REPORT

Centre for
Mental Health

A need to belong

What leads girls to join gangs

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Executive summary

A small minority of young people is involved in gangs in the UK but they are the subject of considerable public and political concern. This has been prompted by reports of a rise in gang-related violence, fear about links between gang activity and the 2011 riots, and concern about the sexual exploitation of young women.

There is still, however, limited national information on the scale and pattern of health and social risk factors experienced by young people associated with gangs in the UK; and less still is known about the risks faced by girls and young women.

This report is the result of a comprehensive review of international literature on girls involved in gangs and an analysis of data collected for more than 8,000 young people from 37 newly developed youth point of arrest health screening initiatives in England. Screening was focused primarily on 10 to 18 year olds and took place between August 2011 and November 2012.

Risk factors for gang affiliation

Existing literature highlights a wide range of risk factors for females to become members of gangs. These include:

- severe childhood behavioural problems and mental ill health
- poor maternal mental health, exposure to violence in the home and experience of trauma
- low academic aspiration and disengagement with school
- association with antisocial or gang-involved peers and peer rejection or victimisation
- feeling unsafe or marginalised in their neighbourhood
- high income inequalities and social influences that devalue female roles.

Many studies identify a particular sensitivity on the part of girls to poor quality family attachments and social bonds as a driver for gang affiliation. Girls were more likely to

describe experiences of membership in terms of providing an alternative and compensatory family structure. A history of sexual abuse was also identified in many studies of females involved in violence or with gang connections.

Evidence from point of arrest data

Our database identified 80 young women with gang associations from the sample of 8,029 young people and their mean age was 15.

They were screened for 28 different risk factors and health issues including histories of poor mental health, family conflict, homelessness and victimisation.

On average, young women involved in gangs had a threefold greater risk of health and social difficulties compared with average youth justice entrants and over double the number of vulnerabilities of other females being screened.

We found that the more risk factors a young person accumulates, the greater their chance of being identified as involved in gangs.

Average number of vulnerabilities per person			
General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
2.9	3.7	7.0	9.5

Major risk factors

Young women with links to gangs were generally four times more likely than other females entering the Youth Justice System to report poor relationships with their families and peers.

Parental imprisonment, substance misuse or poor mental health were particularly linked to gang membership in their children in our sample, with young women with such histories being around three to five times more likely to be involved in gangs than other females. These young women were also nearly four times more

likely to have a sibling involved in antisocial behaviour than other girls being screened.

Our data show clear links between experiences of **victimisation** (such as sexual abuse, witnessing or experiencing domestic violence) and gang association. Young women involved in gangs were three times more likely to be identified as victims of **sexual abuse** compared with other young women being screened. They were around three times more likely to witness violence and to experience **physical abuse and neglect** in their homes and about four times more likely to disclose **being bullied** than other females in the sample.

Gang-involved young women were around three or four times more likely to have histories of **running away,** poor educational performance and **exclusion from school** than the average female youth justice entrant. They were also more than five times more likely than other young women screened through this initiative to be involved in **sexually risky or sexually harmful behaviour** (although without more detailed qualitative investigation, it is unclear whether sexually risky behaviour is a precursor to, or a consequence of, gang involvement).

We found clear evidence of the psychological vulnerability of gang-involved young women. Just over a quarter were identified by workers as having a suspected diagnosable **mental health problem**. 30% were also identified as **self-harming** or at risk of suicide. 30% also identified having **sleeping or eating problems**. Finally, nearly 40% of girls with gang associations showed signs of **behavioural problems** before the age of twelve. These early behavioural problems represent one of the most common childhood mental health problems with particularly damaging implications for children's life chances. Young women linked to gangs were three times more likely than other females in this sample to be identified with signs of early persistent conduct problems.

Effective interventions

We found that the vast majority of girls involved in gangs were willing to be screened and responded to offers of support. Nine out of ten of those who were offered further support stayed in touch with the services they were offered. Around a quarter were supported back into education while 1 in 5 was referred to physical health services and counselling services and 5% were supported into housing. A small minority were referred into evidence-based family interventions such as Multi Systemic Therapy and Functional Family Therapy which have good track records in improving outcomes for young women involved in offending or violence.

The reasons young women join gangs overlap in some instances with those of male peers, but they can also be quite different. This means that efforts to prevent or address gang association among females need to be gender-specific.

Preventive measures need to tackle multiple risk factors, for example to support secure attachment in early years, to reduce maltreatment and neglect, to promote positive parenting techniques, to strengthen girls' self-esteem and to respond quickly to the first signs of mental ill health among children.

And programmes working with gang members need to be sensitive to the specific requirements of young women, for example to foster respectful, collaborative and empowering relationships to strengthen self esteem, to provide safe housing and to offer positive female role models.

Recommendations

1. All services in regular contact with young people and families should recognise the toxic and undermining impact of both multiple risk factors and prolonged exposure to risk for children's healthy development.

2. All services in contact with girls and young women should routinely open a dialogue with young people about whether and how they are affected by gang activity in their communities.

3. All local authorities with responsibility for conducting Joint Strategic Needs Assessments should identify the number of young women involved in gang activity or who are at risk of it and develop multi-agency strategies to address these risks.

4. Health, social care, education and justice commissioners should all recognise gang membership as a marker for particularly pervasive negative outcomes for young people and communities and take collective action to gather data on prevalence, prevent risk and support those who are involved to exit safely.

5. Local Safeguarding Boards should actively monitor and review local prevalence information on gang activity and membership.

6. NHS England should commission point of arrest liaison and diversion services which are gender-sensitive and recognise the deleterious impact of gang membership on children's health and social outcomes.

7. The Youth Justice Board and the Home Office Violence Prevention Unit should continue and extend work to produce tools, training materials and initiatives for youth services and YOTs on gender-specific practice.

8. YOTs and probation services should work in close partnership with voluntary sector services working with gangs to create engaging and safe spaces and services for highly vulnerable young women.

9. The Government should ensure that the statutory duty on the Secretary of State to reduce local health inequalities translates into meaningful and measurable local action.

10. Academic institutions should prioritise research and development into effective responses to the needs of young women involved in gangs.

Introduction

Over the last decade, there has been growing interest in the small minority of young people involved in gangs in the UK. There are concerns over increasingly young gang members (The Centre for Social Justice, 2009); reports of a rise in gang-related violence; about links between gang activity and the 2011 riots (Home Office, 2011) and general concern about the impact of gang-related activity on offending, communities, the sexual exploitation of young women and on young people's general welfare and wellbeing.

We are still at an early stage of understanding what drives gang enrolment in the UK and the characteristics of those involved. After the recent riots, attempts were made to understand the young people who were prosecuted (a minority of whom had gang associations). Analysis revealed that they came from communities with entrenched and worsening poverty, had much higher than average educational statements of need and inflated indicators of family hardship (DofE, 2011).

Definition of gang membership

When referring to gangs, we will use the definition by the Centre for Social Justice (2009), describing a gang as:

A relatively durable, predominantly street-based group of young people who (1) see themselves (and are seen by others) as a discernible group, (2) engage in a range of criminal activity and violence, (3) identify with or lay claim over territory, (4) have some form of identifying structural feature, and (5) are in conflict with other, similar, gangs.

International literature generally identifies gang membership as an important factor influencing youth crime, and identifies higher crime rates among both female and male members (Gover *et al.*, 2009; Haymoz & Gatti, 2010; Weerman, 2012).

More recently, the vulnerability of young women linked with gangs has been further underlined through the Home Office's Violent and Youth Crime Prevention Unit's working group on Women, Girls and Gangs and through the on-going investigation by the Office of the Children's Commissioner for England, highlighting the safeguarding risks faced by gang-associated young women primarily through experiences of violent victimisation and sexual exploitation (OCC, 2012).

There is still, however, limited national information on the scale and pattern of health and social risk factors experienced by young people associated with gangs in the UK; less still is known about the risks based on gender.

This report aims to add to the body of knowledge on girls with gang associations in the UK. It draws on a database of over 8,000 under 18 year olds screened at the point of arrest for a range of health, educational and social vulnerabilities. Some of these risk factors (such as histories of maltreatment, exposure to harsh and inconsistent parenting, early behavioural problems, school failure, etc) are associated with a range of persistent inequalities over the course of these young people's lives (The Centre for Community Child Health, 2000; Fergusson *et al.*, 2005), affecting multiple cross-sector budgets (Centre for Mental Health, 2009). Numerous studies show that risk factors also have a multiplicative effect: the more risk factors present in a child's life, the more likely they are to have poor behavioural and mental health outcomes, including conduct problems, anti-social behaviour and convictions (Rowe & Farrington, 1997; Appleyard *et al.*, 2005; Murray *et al.*, 2010).

Prevalence of gang membership

Gang membership is still a fairly rare occurrence among young people. Accurate estimates are challenging because of a lack of standardised definitions used in studies (Schram & Gaines, 2008; Petersen *et al.*,

Danielle

A 13 year old girl was referred by the police for screening. She was bullied at school and was a frequent non-attender. She revealed worries about a sexually transmitted infection but was unclear who might have passed this on; she had a 19 year old boyfriend but also described being 'on the edge' of a local gang and was sexually active with some of its members.

