

CHAPTER 6: Wellbeing and mental health



On average, three quarters of young people rate their life satisfaction as 'high' or 'very high'



Three quarters of mental health problems start before the early 20s



A quarter of young women age 16-24 show symptoms of depression or anxiety

Among 16-24 year olds, **common mental disorders** are **three times** more frequent in **young women** than men



1 in 7 16-24 year olds screen positive for **ADHD**

Between **1/4** and **1/3** young women report **self-harming** between the ages 15-24



Since 2007 both self-reported and hospital recorded **self harm** show rises

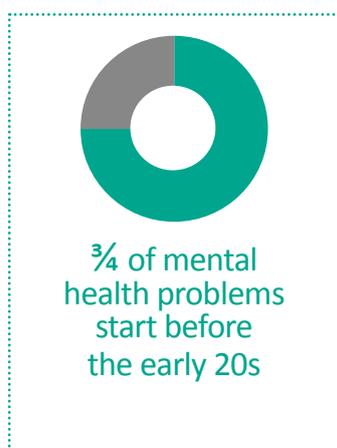


Suicide rates are higher for **young men** than women



Wellbeing and mental health

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



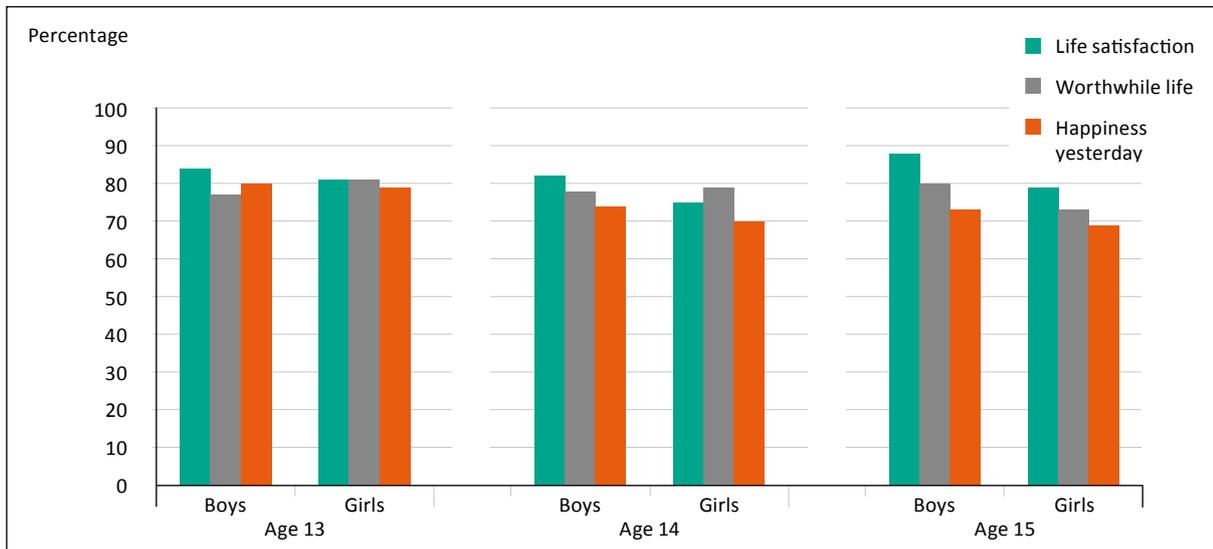
Mental health problems have important implications for every aspect of young people's lives including their ability to engage with education, make and keep friends, engage in constructive family relationships and find their own way in the world. Detection, treatment and support for young people with mental health problems are all important parts of the services provided to this age group. Mental health problems are also a major contributor to the global burden of disease (Whiteford et al, 2013) and untreated problems are likely to be very expensive for health services as young people grow into adulthood. We will return to mental health services in Chapter 7, but it is worth noting that the issue of young people's mental health is currently subject to considerable policy and public debate.

Source: Kessler et al (2014)

Young people's reports of their own wellbeing

Before exploring symptoms of mental ill health, it is worth noting that young people usually rate their own overall wellbeing as fairly high. Wellbeing is not the opposite of poor mental health (you can have a mental health problem *and* high wellbeing) but it is a part of general mental state. Low wellbeing may be a contributing factor to the development of later mental health problems. In recent years the Office for National Statistics has done a considerable amount of work on the measurement of wellbeing, with the result that several large surveys use the same measures with different age groups (ONS, 2014). This usually consists of self-reported ratings for questions including "How satisfied are you with your life nowadays"; "To what extent do you feel the things you do in your life are worthwhile", and "How happy did you feel yesterday". The Health Survey for England 2015 uses these ONS wellbeing measures with children aged 13-15. **Chart 6.1** shows the average proportion of young people of this age who gave high or very high ratings to these questions. Generally the ratings are positive, with life satisfaction ranging from 75% to 88% depending on age and gender.

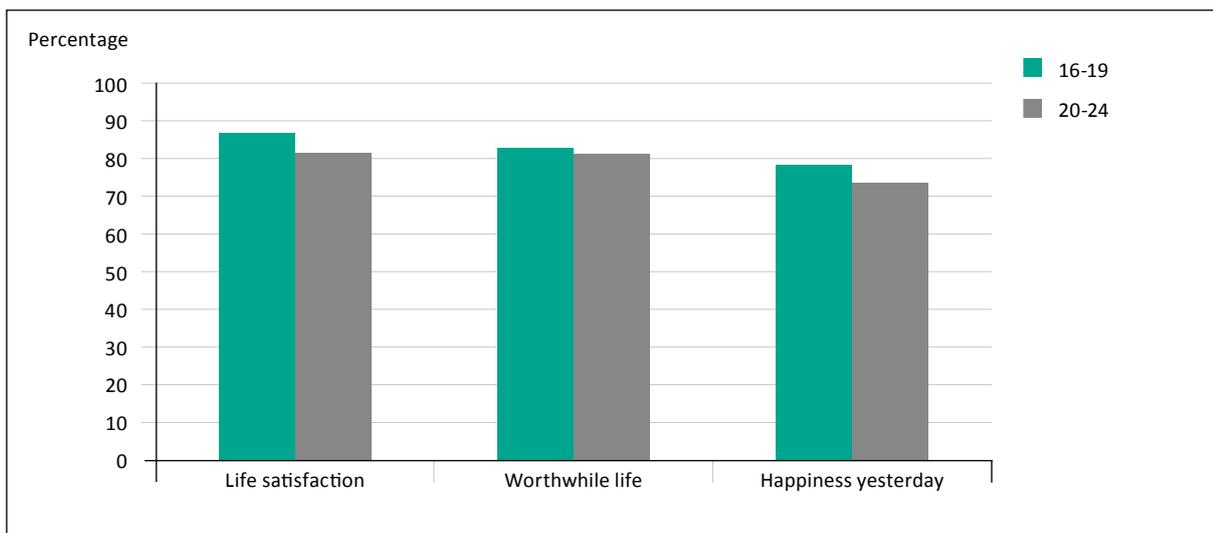
Chart 6.1: Office for National Statistics wellbeing measures, 13-15 year olds by gender, England, 2015



