Population Mental Health in England

2003–2022: Teasing Apart Psychological Distress, Mental Illness and Activity Limitations

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The Problem: A 'Mental Health Crisis' — But Which One?

Public and policy debates frame rising mental ill-health as a 'crisis' — but offer little clarity on what is actually rising, or why.

① Rising Distress

Genuine increase in psychological symptoms and suffering in the population

Indicator: GHQ-12

② Rising Medicalisation

People increasingly label distress as long-term mental illness — cultural, clinical, or systemic

Indicator: Self-reported mental illness

③ Rising Exclusion

Environments create more barriers for those experiencing mental distress — work, welfare, care

Indicator: Self-reported Activity limitations due to mental health

Each explanation calls for a different policy response — yet most studies track only one indicator.

Evidence before the study

Psychological distress (GHQ / APMS)

Clear rise since ~2015; inconsistent evidence before 2015

Self-reported longstanding mental illness

Consistent rise, starting from an earlier period

Mental health-related activity limitations

No evidence exists for England

Simultaneous comparison — all three measures

No prior English study; no post-pandemic data

International evidence (USA, Canada) shows these measures can diverge sharply — but no comparable UK analysis exists.

Morris et al. 2025; Zhang et al. 2023; Ross et al. 2017; Pitchforth et al. 2019; Geiger 2020; Barr et al. 2015; Mojtabai & Jorm 2015; Chiu et al. 2020.

Data and methods

Data Source

Health Survey for England (HSE)
2003–2022 · N = 109,113
Nationally representative, repeated cross-sectional
Working-age adults: 16–64 years

Three Measures

- **Psychological distress**
  GHQ-12 caseness (≥4 threshold)
- **Longstanding mental illness**
  Self-reported condition type
- **Activity limitations**
  'A little' or 'a lot' (measured from 2013 onwards)

Research questions

RQ1: How have all three measures trended 2003–2022?

RQ2: Do trends differ by age group (16–29, 30–49, 50–64)?

RQ3: Do trends hold after adjusting for sociodemographic change?

RQ4: Among distressed people, has illness identification risen?

Regression analysis
Survey-weighted logistic regression · Marginal predicted probabilities · Age & sex adjusted

