YOUTH ENDOWMENT FUND

Report 3

Children, violence and vulnerability 2025

Mental health and experiences of violence

Contents

3 Acknowledgements

5 Main findings and summary

6 Executive summary

14 Headline findings

16 Methodology

19 Detailed findings

20 Teenage children affected by serious violence face a dramatically higher risk of mental health problems.

29 Most teenage children experiencing violence and mental health issues aren’t receiving treatment.

38 Teens are turning online for support.

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Main findings and summary

Executive summary

The Youth Endowment Fund (YEF) surveyed nearly 11,000 children aged 13–17 in England and Wales to hear directly about their experiences of violence.

The findings are being shared across several reports, each exploring a different theme. This third report focuses on **mental health and experiences of violence**.

For the first time, we asked detailed questions about mental health, including using the Strengths and Difficulties Questionnaire (SDQ), a 25-item questionnaire that measures the scale of children's struggles. Combined with data on victimisation and perpetration, this provides an unprecedented picture of how violence and mental health are linked — and the complex ways they shape young people's lives.

Here's what we found.

Teenage children affected by serious violence face a dramatically higher risk of mental health problems.

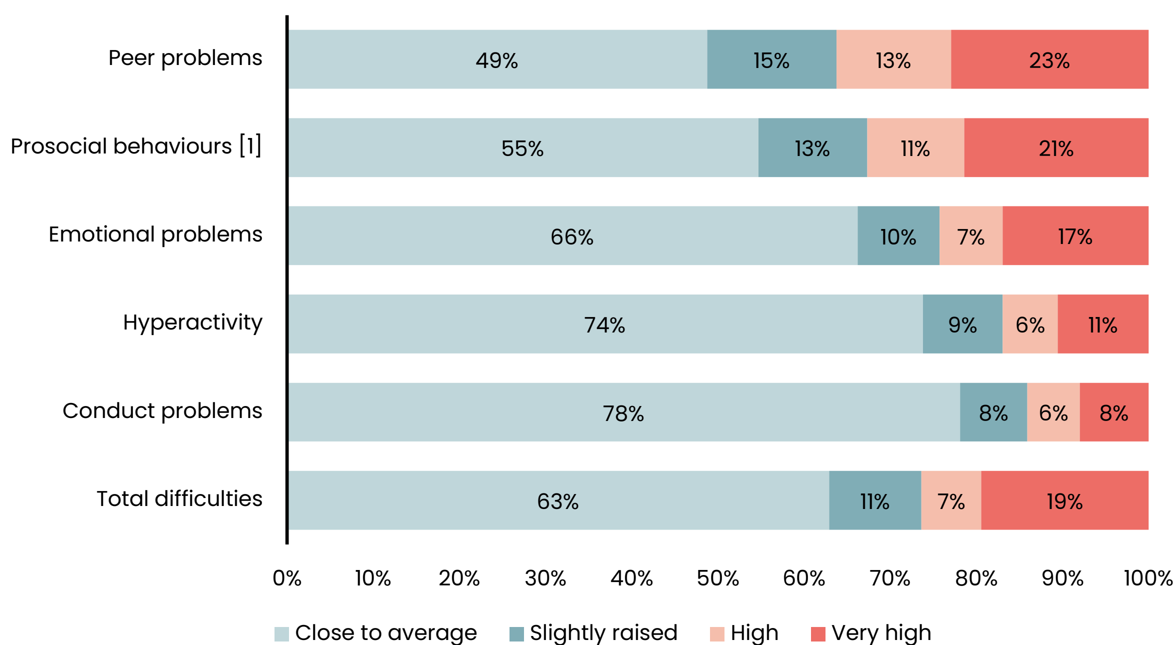
The scale of poor mental health among teenagers is alarming. More than one in four 13-17-year-olds reported high or very high levels of mental health difficulties, as measured by the SDQ — the equivalent of nearly a million teenage children[1] struggling with their well-being.

Behind this figure lie serious and often complex needs. A quarter of teenage children reported a diagnosis of at least one mental health or neurodevelopmental condition, such as depression, attention deficit hyperactivity disorder or speech and communication difficulties. A further 21% suspected they had a condition but had not been formally diagnosed — suggesting large numbers of teenage children are facing difficulties without recognition or support.

[1] Estimates derived using the Office for National Statistics mid-2024 population estimates.

A quarter of all teenage children are suffering from mental health difficulties.

PROPORTION OF 13-17-YEAR-OLDS WITH DIFFERENT LEVELS OF REPORTED DIFFICULTY ON THE DIMENSIONS OF MENTAL HEALTH MEASURED BY THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE



[1] Prosocial behaviours are scored in reverse; the levels are: close to average, slightly lowered, low, and very low.

For some young people, the burden of their struggles can lead to distressing thoughts and actions. Fourteen per cent said they had deliberately hurt themselves in the past year, while 12% had thought about ending their life. In total, almost one in five — around 710,000 teenage children[2] — had self-harmed or experienced suicidal thoughts.

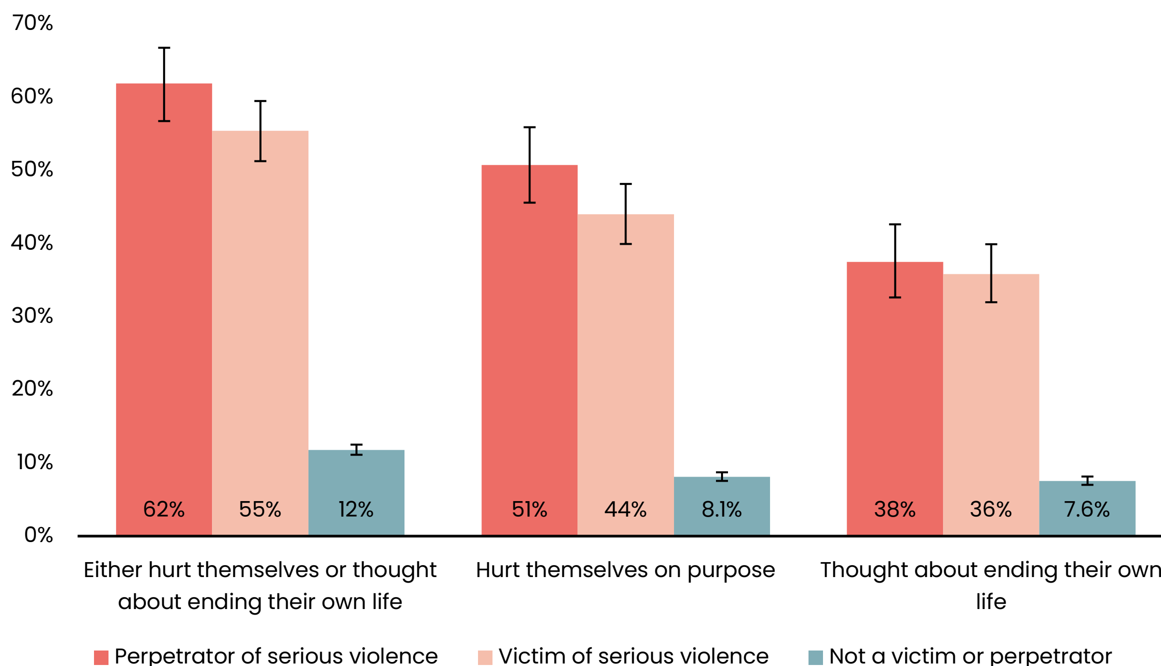
The risks are even greater for teenage children directly involved in serious violence. Nearly two-thirds (62%) of those who had committed violence in the past year that resulted in a victim needing medical treatment (by a doctor or at a hospital) had also hurt themselves or considered suicide, compared with just 12% of teenage children not involved in such violence. Perpetrators of serious violence were also over three times more likely than teenage children not involved in such violence to have high levels of mental health difficulties, as measured by the SDQ (64% compared to 20%), and over four times more likely to have a diagnosed mental health or neurodevelopmental condition (81% compared to 19%).

But the impact isn't only seen in these most severe outcomes. Many teenagers described how the fear of violence shapes their everyday lives. Almost one in five (19%) avoided places or events, while 15% changed how they travel — taking different routes, avoiding public transport or not travelling alone – to stay safe. A smaller but significant minority (3.1%) had taken extreme measures to protect themselves, such as carrying a weapon or joining a gang. In total, 39% of all teenage children reported concrete impacts of fears of violence.

[2] Estimates derived using the Office for National Statistics mid-2024 population estimates.

Nearly two in three teenage children who've perpetrated serious violence have hurt themselves or considered suicide.

PROPORTION OF 13-17-YEAR-OLDS WHO HURT THEMSELVES OR THOUGHT ABOUT ENDING THEIR OWN LIFE, BY EXPERIENCE OF VIOLENCE



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

[For] some of the people I work with [in youth justice] who are experiencing mental health issues and who were involved in violence, mental health is one thing you can avoid dealing with. When they're dealing with immediate violence in their houses or in their social groups, when they're dealing with poverty, those are things you cannot physically avoid. You have to deal with [the] day-to-day. Mental health can take a back seat because 'I need to survive today', and then it ends up becoming worse and worse because you don't have the resources, time or the capacity to deal with that. Or sometimes, it again comes back to what you were saying about the stigma. If you're truly involved in violence and around certain people, there is a stigma around, 'What, you're talking to a therapist?' or 'What, you're on meds? That's weird'. So, a lot of people don't access support because 'who does that?'

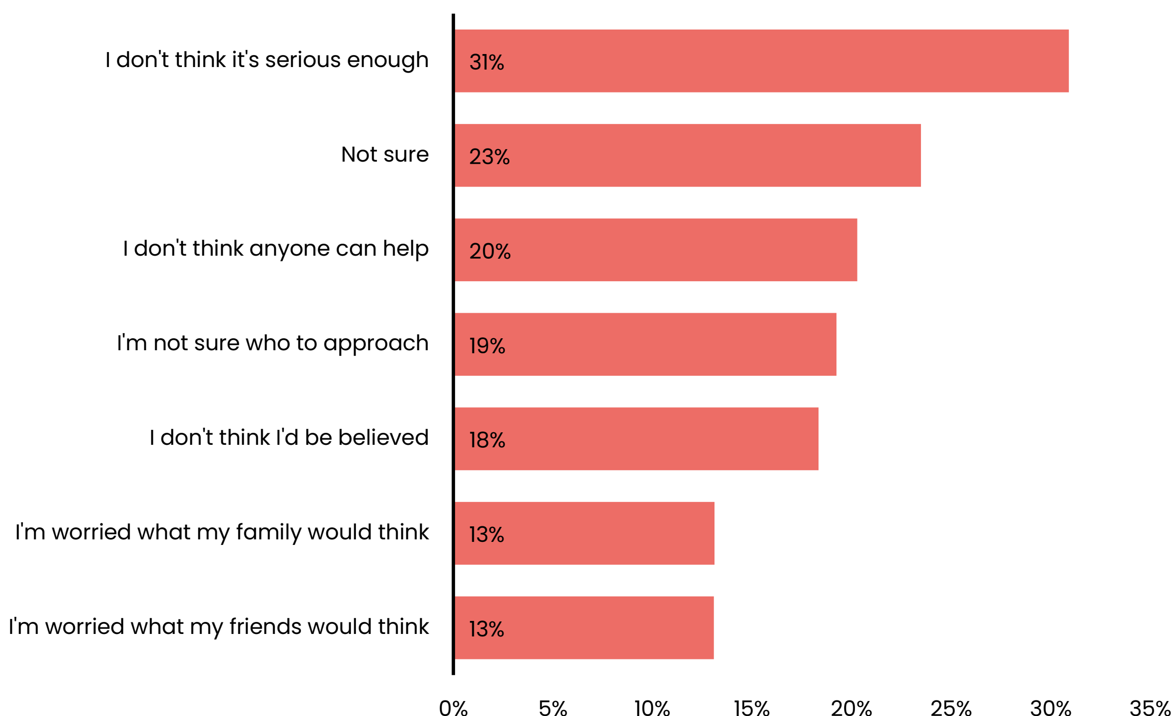
Ajada, YEF Youth Advisory Board Member

Most teenage children experiencing violence and mental health issues aren't receiving treatment.

Most teenagers with a diagnosed or suspected condition had spoken to someone they trust about it — usually a parent or a friend. Among the small minority who hadn't, the most common reason was believing their problem wasn't serious enough.

The most common reason teens don't ask for help is that they think their problems aren't serious enough.