Her background was one of family conflict and her parents had separated. She described women in the family as 'invisible'; her two brothers attracting the majority of attention from her now-distant father. She described not feeling 'worth anything'; but that being part of a gang (and her sexual power over men) made her feel important. She also valued feeling protected and 'cared for' by the gang and by her boyfriend.

Danielle's mother described long-term concerns about her daughter's behaviour (particularly being disruptive at school, staying out late and possible sexual activity with older men), and had asked for help from social services a number of times. But her daughter failed to meet the threshold for support and only came to the police's attention because of her offending.

The worker developed a positive relationship with Danielle, listening, understanding her perspective and empowering her, whilst working collaboratively to solve the practical, psychological and aspirational problems creating barriers in her life. Within a few months Danielle had ended the relationship with her boyfriend, re-entered education and moved away from the gang. She did not re-offend.

Taking an overview of this case, the worker felt that there had been a lack of whole-system commitment and proactive engagement with this girl when risk factors began escalating and multiplying at school as she approached adolescence. She explained:

'Everyone had a different remit… but it's in everyone's interests to work together more closely; we need to wake up to the fact that engaging and working with these children is in everyone's common interests in the longer term.'

2001), regional variations in gang activity and changing trends (Lauderdale & Burman, 2009). Furthermore, gang membership is frequently covert (particularly if gang-surveillance and suppression activities increase in communities or if disclosure of membership jeopardises young people's safety) and this can lead to a general reluctance on the part of young people to discuss affiliations. The British Crime and Justice Survey (Sharp *et al.*, 2006) reported gang-membership rates in the UK of around 6% for those aged between 10 and 19 years of age. However, studies of international prevalence rates point to wide variations suggesting fluctuating membership rates between different countries and sometimes communities (Weerman, 2012).

What we know about gang affiliation in the UK

In the UK, gangs generally organise around and identify with particular postcodes, geographical or, on occasions, drug-dealing territories (Sharp *et al.*, 2006). Although most gangs are associated with larger urban settings, activity may be extending beyond them (Pearce & Pitts, 2011). Higher gang association has been linked with communities facing marginalisation and poor opportunities as well as with populations experiencing higher levels of social deprivation (Esbenson & Deschanes, 1998). High income inequalities (rather than poverty on its own) have been identified as a particular driver for violence in communities (Department of Health, 2012).

There is also some evidence of gun-enabled gang members and victims becoming younger; in 1998, most gang-involved men were in their mid to late 20s (Stelfox, 1998); within a decade, Bullock and Tilley (2002), for example, noted a fairly stable pattern of membership at every age from 12 to 25 years in Manchester. Furthermore, official data on hospital treatment for gun and knife crime victims noted a pattern of increasingly younger victims with an 89% increase in the number of under 16 year olds admitted to hospital in the case of serious stab wounds (The Centre for Social Justice, 2009).

Young women and gangs

International and UK studies generally report a predominance of male gang membership (Esbenson & Deschanes, 1998; The Centre for Social Justice, 2009). Females represent roughly one-third of all youth gang members during early adolescence in US research (Esbensen *et al.*, 1997); however, young women tend to exit gangs at earlier ages than males (Thornberry *et al.*, 2003).

Historically, girls have remained relatively 'invisible' in gang literature for a variety of reasons including:

- a predominant research focus on male gang activity;
- violence, offending and gang membership being regarded as quintessentially male behaviour running counter to traditional notions of femininity; and
- limited police attention paid to female gang membership.

Early studies described young women adopting fairly prescribed and stereotypical gender-specific marginal, sex-object, passive, nurturing or victim roles, rather than adopting equal responsibilities to male gang members, perpetrating violent acts or assuming active leadership roles (Archer & Grascia, 2005; Lauderdale & Burman, 2009). On occasions, alternative descriptions emerge of 'tomboy', hyper-masculine or fearless female gang members (Archer & Grascia, 2005). Differences have been noted between male and female perceptions of the power relationships in gangs

with half the males in one study claiming that female members were 'possessions' but two thirds of female gang members vehemently disputing this view (Moore, 1991).

Over the years, studies have observed increasing female involvement in gangs and heterogeneity in the roles they adopt (Esbensen *et al.*, 1997; Esbenson & Deschanes, 1998; Thornberry *et al.*, 2003; Archer & Grascia, 2005; National Gang Intelligence Center, 2009; The Centre for Social Justice, 2009) including some studies recording increasing parity in the prevalence of male and female acts of violence (Wang, 2000). Regardless of these shifts, there is still overwhelming evidence in the literature suggesting the exploitation, vulnerability and victimisation of women affiliated with gangs (Archer & Grascia, 2005; Vigil, 2008; Young, 2009; Office of the Children's Commissioner, 2012).

Health and social circumstances of young women in gangs

Numerous studies have identified lifetime and developmental risk factors which increase the likelihood of involvement in gangs and in violence; most of these have so far focused on male gang members. These risk factors can affect children even before birth (e.g. maternal depression, smoking, alcohol use during pregnancy etc.) (Office of Juvenile Justice and Delinquency Prevention, n.d.) and generally span a range of domains (see Table 1) influencing children's progress and life chances. There seems to be an association between the number of risk factors experienced by young people and gang membership; for example, Hill (1998) noted that youth exposed to seven or more risk factors were observed to be thirteen times more likely to join and become embedded in gangs (also Hill *et al.*, 2001). However, increased likelihood of gang affiliation was not just dependent on a simple multiplication of risk, but also dependent on the extent to which these risks spanned all six broad developmental domains in Table 1. For example, a majority (61%) of the boys and 40% of the girls who exhibited elevated risk across all risk domains reported gang membership in one study (Thornberry *et al.*, 2003).

A growing (mainly US) literature on gang-affiliated females has highlighted the importance of understanding gender-specific routes to gang involvement. Based on the Centre's literature analysis, Table 1 draws together evolving learning on female-specific risk factors.

Social risk factors

Over half of female gang members identified problems at home as a motivator for involvement (Wang, 2000; Vigil, 2008). Girls were more likely to describe experiences of membership in terms of providing an alternative and compensatory family structure (Molidor, 1996; Esbenson & Deschanes, 1998; Snethen & Van Puymbroeck, 2008). A history of sexual abuse was common in many studies (Archer & Grascia, 2005; Snethen & Van Puymbroeck, 2008); gang membership

being associated with respite or protection from abusive family relationships (Miller, 1998; Wang, 2000). Membership has also been seen as a mechanism to attract the attention of emotionally distant carers (Archer & Grascia, 2005).

After family drivers, peer relationships were often linked to female gang involvement. Just over a third of young women reported being enrolled through peer pressure; either being intimidated or 'beat in' to gang membership or sexually 'groomed' by more sophisticated gang-involved partners (Archer & Grascia, 2005; Fleisher & Krienert, 2004). A sense of belonging was identified as the second most common driver underpinning female decisions to join gangs (Esbenson & Deschanes, 1998; Wang, 2000).

Some young women also said gangs offered a degree of security from hostile neighbourhoods (Archer & Grascia, 2005). High levels of local gang activity or cannabis availability in communities were further identified as risk factors for both male and female gang enrolment (Hill *et al.*, 1999, 2001). Experiences of marginalisation, discrimination, poor social trust and income inequality also drive serious violence and gang-related behaviour (Esbenson & Deschanes, 1998; Elgar & Aitken, 2010; Department of Health, 2012). Marginalisation and discrimination are a particular feature of some young women's lives, particularly for those from black and minority ethnic or highly deprived communities (Esbenson & Deschanes, 1998).

Other significant factors associated in the literature with gang enrolment included:

- Weaker attachments to school and academic under performance (Wingood *et al.*, 2002).
- Living in areas with generally lower levels of parental education (Esbenson & Deschanes, 1998).
- Having a family member involved in gang activity (Chesney-Lind *et al.*, 2008)

Table 1: Risk factors for female gang involvement (and violence)

1. Individual/cognitive risk factors

- Severe childhood behavioural problems including aggression (under 12 years old)
- Pattern of attributing hostile intentions to others
- Poorly developed problem solving skills
- Low self esteem
- Poor control over emotions
- Risk seeking tendency
- Mental health problems

2. Family risk factors

- Poor maternal mental health
- Experiences of maltreatment and victimisation, particularly
  - Exposure to violence in the home as a child
  - Experience of childhood trauma and prolonged life stressors
- Harsh parenting
- Low parental attachment and supervision of child
- Pro-violent parental attitudes
- Sibling anti-social behaviour
- Gang-involved relatives
- Family poverty

3. School risk factors

- Low academic aspiration
- Poor school achievement or motivation
- School disengagement (truancy, expulsion etc.)

