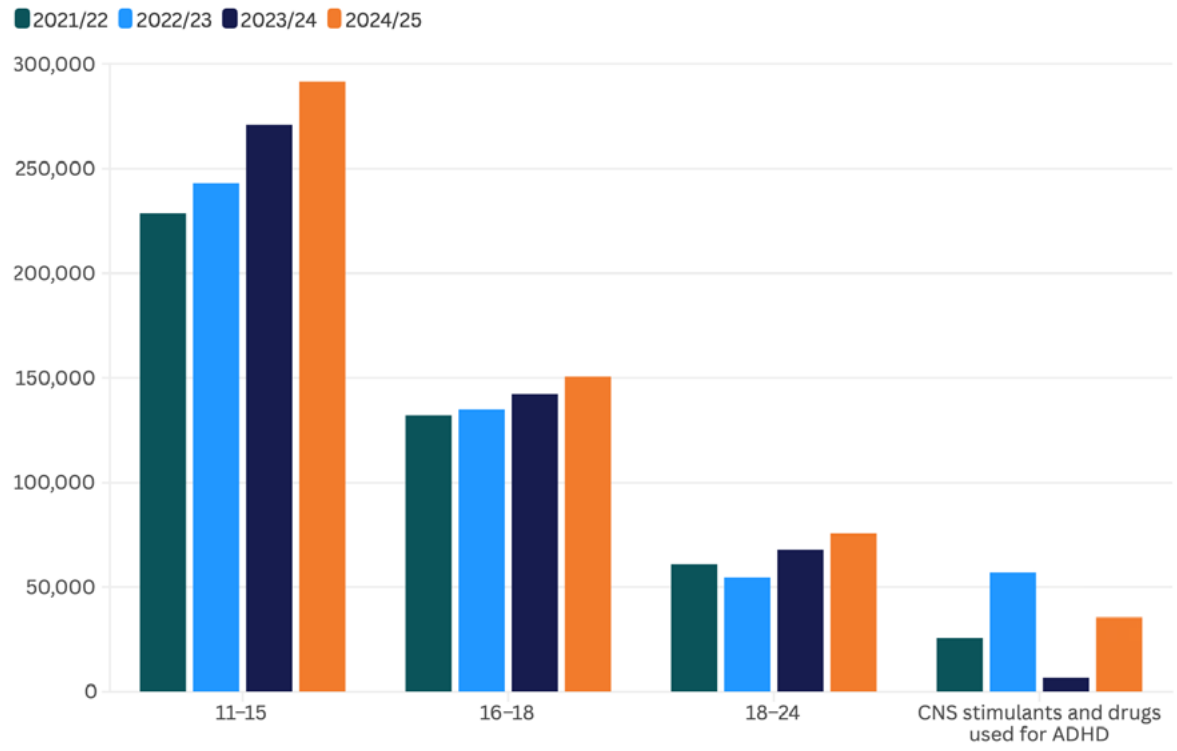
As explained earlier in this report, around **1 in 10 of 16–24-year-olds were in contact with NHS secondary mental health services in 2024/25**. Young people aged 16–24 make up 17% of those in contact with NHS-funded mental health services, which is higher than the proportion

of this age group in the population (around 11%, based on data from *NHS England Annual bulletin 2024/25 on mental health and ONS mid-year population estimates 2025*).

Being in contact with services does not equate to receiving treatment. NHS Digital explanation of measures states that *"'In contact' simply means that the people who have an open referral. This does not necessarily mean that they have had any care activity as part of that referral"*[106]. While it may be the case that one contact for some young people may result in accessing some support, it is difficult to establish. Data on young people who had two or more contacts with services is considered to be a better proxy measure on children accessing treatment[107].

Figure 10 presents the number of young people who received two or more contacts from NHS-funded secondary mental health, learning disability or autism services for ages 11–24 from 2021/22 to 2024/25. It shows some increase, particularly for the 11–15 age group, but less so for other age groups. This statistical collection needs to be treated with caution due to its experimental status, particularly for comparisons over time but, together with the data on young people in contact, it does raise the question of whether access to services for young people aged 14–24 is growing fast enough to match the rise in prevalence. **Best estimates suggest that, 4% of young people aged 16–24 received two contacts with services – 1 in 25 young people.**

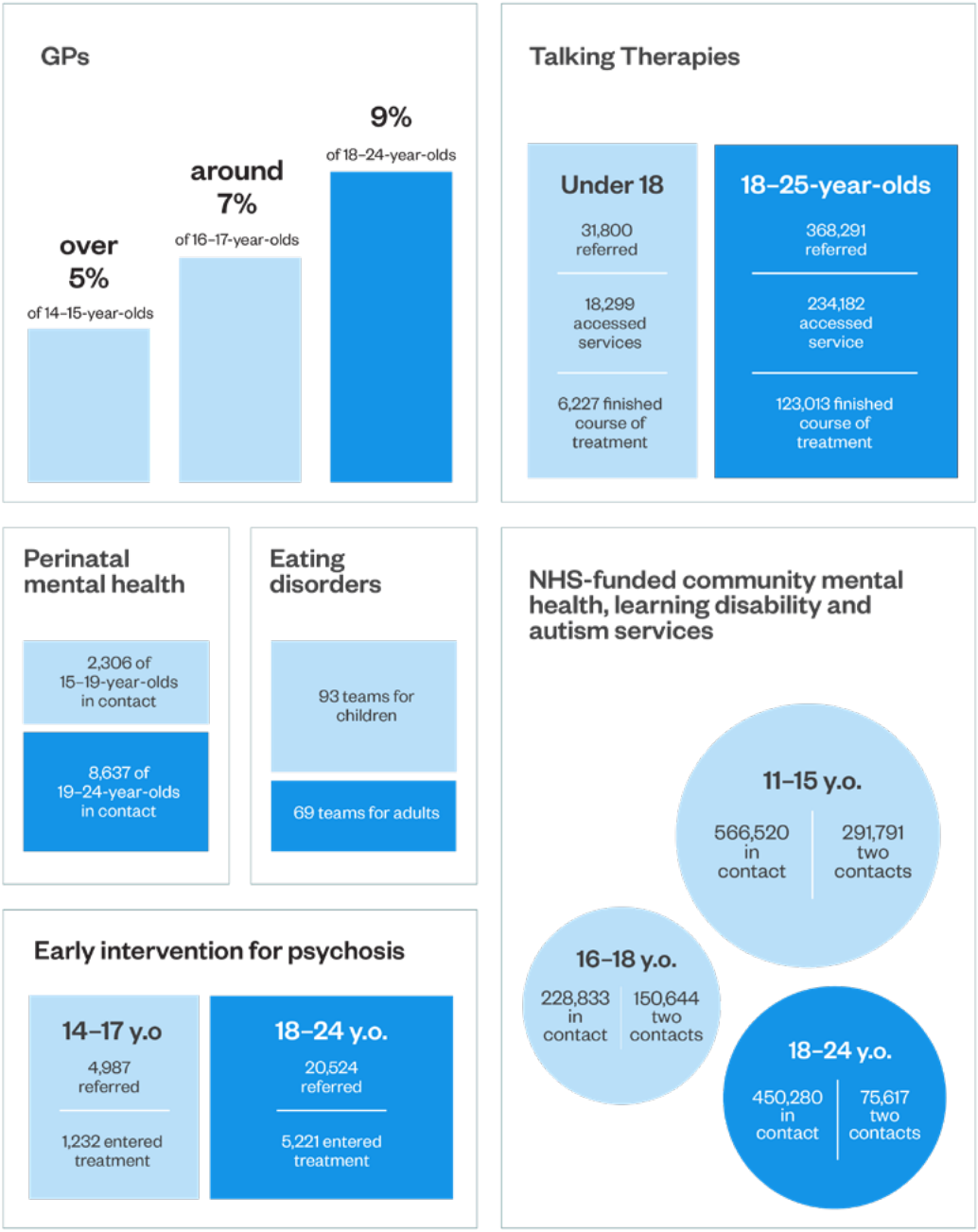
Figure 10: Number of young people who received two or more contacts with community mental health, learning disability and autism services, by age, 2021/22 to 2024/25[108]



Full description of Figure 10.

Administrative data from primary and secondary health services provides insight into the number of young people who have been in contact or accessed treatment from those specific mental health services for which there is data (see Figure 11).

Figure 11: The scale at a glance of interaction with support for mental health needs in primary and secondary health settings in England (during year of most recent reporting)[109,110,111,112]



Full description of Figure 11.

The data is patchy and incomplete; it does not paint a comprehensive picture of access to mental health services. While it may be the case that not all who are referred meet the threshold for treatment, it would be helpful to understand if any lower-level support

is offered. The gaps shown by the data in our understanding of support offered or accessed include: First, data on NHS-funded services combine data from mental health specific services with learning disability and autism services, which are neurodivergent conditions that require separate data reporting, except where both mental health and neurodivergence are present. Second, the data, apart from talking therapies, does not show the treatment completion rates and treatment outcomes, or indeed the level of need that was identified. **There is a great need for improvement in data to enable better understanding of needs and access to services by this age group.**

Barriers and enablers of access to formal mental health support

Alongside young people expressing deep appreciation for individual professionals who go "above and beyond", they perceived the overall system as operating at the limits of its capacity. Two key comments shared by young people about formal mental health services were an overreliance on medication and access often being limited to those with a high clinical level of need. Other experiences include short and impersonal GP appointments; years-long waiting lists for specialist services; limited continuity of care; rigid pathways; and support not tailored to the young person's individual circumstances, identity, and evolving needs. Young people also described the systems of mental health support as "higgledy piggledy", fragmented, and difficult to navigate. These views of young people echo those from research[113].

Young people's views of the system also resonate with key themes in the wider research which point to services having different levels on either side of childhood/adulthood boundary and being variable by location[114,115].

The reasons why half of young people who would probably benefit from treatment are not accessing any may extend beyond lack of capacity within the system. For example, stigma, fear of being judged, and worry about being a burden on overstretched services were some of the barriers repeatedly mentioned by young people.