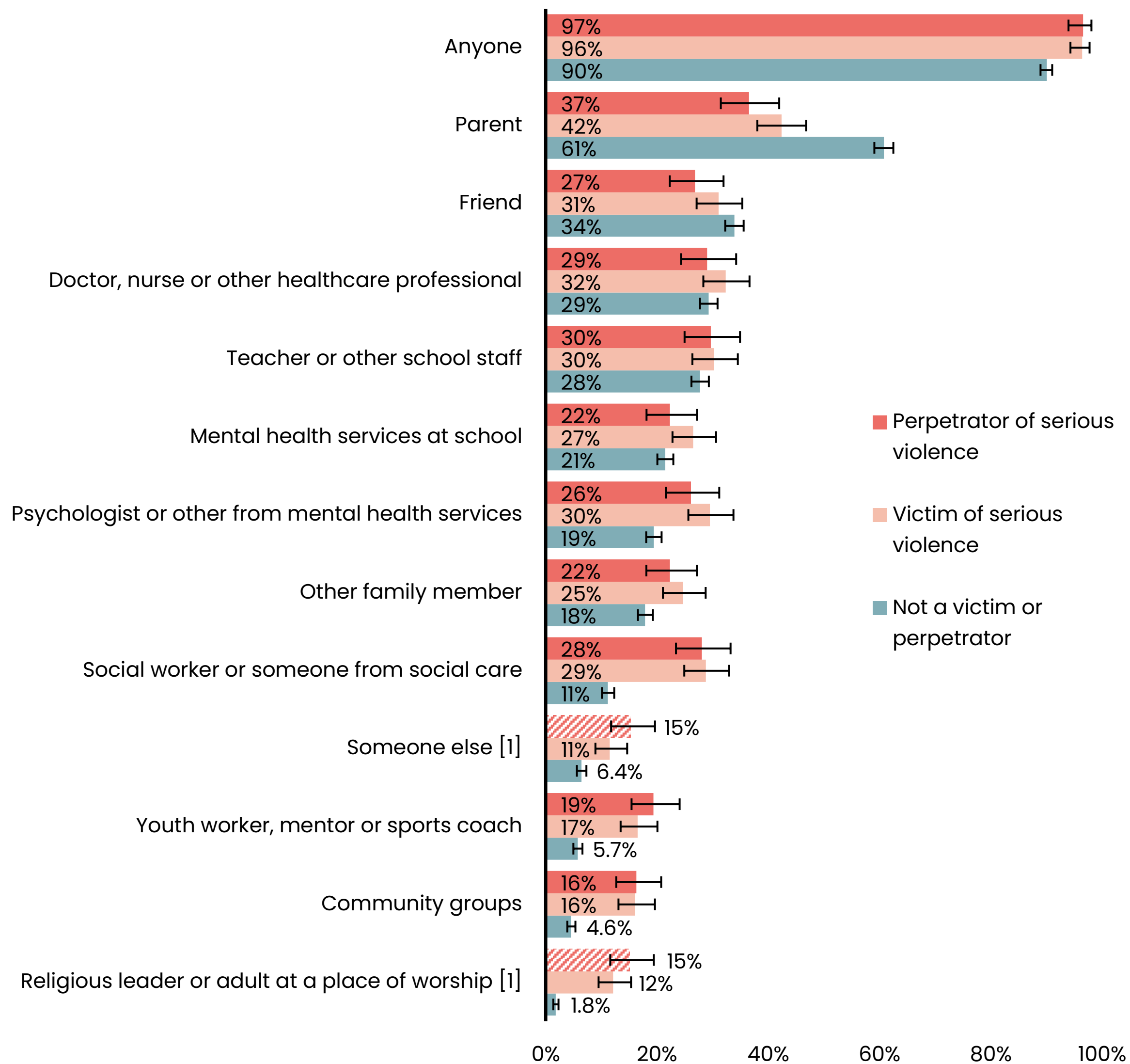
REASONS 13-17-YEAR-OLDS WITH MENTAL HEALTH DIFFICULTIES HADN'T SPOKEN TO ANYONE ABOUT IT



For teenage children affected by serious violence, the picture looks different again. Almost all (96%) had spoken to someone about their mental health — more than their peers who hadn't experienced violence (90%). But who they turned to is telling. They were less likely to confide in a parent and more likely to seek help from adults outside the family — social workers, psychologists, religious leaders, youth workers, mentors or sports coaches.

Teens affected by serious violence are more likely to turn to adults outside their families.

PROPORTION OF 13-17-YEAR-OLDS WITH SUSPECTED OR DIAGNOSED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITIONS WHO SPOKE TO SOMEONE ABOUT IT, BY EXPERIENCE OF VIOLENCE



[1] Bars with striped shading have cell counts of less than 50, so these figures should be interpreted with caution.

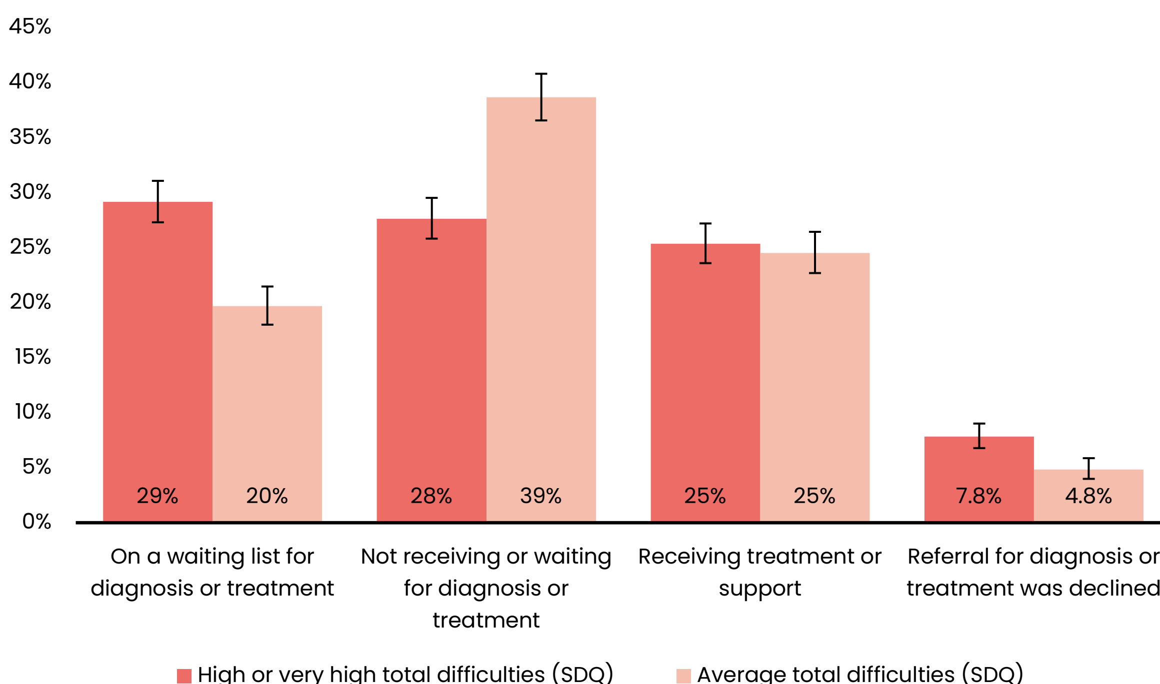
Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

While it is positive that the vast majority are speaking to someone, far fewer are accessing formal treatment or support. Over half (53%) of teenage children with a diagnosed mental health condition were receiving no support. Of those not receiving support, around half (51%) were on a waiting list. Over a third (36%) were not receiving treatment or waiting to receive any support, and a further 13% had been referred to treatment but had been declined. This means many teenage children with a diagnosed mental health condition were neither seeking, receiving nor expecting any form of professional support.

Worse still, the majority of teenage children who'd perpetrated violence and had diagnosed or suspected mental health problems weren't getting any professional support. Of this group, 32% were receiving treatment, which was higher than the 23% of teenage children who had a diagnosed or suspected mental health condition but hadn't been involved in violence. However, the majority were still not receiving support – 50% of perpetrators of violence with a suspected or diagnosed condition were on a waiting list, compared to 22% of those who hadn't experienced violence.

Teens with high levels of difficulty are no more likely to receive treatment but are more likely to be on a waiting list.

PROPORTION OF 13-17-YEAR-OLDS WITH DIAGNOSED OR SUSPECTED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITIONS RECEIVING OR WAITING FOR DIAGNOSIS OR TREATMENT, BY TOTAL LEVEL OF DIFFICULTY ACCORDING TO THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

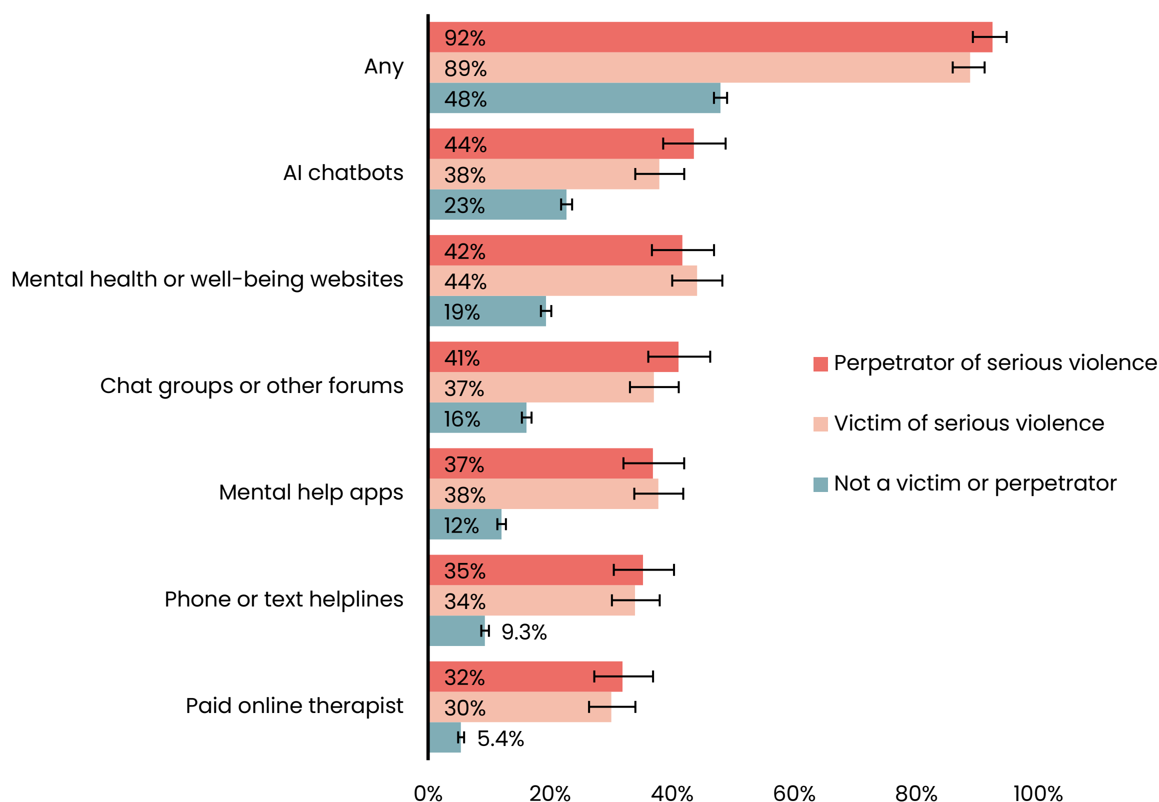
Teens are turning online for support.

With so many teenage children unable to access timely treatment and worried that their problems might not be serious enough to share, it's perhaps unsurprising that many are turning online for advice and support. More than half (53%) of all teenage children said they had used at least one form of online mental health support, rising to two-thirds (67%) among those with the highest levels of difficulties, as measured by the SDQ.

Strikingly, a quarter of all teenage children had turned to AI chatbots for help — making them more commonly used than longer-established resources, such as mental health websites or telephone helplines.

Four in ten teens who've perpetrated serious violence have used AI chatbots for advice and support.

PROPORTION OF 13-17-YEAR-OLDS SEEKING ADVICE AND SUPPORT ONLINE, BY EXPERIENCES OF VIOLENCE



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

The turn to online support is even more pronounced among teens affected by serious violence. Over nine in ten (92%) teenage children who perpetrated serious violence said they had sought advice or help online — nearly twice the rate of those who hadn't experienced any violence as victims or perpetrators (48%). This potentially highlights the high rates of mental health difficulties amongst these children. They were especially more likely to use dedicated mental health resources: over four in ten (42%) perpetrators of serious violence used dedicated mental health websites, over a third had tried apps (37% compared to 12% of those not affected by violence), over a third had turned to helplines (35% compared to 9.3% not affected by violence) and over three in ten had accessed online therapists (32% compared to 5.4% not affected by violence).

What works to prevent violence?

Teenagers affected by serious violence — whether as victims or perpetrators — are at far greater risk of experiencing mental health difficulties. While formal diagnosis and specialist psychological care should always be the first line of support, other types of therapies and accessible interventions can also play an important role in supporting young people's well-being and reducing the risk of violence.

The **Alternative Provision Specialist Taskforce** offers a practical example. This programme placed professionals — including mental health practitioners, speech and language therapists, and psychologists — directly into alternative provision settings to provide specialist and targeted therapeutic support to young people who are at higher risk of violence.

When professional help is unavailable or feels out of reach, some young people turn to online spaces and AI for advice. The immediacy and anonymity of the support these platforms offer can make young people feel safer and make them more accessible than formal mental health services. But convenience isn't always a substitute for human connection.

Activities such as **sports** and **arts programmes** give young people positive ways to express their emotions, build confidence and form trusted relationships with adults and peers. More structured, evidence-based therapies — such as **trauma-specific therapies**, **Cognitive Behavioural Therapy**, **Functional Family Therapy** and **Multi-Systemic Therapy** — have also been shown to reduce violence effectively by helping young people process experiences, change thought patterns and strengthen family relationships.

When young people are supported to feel safe, connected and understood, violence is not inevitable — it's preventable.

Headline findings

	Teenage children affected by serious violence face a dramatically higher risk of mental health problems.
A quarter of all teenage children are suffering from mental health difficulties.	26% of 13-17-year-olds reported symptoms associated with a high level of mental health difficulty, according to the Strengths and Difficulties Questionnaire. 25% have a professionally diagnosed mental health or neurodevelopmental condition, and a further 21% suspect they have a condition they don't have a diagnosis for. 19% have hurt themselves or thought about ending their own life in the past year.
Fears of violence impact teen's mental health and behaviour.	39% of all 13-17-year-olds reported that worries about violence were impacting their day-to-day life. 11% said they've had trouble eating, sleeping or concentrating. 19% have changed where they go and what they do. Almost all 13-17-year-olds affected by serious violence (violence that required medical treatment by a doctor or at a hospital) reported impacts: 95% of perpetrators and 90% of victims.
Nearly 2 in 3 teens who've perpetrated serious violence have self-harmed or thought about suicide.	64% of 13-17-year-olds who've perpetrated serious violence had high levels of mental health difficulties, over 3 times the 20% of those who haven't experienced violence. 81% have a diagnosis of a mental health or neurodevelopmental condition, over 4 times the 19% of those who haven't experienced violence. 62% have hurt themselves or thought about ending their life in the past year, over 5 times the 12% of those who haven't experienced violence.
	Most teenage children experiencing violence and mental health issues aren't receiving treatment.
Most teens have spoken to someone about their difficulties …	91% of 13-17-year-olds with a diagnosed or suspected difficulty have spoken to at least one person about it, most commonly a parent (58%). 68% have spoken to an adult outside their family, such as a teacher, counsellor, psychologist, doctor or social worker. 36% have spoken to a friend.
… but less than half of those with a diagnosed condition are receiving professional help.	Around half (53%) of the 13-17-year-olds with a diagnosed mental health condition were receiving no support. Of those not receiving support, around half (51%) were on a waiting list. Over a third (36%) were not receiving treatment or waiting to get any, and a further 13% had been referred to treatment but had been declined. This implies that many with a diagnosis were neither seeking, receiving nor expecting any form of professional support.
Half the teens with mental health difficulties who've perpetrated serious violence are on a waiting list.	Of 13-17-year-olds with a diagnosed or suspected mental health condition who'd perpetrated serious violence, 32% were receiving treatment, compared to 23% who hadn't experienced any violence as a victim or perpetrator. But the majority were not receiving support, with 50% of perpetrators of violence with a suspected or diagnosed condition on a waiting list, compared to 22% of those who hadn't experienced violence.