4. Peer risk factors

- Association with anti-social/aggressive/ older male delinquent peers
- Association with gang-involved peers/relatives
- Rejection by peers or victimisation
- Early sexual activity
- High alcohol use
- High cannabis use

5. Community risks

- Feeling unsafe in neighbourhood
- Low connectedness within neighbourhood
- High levels of gang activity
- Poor opportunities and marginalisation
- Availability of drugs in neighbourhood
- High crime neighbourhood

6. Societal risks

- High income inequalities
- Media influences which devalue female roles
- Patriarchal, oppressive or gender abusive values
- High economic dependence on males

Health risk factors

Although many studies have focused on the emotional risk factors for female gang involvement, few have focused more specifically on mental health. Assumptions about mental health vulnerability are often based on broader information available on young women involved in violence or crime (and particularly those in custody), who often have significantly higher levels of mental health problems than non-delinquent female peers (e.g. depression, self-harm, separation anxiety, ADHD, conduct problems) (Harrington, 2005; Chitsabesan et al., 2006; Douglas & Plugge, 2006; Chesney-Lind, et al., 2008; Fazell, 2008). These young women in custody have higher histories of child trauma (particularly abuse) (Gooselin, 2005) and are more likely to self-harm or attempt suicide (Douglas & Plugge, 2006; Snethen & Van Puymbroeck, 2008).

The literature on young women in gangs details family histories characterised by exposure to violence, maltreatment and abuse. Sexual abuse is a common theme (Moore, 1996; Miller, 2001; Fleisher & Kreinert, 2004; Vigil, 2008) as well as a range of behavioural difficulties which are seen as attempts to escape chaotic family backgrounds and blot out trauma. Persistent problematic behaviour is often a significant marker of children and young people's internal distress; behavioural problems most commonly associated in studies with females in gangs included:

- a history of running away
- a fourfold increase in risk of school expulsion
- a fourfold greater risk of involvement in fights
- early and risky sexual activity
- teenage pregnancies
- involvement in substance abuse
- involvement in violence
- offending.

(Fleisher, 1998; Miller, 1998; St Cyr & Decker, 2003; Wingood et al., 2002; Chesney-Lind et al., 2008; Snethen & Van Puymbroeck, 2008; Minnis et al., 2008)

Young women in gangs are identified with a range of other health compromising behaviours and difficulties including higher rates of asthma, yeast infections, sexually transmitted diseases and premature pregnancies. They are more likely to be involved in early sexual activity, less likely to have a monogamous partner, around twice as likely than broader youth populations to use illicit drugs (Schalet et al., 2003) and three times more likely to binge drink compared with their peers. Many of these health problems reflect high-risk choices and patterns of behaviour (Wingood et al., 2002).

Definition of sexual exploitation

Young women associated with gangs are at particularly high risk of sexual violence and exploitation. Although definitions of sexual exploitation are contested, we will build on the previous government's definition which describes sexual exploitation as follows:

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive something (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing and/or others performing on them, sexual activities. In all cases those exploiting the child/ young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources (Department for Children, Schools and Families, 2009).

More specifically, literature suggests that girls in gangs not only receive a sense of belonging from compliance with sexual demands but also on occasions receive protection or aim to reduce levels of intimidation and threat by complying with sexual demands. Gang-related sexual exploitation can often be same age violence and intimidation.

Where our data came from – the screening sites

This report analyses data on young people with gang associations from a database set up to support 37 newly developed point of arrest health screening initiatives in England in August 2011. Screening was focused primarily on 10 to 18 year olds.

In total, 8,029 young people were screened. The majority of them were at an early stage of involvement with the Youth Justice System (YJS).

Limitations of this data

A number of qualifications and limitations should be borne in mind when considering this data and the conclusions drawn. One of the challenges of establishing a national network of point of arrest schemes was that sites used very different screening tools. There are other factors that may have affected the accuracy of the data. These include:

- the absence of short, reliable screening tools, particularly for neuro-developmental problems for under 16 year olds during early stages of data capture.
- a lack of access to multi-agency data on multiple risk factors.
- poor awareness by screening staff of some risk factors and hidden disabilities.
- variable rapid engagement skills (encouraging disclosure) particularly where workers sought information about covert risky behaviour.

In some instances, it was also difficult to establish whether risk factors or health difficulties were a precursor to gang involvement or a consequence of membership. Despite these possible limitations, the data on girls in gangs provides an indication of the multiplicity and pattern of need and particularly of this group's relative vulnerability compared with other females entering the justice system.

Gang-associated young women

80 young women were identified with gang associations in this sample of 8,029. In keeping with the general literature on gangs, young women in this sample were around two thirds less likely to be gang affiliated than young men (Curry & Decker, 1998); girls in gangs were 1% of the total Youth Justice entrant group compared with the 3% who were male. These prevalence rates are lower than other UK sources which note self-reported prevalence rates of 6% (Sharp *et al.*, 2006). The mean age of young women identified with gang associations was 15, but their ages ranged from 11 to 17 years.

Regional distribution

The twelve London sites were the most densely urban areas, whereas most of the other sites were in medium-sized cities or large towns. A small minority were in rural areas. Surprisingly, a city in a largely rural area had one of the highest rates of girls in gangs; London reported the next highest rate of prevalence per site. Sites in eastern England identified no girls in gangs.

Ethnic breakdown

In London, the majority of gang-involved young women were from Black and Minority Ethnic (BME) populations (55%) with around 20% of these young women being of Black Caribbean heritage; and the rest (45%) were from White British groups. The higher rate of female BME gang membership in London mirror the capital's generally higher BME population. Northern sites recorded a predominance of White British girls in gangs. The south east was most likely to identify the highest Traveller / Gypsy / Roma females involved in gangs.

Acknowledgements

The vulnerabilities of girls in gangs

On average, young women involved in gangs had a threefold greater risk of health and social difficulties compared with average youth justice entrants (see Table 2) and over double the number of vulnerabilities of other females being screened. Similarly, Table 3 shows that girls with gang associations are at least three times as likely as other female entrants to present with seven vulnerabilities or more and nine times more likely than general entrants to exhibit very high numbers (19 to 28) of vulnerabilities.

Table 2: average number of vulnerabilities per capita			
General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
2.9	3.7	7.0	9.5

Table 3: distribution of vulnerabilities / risks (%)				
No. of vulnerabilities	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
0-6	86	81	55	35
7-12	11	13	29	41
13-18	3	4	10	15
19 +	1	3	6	9

Hill's study (2001) suggested that young people with more than five risk factors for gang membership at the age of 10 to 12 were 13 times more likely to become involved in gang activity compared with low-risk youth. Chen *et al.* (2004) also described a 'snowballing' phenomenon (called 'risk amplification') whereby experiences such as sexual abuse and victimisation led to running away, substance misuse, early sexual activity and then possible gang membership.

Family based vulnerabilities

The data reveal strong links (Figures 1 & 2) between broader family dynamics and girl's affiliation with gangs. Young women with histories of parental imprisonment, poor parental mental health, parental substance misuse and neglect were three to five times more likely to be involved in gangs than other girls; similar challenging family backgrounds are also associated with an increased risk of female involvement in crime (Chesney-Lind *et al.*, 2008). Studies suggest that family conflict is often associated with the development of severe behavioural problems in children (INSRM, 2005) and our data indicate that family conflict and violence have a relatively strong association with girls' involvement in gangs.

Both sexes were around four times more likely than other young people entering the YJS to have a sibling involved in such activities.
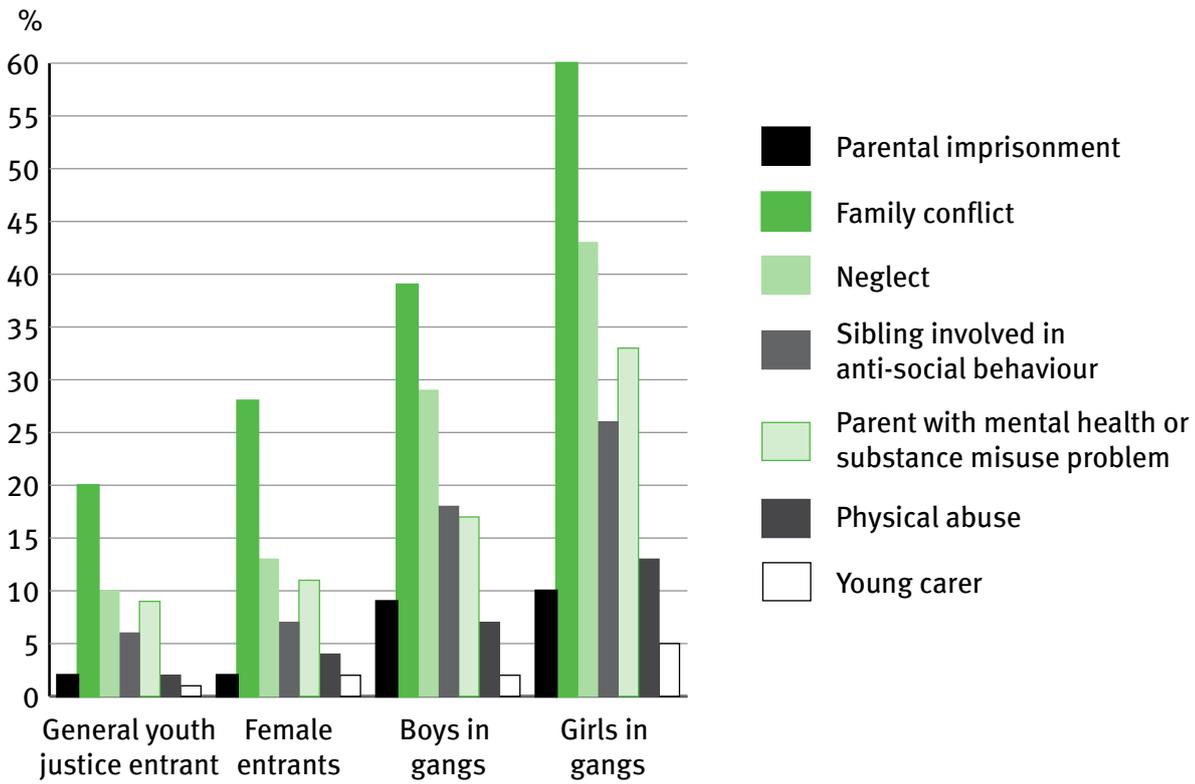
These young women were somewhat more likely than other girls being screened to have a current or previous looked-after status (Figure 2); however they were more than twice as likely to be on child protection plans (where they remained in their families but were the subject of continued monitoring). These women also were twice as likely to have been in foster care or homeless.