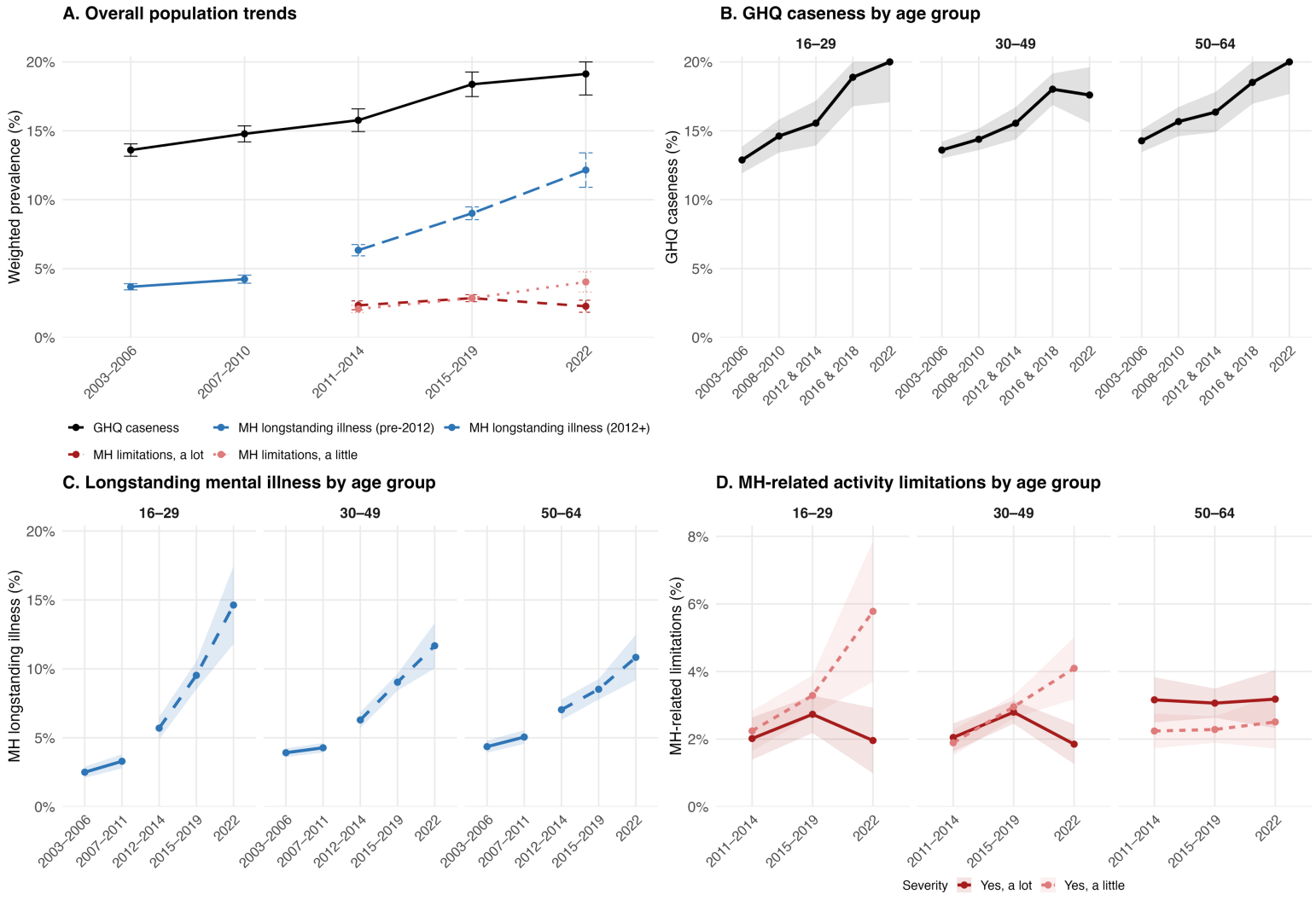
Sample characteristics

Table 1. Characteristics of study population

Variable	Overall
N, unweighted	109,113
Age group: 16–29, %	20.3
Age group: 30–49, %	49.7
Age group: 50–64, %	29.9
Female, %	52.9
Working, %	74.9
GHQ score, mean (SD)[a]	1.49 (2.73)
Education: degree or above, %	32.8
Education: upper secondary, %	26.2
Education: lower secondary / other, %	26.7
Education: no qualifications, %	14.2

Note: values are unweighted descriptive statistics for the pooled analytical sample. [a]GHQ score only available for 2003–2006, 2008–2010, 2012, 2014, 2016, 2018, 2022.

Descriptive trends: overall and by age groups (RQ 1-2)



Overall levels of distress have risen, but longstanding mental illness increased even more.

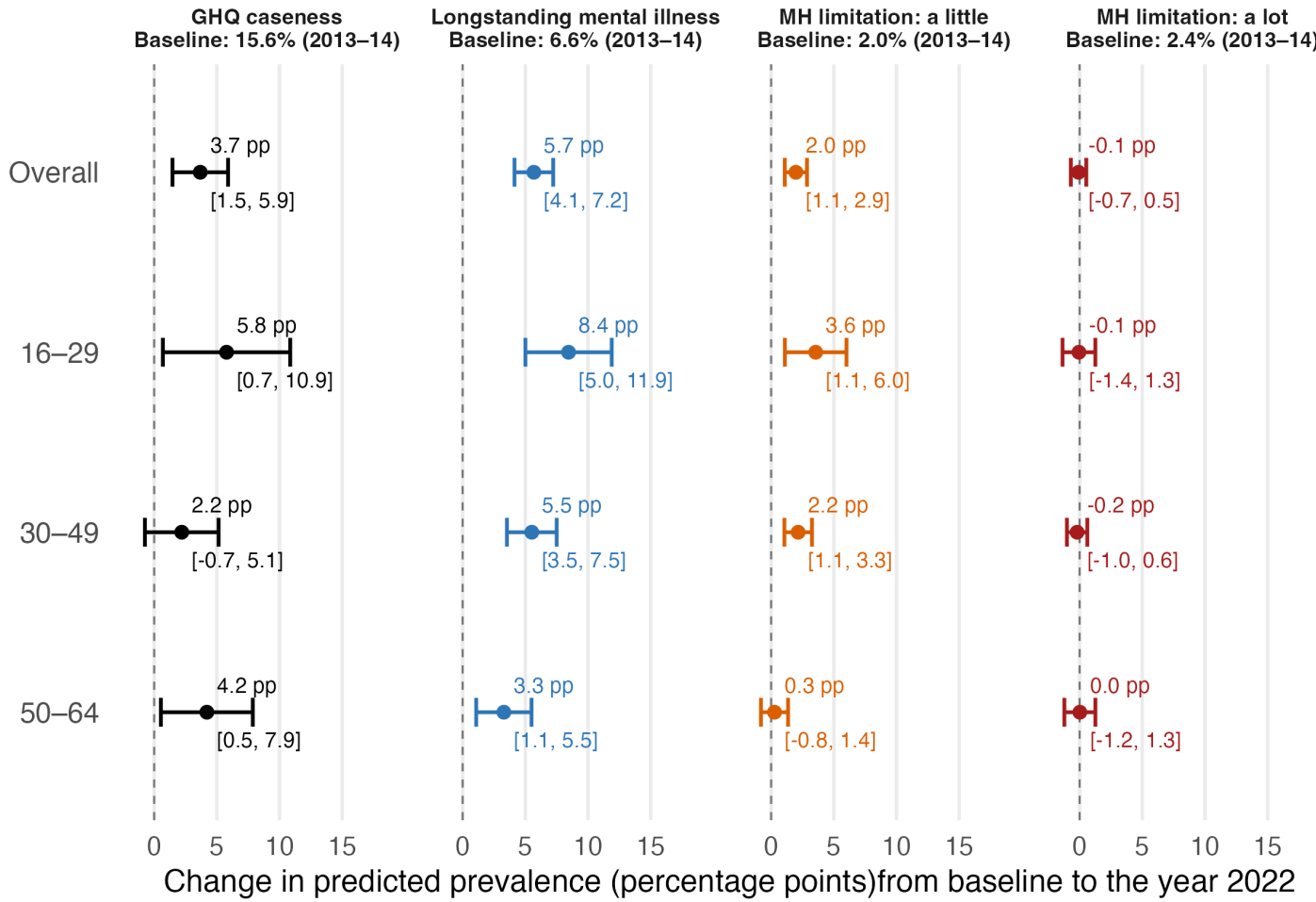
- GHQ caseness increased from 13.6% to 19.1%.
- Self-reported longstanding mental illness increased from 3.7% to 12.1%.
- Limitations (”a little”) also increased
- Young adults experienced the largest increases across indicators.