	Teens are turning online for support.
A quarter of all teenage children have used AI chatbots for advice and support.	53% of all 13-17-year-olds have used some form of online or digital mental health support. 25% have used AI, 22% have used websites about health or well-being, 18% have used chat groups or online forums, and 15% have used mental help apps. Those reporting symptoms associated with a high level of mental health difficulties were more likely to have used online support than those without diagnosed or suspected difficulties (67% vs 53%).
This rises to 4 in 10 amongst those affected by serious violence.	92% of 13-17-year-olds who've perpetrated serious violence have sought advice or support online. 44% have turned to AI. Teens who perpetrated serious violence were also more likely to say they'd used mental help apps (37% vs 12% of those who hadn't been a victim or perpetrator), phone or text helplines (35% vs 9.3%) and online therapists (32% vs 5.4%).
Teens not getting professional help may be turning to online sources.	13-17-year-olds on a waiting list (72%) and those referred for diagnosis or treatment but had their referral declined (76%) were significantly more likely to have sought support online compared to those receiving treatment (68%). They were most likely to be using websites about health or well-being as their source of digital advice or support (37% of those on waiting lists and 38% of those with declined referrals, respectively). There was no difference in the use of AI between those receiving treatment (26%) and those on a waiting list (25%).

Methodology

About this year's survey

Question and thematic overview

This is our fourth annual survey of children's experiences of violence. This year, we surveyed nearly 11,000 13-17-year-olds across England and Wales about their experiences over the past 12 months. In this year's survey, we focused on the following themes.

- What's the scale and nature of violence experienced by teenage children, as victims, perpetrators and witnesses, in person and online? What are the characteristics of the teens most impacted?
- How prevalent is relationship violence? How does this impact boys and girls differently? What do teens view as acceptable behaviour?
- How prevalent are mental health difficulties and neurodevelopmental conditions among teenage children? How do these overlap with experiences of violence? Where do teens turn to for support?
- How many teenage children are at risk of or experience criminal exploitation? What are the routes into and out of exploitation?

This is the third report in this year's series. It covers the prevalence of mental health difficulties and neurodevelopmental conditions, their overlaps with experiences of violence and the types and sources of support received.

What we did

This year, a total of 10,835 13-17-year-olds responded to our survey, compared to 10,387 last year. This slightly larger sample size ensured we heard sufficiently from smaller groups.

As with last year, we used an online survey conducted by our survey partner, Savanta. The average survey completion time was around 14 minutes, and the survey was live between May and July 2025. Questions typically related to children's experiences over the preceding 12 months.

To ensure the results were nationally representative, we did two things:

- Firstly, we set quotas for key groups. These were age, gender, ethnicity, region and socioeconomic status. The quotas were based on each group's share of the population using Census 2021 population estimates for 13-17-year-olds.
- Secondly, we weighted the results to ensure overall representativeness. This year, we worked with survey consultants from University College London (Dr Krisztián Pósch and Ana Cristancho) to refine the methodology for applying weights to ensure the results are as accurate as possible, particularly when looking at findings by subgroup. All results from last year's survey have been updated to reflect the revised weighting methodology to ensure results are as comparable as possible. For more details on this, see the technical report on our website.

How children were kept safe

Children were invited to take part in the survey and were made aware of the types of questions that would be asked. Anyone could refuse to take part. For all children aged 15 or under, a parent or guardian had to consent for them to take part. Participants could drop out of the survey at any time. Participants were asked to complete the survey on their own and in a safe place where their responses could not be seen. It wasn't possible to look back at previous responses once questions had been answered. At the beginning and end and throughout the survey, participants were signposted to relevant support services.

Approach to reporting results

The smaller the number of responses, the less confident we are in the results. For this reason, we generally don't report results where the total number of responses to a particular question was less than 50. All group comparisons mentioned in the report are statistically significant at a 95% confidence level, unless otherwise noted.

What to be aware of

Like all research, our survey has some limitations. We're trying to understand what teenage children across England and Wales have experienced. While our sample of 10,835 13-17-year-olds is comparably large for this type of survey (for context, the Office for National Statistics' Crime Survey of England and Wales reached 1,528 10-15-year-olds in 2023/24 and has consistently reached around 3,000 young people in recent years), it still represents a small proportion of all children in the country. It's important, therefore, to remember these limitations when interpreting the results:

- Weights are applied to ensure that the results are broadly representative of the national populations of England and Wales. This year, we refined the results so we can more accurately speak to certain subgroups (e.g. by race). However, there are limits to the extent to which weights can be applied to cover variations across all interlocking characteristics. There should be particular caution when looking at results by region due to the challenge in applying interlocking weights at this level.
- The sample size is significantly larger than in other surveys of this kind. However, when we look at the results for some smaller subgroups (e.g. by region, ethnicity and age), these individual groups can be small. This makes it hard to draw generalised conclusions for some smaller populations.
- The subject matter (children's experiences of violence) is sensitive. While we ensured the framing of the questions was suitable for children, it's possible that some may have been unwilling to respond openly and honestly, particularly about things they may have done.
- Caution should be taken when making comparisons between this year's survey and last year's. Whilst we've updated the results from last year to reflect some observable differences in who was recruited, we cannot fully rule out that any differences in the results between the years reflect unaccounted-for changes in the characteristics of those who responded.

Detailed findings

What we found

There are clear links between experiences of violence and poor mental health. But we have few good estimates of the mental health needs of children affected by violence and the types of support these children are accessing. Online therapies are a fast-growing sector that can help improve access to mental health support for those struggling to reach in-person services. But the use of AI tools in this space is new and poorly understood. In this report, we look at the prevalence of mental health difficulties among teens, access and barriers to mental health services, alternative forms of support in the online space and how all these experiences relate to experiences of violence.

Teenage children affected by serious violence face a dramatically higher risk of mental health problems.

A quarter of all teenage children are suffering from mental health difficulties.

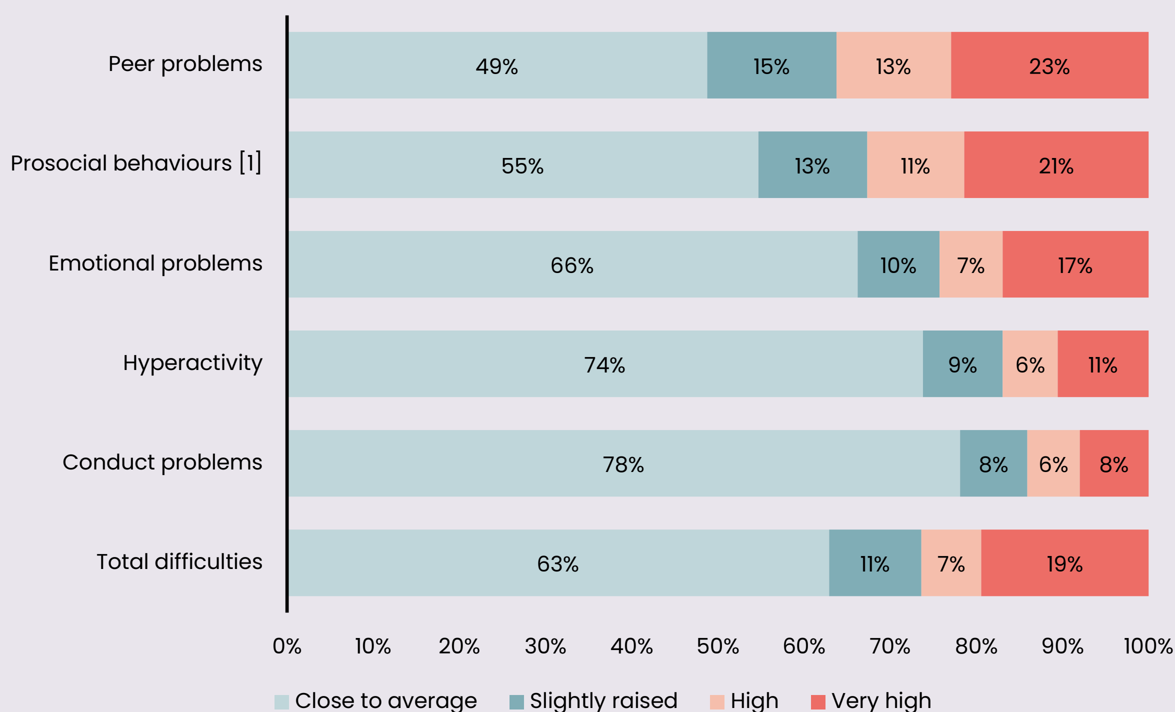
For the first time this year, we included questions about mental health in our survey. We measured three different aspects of mental health:

1. Symptoms of mental health difficulties, using the Strengths and Difficulties Questionnaire (SDQ)
2. Self-harm and suicidal thinking
3. Specific mental health conditions and neurodevelopmental conditions, as diagnosed by a professional or suspected but without a diagnosis

The SDQ provides us with an estimate of how much children are struggling with their mental health. The 25-item questionnaire comprises five subscales measuring emotional problems, conduct problems (i.e. behavioural difficulties), hyperactivity, peer problems and prosocial behaviours. The total difficulties score is created by combining the subscales, except for prosocial behaviours. Children's scores on these subscales can be used to categorise their level of difficulty as being close to average (i.e. fairly typical), slightly raised, high or very high.

According to the symptoms reported by survey respondents via the SDQ, over a quarter (26%) of 13-17-year-olds in England and Wales have high or very high levels of total difficulties – equivalent to 990,000 teenage children.[3] Looking at individual subscales, 14% had high or very high levels of conduct problems, 17% had high or very high levels of hyperactivity, 24% had high or very high levels of emotional problems and 36% had high or very high levels of peer problems. Thirty-three per cent had low levels of prosocial behaviours.

FIGURE 1.1: PROPORTION OF 13-17-YEAR-OLDS WITH DIFFERENT LEVELS OF REPORTED DIFFICULTIES ON THE DIMENSIONS OF MENTAL HEALTH MEASURED BY THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE



[1] Prosocial behaviours are scored in reverse; the levels are close to average, slightly lowered, low, and very low.

To measure self-harm and suicidal thinking as indicators of more extreme symptoms of poor mental health, we asked children whether they had hurt themselves on purpose or thought about ending their own life in the past 12 months. Concerningly, 14% of 13-17-year-olds said they'd hurt themselves physically on purpose in some way in the past year, while 82% said they hadn't, and 4.9% chose 'prefer not to say' or skipped the question. Twelve per cent said they'd thought about ending their own life, while 82% said they hadn't, and 10% chose 'prefer not to say' or skipped the question. Overall, almost one in five (19%) had done one or the other of these things, equivalent to 710,000 13-17-year-olds across England and Wales.

[3] Estimates derived using the Office for National Statistics mid-2024 population estimates.

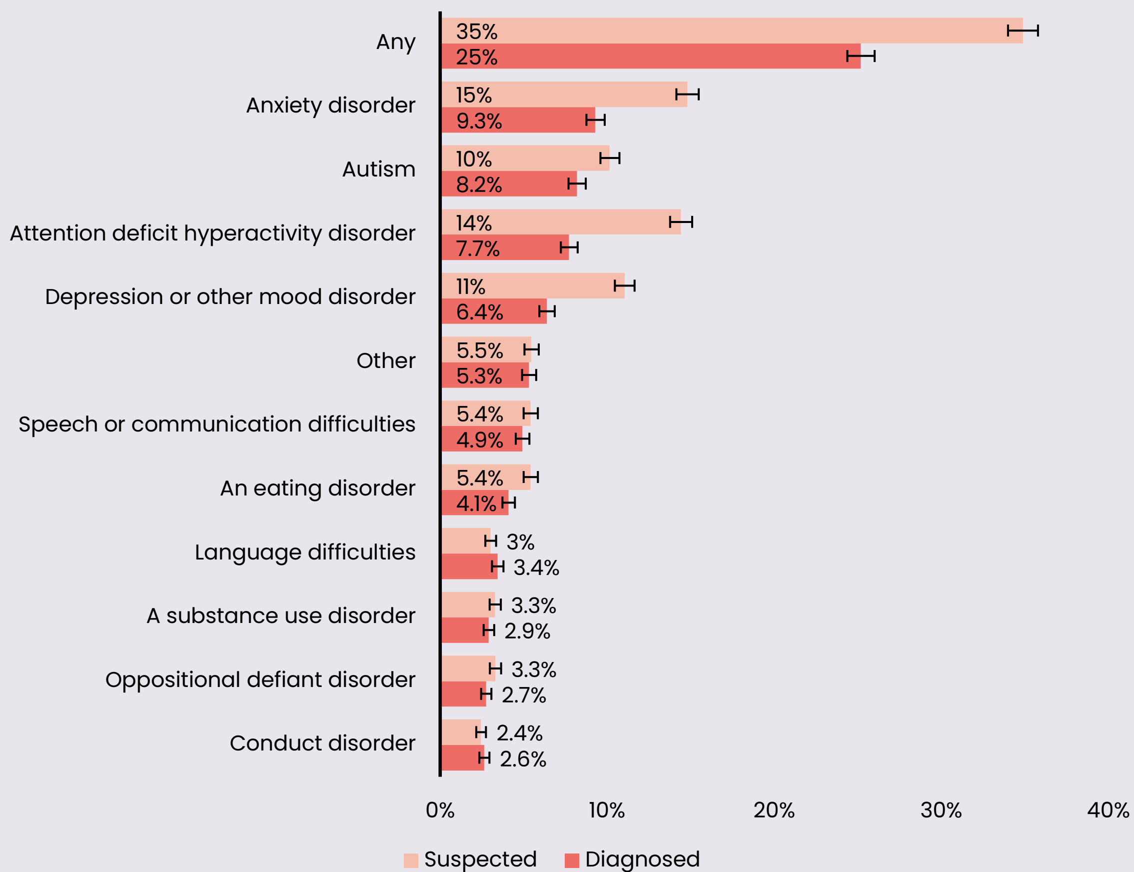
How do these findings compare with other data sources?