Professionals identified a key barrier of a complex system that is difficult to navigate and doesn't provide uniform points of access for young people in different locations. They gave some positive examples of the co-design of local services with young people, and ways of accounting for their developmental and other needs; however, they described the overall formal system as a "hotchpotch" of different services, a "patchwork" of commissioning arrangements, informed by a "scatty" knowledge of what works, consisting of pilots and driven by multiple policy changes. While they recognised that many of the developments were a move in the right direction (pilots are a robust way of testing effectiveness before rolling out), questions were raised about whether changes represent a true move towards more support being available for young people across the whole continuum of mental health needs – or just a "ladder with missing rungs".

Evidence from research, young people and professionals suggests that a young-person-focused relational approach that makes the young person feel 'seen and heard' and helps them access and engage with treatment. However, the support they receive is sometimes too narrowly focused on specific conditions, ignoring a wider range of stressors in the young

person's life – or is siloed and not coordinated with other services, like education or social care. This is not to say that support for specific conditions is not important; it forms a vital component of the mix for those with complex or specific needs.

Other factors mentioned include generational bias (that is, often unhelpful and unfair stereotypes and assumptions made about individuals based on their generational affiliation), workforce capacity, and the system not being designed with diverse groups and needs in mind (discussed further in this report). Financial barriers were also identified: cost of travel to reach services, particularly in rural or remote areas; affordability of devices for digital services; and being able to afford private support when waiting times and thresholds to NHS services make support unattainable. Both professionals and young people mentioned that many young people and families are accessing paid-for treatments in person or online with limited guidance – and there is very little data on this.

Key questions and further research

Formal systems of support are very important for young people with poor mental health. Therefore, understanding how these systems operate through data on scale and effectiveness – alongside qualitative research with young people and practitioners in these systems – is paramount for improving accessibility and quality of intervention. Administrative data considered alongside prevalence data can help understand the gap in reach, but more nuanced data is needed to allow fine tuning of the formal systems to the needs of young people aged 14–24 and to address some of the barriers to access identified by young people and professionals.

Key research questions

Data is needed to build a fuller picture of access to mental health support for 14–24-year-olds within formal systems and during transition from child to adult mental health services, including:

- Lengths of waiting lists for different services, time waited, and number of people who are referred but drop off the waiting list before accessing services.
- Numbers on waiting lists who do not meet the threshold for treatment and support offered to them, and numbers of children 'ageing out'.

Regarding the effectiveness of contacts with formal mental health systems – what measures need to be built in into data collection to understand the effectiveness of the formal system?

How does generational bias in professional attitudes affect access to mental health

support for young people?

How effective is the use of medication in mental health for young people, and how is information about dosage and side effects communicated to young people?

Exploring co-design of formal support with young people – what do good formal mental health services look like from young people's perspectives?

What is the scale of private mental health provision for young people, and who benefits most from that provision?

4.2 Support outside formal health services is important but patchy

> *"It needs to be more human! Take away all the waiting lists and all the forms and just bring back actual people, nurturing people, because overall, whenever someone's at their lowest, they may not necessarily just want the referral, they may just need someone to talk to or sit down and have a conversation with and to just be, and feel listened to and heard."*
>
> **Young person, Deep dive workshop on mental health**

Other systems of mental health support outside formal health services can play a critical role in meeting lower levels of mental health needs and prevention, but they have many barriers to access[116, 117]. The critical role of other systems was repeated in what we heard from young people and professionals: prioritise early intervention and make support more readily available for young people where they are. Family and friends, education, work and employment, and community systems all play an important role[118, 119, 120, 121]. Wider systems of support may address some of the gaps and even reduce pressure on the formal system by addressing emerging needs earlier[122].

The Mental Health of Children and Young People (MHCYP) survey shows that young people with probable mental health conditions rely on a range of sources of advice and support in relation to their mental health needs:

- The most common sources of help and advice reported by young people aged 17–24 with a probable mental condition were: friends and family (66.1%), health services (45.1%), online or telephone support (42.9%) and education services (20.9%).
- There were some differences in sources of support by sex in this age group. Young women were twice as likely as young men to report contact with education services

(17.9% compared with 9.0%) or health services (26.9% compared with 12.6%). Young men were more likely than young women to say that they had not had contact with any of the services listed (52.1% compared with 35.6%).

Young people and professionals described how support for mental health within education, family and friends, employment, and digital systems can help them develop a "toolbox" to deal with common mental health symptoms, and act as a bridge to NHS services, particularly if needs require clinical intervention. Professionals also spoke of the importance of helping young people as early as possible to learn skills to understand how to regulate their mental health or manage their mental health condition, and to know how and when to seek help. One professional compared it to a "backpack" that each young person needs to have before they set out into adult life – containing knowledge and skills about emotional self-regulation, and how to recognise and act when professional help is needed.

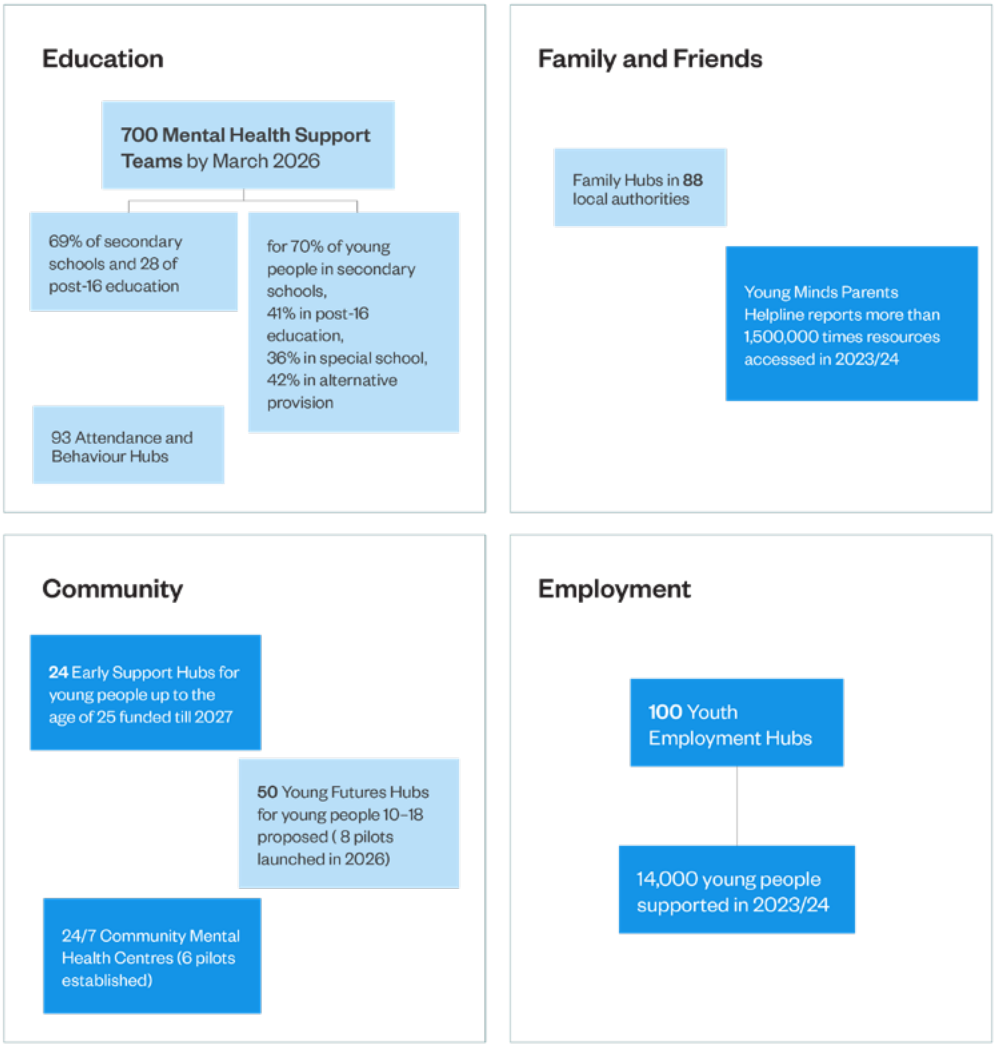
Mapping informal support

> *"I would encourage putting something (on mental health and coping mechanisms) in high school as a class, the same way maths or science is. And certainly with the scale at which people are finding it hard to talk about mental health. There's hiccups in life and I think if people were more equipped to handle the hiccups, I think it would tackle a lot of the problems."*
>
> **Young person, Deep dive workshop on mental health**

Mapping the scale of support available within these systems proved to be very difficult, with limited data (see Figure 12). However, it is important to note that Figure 12 does not in any way cover the entirety of support provided. For example, a lot of support is provided by voluntary sector organisations[123], each with their own metrics. Their data have not been included here. It may be counted within the NHS data, where third sector is a commissioned partner, but third sector support is also funded by private and charitable funding streams.

These informal systems of support differ a great deal from place to place, as illustrated by current coverage of mental health support teams (MHSTs) in school[124] or Early Support Hubs (see Figure 12). Policy reforms also change the configuration of what's on offer, as illustrated by age ranges in Early Support Hubs, and new pilots around Young Futures Hubs and 24/7 Neighbourhood Mental Health Hubs.

Figure 12: The scale of support available or proposed within education, family and friends, community, and employment systems[125,126]



Full description of Figure 12.

Education

Many voluntary sector organisations work in education settings, providing support for young people with mental health needs. Some of the work is commissioned by integrated care boards (ICBs), schools (from education budgets), or funded by the voluntary sector through donations, grants, and other sources.

The MHCYP survey reported that

- Of children aged 11–16, 23.3% reported having accessed support at school for mental health and well-being.
- Of young people aged 17–25, 72.5% of Further Education students and 73.1% of Higher Education students agreed that 'There is support available for student mental health and wellbeing'.

One of the most notable developments in the education space in recent years has been the development of MHST in schools. Piloted from 2018 and expected to cover all young people in school by 2029, these offer an opportunity to reach young people earlier and within their environment. There are different operational models of the service with evaluations highlighting their different strengths and challenges[127,128]. It is important to note that voluntary sector organisations have worked in schools prior to MHST pilots and continue to do so.