Data sources: Health survey for England, accessed from UK data service, https://datacatalogue.ukdataservice.ac.uk/series/series/2000021#abstract

‘Chart created by Christoph Henking using R. Data source: Health survey for England, 2003-2022’

Trends adjusted for sociodemographic change (RQ 3)

Note: Here, all analyses start from a baseline of 2013-2014



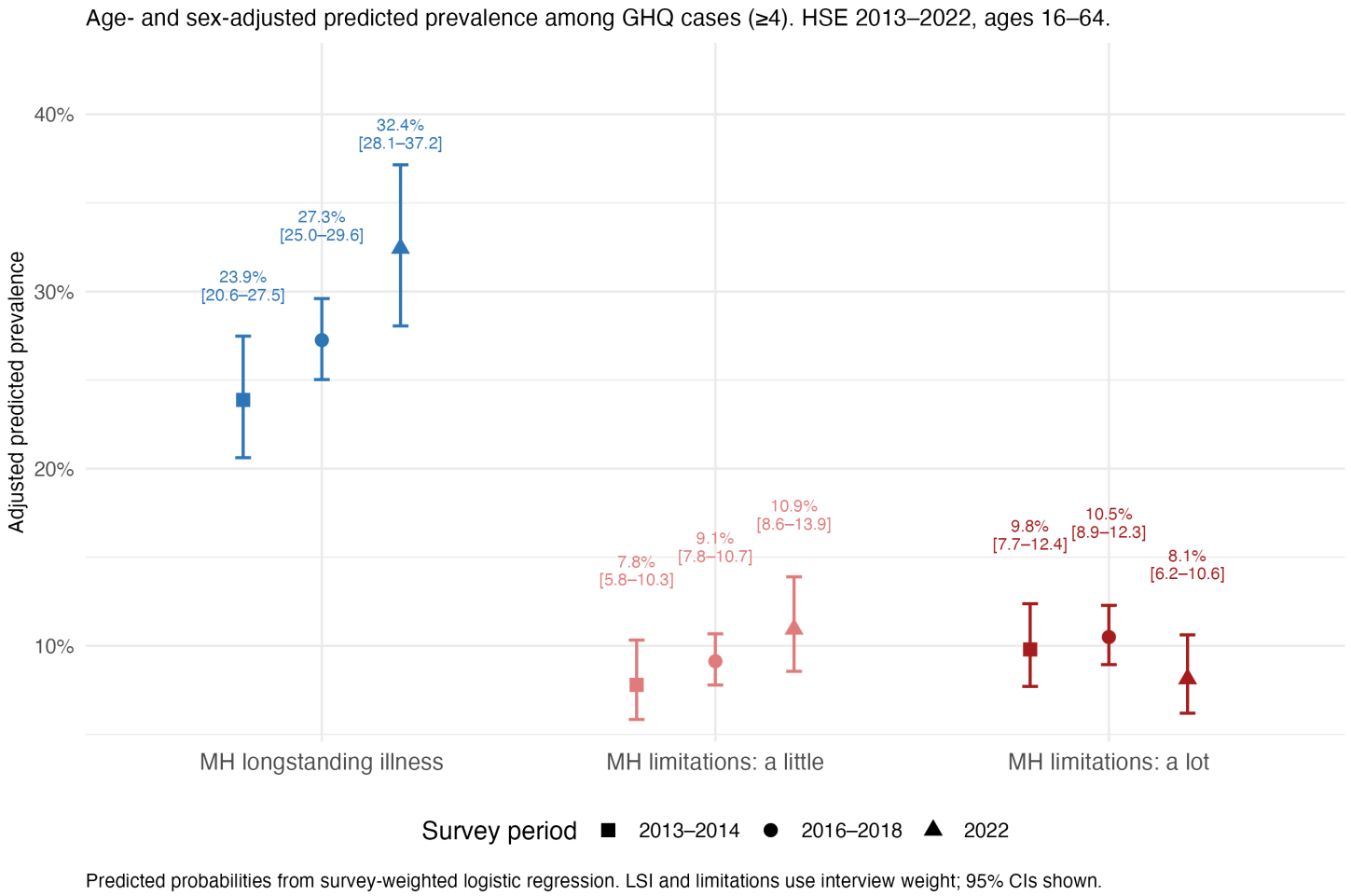
Trends persist after adjustment for sociodemographic change