Maltreatment has been identified in other studies as a precursor for reoffending and re-entry into the justice system (Smith & Thornbury, 1995; AIC, 2006). It is also strongly associated with the development of early conduct problems (Aguilar *et al.*, 2000; Jaffee *et al.,* 2005) which in turn link to multiple negative outcomes in adulthood (Fergusson *et al.*, 2005).

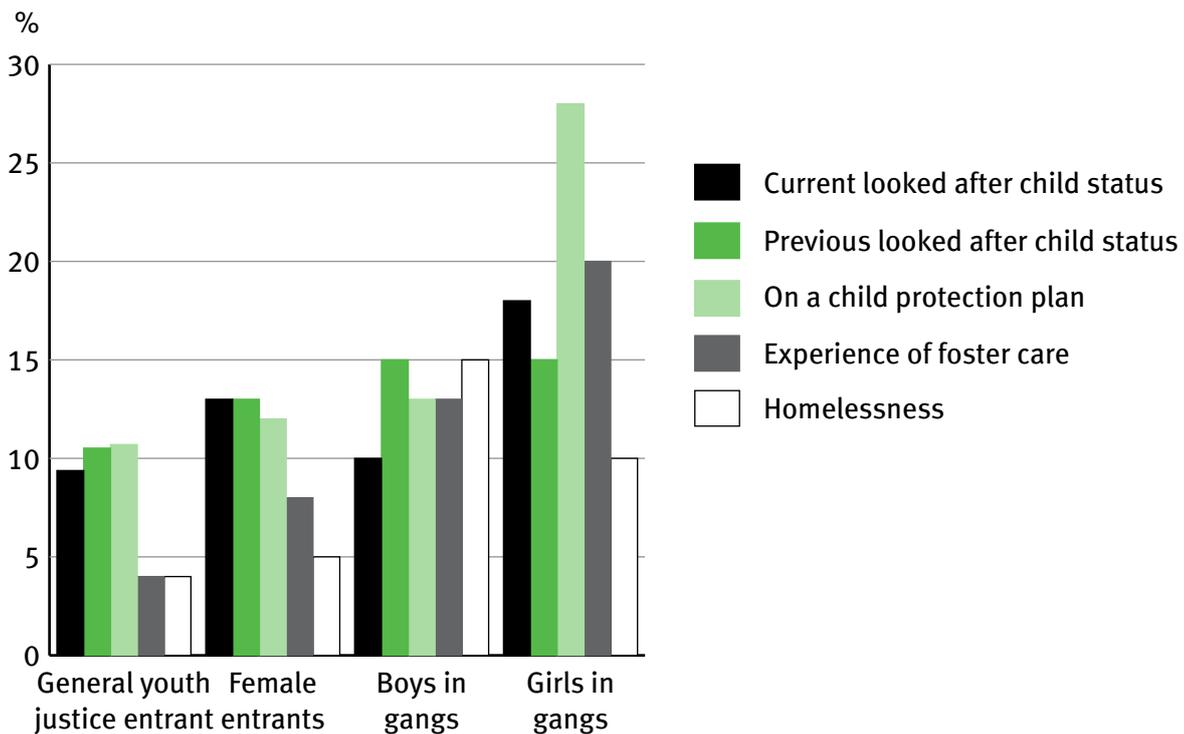## Victimisation and social relationships

The data indicate relatively strong links between experiences of victimisation (such as sexual abuse, witnessing or experiencing domestic violence) and gang association. Young women involved in gangs were eight times more likely to be victims of sexual abuse than the general youth justice entrant and three times more likely

Figure 1: family-based risk factors and vulnerabilities

%

Legend:
- Parental imprisonment
- Family conflict
- Neglect
- Sibling involved in anti-social behaviour
- Parent with mental health or substance misuse problem
- Physical abuse
- Young carer

(The data for all figures are at the end of the report.)

Figure 2: child protection and safeguarding histories of those screened at point of arrest

%

Legend:
- Current looked after child status
- Previous looked after child status
- On a child protection plan
- Experience of foster care
- Homelessness

than other girls entering the system. They were also over three times more likely to experience physical abuse and neglect in their homes (see Figure 3) and they were roughly four times more likely to disclose experiences of bullying.

Whether experiences of abuse and bullying predate or occur after gang enrolment is not clear; however, US studies tend to identify sexual abuse as a precursor for early sexual activity leading to gang involvement (Moore, 1996; Joe-Laidler *et al.*, 2001; Miller, 2001).

Ironically, although studies describe girls enrolling in gangs for protection from hostile homes or neighbourhoods, patriarchal and abusive gang cultures and dynamics often extended and prolonged their experiences of victimisation and abuse (Wingood *et al.*, 2002).

There was a much stronger association here between poorer quality social relationships and female gang membership in comparison with males in gangs. Girls in gangs were over four times more likely to report poor peer relationships compared to females entering the Youth Justice System. This mirrors US research which also noted links between low levels of self-esteem in females and gang involvement;

whereas low self-esteem appeared to protect males from joining gangs (Esbenson & Deschanes, 1998). Gangs have often been seen to meet predominantly emotional, protection and status related needs for females (Wang, 2000; Wingood *et al.*, 2002).

Educational achievement

Hill (1999) noted other risk factors for female gang initiation, including educational failure and low academic attachment and aspiration. In our data, young women in gangs (see Figure 4) were over three times more likely to be under-performing at school than other women entering the YJS.

Behaviour, mental health and emotional wellbeing

Persistent and severe behavioural problems represent one of the most common childhood and youth mental health difficulties. These behavioural problems affect more boys (7.5%) than girls (3.9%) (Green *et al.*, 2005) and signs include persistent bullying, intimidation, fighting or aggression, rule breaking, lying,

Figure 3: abuse, victimisation and social connectedness and gang involvement
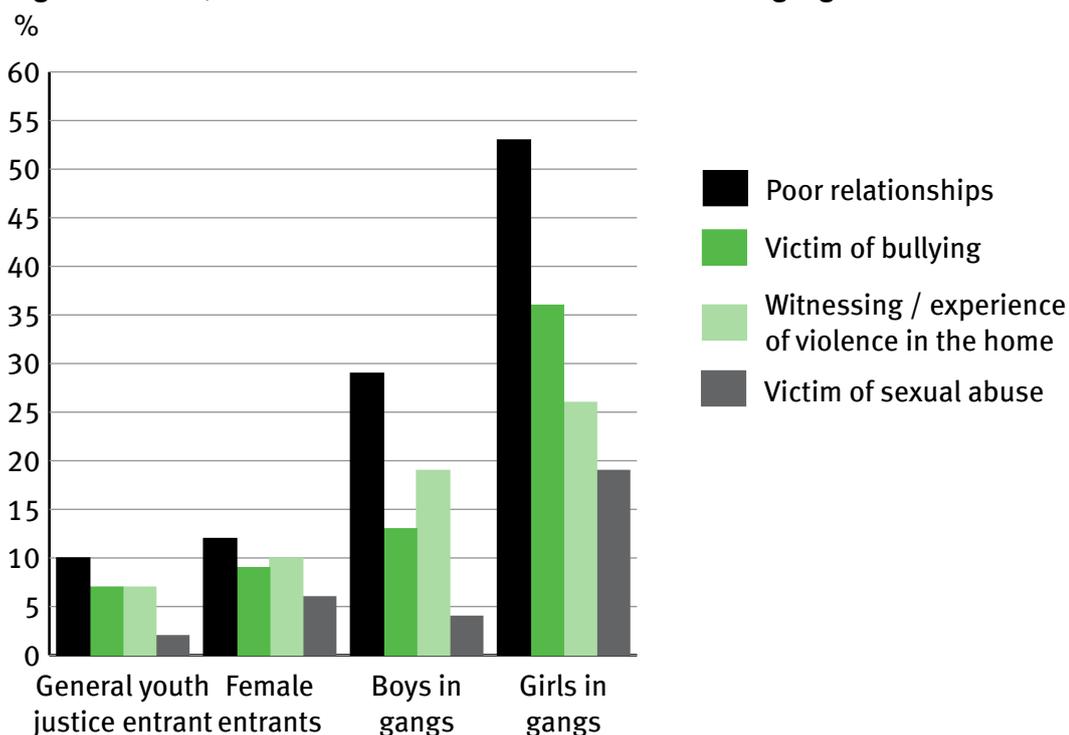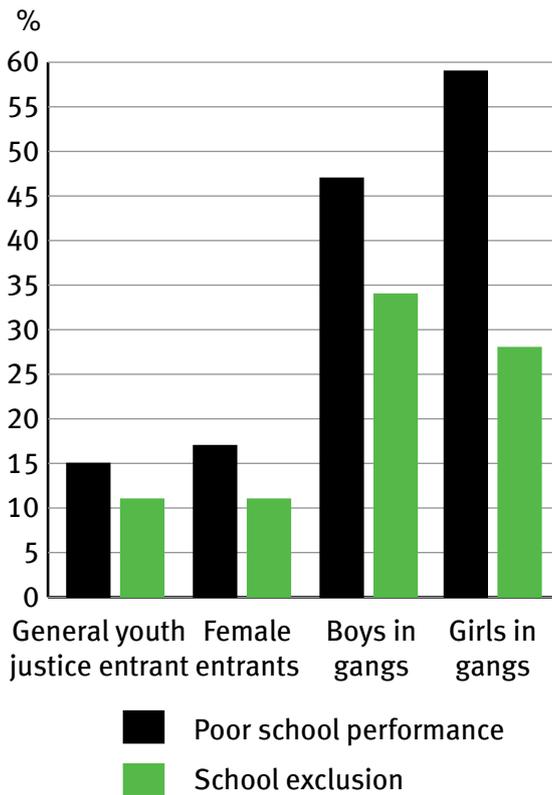
Figure 4: school performance