Source: Office for National Statistics: Measuring National Well-being; Life in the UK 2015/2016 [DOWNLOAD DATA](https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing)
<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing>

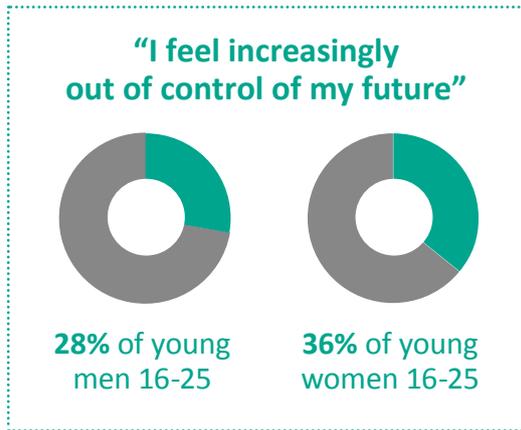
A similar question on life satisfaction was also included in the 'What About YOUth' (WAY) survey of 15 year olds, where 75% of boys and 55% of girls gave high or very high ratings (HSCIC, 2015). The questions are also asked of 16-24 year olds in the ONS annual population survey, although results in the main publications are not broken down by gender. **Chart 6.2** shows their responses to the same three questions on life satisfaction, worthwhile life and happiness yesterday. As with the younger age group, the majority reflect high levels of wellbeing according to these questions. Between 82 and 89% rate their life satisfaction as high or very high.

Chart 6.2: Office for National Statistics wellbeing measures, 16-24 year olds, UK, 2015



Source: Office for National Statistics, Annual Population Survey [DOWNLOAD DATA](#)

Young people who report being bullied in the last couple of months tend to give lower ratings to their wellbeing. In the What About YOUTH survey 2014, 19% of those bullied reported low life satisfaction, compared to 7% of those who had not been bullied (HSCIC, 2015).

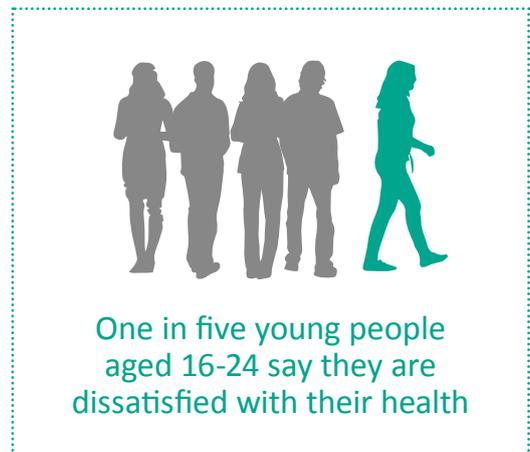


Source: Prince’s Trust Youth Index 2017

The most recent Prince’s Trust Youth Index drew attention to gender differences in aspects of life satisfaction. Young women aged 16-25 were more likely than young men to feel they have no control over their lives or future, and more likely to struggle with feelings of self doubt (Prince’s Trust, 2017).

There is always interest in international comparisons of life satisfaction in young people. The 2013 Unicef Innocenti Report Card (Unicef, 2016) ranked the life satisfaction of secondary school-aged children in rich countries, drawing on data from the Health Behaviour in School-aged children surveys. **Chart 6.3** shows that of the 35 countries listed, the UK ranks at number 20.

Finally, young people aged 16-24 seem to give slightly less positive satisfaction ratings in relation to their health, compared with their general life satisfaction responses. In the British Understanding Society survey, 56.2% were mostly or completely satisfied with their health. More than one in five (21.4%) said they were dissatisfied (ONS, 2017).



Source: ONS Understanding Society: the UK household longitudinal study

Chart 6.3: International comparisons in life satisfaction

Rank	Country
1	Netherlands
2	Australia
3	Denmark
4	Greece
5	Romania
6	Latvia
7	Switzerland
8	Norway
9	Austria
10	Estonia
11	Finland
12	Slovenia
13	Ireland
14	Malta
15	Hungary
16	Bulgaria
17	Sweden
18	Portugal
19	Iceland
20	United Kingdom
21	United States
22	Italy
23	Croatia
24	Spain
25	Canada
26	Slovakia
27	Lithuania
28	France
29	Germany
30	Belgium
31	Israel
32	Luxembourg
33	Poland
34	Czech Republic
35	Turkey

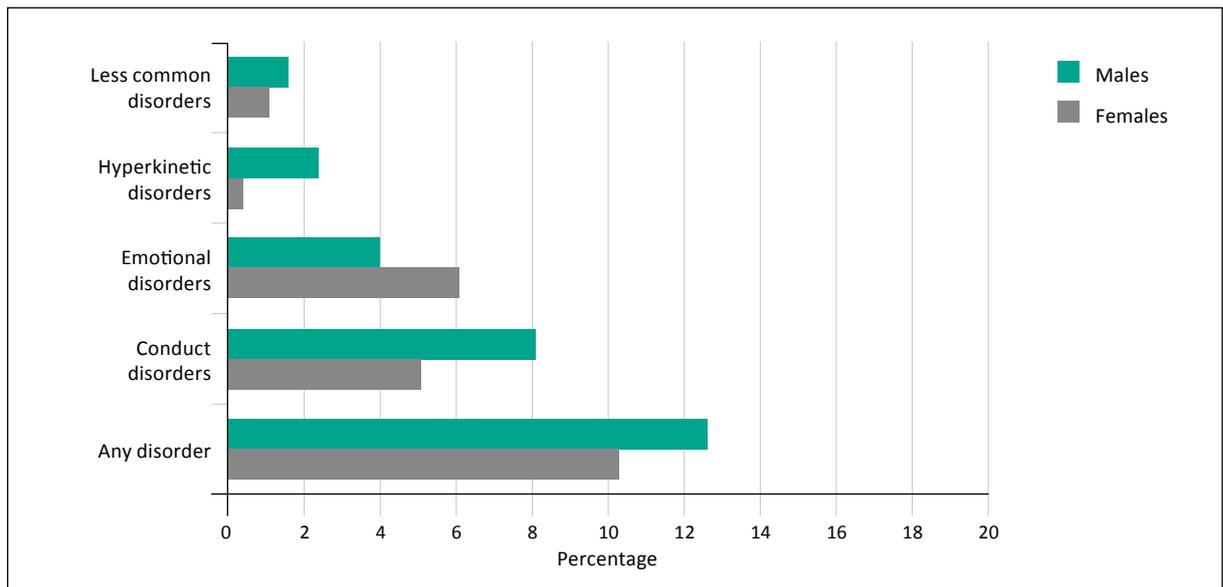
Source: Unicef (2016) Fairness for Children: A league table of inequality in child well-being in rich countries. Innocenti Report Card 13. Unicef: Florence
[DOWNLOAD DATA](#)

Prevalence of mental health problems among young people

The data on the prevalence of diagnosed mental health conditions in the UK’s population of young people aged 10-15 is not measured regularly and this shortage of good, up to date, data is a real issue in understanding the picture. Two large scale and robust surveys by the Office for National Statistics (ONS) in 1999 (Meltzer et al, 2000) and 2004 (Green et al, 2005) are the source of most information on the younger end of the age range, but these data are now very out of date. A new survey is underway but results are not available at the time of writing. There are some routine data on 16-24 year olds in, for example, the Adult Psychiatric Morbidity Survey, but overall we lack a complete picture of mental health problems for the 10-24 age group as a whole. It is critical to repeat these kinds of representative population surveys, particularly as there has been concern expressed recently by academics and practitioners about the possible impact on this age group of the economic crisis of 2008, ongoing cuts to services, changes to the examination system, and concerns about the impact of exiting from the European Union (Faculty of Public Health, 2010; Young Minds, 2015; Young Women’s Trust, 2016).