Our survey finds broadly similar rates of mental health difficulties amongst children in England and Wales as measured by the SDQ as those found in other large surveys. The 2023 NHS Mental Health of Children and Young People in England survey found comparable rates of difficulties, as measured by the SDQ, to our own findings. Twenty-three per cent of 11-16-year-olds in England were estimated to have a probable mental health disorder based on the SDQ, which is similar to the 26% we found for the 13-17-year-olds in our survey. The 2023 Student Health and Wellbeing Survey, completed by over 100,000 children in schools in Wales, found that 35% of 11-16-year-olds reported symptoms on the SDQ associated with high or very high levels of total difficulties. This is higher than the 26% of 13-17-year-olds across England and Wales that we found in our survey and the 29% of 13-17-year-olds that we found in Wales specifically.

The rates of self-harm and suicidal thinking in our survey were also broadly in line with other sources. The NHS survey found that 11% of 11-16-year-olds had tried to harm themselves at any point in their lifetime, compared to 14% of the 13-17-year-olds who responded to our survey who said they'd hurt themselves in the past year, but lower rates are to be expected amongst younger children. Estimates from slightly older groups found even higher rates: according to the NHS Adult Psychiatric Morbidity Survey, 25% of 16-24-year-olds had self-harmed and 32% had thoughts of taking their own life at some point. This is almost triple the 12% of 13-17-year-olds from our survey who'd thought about ending their life in the past year, but we'd expect lifetime estimates to be higher than our own estimates, which were based only on the preceding 12 months.

When we asked children about the specific mental health and neurodevelopmental conditions they had, a quarter (25%) said they had at least one diagnosis and 35% suspected they had a condition they didn't have a diagnosis for. In total, almost half (46%) were either diagnosed with or suspected they had at least one condition. Anxiety disorders were the most common, both in terms of professional diagnosis and suspected conditions, with 9.3% of 13-17-year-olds having a diagnosis and a further 15% suspecting they had an anxiety disorder. This was followed by autism, which 8.2% were diagnosed with, and a further 10% suspected they suffered from. For attention deficit hyperactivity disorder (ADHD), while 7.7% were diagnosed, almost double that (14%) suspected they had it. For depression and other mood disorders, 6.4% were diagnosed, and a further 11% suspected they had these disorders in some form. Overall, the proportion of 13-17-year-olds with a diagnosed condition (25%) was similar to the proportion with high total difficulties according to the SDQ (26%).

FIGURE 1.2: PROPORTION OF 13-17-YEAR-OLDS IN ENGLAND AND WALES WITH SUSPECTED OR DIAGNOSED MENTAL HEALTH AND NEURODEVELOPMENTAL CONDITIONS

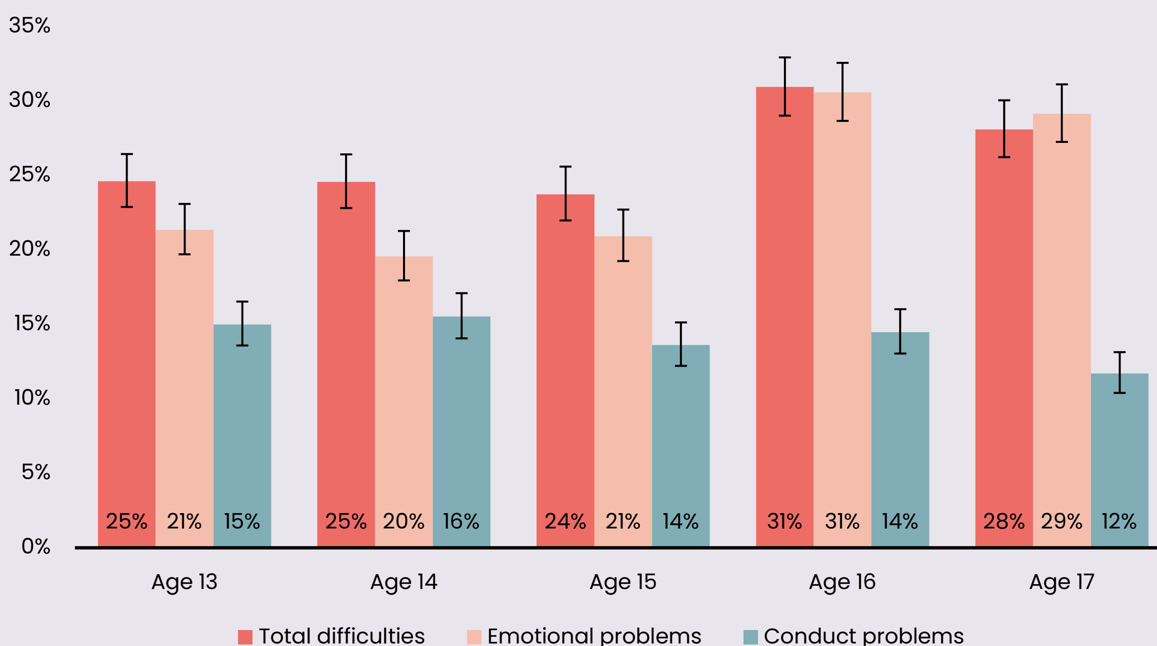


Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Rates of emotional difficulties increase with age, while conduct problems become less common.

Based on the SDQ and children's diagnoses, emotional difficulties appeared to increase with age, while conduct difficulties appeared to decrease. Sixteen- and 17-year-olds were significantly more likely to have high levels of emotional difficulties as measured by the SDQ, whereas younger teens were more likely to have high levels of conduct problems, according to the SDQ. Overall, 16-year-olds had the highest rates of difficulties with their mental health, according to the SDQ total difficulties score.

FIGURE 1.3: PROPORTION OF 13-17-YEAR-OLDS WITH HIGH OR VERY HIGH LEVELS OF SYMPTOMS, ACCORDING TO THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE TOTAL DIFFICULTIES SCORE AND EMOTIONAL AND CONDUCT PROBLEMS SUBSCALES, BY AGE



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Children's diagnoses showed the same pattern: older teens were more likely to have had a diagnosis of an anxiety disorder and depression or another mood disorder and less likely to have a conduct disorder diagnosis, in comparison to younger teens. For example, 12% of 16-17-year-olds had been diagnosed with some form of anxiety, compared to 7.5% of 13-14-year-olds. Also, 16-17-year-olds were significantly more likely to have hurt themselves or thought about ending their own life in the past year (25%) than 13-15-year-olds (15%).

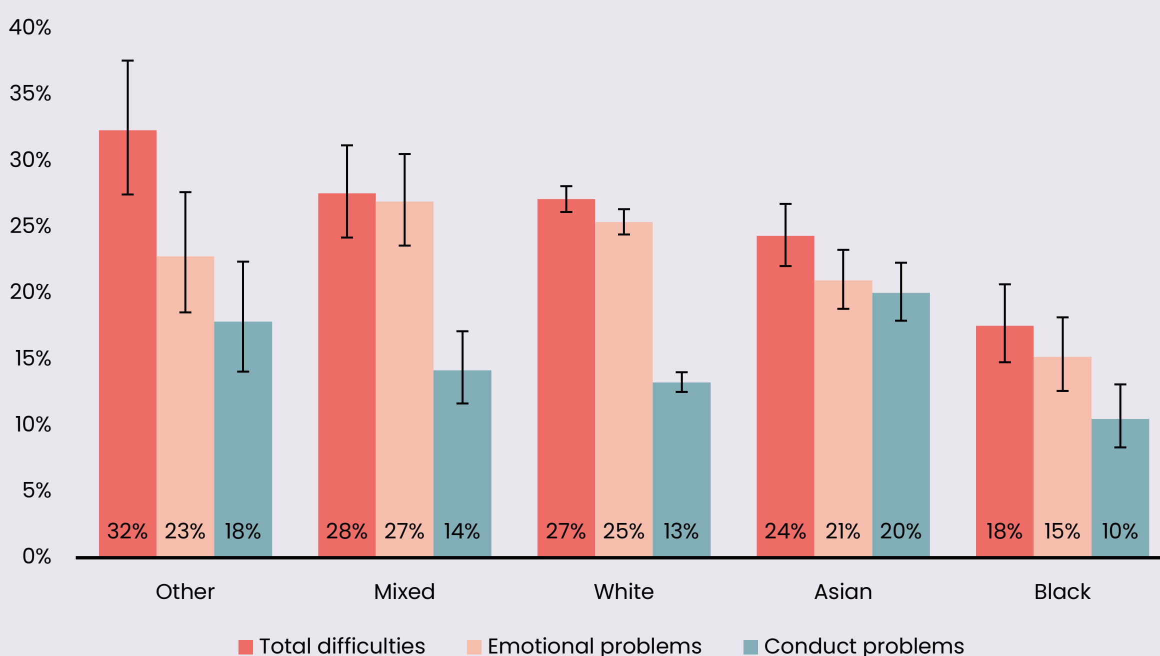
When considering gender, girls appeared to have higher rates of mental health difficulties than boys. According to the SDQ, 29% of girls scored high or very high on the total difficulties score, compared to 23% of boys. The difference was particularly large for emotional problems, for which 31% of girls had high or very high levels of difficulty, compared to 17% of boys. Girls were also significantly more likely to say they'd self-harmed (17%) or thought about suicide (15%) in the past year, compared to boys (10% and 9.1%, respectively). Prosocial behaviours were the only area where boys appeared to have significantly higher rates of difficulty; 37% of boys had low or very low prosocial behaviour scores, compared to 28% of girls.

Despite these differences, girls and boys were equally likely to have had a diagnosis of a mental health or neurodevelopmental condition (25%). Looking at specific diagnoses, girls were more likely to have an anxiety disorder diagnosis (11%) than boys (7.5%). The difference in mood disorder diagnoses wasn't statistically significant (6.6% of girls compared to 5.9% of boys). In contrast, boys were significantly more likely to have a diagnosis of oppositional defiant disorder (3.1% compared to 2.3% of girls), conduct disorder (3.3% compared to 1.9% of girls) and ADHD (8.6% compared to 6.7% of girls). Boys were also more likely than girls to have a diagnosis of autism (8.9% compared to 7.2% of girls), speech or communication difficulties

(5.7% compared to 4% of girls), language difficulties or developmental language disorder (3.9% compared to 2.8% of girls) and a substance use disorder (3.4% compared to 2.4% of girls).

In terms of race, teenage children from Black ethnic backgrounds were the least likely to have high levels of total difficulties according to the SDQ (18%), with those from Asian (24%), White (27%) and Mixed (28%) backgrounds all significantly more likely to report high levels of difficulty, and teenage children from any other ethnic background the most likely (32%). Teens from White (25%) and Mixed (27%) backgrounds were the most likely to report high levels of emotional problems, while teens from Asian (20%) and Other (18%) backgrounds were the most likely to report high levels of conduct problems. Some other studies have pointed to higher rates of externalising and internalising problems amongst children from White backgrounds compared to children from other ethnic backgrounds, based on the SDQ for children.

FIGURE 1.4: PROPORTION OF 13-17-YEAR-OLDS WITH HIGH OR VERY HIGH LEVELS OF SYMPTOMS ACCORDING TO THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE TOTAL DIFFICULTIES SCORE AND EMOTIONAL AND CONDUCT PROBLEMS SUBSCALES, BY RACE



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

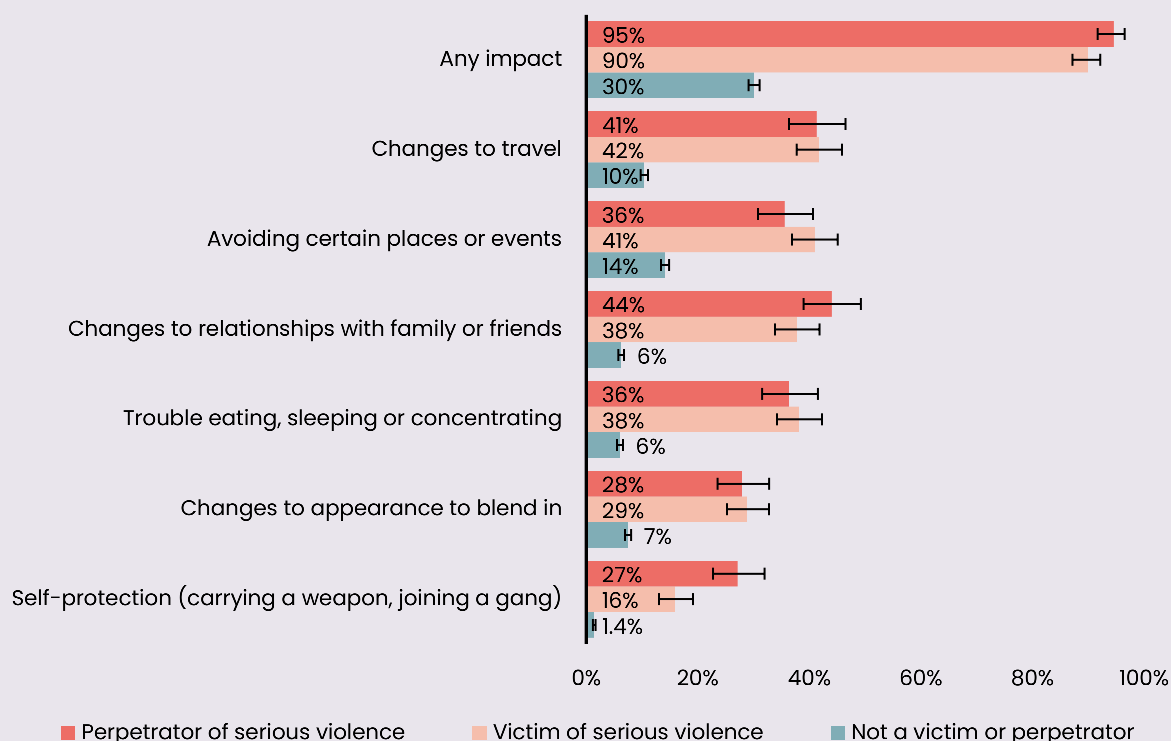
This pattern by race was broadly similar across rates of diagnosed mental health or neurodevelopmental issues. Teenage children from Mixed (25%), White (28%) and Other (27%) ethnic backgrounds were the most likely to have some form of diagnosis. Similarly, teenage children from Mixed ethnic backgrounds were the most likely to have reported having hurt themselves or having thought about ending their own life in the past year (24%), while Asian teens were the least likely (15%). Nineteen per cent of teens from White ethnic backgrounds said they'd hurt themselves or thought about ending their own life in the past year. Due to the small numbers of 13-17-year-olds diagnosed with specific mental health or neurodevelopmental conditions in our sample, it's not possible to look at rates of individual conditions by race.