%

60
55
50
45
40
35
30
25
20
15
10
5
0

General youth justice entrant | Female entrants | Boys in gangs | Girls in gangs

■ Poor school performance

■ School exclusion

cruelty toward animals, fire setting, running away from home, theft, truancy, and vandalism (Lahey *et al.*, 1999; INSRM, 2005; NICE, 2013). Risk taking is also commonly associated with conduct problems linking to early substance misuse, bulimia, crime, extreme sports, dangerous driving, harassment, involvement in gangs.

Behavioural problems that emerge before the age of 12 result in some of the very worst outcomes for children, such as lower life expectancy, poorer health, higher risk of substance reliance and early promiscuity and pregnancy (Loeber & Farrington, 2000; Fergusson *et al.*, 2005; Rutter *et al.*, 2006). They also impose costs across a range of multi-agency budgets (Centre for Mental Health, 2009). Furthermore, these children are at greater risk of every type of adult mental illness and of suicide (Kim-Cohen *et al.*, 2003; Fergusson *et al.*, 2005; Rutter *et al.*, 2006). On the other hand, behavioural problems which emerge for the first time during adolescence often have fewer long-lasting, damaging and costly effects (Moffitt & Scott, 2008; Centre

for Mental Health, 2009) being linked more closely with identity formation, peer relationships and changes taking place in the brain during adolescence (Steinberg, 2008). Later-starting conduct problems generally resolve themselves with age and as young people adopt adult responsibilities.

Early behavioural problems are also a significant risk factor for prolonged gang involvement (Hill *et al.,* 2001); those with early aggressive traits (and anti-social peers) were twice as likely to remain in gangs for more than one year.

Nearly 40% of girls in gangs in this database had signs of severe behavioural problems before the age of twelve; roughly equivalent to the proportion of boys in gangs (see Figure 5). These data warrant further investigation given that severe conduct problems are generally half as prevalent in females as in males in the general youth population (Green *et al.*, 2005). Girls in gangs were also three times more likely than other females in the sample to be identified with early conduct problems.

Childhood aggression is rarer in females. Female conduct problems present in more

Figure 5: behaviour problems before the age of 12

%

40
35
30
25
20
15
10
5
0

General youth justice entrant | Female entrants | Boys in gangs | Girls in gangs
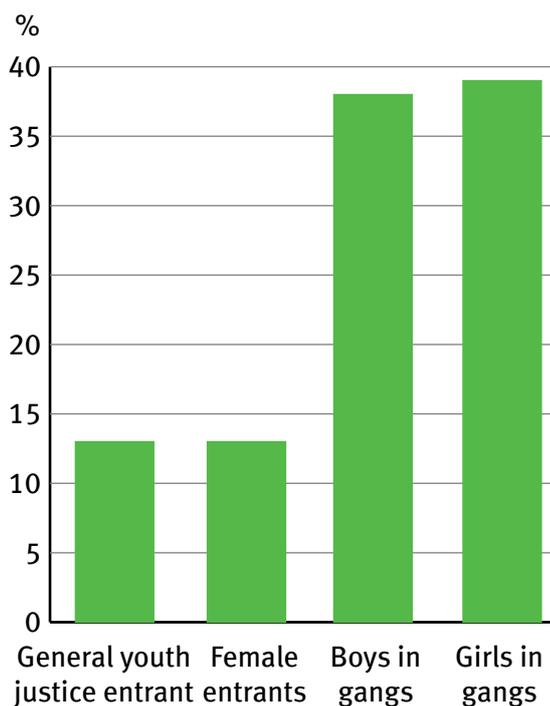
subtle ways, sometimes masked by depressive symptoms and often manifesting at a later stage in early sexual activity, pregnancy, running away, truancy etc. (INSRM, 2005). Post-traumatic stress is commonly associated with conduct disorder, often linking to histories of sexual violence.

Girls in gangs were just over four times more likely to have histories of running away and were over twice as likely to be excluded from school compared with the average female youth justice entrant (see Figure 6). They were just between two and three times more likely to misuse alcohol and drugs, although drug use was more likely in male gang members.

Girls in gangs were over five times more likely than other girls to be involved in sexually risky or harmful behaviour. Broader literature on girls in gangs suggests that these risks include:

- sexual activity as a gateway or initiation into gangs, sometimes via older partners;
- a higher risk of early pregnancy;
- sexual activity with non-monogamous partners as well as sexual activity with casual, multiple and serial partners (sometimes without consent);

- regular exposure to sexually degrading experiences;
- young women feeling under threat to comply with sexual or degrading demands from gang members;
- sex in return for (perceived) status, protection or material gain;
- rape being used as a weapon by rival gangs or as a punishment or for sexual gratification within gangs;
- young women being used to entrap or set up rival gang members.

(Miller, 2001; Wingood *et al.*, 2002; Cepeda & Valdez, 2003; Schalet *et al.*, 2003; Archer & Grascia, 2005; Firmin, 2011; Beckett *et al.*, 2012)