In the meantime, drawing on the older data from the last Office for National Statistics survey of child and adolescent mental health in 2004, we can see (**Chart 6.4**) that the most common mental health problems in young people aged 11-16 at that time were conduct disorders in boys and emotional problems in girls, although both were common in the opposite gender too. Overall, around 13% of boys and 10% of girls were rated as having some kind of disorder.

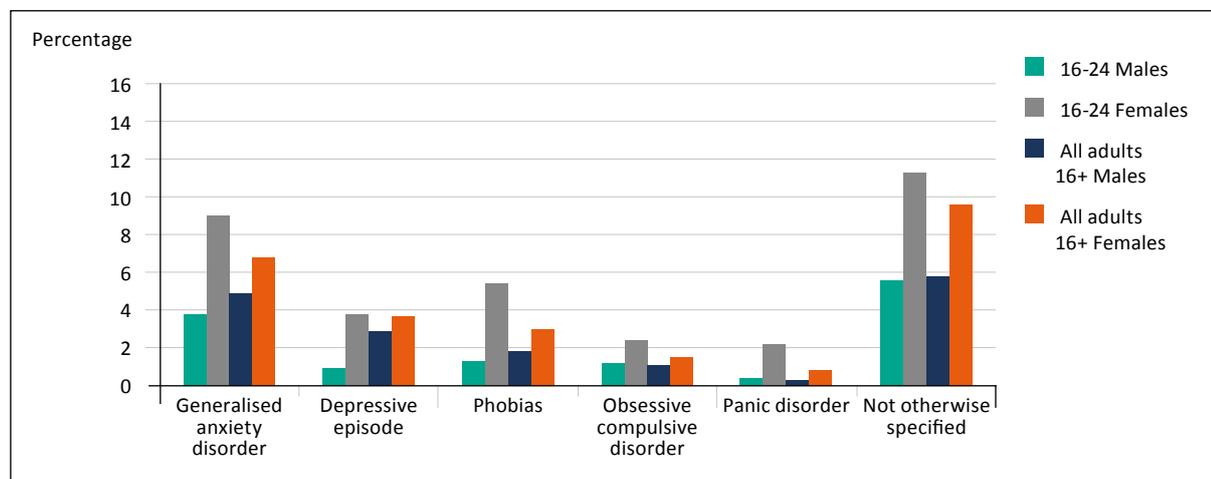
Chart 6.4: Prevalence of mental disorders in 11-16 year olds in Great Britain, by gender, 2004



Source: Green et al (2005) Mental health of children and young people in Great Britain 2004 [DOWNLOAD DATA](#)

In the adult psychiatric morbidity survey which included 16-24 year olds, the overall rate of common mental health problems for adults over 16 was one in six. In the 16-24 age group, total symptoms of common mental disorders in this age group were about three times more common in women of that age (26.0%) than men (9.1%). **Chart 6.5** shows the rates of various different common mental disorders in this age group.

Chart 6.5: Rates of common mental disorders in past week, by age and sex, all adults, England 2014



Source: McManus et al (2016) Adult Psychiatric Morbidity Survey [DOWNLOAD DATA](#)

Turning to time trends, analyses of successive British birth cohorts suggested that there was a significant increase in some mental health problems up to the year 2000 (Collishaw et al, 2004). However in the beginning of the 21st century this trend seemed to have slowed down or stopped. Comparison of the two large scale ONS surveys in 1999 and 2004 mentioned above showed little change over this five year period (Collishaw et al, 2004). Since then the trends have been unclear and there is a shortage of data.

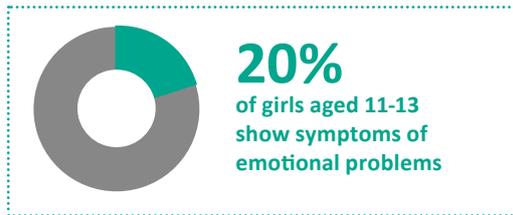
One study compared overall rates of mental health difficulties in early adolescence (11-13 years) in two cross-sectional studies from secondary schools in England from 2009 to 2014, using the Strengths and Difficulties Questionnaire (SDQ). The samples were not nationally representative as the second study had a larger than usual ethnic minority sample, and the first study was weighted to match. However, the results were interesting finding no large differences between the cohorts but a change in pattern. The results suggested an increasing burden of emotional problems for girls, and an indication of a decrease in overall difficulties for boys (Fink et al, 2015).

Although not based on any representative sample, it is interesting to note that ChildLine (the UK's free, 24-hour helpline for children and young people) has reported rising levels of counselling sessions, with over 300,000 sessions in 2015/16, an increase of 5% on the previous year (Childline/NSPCC, 2016). Finally, analysis of data returns to the Higher Education Funding Council for England has shown that the proportion of university students who formally identify themselves as having mental health problems doubled between 2008/9 and 2013/14 (Institute for Employment Studies, 2015).

Emotional disorders, low mood and anxiety

ONS does not routinely collect data on clinically diagnosed cases of depression or anxiety, although it does collect them on symptoms of depression, self-report anxiety and other indicators. Some psychiatric data for common mental disorders in those over age 16 are available from the 2014 Adult Psychiatric Morbidity Survey in England (McManus et al, 2016). As noted above, we have no data on clinically diagnosable depression and anxiety in the younger age group beyond those available from 2004. Some other population surveys include measures that indicate symptoms of depression or anxiety for this younger age group even if they do not provide a diagnosis.

Pulling together information from these sources, it seems that a significant proportion of young people 10-24 will have symptoms of depression or anxiety at some point through these years, and that young women are more likely to suffer (or to report) than young men. However, estimates of the levels of emotional problems vary by the age of the sample, and by the types of measurements used.