The young people and professionals emphasised the postcode lottery of mental health support in education settings and that availability gradually decreased as a young person progresses through secondary school, particularly for young people moving to FE colleges or into apprenticeships. This coincides with when mental health needs intensify at the age of 16 or 17. However, this should improve as the MHST programme is fully rolled out in England.

> *"My college just point blank didn't offer counselling at all because we were only there once a week. When I was in college, I went through a lot of stuff and there was no support at all, like literally at all."*
>
> **Young person, Deep dive workshop on mental health**

With the establishment of MHSTs in schools, the question still remains whether these teams will have capacity to meet the demand in full.

The drop in the level of service as young people transition from childhood to adulthood can be explained in part by financial constraints within the mental health and education sectors, greater complexity of need and workforce shortages[129,130].

Within the post-18 landscape, there has been increasing emphasis on support for students in higher education. No data on how many benefit from it is available, but feedback from young people suggests that where services / helplines / group support is available, it is a "lifesaver" for young people during stressful times. There is much less attention on mental health support for those on apprenticeship and training pathways.

While education settings may be well placed to reach young people with mental health needs earlier in their journeys and help them develop skills, provide specialist support or signpost to designated services outside school, they are not able to catch all. Some groups of young people – for example, looked after children or young people not in education, employment or training – miss out on the offer as we discuss in section 4.5.

Employment

The scale of young people receiving mental health support from workplaces is not known.

Workers aged 16–24 years make up 10% of the total workforce, but they made up around half of the workers in some hospitality roles, including waiters and waitresses (50%), bar staff (48%), and coffee shop workers (48%). They also account for 1 in every 8 people working in retail (13%)[131].

Young people entering the job market often face uncertain career paths. They tend to change jobs more frequently, partly because they're more likely to hold temporary roles and are still exploring their career interests. They're also more likely to hold low-wage, short-term jobs, especially in sectors like retail and hospitality, leading to higher overall job insecurity and higher prevalence of low-paid insecure work[132].

This may impact on young people's mental health needs. For example, a recent survey on well-being and mental health in the hospitality industry showed that almost half of respondents say they have a poor work/life balance, and of those, two in three (62%) junior hospitality employees say burnout is just part of the job[133]. Although two-thirds (66%) agree that their workplace has created a working environment where mental health can be openly discussed, 63% remain concerned that vocalising a mental health challenge could negatively impact their progression[134]. Another survey of workers found one in five (20%) took time off due to poor mental health caused by stress, rising to two in five (39%) among young adults (aged 18–24)[135].

This resonates with what we heard from young people in deep dives who observed that to access therapy through work often relies on a manager requesting that support for a young person. That is a barrier, as young people struggle to ask for help and are worried about the impact it will have on their employment; additionally understanding of mental health differs among managers and some may hold biased views on mental health needs and young people.

Families/friends

There is little available evidence or data for the availability of advice for, or the involvement of, families (parents, carers, and/or partners) of young people aged 14–24 (especially those aged 16–24) who experience mental health needs. Considering the important part families, carers, and friends play in lives of young people, it is important to understand the role they play in supporting young people's mental health needs.

MHCYP asked parents of children under 16 about seeking help and advice. In 2023, the most commonly reported sources of help and advice for parents of children with a probable mental disorder were: education services (73.6%), health services (48.9%), friends or family (42.3%) and online or telephone support (35.4%). Children with a probable mental health condition were also more likely than those without a mental health condition to have parents who sought help from community groups (14.9% compared with 1.4%); a private, paid for service (8.6% compared with 1.4%); or Accident and Emergency (3.6% compared with 0.3%)[136].

Some ICBs commission support such as helplines or text services for parents, which are usually for parents of young people under 18 or 19 years maximum. Some voluntary sector organisations like Young Minds provide helplines for parents of young people up to the age of 25 (see Figure 12).

Different issues were raised in conversations with young people and professionals in relation to support with mental health from families and friends:

- There is recognition that involvement of parents/careers is not going to be suitable for all young people as generational, cultural barriers in attitudes to mental health, as

well as unsupportive or abusive relationships, may jeopardise a young person's mental health if parents/carers are involved.

- Consent for involvement of parents from a young person is an important issue as growing-up young people will require greater agency over decisions to involve parents.
- The transition between child and adult mental health services, which is underpinned by a legal framework, has implications for how services communicate with families, mostly stopping communication altogether. It is essential to plan that transition properly and encourage young people to develop the necessary understanding and skills to navigate complex systems.

Community

> *"Now with the internet and everything, community is like something you read about in a history book."*
>
> **Young person from the Youth Insights Group**

In recent years there has been an acknowledgement in public policy and service development of the importance of holistic and earlier support for young people closer to where they are and in settings they are more likely to access[137]. To this end, a number of hubs have been, or are being, piloted in community settings. These include: Early Support Hubs, family hubs, new Young Futures Hubs (about to be piloted), and Neighbourhood Mental Health Centres (in initial development). While these initiatives are welcome, the concern is that they are being developed in a piecemeal way without enough thought about the overall system; some parts are being left out (for example, adolescent health) and others framed in an unhelpful way (for example, set within youth justice rather than public health). Data on how many young people are accessing different community-based, hub services is not readily available; however, looking at their availability and geographies it is clear that there are major differences between locations and the age groups who can benefit from provision.

Young people and professionals stressed the importance of community-based mental health support for young people, whether it was delivered through hubs, youth clubs, social prescribing, shared experience groups or other community settings, like faith groups, sport, and art activities. Young people reflected that community facilities/services are disappearing or are costly, and that their generation does not feel as connected to local communities as the previous generations were – an issue also highlighted by the research[138]. Despite new measures to increase youth centres and services, it will take considerable time and resource to rebuild them following sharp reductions over the last two decades.

Professionals also reflected that while existing provisions are valued by young people , the evidence on their effectiveness is limited, indicating the difficulty of evaluating preventative approaches. This lack of evidence on effectiveness is also a barrier to commissioning these facilities.

Key questions and further research

Young people and professionals stressed the importance of accessing mental health support through informal systems. The importance of these systems is consistently highlighted in research as well. However, as discussed, the data is patchy and incomprehensive on what is available for young people within those systems, on how well the provision is able to meet the demand for support and on the complexity of needs. Within different informal systems, there are some that are valued by young people but are particularly underexplored in data and research, such as communities and families and friends. Informal systems are key in the wider landscape of support for young people with poor mental health, yet there are many research questions that still need to be answered.

Key research questions

What proportion of young people with poor mental health are accessing support within the informal systems? To what extent are these systems able to meet the demand for their services?

How can informal systems interface with formal services to help young people with poor mental health better transition to adulthood? And how can pathways across informal and formal services be better integrated?

What does good parenting intervention look like for parents of adolescents with mental health needs pre- and post-18?

What are the experiences of young people aged 16–24 who are not in education, employment or training for mental health reasons in getting holistic support with their mental health needs?

4.3 The digital dimension to mental health support is rapidly expanding

"A lot of us will turn to things like Discord to build our own communities and find people who are like-minded and find people who can support us informally rather than reaching out to GPs and charities and things like that."

Young person, Deep dive workshop on mental health

Mapping digital support for mental health

Of recent societal changes, the explosion of digital life has been one of the most prominent aspects of Gen Z lives.

Discussion tends to be centred on the harmful aspects of digital use – in particular, social media and AI and its influence on young people's mental health[139, 140, 141]. This is explored in depth in reports under the *Grown up*? programme: *Growing up online*[142], *Born Connected*[143] and *'I love it but I hate it': Young people's experiences and expectations of growing up digital*[144].

Here our focus is on how digital space has at the same time created new opportunities to deliver mental health support for young people, accelerated by COVID-19 lockdowns necessitating moving services online. Digitalisation of health services has been a high-priority issue in the NHS health strategy as well[145]. People in England and Wales can now press Option 2 when they dial 111 to access mental health support from someone in a local crisis team. From April 2025, every region in England is required to commission a crisis text messaging service. Digital mental health help can be commissioned by integrated care boards (ICBs) from NHS budgets, or can be funded through voluntary donations and private investments, with services delivered by trained volunteers and paid staff. It can also be delivered by private companies.

For many young people, seeking advice online is one of the first steps in their mental health journey. This has been the key message from our conversations with young people and professionals. Establishing how many young people access help this way is challenging as there is no consistent monitoring or reporting on the issue. Box C presents information on some of the key players in the digital space (identified through our mapping exercise) and a snapshot of their reach.

Box C: Selection of providers of digital mental health support

Kooth is a provider of digital mental health support, reporting that 65+% of 11–18-year-olds or around 60% of 10–25-year-olds across the UK are able to access their services, which are largely commissioned by the NHS or Local Authorities and insurers. They provide individuals with free access to mental health support through a range of tools and interventions, spanning self-therapy and professional support (including coaching and counselling)[146].

Qwell is a partner service of Kooth aimed at adults. Kooth's latest (2024) annual report also highlighted that the lack of sustainable funding for population-based mental health for adults had a particular impact on Qwell, leading to a number of contract losses[147].

Childline is a service run by the NSPCC charity for anyone aged under 19 in the UK to talk about any issue they're going through. On average, a child contacts Childline every 45 seconds[148]. In 2024/25, Childline counsellors provided 162,018 counselling sessions to children and young people. In 2024/25, the top five main concerns that children and young people talked to counsellors about were: mental and emotional health, suicidal thoughts and feelings[149], family relationships, self-harm, and friendship issues. Children and young people can contact Childline by telephone, email, and online chat.

Shout is the free, confidential, 24/7 text messaging mental health support service for anyone struggling to cope, created by the charity Mental Health Innovations. Shout conducted 2.5 million conversations between its launch in May 2018 and April 2024. They reported having around 2,000 conversations every day, most commonly supporting texters with suicide, depression, anxiety, relationships, loneliness, and self-harm. The majority (62%) of Shout's texters are under 25 years old[150].

The Mix is another service from Mental Health Innovations that provides free and anonymous online advice to people aged 25 and under about the important issues in their lives. The Mix's helpline provided essential support to more than 43,000 young people between 2018 and 2023 adapting to their evolving needs during unprecedented challenges like the COVID-19 pandemic and the cost-of-living crisis[151].