When it comes to geography, there was no consistent pattern in the areas where children lived in relation to their experiences of psychological difficulties; it varied by the type of difficulty experienced. Teenage children living in cities had higher rates of conduct problems (16%) but lower rates of emotional problems (22%) compared to those living in towns (13% and 27%, respectively) and rural areas (11% and 28%, respectively). Looking at differences between regions, London had the lowest rate of total difficulties. Rates were highest in the East, South West and East Midlands. However, despite rates of emotional problems being particularly low in London (18%), London was one of the regions with the highest rates of self-harm or suicidal thinking (21%), second only to Wales (22%).

Fears of violence impact teen's mental health and behaviour.

To find out about the concrete impacts of violence on children's mental health, we asked whether children had experienced a range of day-to-day impacts because they were worried about violence. Thirty-nine per cent of all 13-17-year-olds said they'd experienced at least one of these impacts, and 11% reported specifically mental health–related impacts, such as having trouble sleeping or concentrating in school and loss of appetite. Children also reported that worries about violence affected their behaviours. The most common impact was avoiding certain places or events (19%), followed by changes in how they travel, such as taking a different route to school, how they use public transport and whether they travel alone (15%). Three point one per cent said they'd done things to protect themselves, such as carrying a weapon or joining a gang.

FIGURE 1.5: PROPORTION OF 13-17-YEAR-OLDS WHO REPORTED DAY-TO-DAY IMPACTS OF FEARS OF VIOLENCE, BY EXPERIENCE OF VIOLENCE



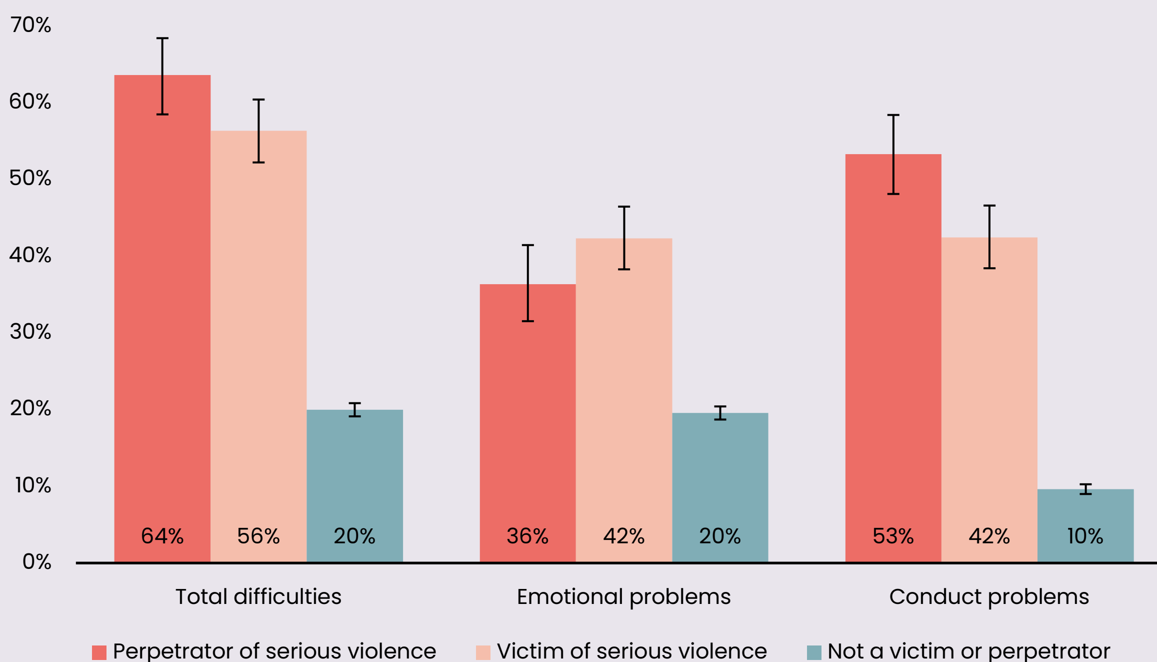
Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Children who'd directly experienced violence, particularly serious violence (violence leading to treatment by a doctor or at a hospital), were even more likely to report that fears of violence impacted their lives. Most 13-17-year-olds (90%) who'd been victims of serious violence reported at least one impact – three times the rate amongst those who hadn't directly experienced violence (30%). This rose even further to almost all 13-17-year-olds who'd perpetrated serious violence (95%). Over a third (36%) of perpetrators of serious violence said they'd had trouble eating, sleeping or concentrating as a result of these fears, six times the rate of those who had no direct experiences of violence as victims or perpetrators. Twenty-seven per cent had done things such as carrying a weapon or joining a gang for self-protection, nearly 20 times the rate of 13-17-year-olds who'd experienced no forms of violence as a victim or perpetrator.

Nearly two in three teens who've perpetrated serious violence have self-harmed or thought about suicide.

According to symptoms as measured by the SDQ, children affected by violence, as both victims and perpetrators, were significantly more likely to have mental health difficulties than their peers who hadn't directly experienced violence. Over half (56%) of 13-17-year-olds who'd been victims of serious violence that required medical treatment by a doctor or at a hospital had a high total difficulties score – making them almost three times as likely to have high levels of difficulty as children who hadn't experienced violence (20%). Teenage children who'd perpetrated serious violence were even more likely to have high total difficulties (64%) than those who'd been victims. They were also more likely to have high levels of conduct problems, whereas victims of violence were more likely to have high levels of emotional problems.

FIGURE 1.6: PROPORTION OF 13-17-YEAR-OLDS WITH HIGH OR VERY HIGH LEVELS OF SYMPTOMS ACCORDING TO THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE TOTAL DIFFICULTIES SCORE AND EMOTIONAL AND CONDUCT PROBLEMS SUBSCALES, BY EXPERIENCE OF VIOLENCE



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

This elevated likelihood of mental health problems in those affected by violence is mirrored in their rates of diagnosis for mental health and neurodevelopmental conditions. Nearly three-quarters (73%) of 13-17-year-olds who've been victims of serious violence have at least one diagnosis of a condition, nearly four times the rate amongst those who haven't experienced violence (19%). This rises to 81% of 13-17-year-olds who've perpetrated serious violence, more than four times the rate for those not affected by violence.

There were also considerable overlaps between experiences of violence and self-harm and suicidal thinking. Teens directly affected by serious violence as victims were almost five times as likely to have hurt themselves or thought about ending their own life in the past year (55%) than teens who hadn't experienced violence (12%). Nearly two-thirds (62%) of those who'd perpetrated serious violence had hurt themselves or thought about ending their life – over five times the 12% of those not affected by violence.

FIGURE 1.7: PROPORTION OF 13-17-YEAR-OLDS WHO HURT THEMSELVES OR THOUGHT ABOUT ENDING THEIR OWN LIFE, BY EXPERIENCE OF VIOLENCE

Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

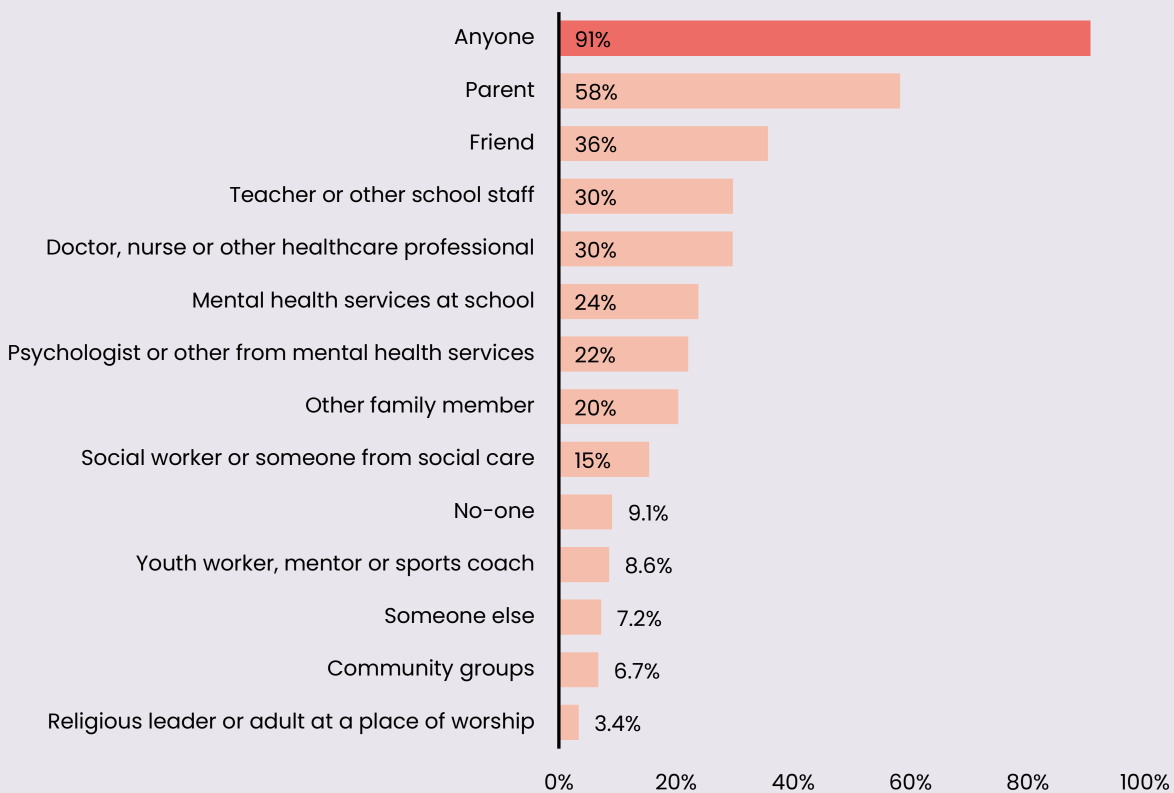
The association between self-harm and experiences of violence shows notable gender differences. Although girls were more likely to have hurt themselves or thought about ending their own lives than boys, for boys, there was a stronger association between experiencing these things and being involved in violence. For example, of the boys who'd hurt themselves in the past year, 23% had perpetrated serious violence – over 11 times the rate for boys who'd not hurt themselves (2.1%). This compares to girls who'd self-harmed, where the rate of perpetrating violence (6.6%) was four times the rate of girls who had not self-harmed (1.6%). There's a similar pattern for children who had thought about ending their own lives. Boys who had thought about ending their own lives were nearly eight times more likely to have perpetrated violence than those who had not thought about ending their own lives (18% compared to 2.4%). For girls, the likelihood of having perpetrated violence was nearly three times higher for those who'd thought about ending their own lives (5.2%) compared to those who hadn't (2%).

Most teenage children experiencing violence and mental health issues aren't receiving treatment.

Most teens have spoken to someone about their difficulties …

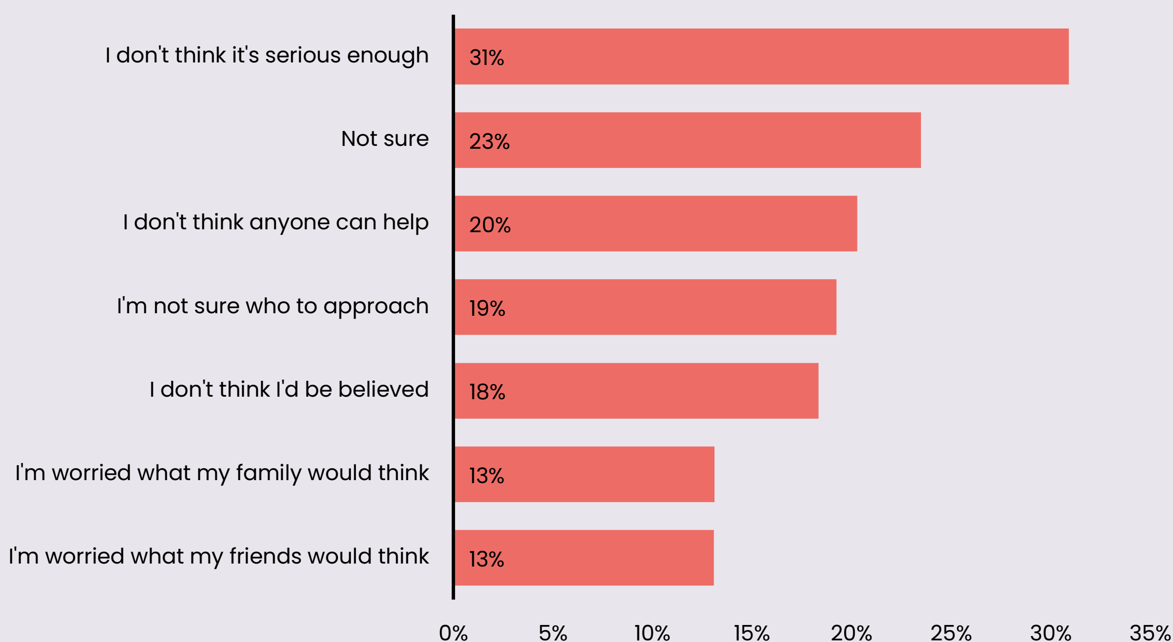
Of the 46% of 13-17-year-olds who said they either suspected or had been diagnosed with a mental health or neurodevelopmental condition, the majority (91%) said they'd spoken to someone about it – 94% of those with a diagnosed difficulty and 87% of those with a suspected difficulty but no diagnosis. The most common person they had spoken to was a parent (58%). Sixty-eight per cent had spoken to an adult outside their family, such as a teacher, counsellor, psychologist, doctor or social worker. Teens were slightly more likely to have spoken to adults who weren't mental health specialists, such as a teacher (30%) or a healthcare professional (30%), than to specialist mental health services, either at school (24%) or elsewhere (22%). Just over a third (36%) had spoken to a friend.