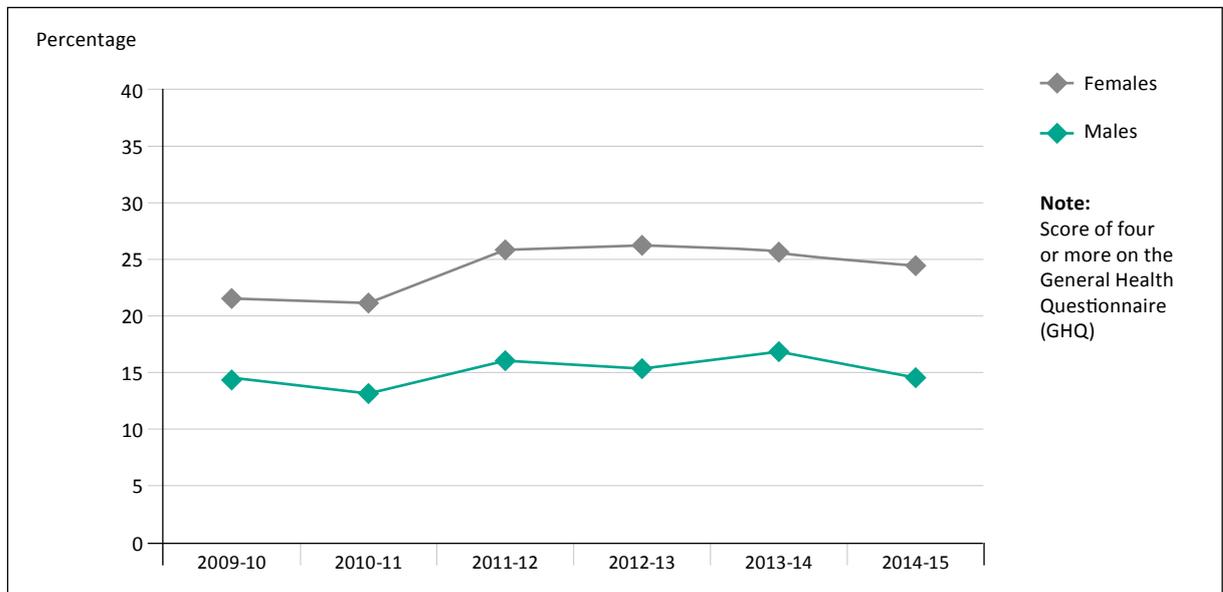
Source: Fink et al, 2015

Data from the 2004 population survey of children concluded that 6% of girls and 4% of boys aged 11-15 had clinically significant levels of anxiety or depression. A cross-sectional survey of young people aged 11-13 in 2014 also concluded that emotional problems (a high score on the Strengths and Difficulties Questionnaire, not a clinical diagnosis) were more common in the girls; 20%

compared to 7% in the boys (Fink et al, 2015). In the Adult Psychiatric Morbidity survey undertaken in 2014/15, 24.6% of young women aged 16-24 and 14.7% of young men showed signs of depression or anxiety. The authors concluded that young women were a high-risk group in the population (McManus et al, 2016).

However, comparing these data cannot tell us anything about time trends as the surveys were very different and applied to different age groups. For this we have to look to surveys that repeat the same methods at several different time points. Fink et al (2015) compared the 2014 results to the same survey undertaken in 2009, and concluded that there was an increasing burden of emotional problems for girls. Some time trend data for the older age group were presented in the Adult Psychiatric Morbidity survey, as again the same measure was used across several years. **Chart 6.6** shows the proportions of young people aged 16-24 showing signs of depression or anxiety by gender from 2009/10 to 2014/15. The trends are not very clear although there was a slight rise for young women from 21.7% in 2009/10 to 24.6% by 2014/15. The rates for young men did not change substantially across the period.

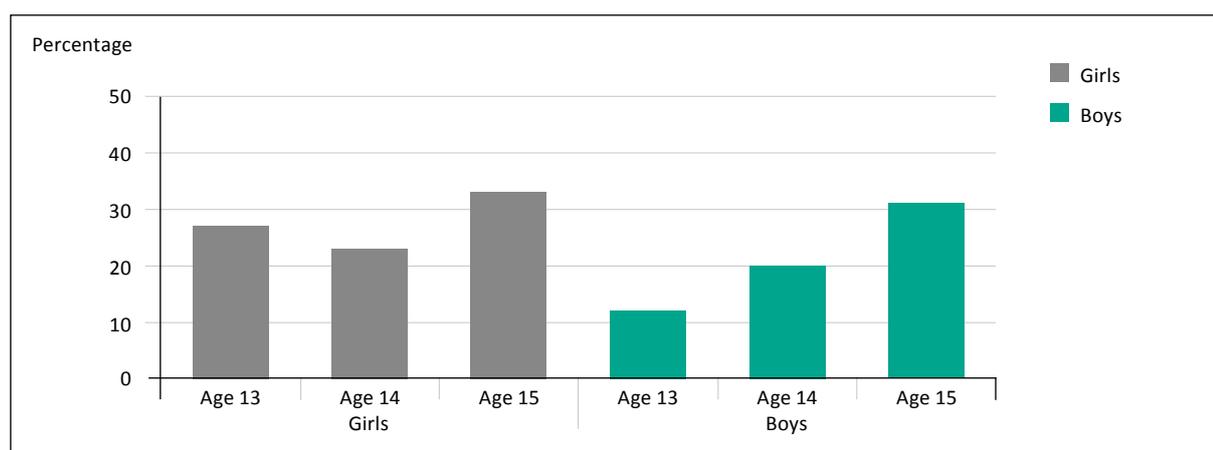
Chart 6.6: Proportion of young people aged 16-24 showing signs of depression or anxiety by gender, 2009/10 to 2014/15



Source: ONS Understanding Society: the UK household longitudinal study [DOWNLOAD DATA](#)

Measures of self-reported symptoms of anxiety and depression also suggest higher rates in young women. Although it is not possible to extrapolate from day to day feelings of depression and anxiety to a full blown diagnosis (the former is normal, the latter an illness), the former may shed some light on the mental health of a cohort. **Chart 6.7** shows the proportion of young people aged 13-15 reporting that they felt anxious yesterday. At each age the rates are higher for girls, and there is a trend for rates to increase with age.

Chart 6.7: Proportion of young people 13-15 reporting they felt anxious yesterday, by gender, England, 2015



Source: Office for National Statistics: Measuring National Well-being; Life in the UK 2015/2016 [DOWNLOAD DATA](https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing)
<https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing>

The same question was asked of 16-24 year olds in the ONS Annual Population Survey 2016, and 17% reported that their anxiety yesterday was high. This is a little lower than the overall average for the young people aged 13-15 which was 24%.

Self-harm

Self-harm (usually deliberate cutting and scratching) is a key part of the picture of mental health for young people as the majority of people who self-harm are aged between 11 and 25 years (Mental Health Foundation, 2006; Association for Young People's Health, 2013).

Self-harm is not a psychiatric disorder in its own right, but it is indicative of major mental distress (McManus et al, 2016). However, self-harm is a very private behaviour and a very sensitive topic, which means that there is a shortage of reliable information about young people who do not make use of accident and emergency or other services.