As well as experiencing violence, girls in gangs were over twice as likely to use violence as other girls in this sample (see Figure 6). Indeed, the number of young women involved in violence slightly exceeds rates for young men in this sample. This finding raises questions for further investigation. Similar patterns of elevated aggression have been noted in other studies, with gang involved females being 3.6 times more likely to have been involved in three or more fights in the past six months than non-
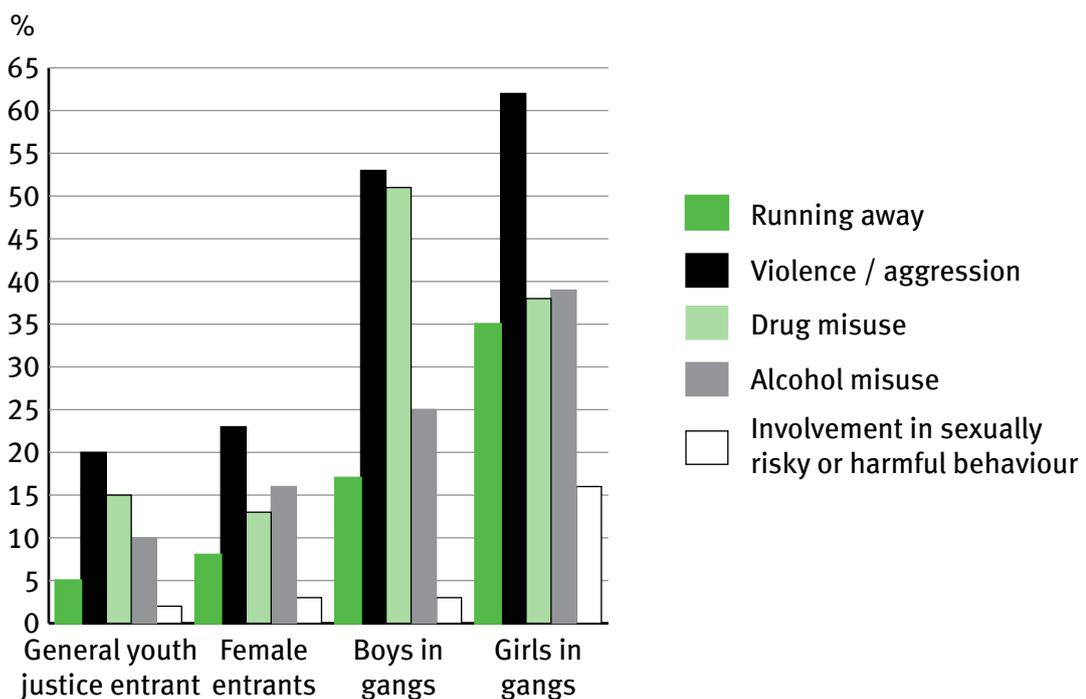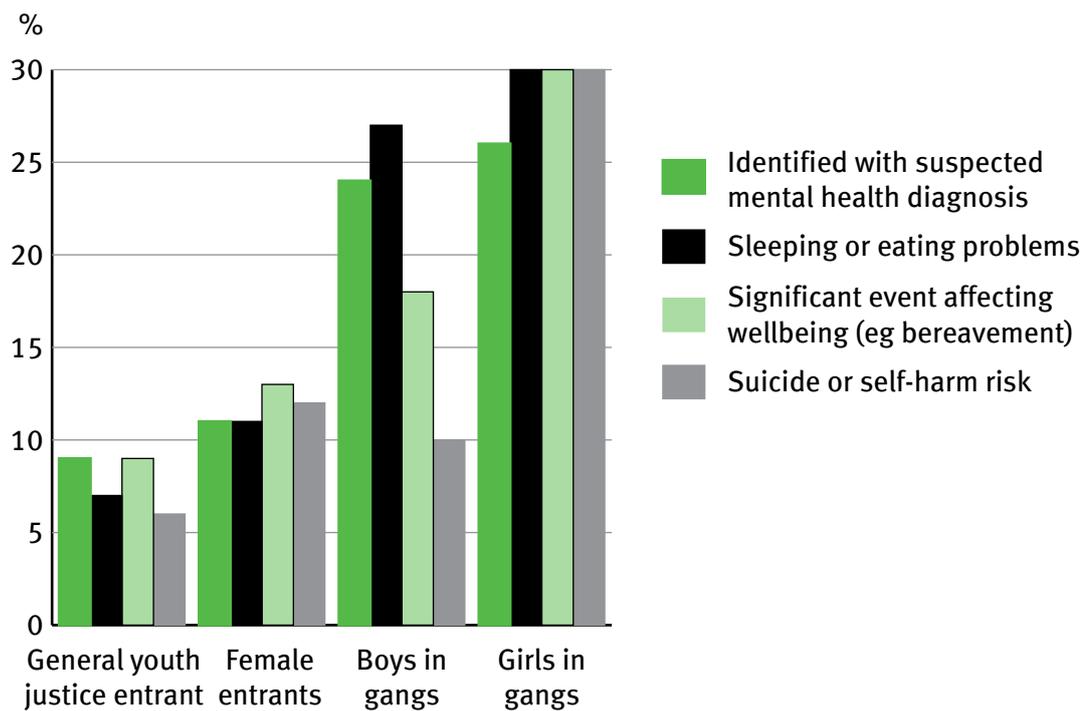
Figure 6: risky behaviours

Figure 7: mental health and emotional wellbeing

Legend:
- Identified with suspected mental health diagnosis
- Sleeping or eating problems
- Significant event affecting wellbeing (eg bereavement)
- Suicide or self-harm risk

affiliated females (Wingood *et al.*, 2002). This is perhaps not surprising in that the risk factors for gang membership broadly overlap with those for violence (Mackenzie & Johnson, 2003).

Our data provide no clues as to the relative frequency or severity of aggression and violence in comparison with young males, and it has been suggested that female aggression is generally different in motivation (linked to social ties), nature and severity than male acts of violence (Putallaz & Bierman, 2004). For example, Campbell (1999) argued that for gang males, violence provides power whereas for gang females, violence has its root in fear and survival; a protective response to their vulnerability (Bell, 2009). Disrespect, jealousy and accumulated tension may also prompt some women to behave violently (Cunningham, 2000; Kruttschnitt & Carbone-Lopez, 2006).

Other mental health problems

The Centre's database highlights a wealth of other information pointing to the psychological vulnerability of these young women (Figure 7). Just over a quarter of them have a suspected diagnosable mental health problem (and if

early starting behavioural problems had met diagnostic thresholds, suspected prevalence rates could approach 40%). 30% of girls in gangs were self-harmers or at risk of suicide, with two and a half times the risk of self-harm of other girls. 30% of girls in gangs also have sleeping or eating problems. Although on the face of it these are physical symptoms, it is not uncommon for children and young people's emotional difficulties (such as depression, anxiety or distress) to be displayed in this way.

Younger people with emerging poor mental health or high risk factors for mental illness often present with less clear-cut symptoms which make them much easier to miss. Furthermore, many professionals fear unhelpfully stigmatising young people with diagnostic labels. But delays in identification prevent early intervention, can result in the multiplication of problems and undermine longer term prospects (Patel *et al.*, 2007). There is the strongest evidence that intervening early has the best effect on a child's quality of life; it can also reduce the burden of cost on a range of multi-sector budgets (Bonin *et al.*, 2011).

Figure 8: Neuro-developmental difficulties
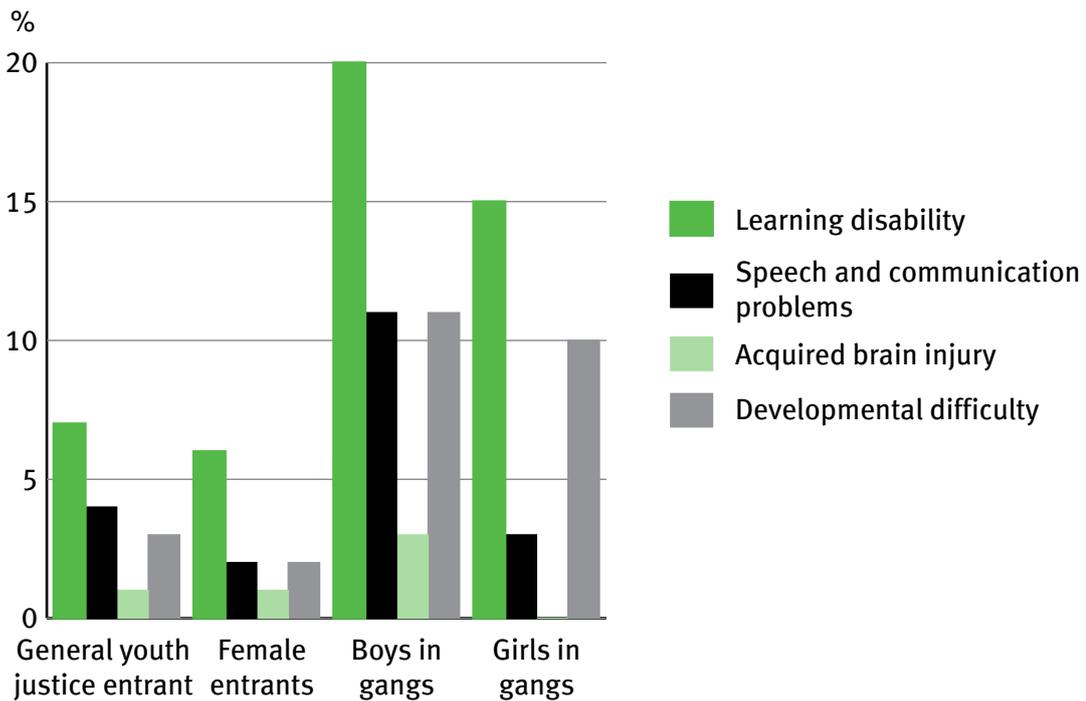
Neuro-developmental difficulties and broader physical health

Levels of speech and communication problems, learning disabilities and Acquired Brain Injury (ABI) in this sample appear lower than one would expect, perhaps reflecting poor screening practices. 15% of young women had a learning disability as opposed to 20% of young men in gangs; screening at later stages in the YJS has previously identified around a third of young people as having a learning disability (Harrington, 2005).

Only 3% of these girls in gangs had speech and communication difficulties (Figure 8). Again, screening at later stages in the YJS identifies around 60% of young people (mainly males) experiencing these difficulties (Bryan, 2007; Gregory & Bryan, 2009). Less attention has been paid so far to females in this research.

Neuro-developmental difficulties are much less frequently identified in girls in the general population compared with boys. Boys under 16 years old are usually around four and a half times more likely to be on the autistic

spectrum and nearly seven times more likely to have hyperkinetic difficulties than girls (Green *et al.*, 2005). On the other hand, in custodial samples international studies point to higher levels of Attention Deficit Hyperactivity Disorder (ADHD) among females compared with young males (Fazell, 2008). Point of arrest screening identified 10% of girls in gangs with suspected developmental difficulties (such as ADHD or autism) which is roughly comparable to rates found in males in the same sample and five times that of other females.

No young women were identified with a previous history of head trauma; whereas a US study found reasonably high levels of ABI among young women in custody (15%). ABI usually results from trauma to the head and subsequent loss of consciousness. Damage can remain hidden for many years but then lead to a sudden dip in a child's developmental progress. High levels of ABI have been seen in young men in custodial settings, linked to higher levels of violence and increased risk of suicide.

