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# Editorial Perspective: Why I am now convinced that emotional disorders are increasingly common among young people in many countries

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> Children are one third of our population and all of our future. – Select Panel for the Promotion of Child Health, 1981

Mental health conditions in childhood and adolescence are probably increasing in prevalence while leading to worse outcomes (Collishaw, 2015; Sellers et al., 2019), which suggests that we are potentially failing the current generation and undermining our future. I write this as someone who was only recently convinced by reports of deteriorating mental health among children and young people, and use this editorial to explain my change in mind.

While considering the implications of epidemiological studies about mental disorders, it is worth also remembering that point prevalence estimates, such as those described above for the UK Child and Young People's Mental Health Survey below, conceal the larger number of young people who are affected by a mental health condition at some point during childhood and adolescence, but may be functioning fine at the time of the survey. Moreover, psychological distress is one extreme in the continuum of psychological functioning; impairment is not confined only to those who score above somewhat arbitrary diagnostic thresholds (Patel et al., 2018). For each child meeting diagnostic criteria, there will be several others struggling with subclinical difficulties whose developmental trajectory is at risk and who could still benefit from effective intervention.

In order to be clear that a change in prevalence has occurred, you need studies that apply comparable methods (sampling, measures and analysis) to comparable samples. Unless all cases in the community are likely to come to the attention of services, and we know that this is nowhere near the reality anywhere in the world in relation to children's mental health conditions (Patel et al., 2018), studies should be population-based. Furthermore, only comparisons between population-based cohort studies can disentangle the effects of age, cohort (exposure of particular children to a particular pattern of risk factors at that point in their development) and period (exposure to factors such as war or famine at a particular time in history; Collishaw, 2015). Few such studies exist.

Differences reported in clinical cohorts may reflect changes in reporting, help-seeking, recognition, diagnostic practice or service provision, rather than true variation in the number of children affected in the community (Collishaw, 2015). Indeed, annual surveys from England (1995–2014), Scotland (2003–2014) and Wales (2007–2014) suggested a consistent and significant increase in the willingness to report mental health conditions by both parents and young people, which was not consistently matched by young peoples' scores on validated scales (Pitchforth, Viner, & Hargreaves, 2016). More people willing to admit their child has a mental health condition could be beneficial if it could be translated into more children and young people with access to effective and evidence-based interventions.

Given these complex methodological issues, it is hardly surprising that a meta-analysis of 41 population-based mental health surveys of children and young people under the age of 18 ($n = 87{,}742$; Polanczyk, Salum, Sugaya, Caye & Rohde, 2015) reported that the estimates of mental disorders were affected by considerable heterogeneity. Metaregression attributed this largely to methodological differences (sampling frame, representativeness, type of mental health and impairment assessment) rather than by the year (1985–2012) or location (27 countries) of the study. In contrast, others conclude that there is evidence for deterioration in young people's mental health in recent years, with most reports suggesting increased levels of emotional difficulties, particularly among adolescent girls (Collishaw, 2015; McManus et al., 2019; Sadler et al., 2018).

Conducted at the same time as the meta-analysis of cross-sectional studies, Collishaw's review of secular trends found large gaps in the population-based literature, particularly in relation to autism spectrum conditions and studies in lower- and middle-income countries. What follows therefore applies mostly to higher income countries, despite the vast majority of children living in lower- and middle-income countries. Collishaw concluded that there was some evidence of significant changes in antisocial behaviour and emotional problems over the previous half decade, with periods of both increase and decrease. These variations applied


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equally to the mean scores and those scoring above diagnostic threshold. The change in emotional symptoms seemed confined to adolescence and more prominent in girls than boys. Collishaw rightly argues that changes in potential explanatory characteristics of children, families and society need further study in relation to secular trends but highlight maltreatment, bullying, poverty and income inequality in particular as having evidence to support their influence. The salience and attributions of some psychosocial risk factors vary with time and place, for example parental separation, corporal punishment, sexuality and gender identity, which can complicate aetiological research. The role of poverty and income inequality within and between countries are also highlighted by the Lancet Commission on Global Mental Health (Patel, et al., 2018) and point to the need for system-level change to promote an environment that supports mental health for all.