There have been several attempts to estimate prevalence of self-harm among young people in recent years. In the English Health Behaviour in School-aged Children study (Brooks et al, 2015), 22% of the 15 year olds in the study reported that they had self-harmed. These rates were three times as high for girls (32% of girls compared with 11% of boys). The majority of those self-harming said they were doing so once a month or more. One in four



Source: Brooks et al, 2015

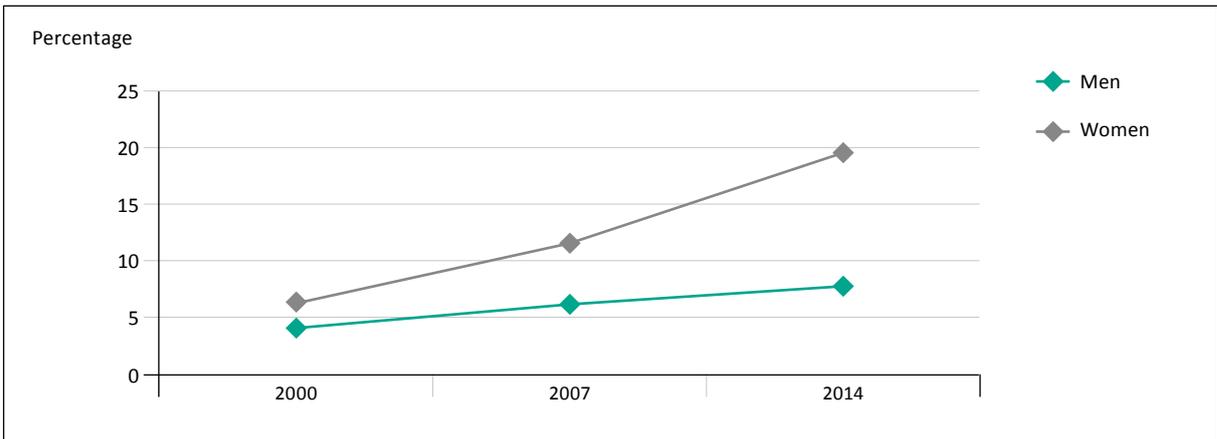
(25.7%) of the young women aged 16-24 in the Adult Psychiatric Morbidity Survey reported that they had self-harmed, compared to one in ten (9.7%) of the young men. In this age group self-harm was predominantly self-cutting.

In face to face interviews with 16-24 year olds **25.7%** of young women and **9.7%** of young men report self-harming

Time trends in self-harm were estimated from face-to-face interviews in the Adult Psychiatric Morbidity Survey. Overall, less self-harm was reported face-to-face than in the self-completion part of the study. However, rates did increase across time. **Chart 6.8** shows the increase in reporting for men and women from 2000 to 2014. The increase may reflect an increase in self-harm, or may be a function of reduced stigma, or increased categorisation of the behaviour as self-harm.

Source: McManus et al (2016) Adult Psychiatric Morbidity study

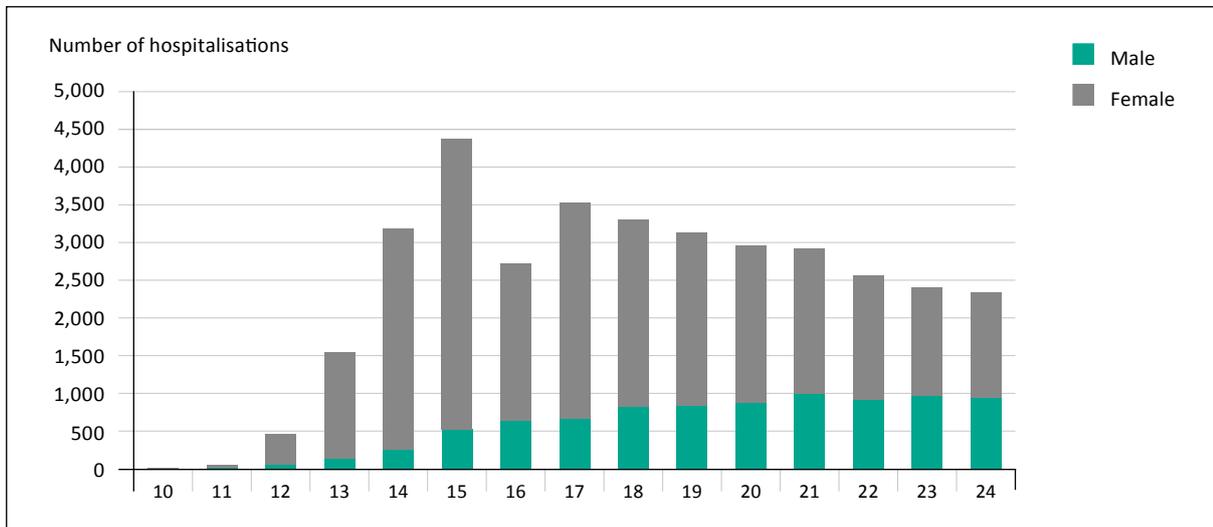
Chart 6.8: Self-harm ever (reported face to face) age 16-24, by gender, England and Wales, 2000, 2007 and 2014



Source: McManus et al (2016) Adult Psychiatric Morbidity study [DOWNLOAD DATA](#)

A minority of people who are self-harming will end up in hospital, but these cases provide important information about this behaviour. Reducing hospital admissions caused by self-harm in under 18s is a key public health outcome indicator (NICE, 2012). **Chart 6.9** shows the age distribution for young people age 10-24 admitted to hospital after an episode of self-poisoning in England, 2015/16. The majority of these episodes will be drug overdoses but some will include methods such as swallowing bleach. Although the peak age for admissions is 15, with a total of 3,853 admissions, there are steady rates of admissions into the early 20s. In total there were 36,624 admissions of 10-24 year olds for self-poisoning in 2015/16. These numbers do not necessarily reflect the numbers of individuals admitted, as some young people will be admitted several times over the course of a year. In addition, some incidents will be accidents. Nonetheless, this figure represents a huge number of young people in extreme distress, particularly if we consider this to be the tip of a much larger iceberg including those who do not go to hospital. Self-poisoning is one of the most common acute medical presentations in the UK (Camidge, Wood and Bateman, 2003).