- Increasing distress cannot be explained by changes in age and sex (education also controlled for in senstitivity analysis)
- Longstanding mental illness increased even more strongly than distress (+5.7 pp vs. +3.7 pp overall).
- Limitations (“a little”) also increased substantively, especially for young people

Data sources: Health survey for England, accessed from UK data service, https://datacatalogue.ukdataservice.ac.uk/series/series/2000021#abstract

‘Chart created by Christoph Henking using R. Data source: Health survey for England, 2003-2022’

Analysis among individuals with psychological distress (GHQ ≥4), RQ 4



More distressed individuals identify as having a longstanding mental illness

- Longstanding mental illness idenfitication rose from **24% to 32%, among those with GHQ of 4 and higher.**
- Mild limitations rose modestly.
- Severe limitations remained around **10% throughout**.

Data sources: Health survey for England, accessed from UK data service, https://datacatalogue.ukdataservice.ac.uk/series/series/2000021#abstract

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Summary of findings

Rising distress

- Psychological distress increased across all age groups from 2003 to 2022. Most substantive increase occurred **before COVID-19**
- Largest increases among young adults.
- Symptoms most driving the changes: loss of confidence, constant strain, sleep problems.

Exclusion

- Mild limitations increased substantively.
- This may partly reflect rising distress, and partly medicalisation, but may also reflect rising exclusion: that is, that there are more barriers for people experiencing mental distress, potentially due to cuts to social care and declining job quality/autonomy

Rising medicalisation

- Longstanding mental illness rose disproportionately, almost threefold.
- Among GHQ cases, illness identification increased from 24% to 32%.

Important: Rising distress and medicalisation are not competing explanations, but occur at the same time

What might explain rising medicalisation?

Several mechanisms may contribute

- **Improved recognition and treatment**
- Greater awareness
- Reduced stigma
- More help-seeking

Cultural medicalisation

- Distress increasingly interpreted as a long-term condition
- Changing language and mental health literacy

Systems medicalisation

- Restrictive welfare and employment systems may incentivise illness identities
- Limited evidence, further research needed

Note: These mechanisms are not mutually exclusive.

Selected references: Conrad 2007; Horwitz & Wakefield 2007; Furedi 2004; Rose 2007; Henderson & Thornicroft 2013; McManus et al. 2024; Barr et al. 2016; Patrick 2017; Dwyer et al. 2020.

Implications and conclusion

Conclusion

- Rising distress and some form of medicalisation/exclusion appear to have occurred simultaneously, rather than representing competing explanations for the contemporary mental health crisis.
- Population mental health cannot be monitored with a single indicator

Limitations

- **Measurement:** All outcomes are self-reported and may be influenced by changing reporting norms.
- **Clinical information:** HSE does not include diagnoses or information on treatment utilisation.
- **Activity limitation:** Limitations are only asked among respondents first reporting a longstanding illness, potentially underestimating prevalence.
- **Population coverage:** Institutional settings (care homes, prisons, psychiatric hospitals) are excluded.
- **Generalisability:** Findings relate to England; comparative evidence from other countries is needed