Tellmi is an anonymous app for under-18s, providing pre-moderated and anonymous peer support to talk about any issues – from anxiety to autism, depression to divorce, or self-harm to self-esteem. Moderators check everything to keep young people safe, and in-house counsellors are on hand for young people who need extra support. It can provide pre-emptive counsellor intervention for people who are in crisis and scheduled 1–2–1 solution-focused therapy.

Samaritans provide help to people at risk of suicide. In 2024 they responded to over 3.3 million calls for help. This included more than 3 million phone calls, over 180,000 emails, around 50,000 online chats, and nearly 800 letters. On average, more than 70,000 people reached out each month, and volunteers answered a call for help every 10 seconds. Just over 1 in 5 emotional-support contacts involved someone talking about suicidal feelings or behaviour, and self-harm was mentioned in more than 1 in 16. The demand for support was also clear online, with almost 1.8 million visits to the contact pages on the Samaritans website[152].

Wysa is an AI-based "emotionally intelligent" service which responds to the emotions you express and uses evidence-based cognitive-behavioural techniques (CBT), dialectical behaviour therapy (DBT), meditation, breathing, yoga, motivational interviewing and micro-actions to help patients build mental resilience skills and feel better. It supports patients through the NHS pathway, starting from prevention support in the community, through interactive e-triage, waitlist support, AI-guided CBT practice and relapse prevention. Wysa App is intended for use as emotional

well-being support by individuals aged 13+. Different institutional partners use different versions of Wysa[153].

The examples show some of the benefits of digital services – 24/7 availability, suitable for a range of issues and anonymised interactions. Minoritised communities and boys in particular were highlighted in our roundtable on AI and mental health (see Methodology) as those relying more on digital services. Digital services offer different forms of communication / routes into mental health support and, where commissioned by NHS, act as a digital front door to formal mental health services. They can make it easier to deal with transitions across age boundaries. And where online support is combined with counselling, they can offer support for different levels of need.

Digital services are important for young people – particularly those who may struggle to engage with face-to-face services, either because they are not available when young people need them or are not accessible because of socio-economic or cultural issues (see section 4.5). Therefore, understanding how and where these services are commissioned by ICBs and how many young people are accessing NHS-funded digital services is essential – as is evaluation of the quality and effectiveness of support, key strengths and what makes these services valued by young people. There are already some evaluations of certain digital services showing value for money and positive outcomes for young people[154,155].

While digital services can reduce the financial pressure on NHS-funded services and meet the needs of some young people, it is important to ensure that there is a balanced provision of digital and face-to-face services. Young people were very clear that despite many advantages of digital support, face-to-face interventions are very important and – if delivered by someone with whom they have a good rapport – a preferred way of getting support. The importance of face-to-face support has also been highlighted by Wysa[156].

AI and mental health advice

A growing body of evidence points to an increase in the number of young people turning to generative large language models for well-being and mental health support[157], which was echoed in our youth engagement work on digital lives[158] and mental health support[159]. Reliance on easily accessible AI chatbots for mental health advice has been linked to negative outcomes for mental health[160,161]; however, the research evidence in this arena is scarce. Even so, some high-profile cases have been reported in the media on tragedies that are associated with AI chatbot apps providing dangerous or harmful advice to young people seeking help with their mental health[162,163].

Key issues raised at the Nuffield Foundation AI and mental health roundtable include:

- The lack of literacy about generative AI and chatbots: young people can use these but may not understand the risks and 'unreal' nature of relationships; parents/carers,

teachers, and health professionals have limited knowledge of risks and use of AI and how to talk to young people about it.

- Limited knowledge of what good AI support looks like and the implications for signposting and safeguarding needs.
- Concerns about ethical principles and accountability of generic platforms offering generative AI support and the lack of evidence about the effectiveness.
- Yet there are potential benefits: the opportunity for fine-tuned AI services – such as specific large language models trained on clinical and therapeutic responses – to be the first-step in early intervention, with wider reach to young people who may not engage with in-person services, and may free up resources for more in-person contact.
- This is an area where there is a heightened need for stakeholders from across different sides of the debate to come together to research, share learning and develop joint solutions.

Key questions and further research

With the rapid expansion of everything digital, the many opportunities and risks associated with the digital realm, and the expansion of AI, this area is quickly becoming one of the priority areas for further research. The speed of change within digital resources for mental health also poses a question about which research methods can quickly capture learning in this area.

What is the extent and type of digital/AI support used by young people for their mental health, by age, characteristics, and level of need, and what are the risks and benefits of this provision?

What models of delivery that combine online and in-person support for young people with mental health needs are safe and effective?

4.4 Transition experiences vary

"I was on the CAMHS waiting list for five years. I got an appointment finally two weeks before my 18th birthday and it was with an English man and he was a trainee so I felt like they didn't really care at all... who doesn't understand the schooling system in Scotland, doesn't understand what it's like to be a girl to start with, it probably wasn't the best starting point. And then by the time I had got my third session, I was too old for the system. So then I had to just go on to my GP and they

> *just put me on medication."*
>
> **Young person, Deep dive workshop on mental health**

Transition points, such as turning 18 or moving from school to college or employment, were described by young people in our deep dive workshops as a "shock to the system". For some it was marked by isolation and a sudden loss of facilitated social networks as well as a loss of access to some structured mental health support. Transitions across children and adult mental health services require specific attention.

Data is not routinely reported on how many young people are moving from child to adult mental health services or those being discharged back to GPs on reaching the transition age. One estimate is that 25,000 young people are experiencing transitions from child to adult mental health services each year[164].

Even though there is an understanding that adolescence is a developmental stage that lasts beyond the age of 18, the transition between child and adult services is often demarcated by rigid age boundaries[165] – except for some groups, such as disabled young people or care-leavers.

Despite important policy developments which have recognised the need for greater flexibility around age boundaries to address the transition 'cliff edge' (see Box D), implementation has been slow. Transitions are still characterised by rigid age boundaries, lack of support, gaps in provision, stress, and long waiting times in adult services[166,167]. Young people with the most serious mental health needs can often transition successfully to adult mental health services, while young people whose needs are below that threshold experience more challenges in transitions and accessing support post-18[168].

Box D: Transition-focused policy developments

2014	The review of transitions in health services by Care Quality Commission
2015	Future in Mind and NHS England's Model Specification for Transitions from Child and Adolescent Mental Health Services: the need to carefully plan transitions with the young person and, where appropriate, their family;
2016	Nice guidelines on transitions: determining the age of transition by the individual needs and maturity of each young person, with children's and adult services working together
2019	NHS Long Term Plan (now archived) made a commitment to create a comprehensive offer for 0–25-year-olds that reaches across mental health services for children, young people and adults[169].
2023	Funding for Early Support Hubs for ages 11–25

A policy focus on softening the boundaries across children and adult mental health services has not yet translated into services being commissioned differently across the country, possibly due to policies not being long-term and requiring certain financial commitments to embed the change. Of 33 mental health trusts that responded to our freedom of information (FOI) requests about transitions:

- 22 deliver services commissioned for children up to 18 and then for adults from 18+.
- 11 have in place or are in the process of developing services that either support young people up to the age of 25 or provide dedicated transition support, especially for young people aged 18–24.

Local variation exists and there are some examples of how things can be done differently: regular meetings between children/adult services to plan transition, advocacy support during transition time, specialist transition teams, commissioning of services for 11–25-year-olds, and establishment of services for 18–25.

Early Support Hubs for 11–25-year-olds have been a promising example of delivering services across the transition age[170, 171, 172]. Their funding has recently been extended for another year[173]. Other hubs include Young Futures Hubs that will cover ages 10–18 (these can go up to 25 if local areas decide), and the new Neighbourhood Mental Health Hub pilots being developed for people 18+. With the long-term future of the Early Support Hubs programme led by the Department of Health and Social Care unknown (particularly in relation to any further funding), and other hubs being delivered by specific childhood/adulthood boundaries, the question about transitions is likely to remain open.

Transitions from child to adult mental health services are also characterised by long waiting times. In the FOI requests to 49 mental health trusts, we asked about median, longest, and shortest waits in days for access to treatment through adult mental health services for young people referred from children's mental health services over the last four years.

26 mental health trusts could provide a full or partial answer to this question. The averages of the full answers are shown in Table 4.

Table 4: Average median, longest, and shortest wait in days for access to treatment for young people transitioning from child to adult mental health services, 2021/22 to 2024/25[174]

	2021/22	2022/23	2023/24	2024/25
Average median wait in days	132	159	166	111
Average longest wait in days	525	579	651	528
Average shortest wait in days	12	13	13	12

This data also illustrated how individual experiences of accessing services may vary from area to area. For example, within the median wait times in 2024/25 year the longest median wait time was 285 in one area, compared to the shortest median wait time of 30 in another area.

Transitions within other systems, most notably education, often result in reduced access to mental health support when young people are 16 and 17, and 18+ for those young people who do not progress towards higher education. Siloed working and the challenge of transition points and cliff edges can leave young people at risk of being left without care at critical periods, making them vulnerable to becoming NEET in young adulthood[175].

Key questions and further research

Despite the wide recognition that transitions between child and adult mental health services are important but do not work well for many young people, and various policy attempts over years to address some of the shortcomings in the system, this transition still remains one of the areas where data collection lags behind. It is important to use data to inform improvements in how the system operates at transition points. Quantitative data alone cannot answer all the questions, and there is a need to capture more experiences and views of young people, practitioners, and carers/parents.

Key research questions

How many young people experience transition from child to adult mental health services every year, and what are their transition experiences?

What are the transition experiences of young people in care with mental health needs and children with special educational needs and disabilities?

What do good integrated transition systems look like for young people with mental health needs across all systems of support?

What role should parents and carers play in transitions for young people aged 16–17 and 18–24, and how can the issue of consent be approached to best reflect the wishes of the young person?

4.5 Inequalities in access to treatment

Conversations with professionals and young people highlighted some groups of young people who experience inequalities in access to treatment for mental health (see Box E). As discussed in section 2.3, there is a lack of consistent data collected on needs for and access to clinical and wider mental health services by young people aged 14–24 with these characteristics. Inequalities experienced by these groups of young people have been highlighted in other reports as well[176,177,178].