There does seem to be a consistent signal from recent studies that strongly suggests an increase in the prevalence of depression, anxiety and self-harm, particularly among young women. The United Kingdom has a series of three large ($n$ = 10,438 in 1999; $n$ = 7,997 in 2004 and $n$ = 9,117), single-phase, population-based mental health surveys of children that applied a multi-informant standardised diagnostic measure to generate ICD 10 diagnoses (Ford et al., 2020). These studies demonstrated small increase in overall prevalence of mental disorders among 5–15 years from 9.7% in 1999 (9.0%–10.4%) to 10.1% in 2004 (9.2%–11.0%, 2004) and 11.2% in 2017 (95%CI 10.3%–12.1%), which was almost entirely accounted for by an increase the prevalence of emotional disorders (4.3% in 1999 to 5.8% in 2017; Sadler et al., 2018). The most recent survey conducted in 2017 also included young people aged 17–19 years old for the first time and reported the prevalence of emotional disorders in this age group as 14% overall, but nearly 23% among young women. Half of these young women also reported self-harm. Furthermore, the UK adult mental health surveys have reported a similar increase in the prevalence of emotional disorder and self-harm that was only detected among young women aged 16–24 years in 2014, compared with the earlier similar surveys in 2000 and 2007 (McManus et al., 2019). Both series of studies were conducted by the same teams using the same methods at all three data points and provide the same signal; that we should be worried about the mental health of our young women. These findings chime with others in other countries of the world that suggest that depression will explain the largest proportion of the burden of morbidity globally by 2030 (Patel et al., 2018). Add to this the recent evidence from a comparison across the three birth cohorts (the National Childhood Development Study, the Avon Longitudinal Study of Parents and Children and the Millennium Cohort), which reported that poor mental health in childhood more strongly predicted adverse educational, social and mental health outcomes in adulthood in the later cohorts, and we should be very worried indeed. Potentially we have more young people who are struggling and who are more impaired by their difficulties.

So what can we do? We desperately need longitudinal data on individuals to study the trajectories of symptoms and impairment, and their potential influences, so that policy for prevention and intervention can be based firmly on evidence and recent data. A prime example of the need for scientific analysis is the role of social media, which is frequently posited as an explanatory factor, despite only cross-sectional and inconsistent evidence that this is the case (Sadler et al., 2018). As the global commission on mental health suggests, we need to continue the campaign for mental health to be seen as "global public good, rather than an optional extra" (Patel et al., 2018), and also to fight potential cuts in funding for services, training and research at times of recession, when need is likely to increase. While access to evidence-based mental health interventions and services need to be expanded, we need to strive to develop and implement evidence-based and outcome-driven interventions across all services that work with children and young people.

If 'Children are the living messages we send to a time we will not see.' (John F. Kennedy, 35th President of the United States), then recent epidemiological studies suggest that we should be worried about what we are conveying. We should respond by working harder to effect change in policy, practice and research to promote mental health, prevent mental ill-health and to intervene effectively for those who have poor mental health or are vulnerable. Given the strong data on the impact of poor parental mental health on child development, we need to act quickly to support the current cohort of young people, who are battling higher rates of anxiety, depression and self-harm as they become parents, to minimise intergenerational transfer of their parents' difficulties (Patel et al., 2018).

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was commissioned by the Department of Health and the Scottish Executive Health Department, as were the follow-ups, and data collection was led as before. The 2017 survey was funded by England's Department of Health and Social Care, commissioned by NHS Digital and conducted by a consortium from National Centre for Social Research (NatCen), ONS, University of Exeter Medical School and YouthinMind.

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