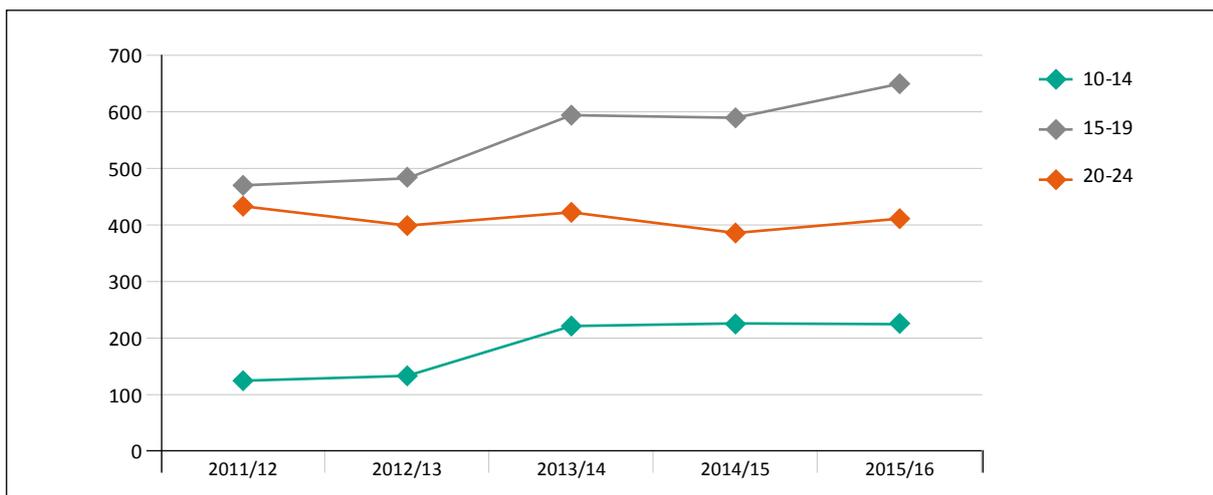
Chart 6.9: Hospitalisations for self-harm by self-poisoning, 10-24 year olds, England 2015/16



Source: NHS Digital: Hospital Episode Statistics 2015/16 [DOWNLOAD DATA](#)

Time trends in hospital admissions for self-harm follow similar trends to the self-report data in the community. **Chart 6.10** shows the rate of hospital admissions for all kinds of self-harm per 100,000 population aged 10-24. This allows us to compare year on year controlling for changes to the numbers of 10-24 year olds in the population, so it is a more accurate way of reporting trends than absolute numbers of admissions. Results are broken down by five year age groupings (10-14, 15-19 and 20-24), which illustrates that the rise is in the younger two groups rather than those in their early 20s.

Chart 6.10: Hospitalisation for self-harm rates (per 100,000) among 10-24 year olds in England, 2007/8 to 2015/16



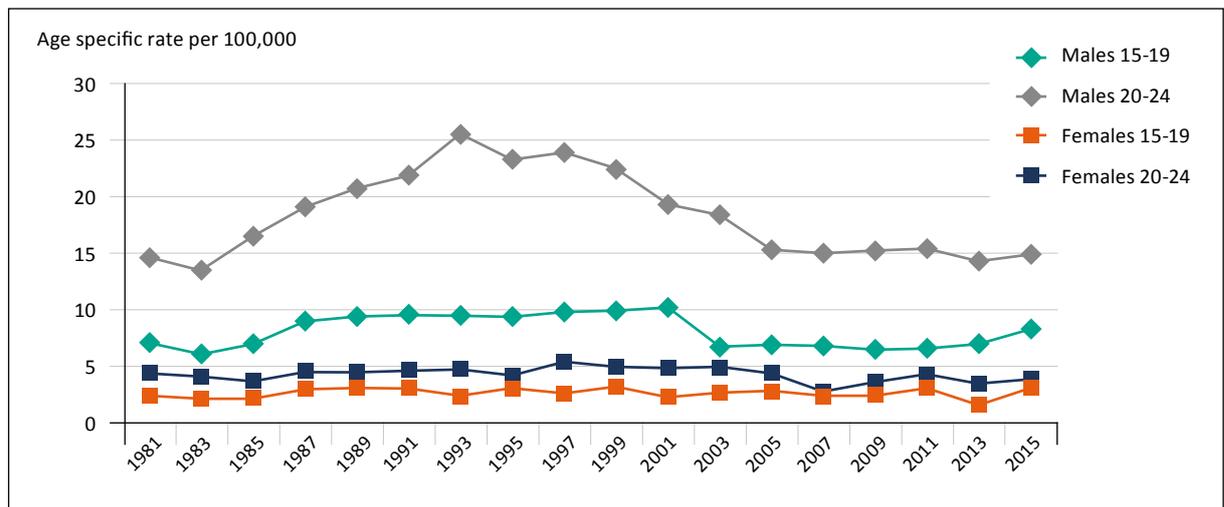
Source: Hospital Episode Statistics (HES) Copyright © 2016, Re-used with the permission of The Health and Social Care Information Centre [DOWNLOAD DATA](#)

Finally, rates of self-harm are particularly high amongst groups of vulnerable young people, such as those in the youth justice system. Youth justice statistics for 2015/16 report 1,400 incidents of self-harm among 11-17 year olds (and some 18 year olds) in the prison estate, with a rate of 8.9 incidents per 100 young people. This is an increase of 5% on the previous year. This is despite the number of young people in custody falling (Youth Justice Board/Ministry of Justice, 2017).

Suicide

Suicide is rare among young people but it remains a key public health target. Reducing numbers who commit suicide is a Public Health England outcome indicator and reducing suicide by 20% has been a recent target of the Scottish Government. **Chart 6.11** shows the age specific suicide rates in the UK for young men and women aged 15-19 and 20-24. Rates are higher in the older age group, and higher among young men than young women; a quite different pattern to that seen above with self-harm. In addition, the chart shows a peak in suicide in the mid 1990s, but a decline in rates from then until around 2005. After this, rates seem to have been fairly stable, although it is not clear if the rise in the last year is the beginning of an upward trend or just fluctuation. In 2015 the rates for young women were 3.1 per 100,000 for 15-19 year olds and 3.9 for 20-24 year olds, and for young men were 8.3 for 15-19 and 14.9 for 20-24.

Chart 6.11: Age specific suicide rates (per 100,000) by gender and age, UK, 1981-2015