FIGURE 2.1: PROPORTION OF 13-17-YEAR-OLDS WITH SUSPECTED OR DIAGNOSED MENTAL HEALTH DIFFICULTIES WHO'VE SPOKEN TO SOMEONE ABOUT IT



Of those who hadn't spoken to anyone, the most common reason was that they thought their problem wasn't serious enough (31%), followed by being doubtful anyone could help (20%), being unsure about who to go to (19%) and worrying about being believed (18%). A fifth (20%) were worried about what friends or family members would think of them.

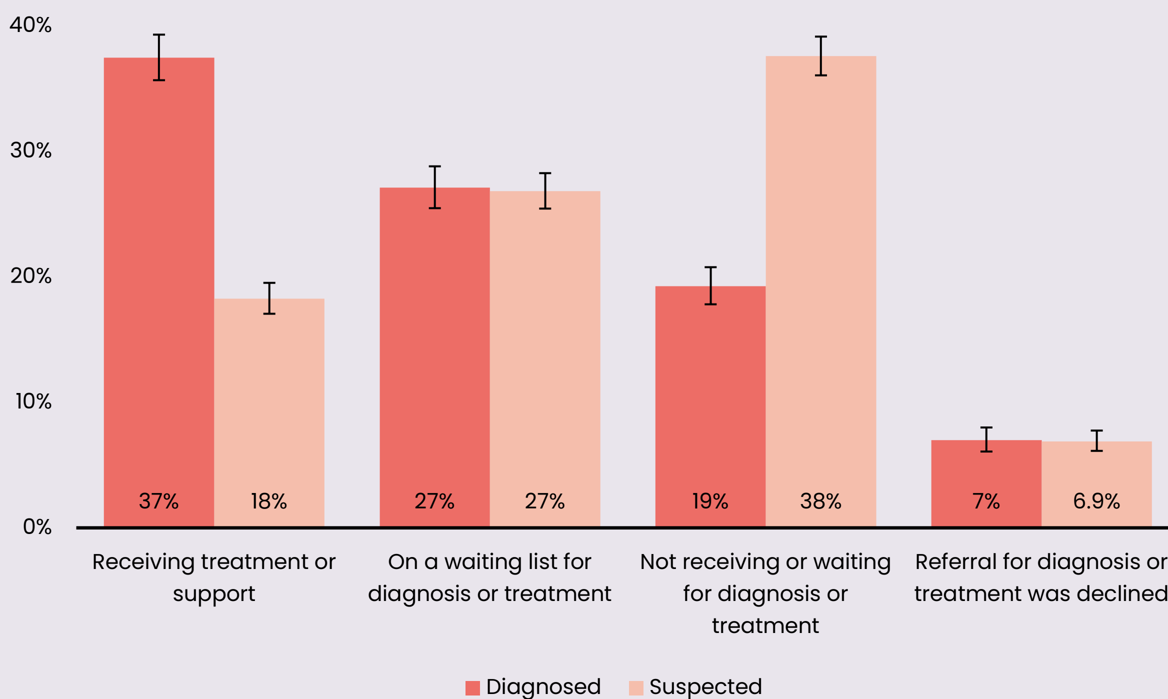
FIGURE 2.2: REASONS 13-17-YEAR-OLDS WITH MENTAL HEALTH DIFFICULTIES HADN'T SPOKEN TO ANYONE ABOUT IT



… but less than half of those with a diagnosed condition are receiving professional help.

Just 18% of 13-17-year-olds with a suspected mental health or neurodevelopmental condition and 37% of those with a diagnosed condition were receiving some form of treatment or support. Most (71% of those with a suspected condition and 53% of those with a diagnosis) were not receiving any professional support. Of those not receiving support, around half of those with a diagnosis (51%) were on a waiting list, compared to 38% of those with a suspected but undiagnosed condition. A further 13% of those with a diagnosed condition who were not receiving support had been referred to treatment but had been declined, compared to 10% of those with a suspected but undiagnosed condition. Over a third (36%) of those with a diagnosed condition and over half (53%) of those with a suspected but undiagnosed condition who were not receiving treatment were also not waiting for treatment or a diagnosis, implying that many were neither seeking nor expecting to receive any form of professional support. Eight point five per cent of all 13-17-year-olds with a diagnosed condition and 10% with a suspected but undiagnosed condition were unsure whether they were receiving treatment.

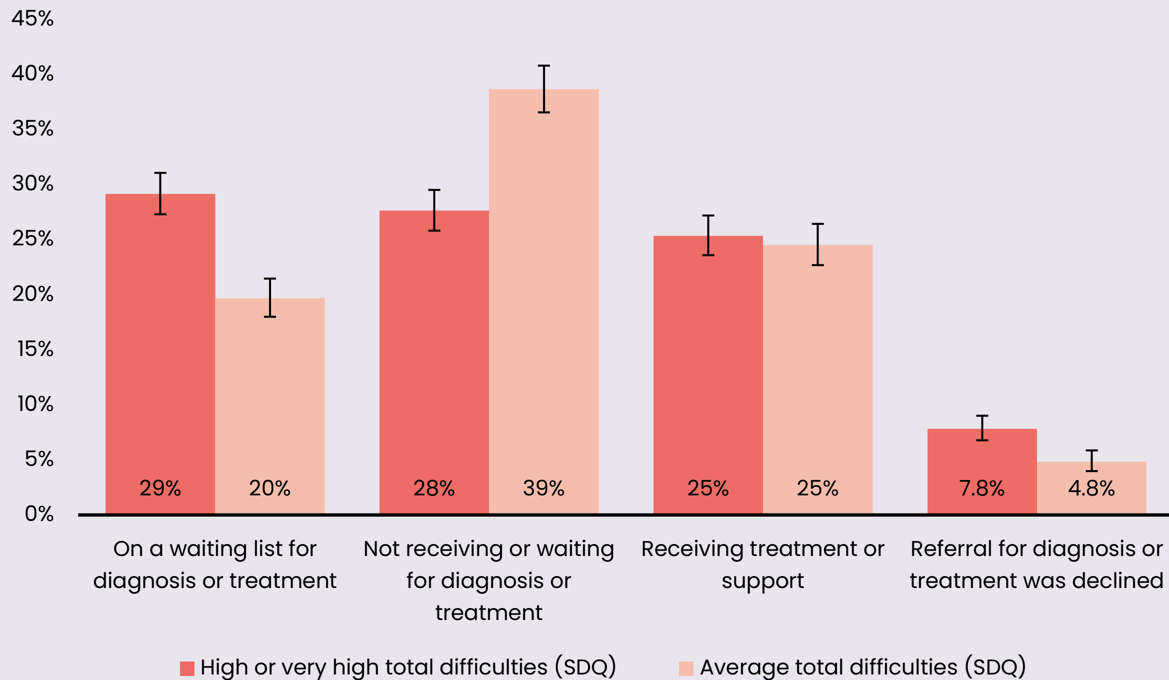
FIGURE 2.3: PROPORTION OF 13-17-YEAR-OLDS WITH ANY DIAGNOSED OR SUSPECTED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITION RECEIVING OR WAITING FOR DIAGNOSIS OR TREATMENT



Notes. There was also a 'not sure' response option, so percentages may not sum to 100%. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

We might expect that access to support would be prioritised for those with the greatest levels of need. However, there seems to be little variation in access to in-person professional support based on the levels of mental health difficulties children experience. Looking at differences in access to professional support, 13-17-year-olds with high levels of difficulties according to the SDQ were just as likely to be receiving treatment or support as those with average levels of difficulties, both 25%. This remained the case even when looking only at teens with a very high level of total difficulty, of whom only 26% were receiving treatment. However, those with higher needs based on the SDQ were more likely to be waiting for either a diagnosis or treatment (29%), compared to those with average SDQ total difficulties (20%). The pattern remains the same when we focus only on teens who have a diagnosed mental health or neurodevelopmental condition. We also see that teenage children who'd hurt themselves or thought about ending their own lives in the past year were less likely to be receiving treatment (22%) and were also less likely to be on a waiting list (23%).

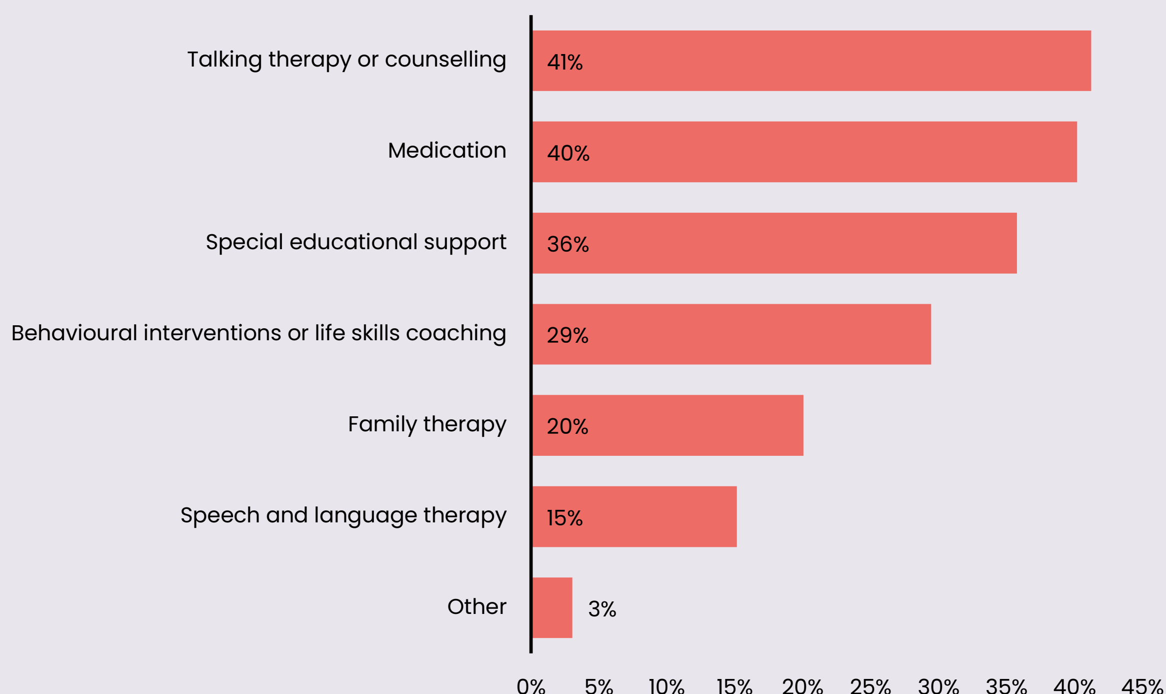
FIGURE 2.4: PROPORTION OF 13-17-YEAR-OLDS WITH ANY DIAGNOSED OR SUSPECTED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITION RECEIVING OR WAITING FOR DIAGNOSIS OR TREATMENT, BY TOTAL LEVEL OF DIFFICULTY ACCORDING TO THE STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

The most common types of support 13-17-year-olds were receiving were talking therapy and medication. Of those receiving treatment or support, 41% have had talking therapy or counselling, 40% have medication (such as antidepressants or ADHD medication) prescribed to them by a doctor and 36% have had special educational support in school. Twenty-nine per cent said they'd had some form of behavioural intervention or life skills coaching, including interventions such as anger management, social skills training or behaviour management plans. The majority (72%) of teenage children on medication also received some other type of intervention in addition, but the remainder (28% of those on medication and 11% of those receiving any support) were on medication only, with no psychosocial support.

FIGURE 2.5: FORMS OF SUPPORT RECEIVED BY 13-17-YEAR-OLDS WHO'VE BEEN GIVEN SUPPORT OR TREATMENT



Boys, younger teens and White children are more likely to receive professional support.

Boys and girls were equally likely to have spoken to at least one person about their mental health difficulties (91% and 90%, respectively), but who they spoke to was different, as was the likelihood they'd accessed treatment and what form that treatment took. Girls were more likely to have spoken to a friend (39%) than boys (31%) and to a mental health professional either at school (27% compared to 20% of boys) or from mental health services (23% compared to 20% of boys). Despite this, boys were more likely to be receiving professional support or treatment – 27%, compared to 23% of girls. Amongst those receiving treatment, girls were more likely to receive talking therapies (51% compared to 31% of boys), whilst boys were more likely to receive special educational support (39% compared to 31% of girls) and speech and language therapy (19% compared to 11% of girls). These differences may be due to girls being more likely to have a diagnosed anxiety disorder – which is commonly treated with talking therapies, such as cognitive behavioural therapy – and boys being more likely to have been diagnosed with neurodevelopmental conditions, such as ADHD, autism, speech or communication difficulties, and language difficulties – which are more likely to be addressed via special educational support in school.