Box E: Groups of young people experiencing inequalities in access to mental health support

Ethnically minoritised communities

The Children's Commissioner for England reported in 2025 the overrepresentation of children of White ethnic groups accessing treatment compared to census data (81% of those accessing treatment vs 73% in under-18 population), and under-representation of Asian children (5% vs 12% of the child population) and Black children (4% vs 6%)[179].

All-population data for the Adult Psychiatric Morbidity Survey also shows that people in Black, Asian and mixed/multiple/other ethnic groups were less likely to get mental health treatment than those who identified as White British[180].

The Cosmo study reported differences by ethnicity in seeking help for mental health: Asian (25%) and Black (30%) respondents classified with experiencing high psychological distress were less likely to report seeking mental health support compared to those of mixed/other ethnicities (39%) and White (40%) respondents[181].

Young people from disadvantaged socio-economic backgrounds

The COSMO study reported that young people aged 17–18 in the most deprived parts of the country are 11 percentage points more likely than those in the most affluent areas to say they are still waiting or have not received the support they applied for (39% vs 28%)[182].

Gender identity and sexual orientation

According to the COSMO study of young people, non-binary+**183** (67%) and females (33%) were more likely to report seeking support with their mental health compared to males (15%). When restricting this analysis only to those classified as experiencing high psychological distress, patterns by gender remain (27% male, 41% female, and 74% non-binary+)[184].

A review led by Dr Michael Brady, the National Advisor for LGBT+ Health at NHS England, launched in 2025 (to report in 2026) and is looking into access to mental health support for this group[185].

Neurodivergent young people

Due to diagnostic overshadowing – where only a primary condition is identified – mental health needs may remain unmet among this group[186].

The issues of a lack of training for staff in mental health services on how to support neurodivergent young people can also impact access to mental health support[187].

Currently there is a lack of data on how many may be accessing mental health support services.

Care-experienced children

The support that care-experienced young people receive is often fragmented and poorly coordinated due to a number of factors: many living in out-of-area placements and therefore not being a priority group within that area; frequent placement moves, disrupted education or not attending school; not meeting the high threshold for services despite living with the impact of trauma; and early transitions to adulthood[188,189].

Some of the most vulnerable young people in care are those deprived of their liberty by the High Court under its inherent jurisdiction – reasons for which include the deterioration of young people's mental health and self-harm. Often this deterioration is linked to a lack of early support[190,191].

The Fostering Network reported in 2024 that 45% of surveyed foster carers said that at least one child they foster is either receiving mental health or well-being support (28%) or is on a waiting list for support (18%). The most common type of mental health support received by children was therapy or counselling, and the most common sources of support were Children and Adolescents Mental Health Services and school. 39% said they are fostering a child who is not receiving mental health or well-being support but should have access to it – an increase from 33% in 2021[192].

Conversations with professionals identified some positive examples – such as some virtual school heads for looked after children (strategic leaders who promote education outcomes for children with a social worker) prioritising mental health in their support, or specific services in some areas. However, the picture is not universal and most of the support still focused on higher needs, not recognising that young people experiencing trauma in childhood all require early and ongoing support with mental health to pre-empt or reduce symptoms of poor mental health.

Young people who are not in education, employment or training (NEET)

We were not able to locate consistent data on access to mental health support for young people classified as NEET.

Key messages emerged from our conversations with young people and professionals about why young people with the characteristics reported in Box E experience barriers in access to mental health support.

First, they identified that the systems are particularly poorly equipped due to the lack of data and evidence around support that is sensitive to their complex unique individual needs, which may be changing and evolving as young people grow.

The biggest challenge is in understanding intersecting experiences related to gender, sexuality, race or neurodivergence. There are few services which are attuned to these differing experiences or informed by learning from young people themselves.

Organisations delivering digital services (see Box C) report that many are reaching groups who are less likely to access in-person or formal services.

- Kooth reported that 19% of UK service users identify as ethnic minorities.
- Tellmi reported that 17% of Tellmi users have attention deficit hyperactivity disorder (ADHD), 19% have an autism diagnosis, 11% have an ADHD diagnosis and 7% have a

physical disability; 56% of users are LGBTQ+, 23% are Black or minoritised ethnic, 21% are young carers and 4% are care-experienced.

- People with certain health or demographic characteristics are particularly likely to access Shout. For example, around 1 in 5 surveyed texters reported having autism, and around 2 in 5 texters identified as LGBTQ+. These rates are many times higher than the wider population in England[193].

Experiences of discrimination, distrust in authorities and worries about stigma around poor mental health were also mentioned as common among young people in these groups. For some young people, like those from minoritised communities or LGBTQ+ young people, worries about information shared with parents may act as a barrier to seeking help and disclosing information.

Professionals reflected that the most vulnerable young people often have intersections of the above characteristics, but they may not meet the high thresholds for clinical support, or may have other needs that are overshadowing their mental health needs.

Key questions and further research

As discussed in section 2.3 for young people from diverse groups who often experience inequalities, both prevalence of need and access to mental health support are areas where further research is needed. This will help ensure that support services are attuned to cultural and socio-economic factors as well as reflecting the needs of young people due to their neurodiversity, gender, and sexual identity. Voices and experiences of these groups themselves need to inform the design of mental health support.

Key research questions

What is the true picture of access to support within formal and informal systems for young people from groups experiencing inequalities?

How can support and services be improved to meet the needs of groups experiencing inequalities?

How we can better equip mental health services to better recognise and respond to the needs of groups experiencing inequalities – for example, through cultural competency or neurodiversity training?

5. Conclusions

This data commentary takes a broad lens in examining the mental health needs and services available for young people aged 14–24, as they move from being teenagers to young adults. It explores what is known about the prevalence of poor mental health in this age group and the support provided, drawing on data from prevalence surveys alongside administrative data, as well as insights from young people and practitioners. Together they map the formal and informal support available, and illuminate key issues that this generation faces in relation to mental health.

The purpose of this data commentary is not just to paint a bigger picture and identify gaps but to also inform and encourage research, policies, and practice that would enable timely access to mental health support for young people aged 14–24 across the whole spectrum of mental health needs, from mild to severe.

There is a clear case for why mental health support for young people in this age group needs special attention. With around two-thirds of mental health conditions emerging during adolescence and young adulthood, a growing understanding that adulthood does not arrive overnight at the age of 18, and the rise in mental health needs, the provision of good and timely mental health support for 14–24-year-olds is vital. Such support can make a difference to young people's lives during their transition to adulthood and to their future life chances.

Across the globe, the increase in young people's mental health has already led to the development of systems and services that provide more holistic and uninterrupted mental health support as young people become adults[194]. Domestically, while some data, policies, and practice have been developed on the issue, there is still some way to go to ensure that provision of support across the country is more flexible, wide ranging, and informed by needs of this age group.

Below are key insights, findings, and areas for further research and exploration drawn from this data commentary (a more detailed list of research gaps identify is provided in Appendix 3):

1. **Data shows the gap between rising mental health needs among young people and the support available to them:**

    - **This generation of young people has a high level of need as measured by diagnostic tools and screening.** Around 1 in 4 young people aged 16–24 have a common mental health condition (CMHC) and around 1 in 7 have symptoms of a CMHC corresponding to a severe level of need.

    - **There is a gap between the level of need and the level of access to support.** Around 1 in 10 young people aged 16–24 had been in contact with mental health services but only around 1 in 25 had 2 contacts or more, indicating limited access to treatment. To understand the level of unmet needs, it is important that prevalence of mental health is considered alongside the administrative data on access to services.

- **Many young people who would benefit from access to support either are choosing not to access it or experience long waits or other barriers to access.** 1 in 2 young people with the level of mental health symptoms that would benefit from treatment are not accessing treatment.

- **The system relies heavily on medication** with over 840,000 young people aged 15–24 – 1 in 8 young people – prescribed some medicine for mental health in 2025. This may or may not be the right response, depending on the mental health condition, but the young people we engaged with were concerned about the limited options beyond medication.

2. **Formal and informal mental health services for young people are fragmented and complex – as mapped by young people and professionals:**

   - **The full scale of what is provided outside formal mental health services – in education, community, digital places and by employers – is difficult to assess.** However, this support plays a crucial role in prevention and early intervention and is valued by young people.

   - Despite the expansion of mental health support teams in schools and new elements of integration through a range of hubs, **prevention and early intervention approaches are under-developed and partial**.

   - **Availability of support is determined by where young people live** with some new initiatives as yet only available as pilots, alongside variations in spending levels and commissioning. Information about what is available is difficult to navigate.

3. **Digital support is rapidly expanding and can play an important role in the wider infrastructure of services for young people's mental health needs:**

   - **There is rightly a great deal of concern about the harms of social media and AI developments** to young people's mental health and well-being, and how to regulate to protect young people in the context of rapid changes in technology. We explore this in other outputs from the *Grown up*? programme. Important areas for further exploration are understanding the reach and impact of the current digital support available, its potential to act as a digital front door to other services, and how to manage risk and oversight.

4. **There is a mismatch between the spectrum of mental health needs – including mild, severe, and multi-faceted conditions – and the way in which services and support are structured:**

   - While there is more evidence built around outcomes when a mental health condition meets a clinical threshold, **there is less evidence around early intervention and when needs are below a clinical threshold**. This is the case for all young people, but particularly for those who have experienced trauma, looked after children, and minoritised and neurodivergent young people.

   - **The system is ill-equipped to respond to young people who have a combination of vulnerabilities in their lives**, such as young people who have a mental health

condition and are NEET, growing up in the care system, and living in poverty. The impact on mental health outcomes of multi-dimensional interventions across different aspects of young people's lives needs to be better understood.

- **There is a gap in provision for young people with moderate needs**, who fall between a relatively low level of difficulties and the more serious ones who need secondary mental health services.

5. **There is a glaring need for better transitions between child and adult mental health services and more integrated approaches to transition across all systems:**

   - **The transition points disrupt access to support for young people and create additional stressors.** Each system (for example education, or children's social services) has its own approach to transition, multiplying opportunities for young people to fall through the gaps.