Figure 9: physical health problems

%
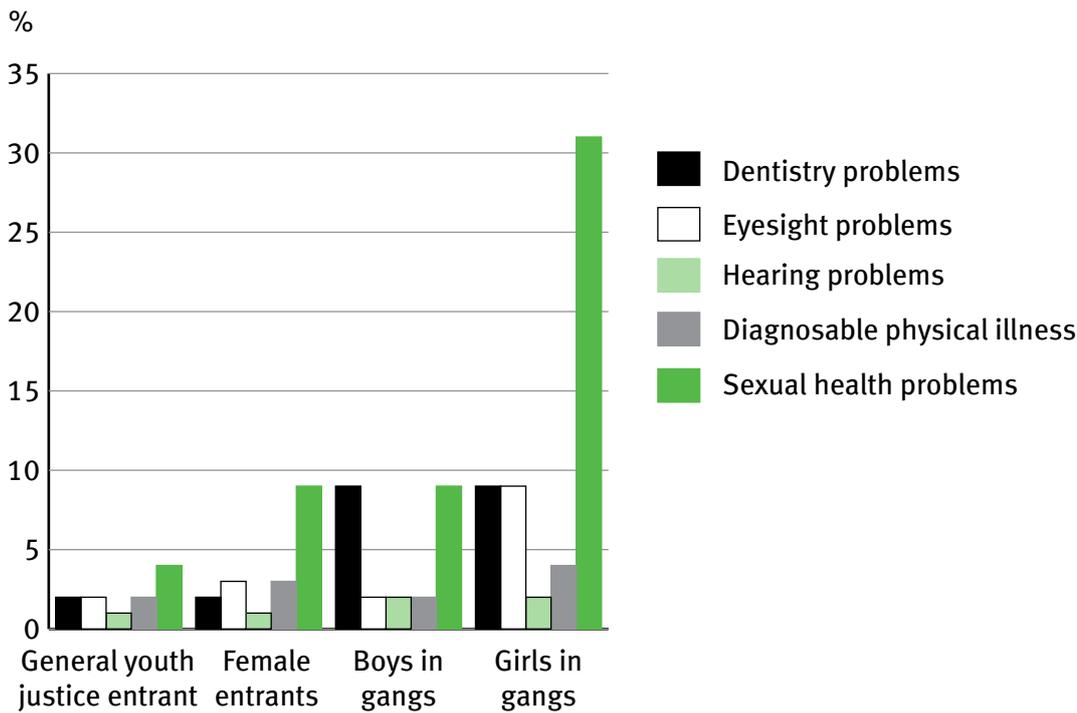
Physical health problems

This study found lower rates of physical health problems compared with previous YOT screening programmes (Bekaert, 2008). But the sites did not have a standardised screening system for routinely checking physical health needs. Nevertheless, in relative terms, young women in gangs had higher physical health needs in all areas in Figure 9. Girls in gangs were over three times more likely to have sexual health problems than other girls. Sexual health needs were particularly high in this sample, reflecting high levels of sexual risk-taking and pointing to possible experiences of sexual victimisation.

Broader literature suggests that these young women experience a range of sexual health problems including higher levels of sexually transmitted infections (STIs), lower levels of condom use and higher teenage pregnancy rates (Miller, 2001; Cepeda & Valdez, 2003; Wingood *et al.*, 2002; Minnis *et al.*, 2008).

In one study gang membership was identified as a risk marker increasing the probability of acquiring a STI (Cepeda & Valdez, 2003).

Engagement and services

The majority of young women in gangs engaged with point of arrest screening; only 3% refused to be screened while a further 11% then disengaged from subsequent support (Figure 10). Young males showed similar patterns of engagement. Overall, this presents a hopeful picture of the willingness of young people to respond to proactive health screening at the point of arrest. It also suggests the need for a more intensively engaging outreach approach with a very small number of very vulnerable young people who will disengage.

Referral pathways for girls in gangs

These highly vulnerable young women were most likely to receive general support, including for substance misuse, parenting and youth-related support. Around a quarter were supported back into education and in 5% of instances exclusions were avoided. Around 1 in 5 was referred to physical health services and counselling services and a further 5% were supported into housing. In a small minority of cases, these young women were referred into evidence-based family interventions such as Multi-Systemic Therapy or Functional Family

Therapy (Lee *et al.*, 2012) which have good track records in improving outcomes and reducing re-offending and associated costs. One pregnant young woman was referred to an Intensive Nurse Home Visiting Programme for teenage parents (Family Nurse Partnerships) which has demonstrated benefits not just for mothers in terms of reduced arrest rates but also those of female offspring (Eckenrode *et al.*, 2010). The children of the young women in these programmes are also noted to be less likely to become teenage parents themselves, generating multi-generational savings. Many of these interventions save significant costs for the public purse over time in comparison with standard youth offending responses (particularly custody) (Lee *et al.*, 2012).

Two thirds of young women identified with gang associations were picked up at an early stage in their offending and diverted away from the youth justice system towards more appropriate health, educational and social services to address their multiple needs (see Figure 10). Diverting young people away from the YJS has been shown in studies to decrease the risk of further reoffending compared with those processed through the formal YJS (Petrosino *et al.*, 2010).

The Nia Safe Choices programme - a gang-specific service

The Nia Safe Choices programme works in a number of London boroughs with young women who experience multiple risk factors in relation to gang culture. These risks include sexual violence and exploitation, gang association and involvement in violent crime. The project worked with young women who had been referred by local agencies such as schools, pupil referral units, youth offending teams and children's social care teams.

Safe Choices works on complex, difficult and sensitive issues with young women who are often alienated from other services and who may not trust adults easily. The young women are frequently exposed to multiple risk factors that can lead to poor life chances and leave them vulnerable to abuse and exploitation in relationships with young men, as well as involvement in criminal activity. The Nia programme offers young women experiential group work and intensive one-to-one support that focuses on developing resilience and positive support networks alongside challenging patterns of offending behaviour to enable young women to develop healthy and safe relationships.

For more information, visit www.niaendingviolence.org.uk/young/index.php

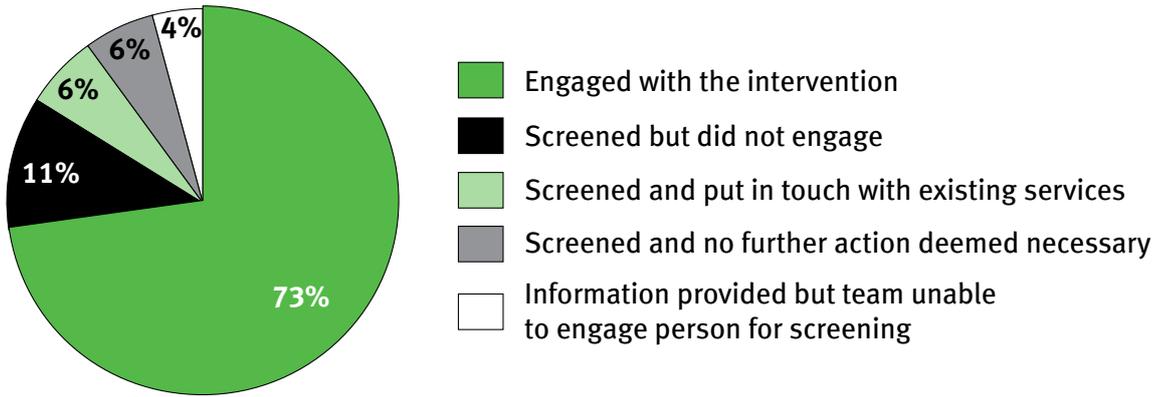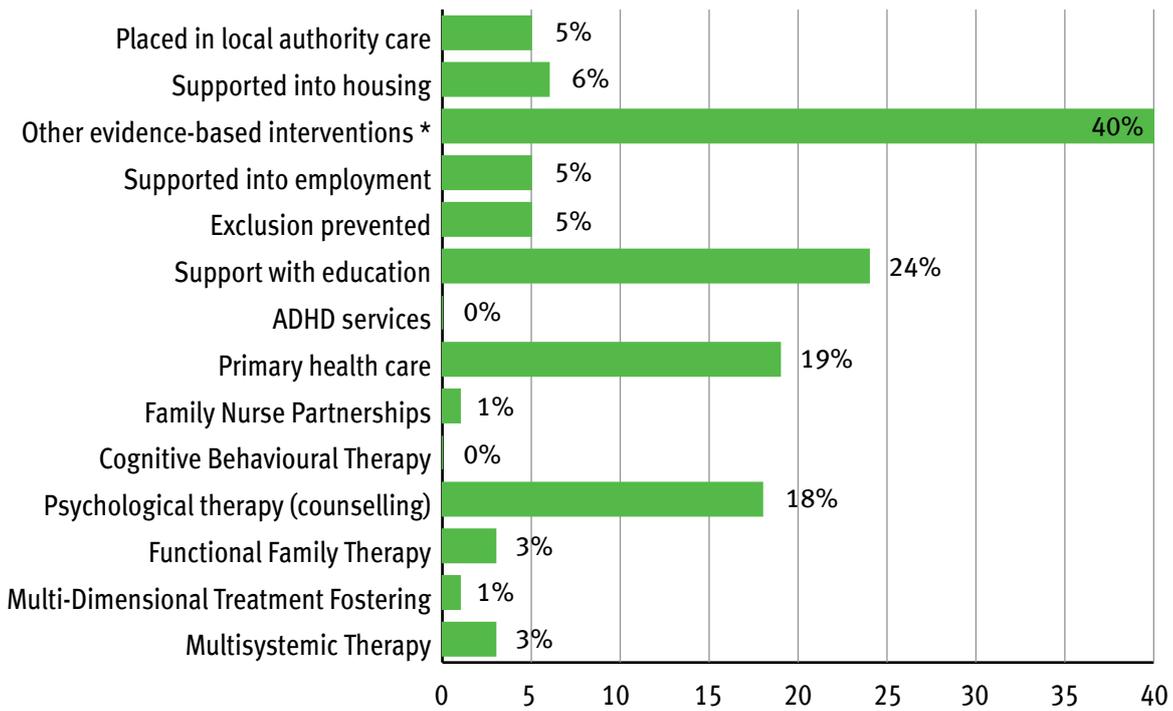**Figure 10: Engagement of girls in gangs with the screening programme**