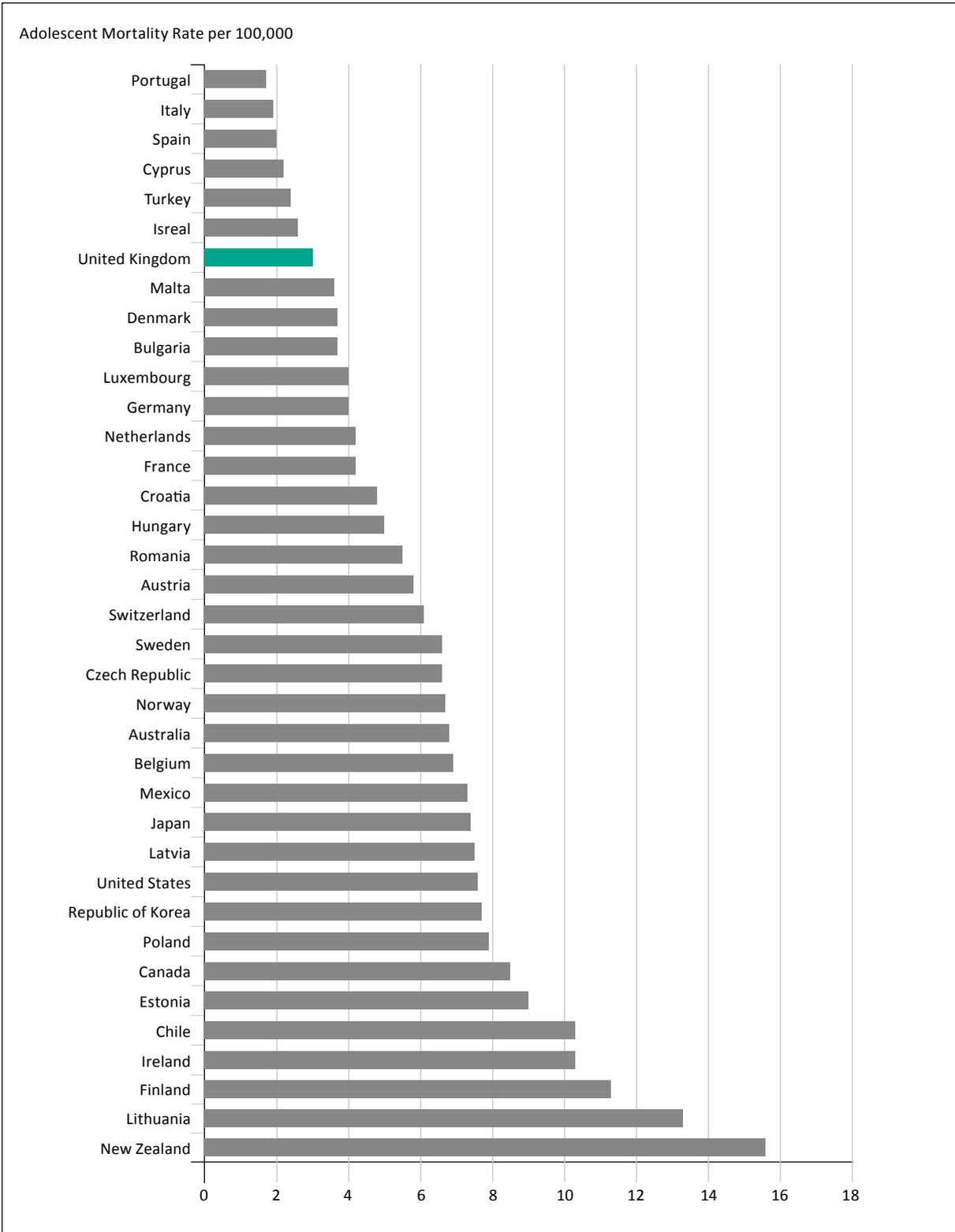


Source: Office for National Statistics, National Records of Scotland and Northern Ireland Statistics and Research Agency
[DOWNLOAD DATA](#)

More information on suicidal behaviour among the older age group is found in the Adult Psychiatric Morbidity Survey. Overall, 1 in 15 people reported that they had made a suicide attempt at some point (6.7% of the population), with more women (8%) than men (5.4%) having done so. Rates for young men aged 16-24 were roughly similar to those for men as a whole. However, rates for young women were notably high, at just under 13%.

Adolescent (15-19) suicide rates vary widely between high-income countries. The 2017 Innocenti Report Card from Unicef presented suicide rates for this age group per 100,000 population based on data from 2012/13. These are presented in **Chart 6.12**, showing that the UK's rate in 2012 was half the average of the 37 high income countries studied.

Chart 6.12: Suicide rates of adolescents aged 15-19 per 100,000 population in high income countries 2012/13



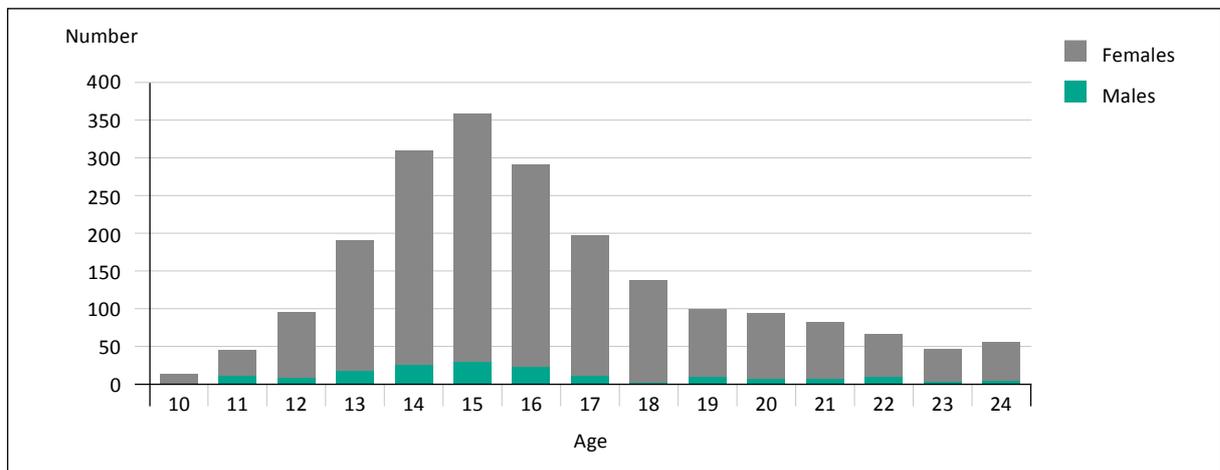
Source: Unicef (2017) Innocenti Report Card 14 [DOWNLOAD DATA](#)

Eating disorders

In western countries the prevalence for eating disorders in adolescents and young adults has been estimated to be approximately 3% for females and 0.1% for males. A larger proportion will have ‘subthreshold’ symptoms (Nagl et al, 2016). A study of the incidence of eating disorders in the UK 2000-2009 using a primary care register reported an age-standardised annual incidence rate of 164.5 per 100,000 for girls aged 15-19 years, more than double the rate for other ages (Micali et al, 2015). About 90% of eating disorder cases are female (NICE, 2017). By mid-life, around 15% of women will have met the criteria for eating disorders (Micali et al, 2017). There can be extensive physical and psychiatric consequences of a longterm eating disorder. Anorexia nervosa in particular has the highest mortality rate of any psychiatric disorder (Arcelus et al, 2011). The average age for the start of eating disorders is in the mid-teens and understanding these complex and distressing disorders is important when thinking about this age group. However, like self-harm, eating disorders may be underestimated in the general population. Significant proportions will not seek help and good representative community surveys are rare.

On the basis of routine Hospital Episode Statistics, the Health and Social Care Information Centre has reported that young people aged 10 to 19 years account for more than half of hospital admissions for eating disorders (HSCIC, 2014). Looking at the age range 10-24 **Chart 6.13** shows, as usual, the largest number of admissions in 2015/16 was for 15 year old girls. Although bulimia is more common, anorexia accounts for a larger proportion of the hospital admissions.