   - **There is a paucity of data on and analysis of young people's transitions into adulthood** in terms of their mental health needs and the services available, specifically including the period of early adulthood from 18–24 years old.

6. **It is vital to strengthen the data infrastructure in the UK to inform effective decision-making and commissioning of services:**

   - We identify **key gaps in the data available which need to filled**, particularly in relation to i) consistent and comparable data across the 14–24 age range; ii) a more detailed picture by age, group, and place and intersections therein; iii) several physical and/or mental conditions occurring together; iv) understanding changes over time in long-term and fluctuating conditions; and v) transitions between child and adult mental health services.

7. **Understanding how well specific interventions work is needed:**

   - This data commentary focused on the scale of and access to mental health support within different systems rather than on specific interventions. **Understanding the impact of these interventions is a critical component** of developing a comprehensive and effective approach to meeting young people's mental health needs. The evidence base for preventative approaches is much weaker again but is also a vital component.

8. Putting young people and their support networks at the centre of policy and practice is critical to ensuring things work for young people:

   - **Young people often struggle to access narrowly defined siloed services.** Better evidence of what formal and informal support would meet their needs is required.

   - **There are barriers that prevent young people seeking help**, which need to be understood. While the focus is rightly on the availability of services, diagnostic tools, and the suitability of responses, two other issues have been persistently raised by young people: First, the impact of public debate about young people's mental health on their perception of 'being a burden' on an overstretched system. Second,

whether 'generational bias' is potentially shaping decisions around commissioning support services for young people at the lower end of the continuum of needs.

- **Evidence needs to be built up with young people and professionals about what to include in the 'toolbox' for young people** to help them regulate emotional needs, manage conditions, and build resilience.

- Parents, wider family, siblings, and carers are in many cases a key part of the scaffolding of support for young people's mental health needs, yet **there is a real lack of research and guidance for parents and carers of those 16+** – particularly in transition and post-18, when mental health needs are persistent or severe.

The mental health of young people is high on the agenda today for decision makers, commissioners, practitioners, parents, and carers, and young people themselves. We are at a critical juncture with future policies and practice responses being considered, whether through the Children's Wellbeing and Schools Act, important reviews led by Professor Fonagy and Alan Milburn, or the development of community hubs such as Young Future Hubs or 24/7 Neighbourhood Mental Health Centres.

It is critically important that these and any future developments in this space are informed by:

- The evidence from research which highlights the need to move away from rigid boundaries between childhood and adulthood, and to address the gaps in data and focus on young people aged 14–24.

- The range of factors which are driving the rise in mental health conditions, making it essential to have multifaceted approaches in response.

- An assessment of the extent to which the current landscape of services meets the whole spectrum of needs. This must include consideration of more radical reform, focused on early intervention and integrated approaches.

- The need to support real-life social connections through continuing to invest in youth spaces and places in the community, across the different phases and stages of a young person's life.

- The voices and experiences of young people whose journeys to adulthood are currently affected by the gaps in mental health support. Their involvement in co-producing a more holistic approach is vital to its success – one which challenges the siloed working of the different systems and stretches across different areas of young people's lives.

Appendix 1: Time line of national policies on mental health

1999 The National Service Framework for Mental Health was launched to establish a comprehensive evidence-based service.

2000 The NHS Plan set targets and provided funding to make the Framework a reality.

2004 A National Service Framework for Children, Young People and Maternity Services was launched.

2008 The NHS Improving Access to Psychological Therapies (now known as NHS Talking Therapies programme) programme pilots started for adults with anxiety and a range of other common mental health conditions.

2011 The Coalition government's Mental health strategy published.

2015 NHS England's Future in Mind publication outlined the government's vision for children's mental health to be achieved by 2020.

2016 NHS Five Year Forward View for Mental Health outlined strategic planning to deliver mental health care for all age groups.

2017 The Department of Health and the Department for Education jointly published a Green Paper – Transforming Children and Young People's Mental Health Provision – which focuses on earlier intervention and prevention in mental health; an increased role for schools and colleges; and better, faster access to NHS services.

2018 Publication of the Care Quality Commission review of children and young people's mental health services: Are We Listening? Review of Children and Young People's Mental Health Services.

2018 The establishment of mental health support teams in schools began.

2019 The NHS Long-Term Plan promised additional investment into adult community mental health services between 2019/20 and 2023/24.

2021 Promoting and supporting mental health and well-being in schools and colleges guidance published by the DFE in response to Covid epidemic.

2021 Training grants for senior mental health leads were offered to all state schools and colleges in England, available between October 2021 and December 2024.

2023 Five years of additional government investment was committed to deliver the NHS Talking Therapies programme.

2023 Government funding announced for 10 Early Support Hubs for young people aged 11–25, extended to 24 hubs in 2024 with funding available till 2025/26.

2024 Lord Darzi's independent investigation of the NHS in England is published.

2025 The 10 Year Health Plan commits to expanding mental health support teams in schools and colleges, and providing additional support for children and young people's mental health through Young Futures Hubs.

2025 National Youth Strategy – launched Dec 2025 – includes commitment to mental health support teams in schools and colleges to reach full national coverage by 2029. This embeds well-being support within Young Futures Hubs with a 'no wrong front door' approach, supporting access to NHS mental health services for young people who need more specialist support.

2025 The review into mental health, attention deficit hyperactivity disorder (ADHD) and autism services, chaired by Peter Fonagy is launched, seeking to understand the factors behind trends in prevalence.

2025 And Milburn review announced investigating the causes of inactivity and unemployment among 16-24 year olds

2025 The violence against women and girls strategy is updated.

2025 Men's Health Strategy for England launched to improve men's health literacy and engagement, particularly around mental health and suicide prevention.

2025 Neighbourhood Mental Health Hub pilots for people aged 18+ are launched – six pilots are being developed in England.

2025 The government commits to launch 50 Young Futures Hubs for 10–18-year-olds to improve health and well-being and reduce crime. 8 hubs opened in spring 2026.

2026 Children's Wellbeing and Schools Act

Appendix 2: List of organisations represented in the roundtable, workshop, and interviews as part of the mapping exercise

Ada Lovelace Institute

Anna Freud Centre

Association of Colleges

Barnardo's

BASW

Become

Behavioural Insights team

Catch 22

Center for Countering Digital Hate

Centre for Mental Health

Children and Young People Mental Health Coalition

Fostering Network

Internet Matters

Kingston University London

Mental Health Innovations (Shout and the Mix helplines)

Mind

NCB

NEUROMANCERS

NHS England

NSPCC

Nuffield Family Justice Observatory

Place2be

Plymouth University

Revealing Reality

Tellmi

The Children's Society

UCL

VoiceBox

Wysa

Youth Access

Appendix 3: List of research topics and questions based on gaps identified

Research questions about prevalence

What is driving the increase in numbers of young people with probable mental health conditions by age, gender, ethnicity, and other characteristics?

- To what extent do reasons behind the increase in mental health needs differ by age?
- Can any transition-related experiences explain an increase over time in the prevalence of probable mental health conditions in the 17–19 population?
- What are the key reasons in increase in mental health needs by gender, and the growing gap between males and females as they transition to adulthood?

What data do we need to provide a more detailed picture about prevalence of mental health needs in the 14–24 population?

- There are gaps in the data or analysis around 14–24-year-olds by race and ethnicity, socio-economic status, place, and cross-section analysis of these experiences in the population of 14–24-year-olds with mental health needs.
- Data on non-binary and trans young people aged 14–24 and their mental health needs.
- Co-morbidity of mental health and physical health among young people aged 14–24.

Research questions about access to treatment

What data is needed to help build a fuller picture of access to mental health support for 14–24-year-olds within formal systems?

- Data on young people aged 14–24 accessing services by different mental health conditions, including co-morbidity with neurodivergent conditions and health conditions.
- Data on young people aged 14–24 by continuum of needs and outcomes of their interaction with mental health support systems, that is: How many of those in contact with mental health services did not meet the clinical threshold of need and what support did they receive? How many met the clinical threshold of need and what support did they receive?
- Data on young people who were repeat referrals into mental health support services, and their experiences of services.

How effective and successful are contacts with formal mental health systems? And what measures need to be built into data collection to understand the effectiveness of the formal system?

- Measures of success informed by young people themselves not just clinical outcomes.
- Addressing the bias in methods for outcome measures towards treatment rather than management of mental health conditions.
- Developing measures for understanding the effectiveness of preventative interventions.

Is there a generational bias in professional attitudes affecting access to mental health support for young people?

How effective is the use of medication in mental health for young people? How is information about dosage and side effects communicated to young people?

What is the scale of private mental health provision for young people, and who benefits most from that provision?

Access to mental health support in informal systems

- What is the level of demand and capacity within informal systems to meet the needs of young people with poor mental health?
- How many young people are accessing mental health support within formal systems and what are their characteristics? What makes mental health support more accessible through these systems?
- The workforce within informal systems comprises paid staff and unpaid volunteers. What is the distribution, and the implications for the ability, of these systems to meet the needs of young people with mental health needs?
- Do these systems provide support on the lower or higher spectrum of mental health needs? And what are the gaps?
- What are the economic benefits of informal systems for mental health support?
- How does the scale of support provided by informal systems differ across the childhood/adulthood boundary? Are there gaps? Can they help with the transition process better than the formal systems?
- What does good parenting intervention look like for parents of adolescents with mental health needs pre- and post-18?
- What are the experiences of young people who are not in education, employment or training getting holistic support with their mental health needs?

Access to mental health support through digital spaces

- Developing a fuller picture of the extent and type of digital/AI support used by young people for their mental health, by age, characteristics, and level of need, mapping risks and benefits of provision.
- Testing different models of delivery which combine online and in-person support for young people with mental health needs.

Access to mental health support during the transition from childhood to adulthood

There is a lack of data on transitions in administrative data collections; this is needed to help map and understand transition experiences of young people.

- Data on number of young people transitioning from child to adult mental health services by diagnosis, level of need, individual characteristics, location, and type of services.
- Data on waiting times during transition and the impact on young people.