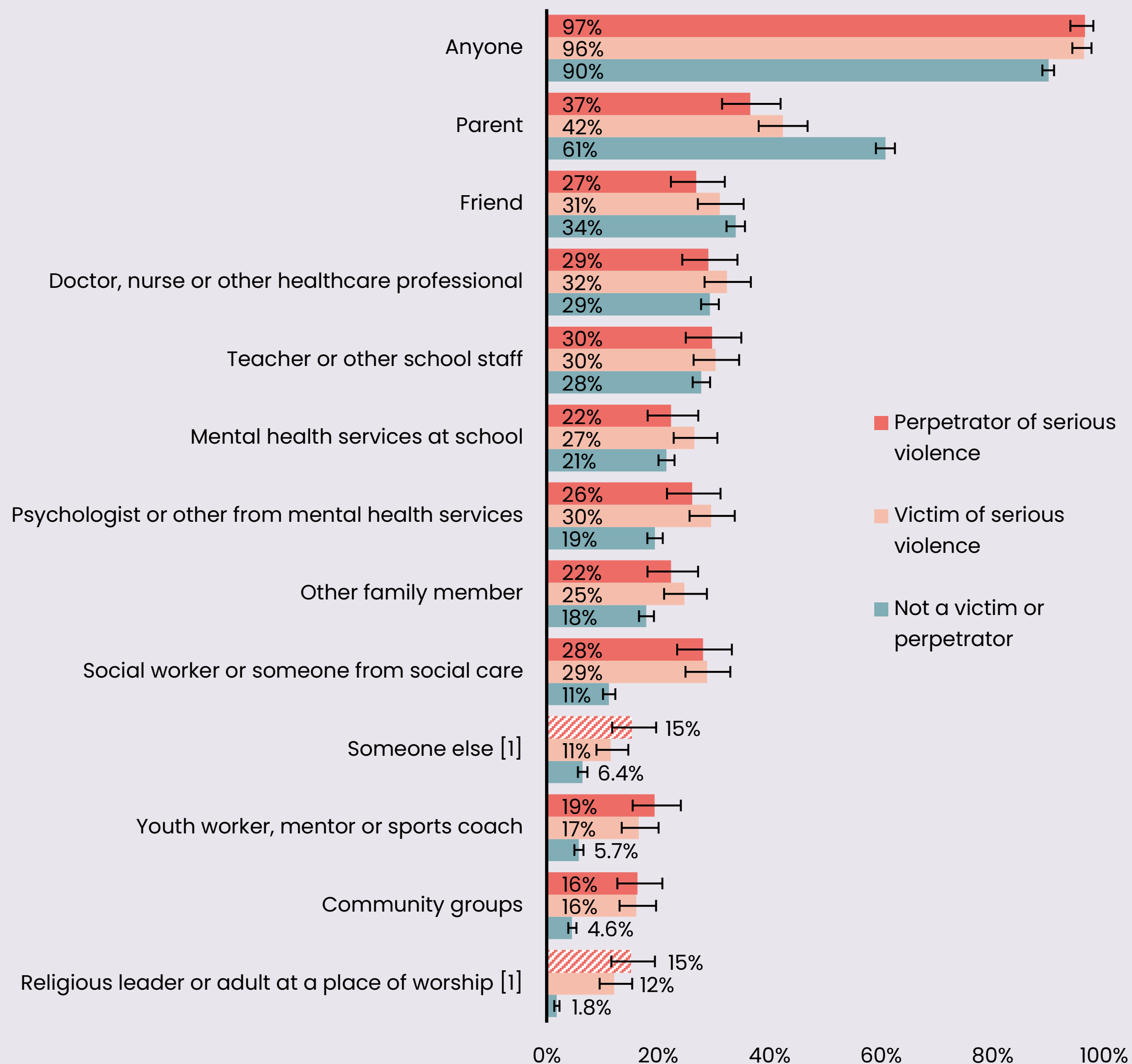
There were also differences by age: older teens were less likely to have spoken to a parent about their difficulties (55% of 16-17-year-olds compared to 61% of 13-15-year-olds) but more likely to have spoken to friends (42% of 16-17-year-olds compared to 31% of 13-15-year-olds). And, although older teens reported higher rates of emotional difficulties according to the SDQ, the older a child was, the less likely they were to be receiving or waiting for treatment or diagnosis.

Looking at differences by race, 13-17-year-olds from Asian backgrounds were the least likely to have spoken to anyone about their mental health difficulties (80%), compared to those from Black (86%), Mixed (88%), White (92%) and all other ethnic backgrounds (90%). There were too few responses about barriers to seeking help when split by race to be able to say why this was the case. Thirteen-seventeen-year-olds from White ethnic backgrounds were the most likely to have spoken to a parent, teacher or someone at school, and a doctor, nurse or other healthcare professional. Thirteen-seventeen-year-olds from White ethnic backgrounds were also more likely to be waiting for or receiving treatment (51%) than those from Asian (44%), Black (40%) and Mixed ethnicity (39%) backgrounds, but small numbers mean that not all differences are statistically significant. This fits what we see in NHS data, which shows children from Black and Asian ethnic backgrounds are underrepresented in referrals and access to mental health services. When looking specifically at 13-17-year-olds with high levels of total difficulties, those from Black backgrounds were the least likely to be receiving or waiting for treatment. Half (50%) said they weren't receiving or waiting for treatment or said they'd had a referral declined, compared to 39% of 13-17-year-olds of Mixed ethnicity, 38% of those from an Asian ethnic background and 34% of those from a White ethnic background.

Half the teens with mental health difficulties who've perpetrated serious violence are on a waiting list.

Teenage children who've experienced serious violence and have mental health concerns were more likely to have spoken to someone about their mental health than those who haven't experienced violence. Almost all victims (96%) and perpetrators (97%) of serious violence had spoken to at least one person about concerns about their mental health. This compares to 90% of those who hadn't been a victim or perpetrator of any violence. Who victims and perpetrators of serious violence chose to speak to was different than those chosen by 13-17-year-olds who hadn't experienced any violence. They were less likely to have spoken to a parent about their mental health concerns (42% of victims and 37% of perpetrators compared to 61% of those who haven't been a victim or perpetrator), but they were more likely to have spoken to adults outside their family, such as a social worker (29% of victims and 28% of perpetrators compared to 11% of those who haven't experienced violence), psychologist (30% of victims and 26% of perpetrators compared to 19% of those who haven't experienced violence), religious leader (12% of victims and 15% of perpetrators compared to 1.8% of those who haven't experienced violence), or youth workers, mentors or sports coaches (17% of victims and 19% of perpetrators compared to 5.7% of those who haven't experienced violence).

FIGURE 2.6: PROPORTION OF 13-17-YEAR-OLDS WITH SUSPECTED OR DIAGNOSED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITIONS WHO'VE SPOKEN TO SOMEONE ABOUT IT, BY EXPERIENCE OF VIOLENCE



[1] Bars with striped shading have cell counts of less than 50, so these figures should be interpreted with caution.

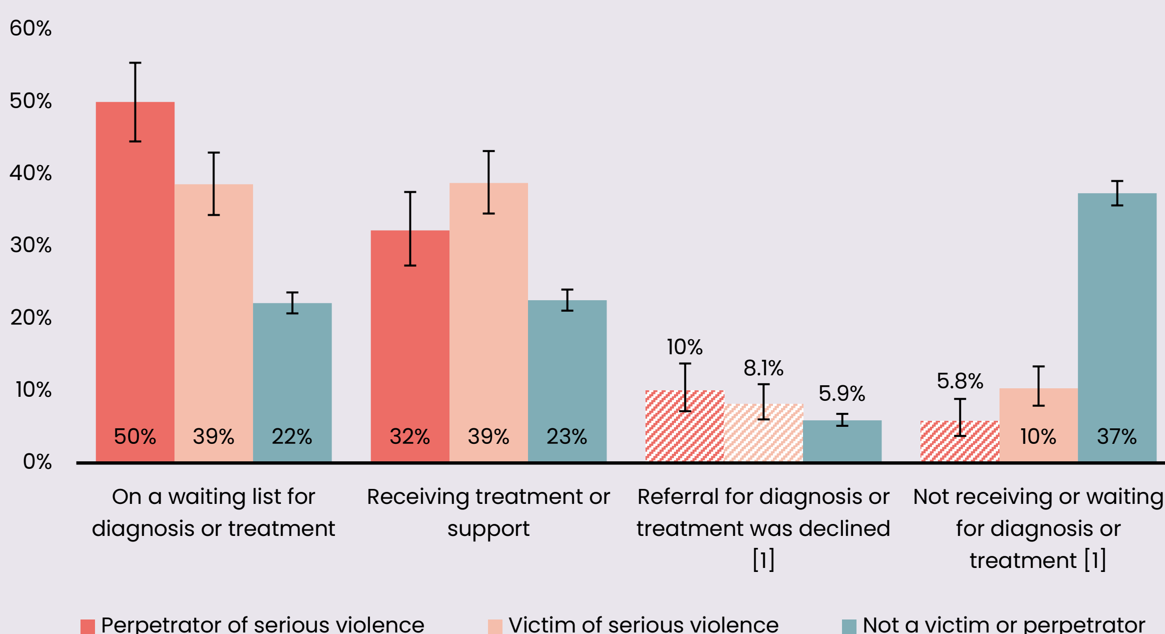
Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Amongst the 13-17-year-olds with suspected or diagnosed difficulties, those who'd been affected by violence were more likely to be receiving treatment or support or be on a waiting list for diagnosis or treatment than those who hadn't experienced violence. However, most were still not receiving treatment. Of those with suspected or diagnosed mental health issues, 39% of 13-17-year-olds who'd been victims of serious violence and 32% of those who'd perpetrated serious violence were receiving treatment or support, compared to 23% of those who hadn't experienced violence. Teens who'd perpetrated serious violence were the most likely to be on a waiting list (50%) compared to those who'd been victims of it (39%) and those who hadn't experienced any violence (22%). This means that two-thirds (66%) of 13-17-year-olds

who've perpetrated serious violence and have either a suspected or diagnosed mental health or neurodevelopmental condition aren't receiving any formal treatment for those difficulties.

Amongst just the 13-17-year-olds with a formal diagnosis of a mental health or neurodevelopmental condition, the proportion of those affected by serious violence receiving treatment is still a minority. Those who'd been victims of serious violence and had a formal diagnosis were no more likely to be receiving treatment (39%) than those with a suspected or diagnosed condition. Teens who'd perpetrated serious violence were slightly more likely to be receiving treatment if they had a formal diagnosis compared to those with a suspected condition, but it was still only 37%.

FIGURE 2.7: PROPORTION OF 13-17-YEAR-OLDS WITH ANY DIAGNOSED OR SUSPECTED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITION RECEIVING OR WAITING FOR DIAGNOSIS OR TREATMENT, BY EXPERIENCE OF VIOLENCE

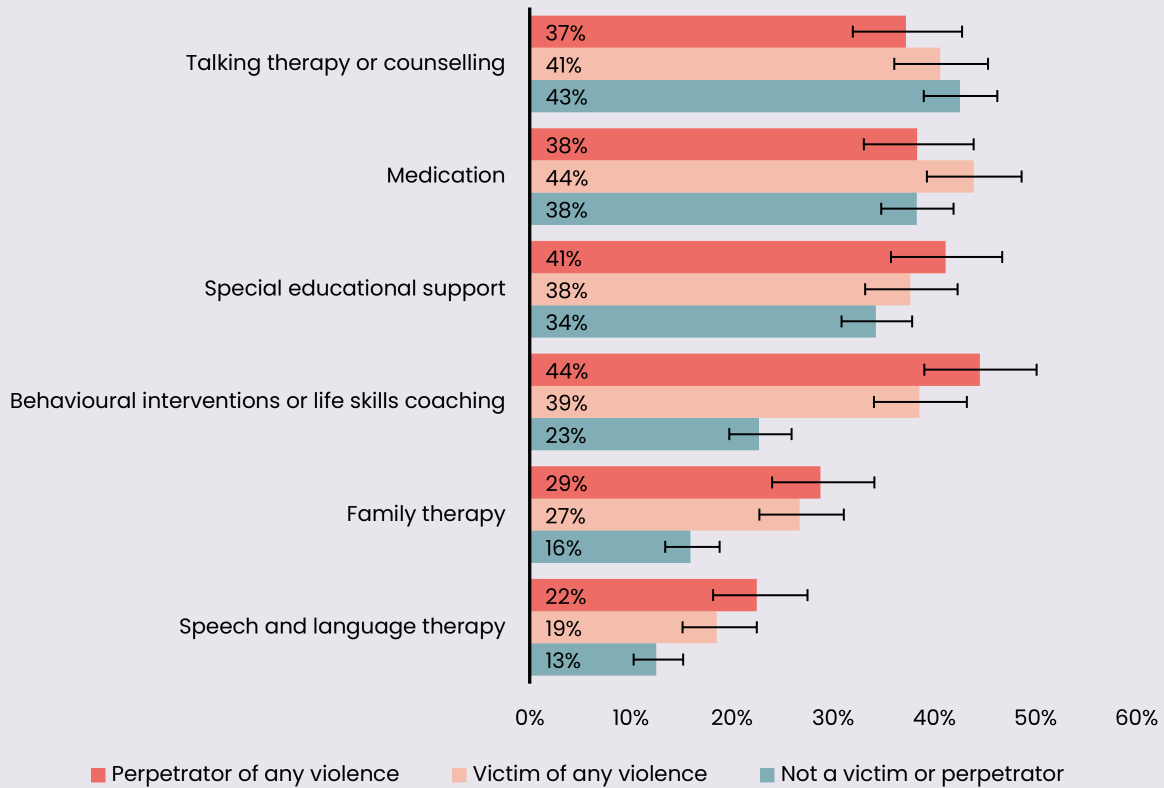


[1] Bars with striped shading have cell counts of less than 50, so these figures should be interpreted with caution.

Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

The proportion of teenage children affected by serious violence who were receiving support was too small to allow us to look at the types of support they were receiving. But looking at the support received by teenage children who'd been affected by any form of violence shows they're more likely to have received more practical skills-based interventions than those who hadn't experienced violence. They were significantly more likely to have received behavioural interventions or life skills coaching (39% of victims and 44% of perpetrators compared to 23% of those who hadn't experienced violence) and speech and language therapy (19% of victims and 22% of perpetrators compared to 13% of those who hadn't experienced violence). They were also more likely to have received family therapy (27% of victims and 29% of perpetrators) than those who hadn't experienced violence (16%).