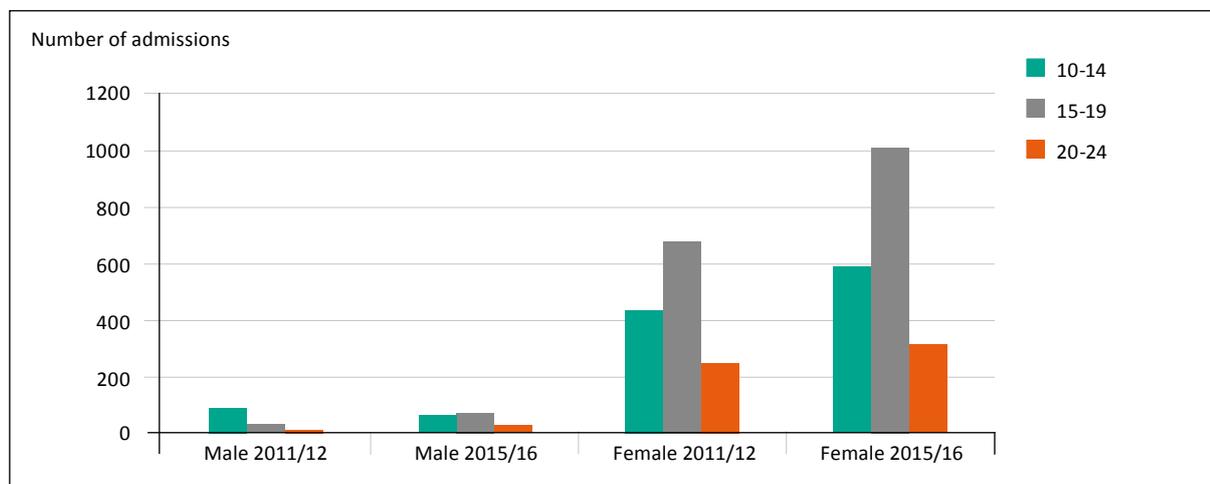
Chart 6.13: Hospital admissions for eating disorders, 10-24 year olds by age and gender, England 2015/16



Source: NHS Digital: Hospital Episode Statistics 2015/16 [DOWNLOAD DATA](#)

Comparing the hospital episode statistics between 2011/12 and 2015/16 for admissions for eating disorders shows that there has been a rise in admissions for young women but the trends are less clear for young men, for whom the numbers of admissions are much smaller (**Chart 6.14**).

Chart 6.14: Numbers of hospital admissions for eating disorders by age and gender, England, 2011/12 and 2015/16



Source: NHS Digital: Hospital Episode Statistics 2015/16 [DOWNLOAD DATA](#)

Conduct disorder and behaviour problems

Almost everyone gets involved in something that would be classified as antisocial at some point. Some risk taking in adolescence is normal. Taking risks and challenging authority can be part of adolescent identity development. In addition, what is defined as antisocial is to some extent culturally and generationally specific. At any time, there are all sorts of different ways to be antisocial, some more concerning than others.

However, serious violent behaviour in this age group is relatively rare and can be associated with longterm negative outcomes. 'Conduct disorder' is the official, psychiatric term for serious antisocial behaviour (for example, American Psychiatric Association, 2013), including the extremes of aggressive behaviour (fighting, being cruel to others or animals), destructive behaviour (arson or vandalism), deceitful behaviour (lying, stealing) and violation of rules (running away, truanting). As we have seen above in Chart 6.4 prevalence estimates for conduct disorder from the 2004 ONS survey suggested a rate of around 6.5% for young people aged 11-15%, with a higher rate in boys than girls.

18,300
first time entrants
to the youth justice
system in England
in 2016

Source: YJB, 2017

Another measure of levels of behaviour problems is the rate of first time entrants to the youth justice system. This is not a completely objective rating of behaviour problems as it is affected by processing by the police and courts, which are themselves affected by policy changes. The number of young people aged 10-17 receiving their first substantive outcomes (reprimand, final warning or court disposal) in 2015/16 was 18,300. This was down 75% from 2003/4. Overall there were 90,769 proven offences by young people under 18 leading to a caution or conviction in 2013/4, down 8% on the previous year and down 83% since 2006 (Youth Justice Board/Ministry of Justice, 2017). A number of reasons have been suggested for the fall including reductions in crime levels as a whole and changes in the way children are dealt with, including the development of more informal and constructive approaches within the youth justice system (Allen, 2011).

Attention deficit and hyperactivity disorder

ADHD is a neurobiological disorder. Key symptoms of ADHD are inattention, impulsiveness and hyperactivity. It has been estimated that it affects around two to four percent of teenagers in the UK, with rates consistently higher in boys than girls (AYPH, 2012). It can affect educational attainment, peer relationships, self-esteem and can contribute to youth offending. In the Green et al (2005) epidemiological survey of 11-15 year olds, 2.4% of males and 0.4% of females of this age met the criteria.

The picture seems rather different for the older age group. For those aged 16-24, the Adult Psychiatric Morbidity Survey estimated that 14.6% of this age group screened positive for ADHD in 2014 (which will produce a larger group than those actually meeting the criteria for diagnosis). In this age group rates were broadly similar for young women and young men (McManus et al, 2016).

Autism spectrum disorders

Approximately
1 in 100
young people
aged 10-24 have autism
spectrum disorder

Sources: Green et al, 2005;
McManus et al, 2016

The majority of young people become increasingly focused on their peer groups and social interaction during adolescence so this can be a very difficult time for young people who find it hard to manage their relationships with others. Those with autistic spectrum disorders (such as Asperger's) may find this a particularly challenging life stage. The newest Diagnostic and Statistical Manual was published in 2013, drawing together the various diagnoses of autism, autistic spectrum disorder and Asperger's under one umbrella diagnosis of 'autism spectrum disorder'. This has three levels of severity and there is also

a related diagnosis of social communication disorder (American Psychiatric Association, 2013). The defining characteristics of autistic spectrum disorders are impairments of social interaction, communication and imagination and often a reliance on repetitive, habitual activities and behaviours. However, as a spectrum, a very wide range of functioning is included under the overall heading and people may vary considerably in their experiences.

Again, the only national survey data we have to draw on relating to prevalence derive from the 2004 ONS survey by Green and colleagues. This suggested a prevalence rate of approximately 1% for autistic spectrum disorders (Green et al, 2005). Similarly, in a prevalence study involving a total population cohort of 56,000 children aged 9-10 in south London, Baird et al (2006) estimated a total prevalence rate of all autistic spectrum disorders as 116 per 10,000. Extrapolating from available figures, the National Autistic Society has estimated that there could be approximately 133,500 young people under 18 years in the UK with an autistic spectrum disorder (National Autistic Society, 2012). It is important to note that there is a strong gender differential in autistic spectrum disorders, with around five times as many boys as girls, and on average half of the children diagnosed with autistic spectrum disorders have learning disabilities (Fombonne et al, 2011).

The Adult Psychiatric Morbidity Survey provided estimates for adults meeting the criteria for autism spectrum disorder, but because of low prevalence rates the data were presented for 16-34 year olds, rather than 16-24 year olds. Rates were 1.7% for men and 0.2% for women (McManus et al, 2016).

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