What effect do different approaches to transition have on outcomes for individual young people – including treatment outcomes and a wider set of outcomes, such as education and employment?

What are the transition experiences of young people in care with mental health needs? What do good integrated systems of transition look like for this group of young people?

What is the role of parents and carers in transition for young people aged 16–17 and 18–24, and how can the issue of consent be approached to reflect best the wishes of the young person?

Access to mental health support for young people experiencing inequalities

- What is the true picture of access to support within formal and informal systems for young people from groups experiencing inequalities?
- What are the individual and societal implications of unmet mental health needs in groups experiencing inequalities?
- What does good practice look like in mental health support for groups experiencing inequalities?

Appendix 4: Full descriptions of figures and infographics

Contents

Figure 1: Percentage of 11–23-year-olds with a probable mental health conditions, by age, 2017 to 2023

Overview

The bar chart shows the proportion of three different age groups of young people who have a probably mental health condition. The data for 11–16- and 17–19-year-olds is for years 2017 and 2020 to 2023. The data for 20–23-year-olds is only for 2021 to 2023. The proportions of all ages generally increase with time, although 17–19-year-olds peak at 2022. The levels of each age group are roughly similar at each year. 11–16-year-olds rise from 13.3% to 22.6%; 17–19-year-olds from 10.1% to 23.3%; and 20–23-year-olds from 16.6% to 21.6%.

Presentation

Each year has a set of three vertical bars, one for each age group. The first two years have only two bars as they are missing the oldest age group. The height of the bars shows the percentage value.

Values

The data below is repeated, along with the source information and confidence intervals, in the full dataset.

Year	11–16-year-olds	17–19-year-olds	20–23-year-olds
2017	13.3	10.1	no data
2020	17.6	17.7	no data
2021	17.7	17.4	16.6
2022	20.4	25.7	18.7
2023	22.6	23.3	21.6

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Figure 2: Percentage of 16–24-year-olds with mental health conditions in 2023/24, by condition and comparison to years 2007 and 2014 where data available

Overview

The bar chart shows the proportions of 16–24-year-olds with a variety of mental health conditions, with a sub-total after the first six items for all common mental health conditions (CMHCs). Each condition has three bars (unless data is not available) to show the levels at 2007, 2014 and 2023/24. The main trends are:

- An increase for any CMHCs from 1 in 6 in 2007 to 1 in 4 in 2023/24. This includes increase in generalised anxiety disorder (GAD), phobias, depressive episodes, obsessive compulsive disorder (OCD).
- Around 1 in 5 (21.2%) young people aged 16–24 reported having self-harmed ever in 2023/24 compared to less than 1 in 10 (8.9%) in 2007.
- Other conditions such as problematic drinking declined, and drug dependence is fairly stable among young people.

Presentation

Each condition has three vertical bars for the three years covered. Some conditions have only two bars if data for one is not available. The height of the bars shows the percentage value.

Values

The data below is repeated, along with the source information, in the full dataset.

Mental health condition	2007	2014	2023/4
GAD (past week)	3.6	6.3	7.6
Depressive episode (past week)	2.2	2.3	3.8
Phobias (past week)	2.1	3.3	4.1
OCD (past week)	2.3	1.8	5.7
Panic disorder (past week)	1.2	1.2	0.8
CMHC-NOS (past week)	9.9	8.4	9.8
Any CMHC (past week)	**17.5**	**18.9**	**25.8**
PTSD (screen positive for, past month)	no data	8	11.4
Psychotic disorder (past year)	no data		0.5
Antisocial disorder (screen positive for)	no data	4.9	1.3
Borderline disorder (screen positive for)	no data	5.7	6.1
Bi-polar (Screen positive for)	no data	3.4	1.9
Drinking score 8+	36.6	28.9	18.1
Drinking score 16+	6.2	4.2	2
Any drug dependence	10.2	8.3	10.1
Suicidal thoughts (past year)	7	8.4	9.9
Suicide attempts (past year)	1.7	2.2	1.3
Self-harm (ever)	8.9	13.7	21.2
Eating disorder (screen positive for, score 2)	13.1	no data	20.1

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Figure 3: Percentage of population in contact with NHS-funded secondary mental health, learning disability and autism services, by age, 2017/18 to 2024/25

Overview

The bar chart shows the proportions of the population in contact with NHS-funded secondary mental health, learning disability and autism services. The value for the total population is given, followed by age groups of five-year intervals from 0–5 to 11–15, single years from 16 to 19, and ten-year intervals from 20–29 to 90+. Each age group and the total population are given eight bars for the years 2017/18 to 2024/25. Across the age groups, the trend is for relatively low values at 0–5-year-olds, rising steeply to 16-year-olds before gradually falling to 60–69-year-olds. It then rises gently for 70–79-year-olds before rising steeply to 90+. The 90+ levels are in the same region as recent levels for 11–17-year-olds. The trends for each age group across time are that the proportion of people in contact with mental health services grew for most age groups (apart from 70+) in recent years, but with higher rises for children and young people.

Presentation

Each age group and the total population has eight vertical bars, one for each year. The height of the bars shows the percentage value.

Values

The data below is repeated, along with the source information, in the full dataset.

Population group	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25
Total population	4.5	4.9	5.1	5.0	5.8	6.3	6.6	7.0
Age 0–5	0.8	0.9	1.1	1.2	1.4	1.5	2.0	2.0
Age 6–10	4.0	4.7	5.3	5.2	6.3	7.4	8.8	10.0
Age 11–15	7.6	9.2	11.1	10.7	14.8	16.7	15.3	15.7
Age 16	10.2	12.0	14.6	14.6	18.2	19.3	17.6	16.9
Age 17	9.6	10.9	12.7	13.6	16.6	17.0	15.5	15.4
Age 18	7.4	8.4	9.4	10.0	12.4	12.9	11.8	12.3
Age 19	6.0	6.6	7.1	7.3	8.6	9.2	8.9	9.2
Age 20–29	4.9	5.4	5.7	5.8	6.6	7.3	7.6	8.2
Age 30–39	4.2	4.5	4.6	4.6	5.2	5.9	6.3	7.0
Age 40–49	3.8	3.9	3.9	3.7	4.0	4.4	4.8	5.3
Age 50–59	3.4	3.5	3.4	3.2	3.4	3.7	3.9	4.2

Population group	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24	2024–25
Age 60–69	2.7	2.8	2.8	2.6	2.9	3.2	3.3	3.5
Age 70–79	4.6	4.5	4.3	3.9	4.3	4.6	4.7	4.7
Age 80–89	11.6	11.3	10.9	9.8	10.4	11.2	11.1	10.8
Age 90 and over	17.0	17.0	16.1	14.7	15.8	16.8	16.1	15.6

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Figure 4: Trends in mental health conditions in 16–24-year-olds, by sex, 2014 and 2023/24 (%)

Overview

The bar chart shows the proportions of 16–24-year-olds with a variety of mental health conditions segregated into values for men and women, at two time points: 2014 and 2023/24. There is a sub-total after the first six items for all common mental health conditions (CMHCs). Overall, the values are highest for any CMHC, hazardous drinking and self-harm. On sex differences, women's rates are higher than men's, except for hazardous/harmful drinking and drug dependence. The values for men and women usually rise over time, except panic disorder, hazardous/harmful drinking and suicide attempts, with men's rates of generalised anxiety disorder (GAD) and drug dependence also falling.

Presentation

Each condition has four vertical bars, two for men (one for each year), two for women (one for each year). The height of the bars shows the percentage value.

Values

The data below is repeated, along with the source information, in the full dataset.

Condition	Men 16–24 in 2014	Men 16–24 in 2023/24	Women 16–24 in 2014	Women 16–24 in 2023/24
GAD	3.8	3.6	9	12
Depressive episode	0.9	0.4	3.8	7.5
Phobias	1.3	1.9	5.4	6.5
OCD	1.2	5.2	2.4	6.2
Panic disorder	0.4	0.9	2.2	0.7

Condition	Men 16–24 in 2014	Men 16–24 in 2023/24	Women 16–24 in 2014	Women 16–24 in 2023/24
CMHC-NOS	5.6	7.5	11.3	12.2
Any CMHC	10	16.3	28.2	36.1
PTSD screen positive	3.6	10.4	12.6	12.6
Drinking score 8+	32	19.6	25.6	16.8
Drinking score 16+	5.2	2.1	3.2	1.9
Any drug dependence	11.8	10.7	4.6	9.6
Suicidal thoughts	6.4	7.5	10.4	12.6
Suicidal attempts	1.9	0.4	2.7	2.4
Self-harm	7.9	17.3	19.7	25.7
Bi-polar disorder	3.1	0.1	3.7	3.9
Antisocial disorder	6.4	1.8	3.3	0.8
Borderline disorder	4.2	2.6	7.3	9.9

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Figure 5: Number of 16–24-year-olds in contact with secondary mental health services, by gender, 2021/22 to 2024/25

Overview

The bar chart shows the numbers of 16–24-year-olds in contact with secondary mental health services, divided into different gender identities. Each gender identity is given values for the four years from 2021/22 to 2024/25. The values for male and female are far larger than the other four categories and noticeably increase across the years. There is no clear trend for the other categories.

Presentation

Each gender identity has four vertical bars, one for each year. The height of the bars shows the number of individuals.

Values

The data below is repeated, along with the source information, in the full dataset.

Gender	2021/22	2022/23	2023/24	2024/25
Male	230,580	241,500	252,976	274,755

Gender	2021/22	2022/23	2023/24	2024/25
Female	351,848	375,726	373,793	389,529
Non-binary	464	5,152	3,127	3,458
Other (listed)	427	989	1,433	1,355
Indeterminate	3,720	873	1,287	1,243
Unknown	8,194	18,750	7,571	8,327

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Figure 6: Key systems young people turn to for mental health support as identified by young people in the Youth Insight Group and deep dive workshops

Alt text description on image is comprehensive.

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Figure 7: Example map of systems of support for young people aged 14–24 years with poor mental health

Overview

The bubble map shows the six key systems that young people turn to for mental health support and the connections between them and their related services. It shows what age ranges these services are available to. The systems are:

- Health services
- Education
- Digital
- Employment
- Community
- Family and friends

Presentation

The six key systems are in large bubbles. Services are in small bubbles surrounding their key system, with arrows coming out to them. Some services are pointed to from more than one system. Each service age application is indicated with a coloured background.