FIGURE 2.8: PROPORTION OF 13-17-YEAR-OLDS RECEIVING DIFFERENT FORMS OF SUPPORT, BY EXPERIENCE OF VIOLENCE



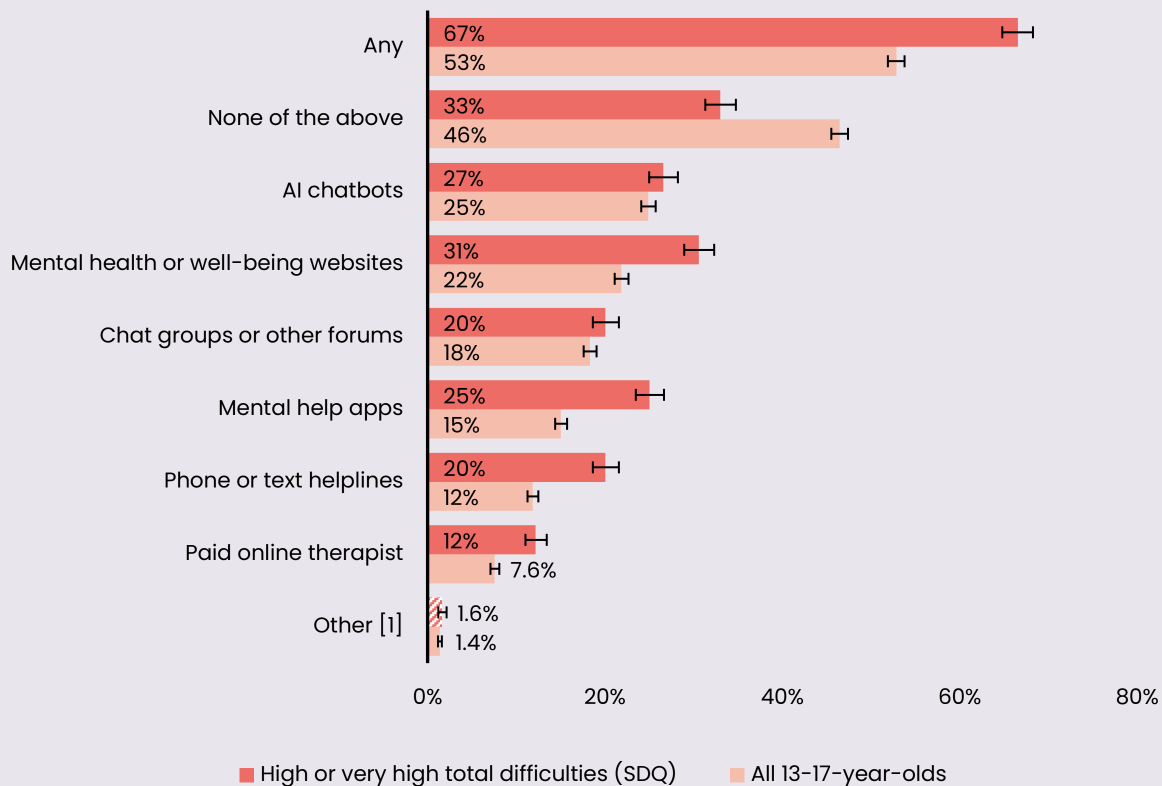
Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Teens are turning online for support.

A quarter of all teenage children have used AI chatbots for advice and support.

To find out about alternatives to in-person professional mental health services that teenage children are accessing, we asked all 13-17-year-olds about the online or digital places from which they sought advice or support regarding their mental health. Over half (53%) said they'd used at least one form of online support in the past year. The most common source of online support across all teenage children was AI chatbots – with a quarter (25%) saying they'd used them for advice or support. This was followed by mental health or well-being websites (22%). Those with high levels of mental health difficulties (as measured by the SDQ) were more likely to have used online forms of support. Around two-thirds (67%) had used some form of online support for their mental health in the past year. They were slightly more likely to have used mental health or well-being websites (31%), but AI chatbots came a close second (27%).

FIGURE 3.1: PROPORTION OF 13-17-YEAR-OLDS SEEKING ADVICE AND SUPPORT ONLINE ABOUT THEIR MENTAL HEALTH



[1] Bars with striped shading have cell counts of less than 50, so these figures should be interpreted with caution.

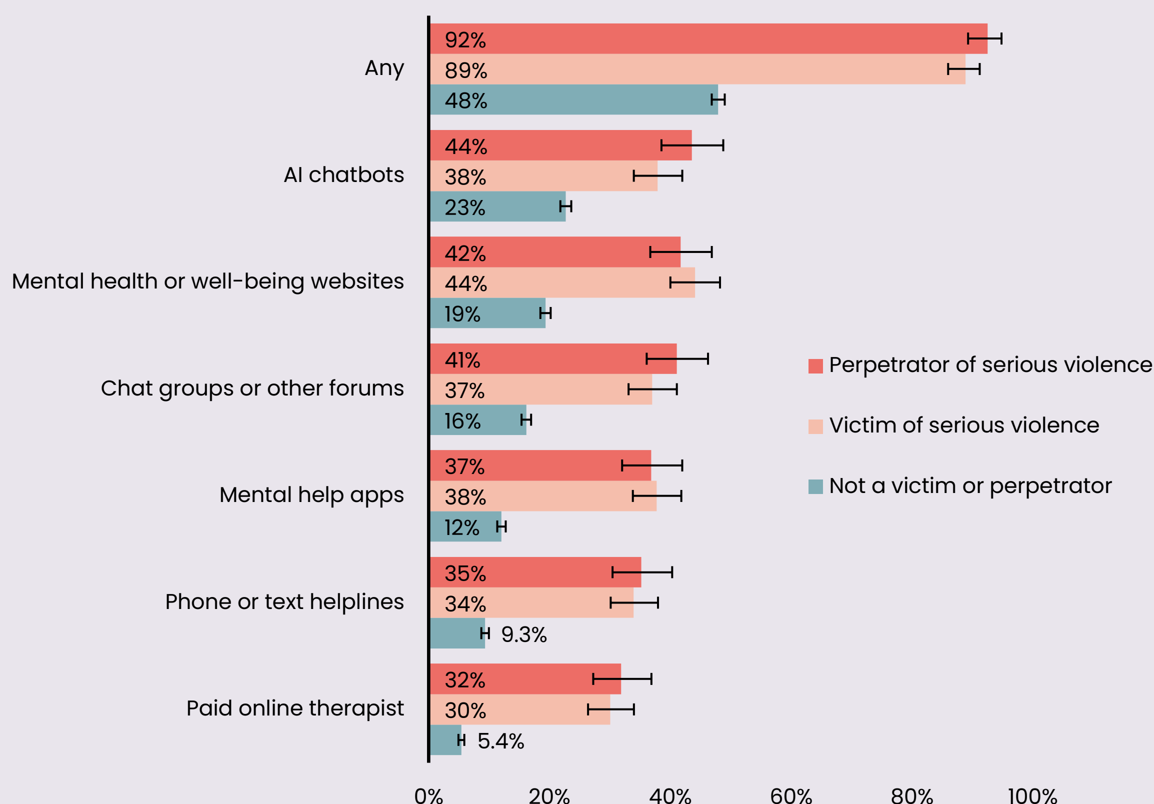
Notes. SDQ = Strengths and Difficulties Questionnaire. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Use of AI chatbots and access to support online differed by race. Overall, 13-17-year-olds from Black ethnic backgrounds were more likely to use any form of online support (65%), compared to those from Asian (59%), White (50%) and Other ethnic (54%) backgrounds. Thirteen-seventeen-year-olds from Black ethnic backgrounds were also the most likely to have used AI for support regarding their mental health (42%), followed by those from Asian (34%) and Mixed (32%) ethnic backgrounds. Thirteen-seventeen-year-olds from White ethnic backgrounds were the least likely (21%). There were also differences by gender. Girls were somewhat more likely than boys to use any form of online support for their mental health – 55% of girls compared to 50% of boys. Girls were more likely to use websites (24% compared to 20% of boys) and mental help apps (18% compared to 12% of boys), and boys were more likely to use AI chatbots (26% compared to 24% of girls). There were few consistent trends by age, with 51% of 13-year-olds saying they used online forms of support, compared to 52% of 17-year-olds.

This rises to four in ten amongst those affected by serious violence.

The majority of 13-17-year-olds who'd been affected by serious violence had sought advice or support online for their mental health. Eighty-nine per cent of those who'd been victims of violence and 92% of those who'd perpetrated serious violence reported using at least one online source of advice and support – almost twice the rate amongst 13-17-year-olds who hadn't been affected by violence as a victim or perpetrator (48%). They were particularly more likely to say they'd used more formally mental health-focused supports, such as mental help apps (38% of victims and 37% of perpetrators compared to 12% of those who haven't been a victim or perpetrator), phone or text helplines (34% of victims and 35% of perpetrators compared to 9.3% of those who haven't been a victim or perpetrator) and online therapists (30% of victims and 32% of perpetrators compared to 5.4% of those who haven't been a victim or perpetrator). Thirty-eight per cent of victims and 44% of perpetrators of serious violence had turned to AI chatbots for advice or support, compared to 23% of those who hadn't been a victim or perpetrator.

FIGURE 3.2: PROPORTION OF 13-17-YEAR-OLDS SEEKING ADVICE AND SUPPORT ONLINE, BY EXPERIENCE OF VIOLENCE



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

As we've already seen, teenage children with higher rates of mental health difficulties are more likely to have direct experiences of violence, as victims and perpetrators. This may therefore explain why victims and perpetrators of violence are more likely to be looking online for support with their mental health. However, looking solely at the 13-17-year-olds who'd experienced serious violence but who reported average mental health symptoms on the SDQ, they were still significantly more likely to use online sources for advice and support. For example, 88% of 13-17-year-olds who had perpetrated serious violence but had average total difficulties on the SDQ had looked online for support regarding their mental health, compared to 43% of those with average SDQ scores who hadn't experienced violence.

Teens not getting professional help may be turning to online sources.

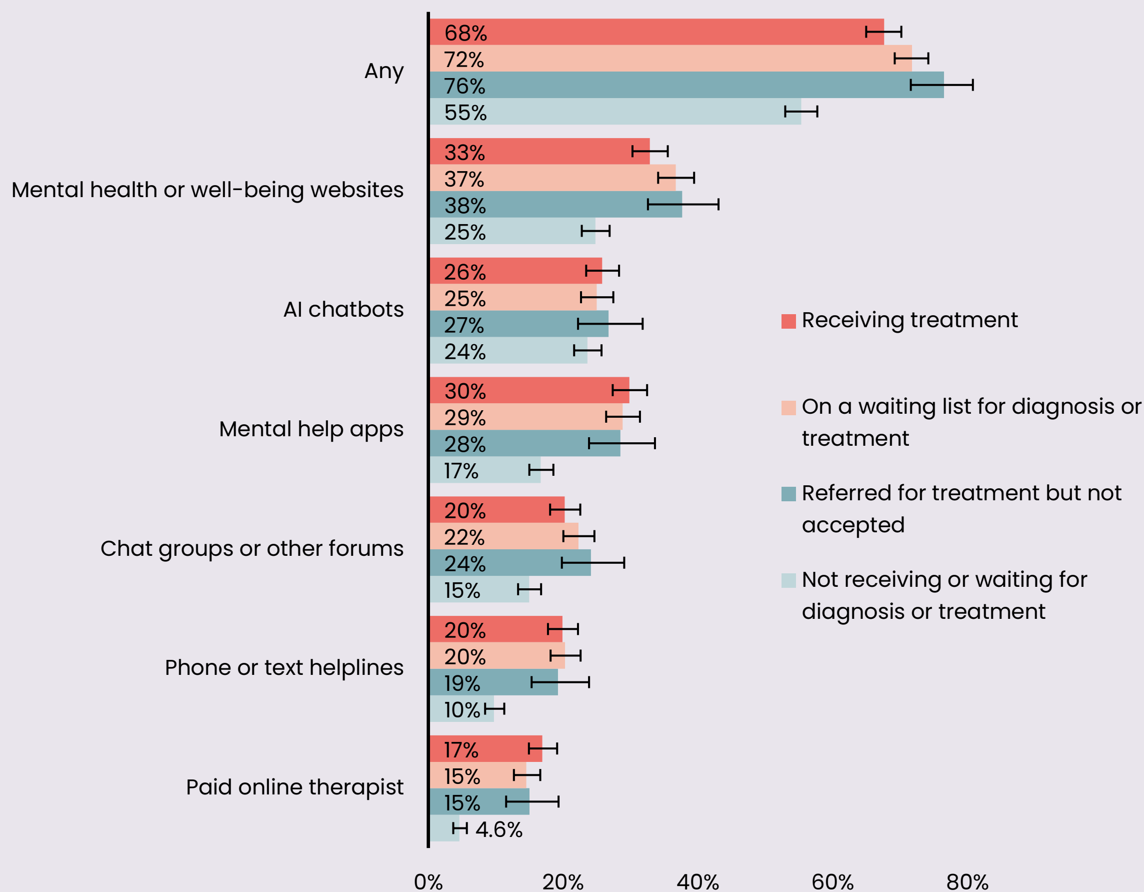
Online sources of support are being disproportionately accessed by those who are not receiving in-person professional help. Sixty-eight per cent of 13-17-year-olds who were receiving in-person support for a mental health condition were also using online sources of support. This increases to 72% of those on a waiting list for treatment or diagnosis, and 76% of those who were referred to treatment, but treatment was declined. Of those who had a suspected or diagnosed condition but who weren't waiting for or receiving

any diagnosis or treatment, 55% had used online sources of support. The lower rate for this group may be because they were experiencing less serious issues than those who had been referred for treatment.

In terms of the types of online support used by teenage children, those who were on waiting lists for diagnosis or treatment (37%) and who'd had their referrals declined (38%) were more likely to use websites on mental health and well-being than those already receiving treatment (33%). The proportions using AI chatbots were broadly similar across those receiving in-person treatment from a professional (26%) and those not receiving treatment, for example, 25% of those on waiting lists.

When we look just at 13-17-year-olds with formal diagnoses, the scale and nature of the online support they report using remain similar, with the exception of a few small differences. Those with a diagnosed mental health or neurodevelopmental condition who were on waiting lists and who'd had referrals declined were even more likely to be using online support: 79% of those on waiting lists and 86% of those with declined referrals, compared to 72% and 76%, respectively, of those with either a diagnosed or suspected condition. And 13-17-year-olds with a diagnosis but who'd had a referral for treatment declined were the most likely to say they'd used AI chatbots for advice and support – 32% compared to 28% on waiting lists, 24% receiving treatment and 23% not receiving or waiting for treatment.

FIGURE 3.3: PROPORTION OF 13-17-YEAR-OLDS WITH A DIAGNOSED OR SUSPECTED MENTAL HEALTH OR NEURODEVELOPMENTAL CONDITION SEEKING ADVICE AND SUPPORT ONLINE, BY ACCESS TO FORMAL TREATMENT



Note. Error bars represent 95% confidence intervals – this reflects the range we expect the true value to fall within.

Youth Endowment Fund

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