Values

The data below consists of six tables, and is repeated on one combined table in the full dataset.

System: Health services

Under-18s	18+	Available across 18 birthday boundary	Age boundaries depend on local commissioning arrangements
Children and young people mental health services	Adult mental health services	GPs	NHS talking therapies
Local chatlines for parents	24/7 Neighbourhood Mental Health Hubs	Mental Health Nurses	Drug and alcohol services
		Therapists (NHS and private)	Chatlines and text services
		Crisis teams	
		Emergency response services	
		Early Intervention for Psychosis	
		The Well Centre	
		Eating disorder services	
		Wysa	
		Shout	

System: Education

Under-18s	18+
Mental health support teams	University counsellors
Attendance Hubs	University helplines
Virtual School Heads for children in care	
Counsellors in schools and FE colleges	
Voluntary sector organisations (Barnardo's, Place2Be, The Children's Society)	

Under-18s	18+
SEND staff	
Pastoral staff	

System: Digital

Under-18s	18+	Available across 18 birthday boundary	Age boundaries depend on local commissioning arrangements
Childline	Mind Helpline	AI chatbots	Shared experience groups
Kooth	Qwell	Calm Harm and Calm Fear app	
Tellmi		Hub of Hope	
Finch self-care app		The Mix	
		NEUROMANCERS	
		TogetherAll	
		Wysa	
		Samaritans	
		Shout	
		AI chatbots	

System: Employment

18+	Age boundaries depend on local commissioning arrangements
DWP Employment hubs	Mentors
Occupational Health	Wellbeing Helplines
	Shared experience groups
	Fitness and wellbeing facilities

System: Community

Under-18s	18+	Available across 18 birthday boundary	Age boundaries depend on local commissioning arrangements
Early Support Hubs	24/7 Neighbourhood Mental Health hubs	Early Support Hubs	Sports groups
Young Futures Hubs	Local Minds	Voluntary sector services	Shared experience groups

Under-18s	18+	Available across 18 birthday boundary	Age boundaries depend on local commissioning arrangements
Youth clubs	Movember, Oddballs campaigns	NEUROMANCERS	Art therapy
Local Young Minds	Men's Shed	Faith groups	
		Outdoor green spaces	

System: Family and friends

Under-18s	18+	Age boundaries depend on local commissioning arrangements
Young Minds Parents helpline	PA for care leavers	Voluntary sector organisations
Anna Freud Centre	Partners	Young Minds Parents helpline
Support for parents of adopted children		
Fostering Network		
Local chatlines for parents		

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Figure 8: Proportion of people (%) with a CIS-R score of 12+ receiving treatment for a mental or emotional problem, by age, 2014 and 2024

Overview

This chart shows the proportions of different age groups receiving treatment for a mental or emotional problem, whether through medication, psychological therapy or both. The ages range from 16–24 to 75+, with values given from 2014 and 2024. The category of no treatment is the most prevalent, usually around 50-60%, sometime higher. Medication only is the most prevalent treatment category.

Trends around no treatment: this has reduced from 2014 to 2024. In 2014 it was generally higher in younger and older groups than the middle ages. In 2024 younger ages have dropped to levels of the middle ages.

Trends around medication only: this has increased from 2014 to 2024 among younger age groups and decreased along older age groups. In 2014 it was low among younger age groups and increased with age. In 2024 there is less difference.

Trends around psychological therapy only: this has increased in all age groups. It is generally higher in younger groups than older groups.

Trends around both medication and psychological therapy: this has increased in younger and older groups, and decreased in the middle ages. It is most prevalent in 25–44s.

Presentation

Each age group has two horizontal bars, one for each year. The bars total 100% and are divided into the four categories.

Values

The data below is repeated in a different configuration, along with the source information, in the full dataset.

	No treatment	Medication only	Psychological therapy only	Both medication and psychological therapy
16–24, 2014	77.3	10.1	8.8	3.8
16–24, 2024	50.1	35.1	12.6	2.2
25–34, 2014	62.6	20.1	6.2	11.1
25–34, 2024	46.5	30.4	10.1	13.1
35–44, 2014	59.7	27.3	3.8	9.2
35–44, 2024	58.6	19.6	8.3	13.5
45–54, 2014	54	34.6	2.7	8.6
45–54, 2024	47.7	31.7	11.3	9.3
55–64, 2014	50.4	39.6	4.5	5.5
55–64, 2024	52.2	33.8	7	7
65–75, 2014	60.9	31	2.9	5.2
65–75, 2024	66.8	28	3.1	2
75+, 2014	64.9	33.3	-	1.8
75+, 2024	78.1	19.1	2.8	-

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Figure 9: Number of patients aged 15–24 who were prescribed medicine for mental health, by type of medicine and gender, 2015/16 and 2024/25

Overview

The bar chart shows the numbers of people prescribed four different medicine types, showing the difference between male and female patients as well as levels in 2015/16 and 2024/25. Antidepressant drugs have a significantly higher level than the other categories. They also show higher levels in females. Conversely, central nervous system (CNS) stimulants / attention deficit hyperactivity disorder (ADHD) drugs are higher in males. Both antidepressants and CNS/ADHD medicines have increased over time. Hypnotics/anxiolytics and psychoses and related drugs have less difference between genders and over time.

Presentation

Each medicine category has four vertical bars, two male (one for each year), two female (one for each year). The height of the bars shows the percentage value.

Values

The data below is repeated, along with the source information, in the full dataset.

	Antidepressant drugs	Hypnotics and anxiolytics	Drugs used in psychoses and related disorders	CNS stimulants and drugs used for ADHD
2015/16 Male	159,414	47,354	23,767	25,683
2015/16 Female	343,561	69,908	20,165	6,743
2024/25 Male	184,722	55,027	19,527	56,957
2024/25 Female	412,637	56,513	24,002	35,497

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Figure 10: Number of young people who received two or more contacts with community mental health, learning disability and autism services, by age, 2021/22 to 2024/25

Overview

The chart shows the changes over time, and the differences between age groups, of the number of young people receiving two or more contacts with community mental health, learning disability and autism services. The three age groups are 11–15, 16–19 and 20–24. The older the age group, the lower the numbers (11–15: 230–290k, 16–19 145-165k, and 20–24 45-60k). Across time, every age group increases its numbers, with the largest change happening in the 11–15 group.

Presentation

Each age group has a set of four vertical bars, one for each year. The height of the bars shows the number of individuals.

Values

The data below is repeated, along with the source information, in the full dataset.

Age group	2021/22	2022/23	2023/24	2024/25
11–15	228,657	243,093	271,083	291,791
16–18	132,177	134,839	142,204	150,644
18–24	61,086	54,759	68,023	75,617

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Figure 11: The scale at a glance of access to support for mental health needs in primary and secondary health settings in England (during year of most recent reporting)

Overview

The infographic shows numbers and proportions of different age groups with access to various mental health support sources:

- GPs
- Talking therapies
- Perinatal mental health
- Early intervention for psychosis
- NHS funded community mental health, learning disability and autism services
- Eating disorder services

Presentation

Each source has a box, within which are bubbles with data points. Bubbles are coloured differently for relating to mostly under-18s or 18+.

Values

The data below is repeated, along with the source information, in the full dataset.

GPs

Proportion of young people with mental health presentation in 2023:

- Over 5% of 14–15-year-olds
- Around 7% of 16–17-year-olds
- Around 9% of 18–24-year-olds

Talking therapies

	Under-18s	18–25-year-olds
Referred	31,800	368,291
Accessed services	18,299	234,182
Finished course of treatment	6,227	123,013

Perinatal mental health

- 2,306 of 15–19-year-olds in contact
- 8,637 of 19–24-year-olds in contact

Early intervention for psychosis

	14–17-year-olds	18–24-year-olds
Referred	4,987	20,524
Entered treatment	1,232	5,221

NHS funded community mental health, learning disability and autism services

	11–15-year-olds	16–17-year-olds	18–24-year-olds
In contact	566,520	228,833	450,280
Two contacts	291,791	150,644	75,617

Eating disorder services

- 93 teams for children
- 69 teams for adults

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Figure 12: The scale of support available or proposed within education, family and friends, community, and employment systems

Overview

The infographic shows numbers and proportions of available or proposed services with four systems:

- Education
- Family and friends
- Community
- Employment

It also shows the numbers or proportions of individuals these services are available to or used by.

Presentation

Each system has a box, within which are bubbles with data points.

Values

The data below is repeated, along with the source information, in the full dataset.

System: Education

700 Mental health support teams established by March 2026, covering 69% of secondary schools and 28% of post-16 education, for:

- 70% of young people in secondary schools
- 41% in post-16 education
- 36% in special school
- 42% in alternative provision

93 Attendance and Behaviour Hubs

System: Family and friends

- Family Hubs in 88 local authorities
- Young Minds Parents Helpline reports more than 1,500,000 times that their resources are accessed in 2023/24

System: Community

- 24 Early Support Hubs for young people up to the age of 25 funded till 2027
- 50 Young Futures Hubs for young people 10–18 (8 pilots launched in 2026)
- 24/7 Community Mental Health Hubs (6 pilots established)

System: Employment

100 Youth Employment Hubs

14,000 young people supported in 2023/24

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Table 4.2: Suicidal thoughts and suicide attempts in the past year and self-harm ever in 2000, 2007, 2014 and 2023/4, by age and sex.
Table 5.2: Harmful and dependent drinking in the past year in 2000, 2007, 2014 and 2023/4, by age and sex.
Table 6.6: Drug dependence in the past year in 1993, 2000, 2007, 2014 and 2023/4 by age and sex.
Table 8.2: Screen positive for antisocial and borderline personality disorder (SCID-II Q) in 2014 and 2023/4, by age and sex.
Table 11.2: Screen positive for bipolar disorder in 2014 and 2023/4, by age and sex.
Table 13.2: Screen positive for features of an eating disorder (SCOFF) in 2007 and 2023/4, by age and sex.

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