- 73%
- 11%
- 6%
- 6%
- 4%

Legend:
- Engaged with the intervention
- Screened but did not engage
- Screened and put in touch with existing services
- Screened and no further action deemed necessary
- Information provided but team unable to engage person for screening

Figure 11: Referral pathways for young women with gang associations entering the YJS

Category	Value
Placed in local authority care	5%
Supported into housing	6%
Other evidence-based interventions *	40%
Supported into employment	5%
Exclusion prevented	5%
Support with education	24%
ADHD services	0%
Primary health care	19%
Family Nurse Partnerships	1%
Cognitive Behavioural Therapy	0%
Psychological therapy (counselling)	18%
Functional Family Therapy	3%
Multi-Dimensional Treatment Fostering	1%
Multisystemic Therapy	3%

* Other interventions include parenting, substance misuse, youth work support, gang and gender-specific support.

Improving lives through gender-specific programmes

While many factors motivating girls to join gangs overlap with those of male peers, there are also key differences (Bell, 2009). For this reason, any interventions should include both gender-neutral (with a proven record of improving female as well as male outcomes) and gender-specific programmes and approaches. This final chapter looks at effective programmes with the best chance of improving outcomes for this very vulnerable group of young women.

Studies suggest that young women who join gangs accumulate multiple risks that undermine their progress over a significant period of time. Although some of these risk factors may be hidden, others can be overlooked, missing vital opportunities for early and cost-effective intervention. This is problematic as early risk factors can create developmental patterns which get more difficult to modify as children mature (Hertzman & Power, 2003).

Early intervention using evidence-based support is essential to prevent violence, escalation of mental health difficulties, educational failure, offending and physical difficulties (Heckman *et al.*, 2010; Bonin *et al.*, 2011; Lee *et al.*, 2012). There is a need for multi-sector attention to these risks. In particular, the first sign of persistent early-starting behavioural problems and the accumulation of risks over a broad range of domains should be seen as critical markers for poor outcomes including gang membership and therefore a signal to mobilise services to provide effective support.

Our findings reinforce the importance of adopting gender-specific approaches to screening and intervention. Although some screening tools and programmes have been tested for effectiveness and responsivity to female risk and needs, many have not (Bell, 2009). Many tools and programmes focusing on violence, crime and gang membership have been designed for the male majority and do not address the very specific histories of young women and build on the strengths and gender-specific levers which support young women to change damaging lifestyles.

A lifetime approach: what works to support better outcomes for vulnerable young women?

For the young people with the highest risks, a stepping stone pattern of risk occurs across a child's lifetime.

Building robust neural architecture in infants

Advances in neuro-scientific research increasingly highlight links between early childhood experiences and later adolescent risk taking, health threatening behaviours and chronic adult health problems (Shonkoff & Garner, 2012). Early adverse experiences are thought to lead to biological disruptions in brain development with, on occasions, damage appearing to occur before birth. Research suggests the importance of prioritising integrated and multi-sector activity to reduce health-compromising environmental factors and to strengthen the protective relationships that mitigate the harmful effects of toxic stress.

Promoting girls' life chances must therefore begin before birth providing expectant mothers with support to:

1. improve healthy lifestyle choices;

2. reduce the impact of stress and toxic stress on children's development (i.e. intervening early and effectively with maternal depression, to address parental substance misuse, to address maltreatment and victimisation in the home and to support positive parenting techniques promoting children's wellbeing);

3. promote healthy early communication between mothers and babies to jump-start electrical activity in the brain.

(National Scientific Council on the Developing Child, 2004; O'Connor *et al.*, 2005; Center on the Developing Child, 2012; Shonkoff, 2012)

Girls Circle: a promising US gang and gender-specific programme

Girls Circle is a strengths-based support group promoting safe and healthy decision making, positive protective connections and empowerment in girls aged 9–18. The approach recognises the importance of good quality relationships for young women's psychological make-up determining their overall psychological health, self-image, and connections with others. The approach relies on growth-fostering relationships (or relational–cultural theory (RCT)) as a primary lever for supporting change. Girls Circle aims to provide experiences of safety in relationships and not only to reduce risk factors for delinquent behaviour but also to increase protective factors for resilience in adversity. The approach combines motivational interviewing, resiliency practices and skills training.

The programme consists of 8- to 12-sessions. In each session, typically held once weekly, a group of girls of similar age and development meet with a trained facilitator for either a 90- or 120-minute session. Within a structured six-step format, the girls take turns talking and listening to one another about their concerns and interests. Gender-specific themes and topics are introduced that relate to the girls' lives, such as body image, goals, sexuality, drugs, alcohol, tobacco, competition, decision-making, friendships, setting personal boundaries, coping with stress, recognising abusive relationship patterns, assertiveness, and trusting oneself. Creative or directed activities such as role-playing, drama, poetry, and other creative projects link to these discussions.

A key component in the model is that one group member speaks at a time, with the expectation that other participants will listen attentively. This form of communication aims to increase empathy skills and mutual understanding among group members. A mother–daughter curriculum extends the Girls Circle model to address the mother–daughter relationship as girls enter and pass through adolescence.

It has been subjected to limited evaluation and is considered a 'promising' programme by the US Office of Juvenile justice and Delinquency Prevention model programme guide.

The importance of good quality attachment

As well as good quality parent-baby communication, children also need to feel safe and secure, usually gained through positive and secure attachments. Being female is usually a protective factor for crime, violence and gang membership. However, some research suggests that poor quality child-parent attachment and severe environmental risk can increase the chance of girls developing behavioural problems, poorly regulated stress-response systems, aggression and risk taking (Del Giudicea, 2009).

Reducing maltreatment

Our overarching findings suggest that poor parenting, maltreatment, neglect and family victimisation have a detrimental impact on young women's development. Although some stress is important to develop children's resilience, extended experiences of stress or maltreatment have a particularly toxic effect on children's health and wellbeing (Center on the Developing Child, 2012; Shonkoff & Garner, 2012). There is a growing call for multi-agency commitment to address all levels of child maltreatment (Shonkoff & Garner, 2012). Many schools and services that identify maltreatment describe current challenges in mobilising

support for anything other than the highest threshold of child protection needs. Overall findings from this study highlight the need for resources to respond not just to severity of neglect but also to sustained maltreatment (and multiple risk factors) in order to support reductions in these damaging experiences.

A portfolio of evidence-based or promising interventions

Preventitive programmes

Some preventitive programmes targeting very high-risk parents have shown considerable promise in improving outcomes for young women at risk. Family Nurse Partnerships have been robustly tested over time and aim to empower teenage parents over two years (before birth and after) to be the best parent they can be, to develop health promoting parenting styles and to problem solve and reduce family life stressors. Outcomes have been tracked for over three decades in the US and have produced multiple improved benefits across a range of domains including reductions in maternal and female offspring offending levels. This intervention saves costs across a range of budgets if implemented well and is being tested and expanded in the UK with high risk parents (Gov UK, 2013).

Other comparable promising initiatives are being tested in the UK to support improvements in outcomes for parents struggling with drug, alcohol and mental health problems. These interventions include:

- Parents Under Pressure, a home visiting intervention for parents with drug and alcohol problems; currently being piloted by the National Society for the Prevention of Cruelty to Children (NSPCC) (Dawe & Harnett, 2007)

- Minding the Baby, an intensive home-visiting programme seeking to help high-risk first time mothers (such as those with mental health or substance related difficulties) develop positive relationships with their baby; currently being piloted by the NSPCC (Slade *et al.*, 2005)

Pre-school interventions

Some pre-school initiatives also demonstrate promising improvements for children's outcomes. The High Scope Perry Pre-School programme in the US targeted children from low income black and minority ethnic backgrounds (Schweinhart, 2005). The programme taught a range of planning and problem solving competencies using active participatory learning and supported through regular home visits by teachers. Numerous cross-budget benefits were noted for females including reductions in teenage pregnancy and arrest rates and a 63% increase in high school graduations compared with young women in comparison groups.

Responding to the first signs of poor child mental health

There are considerable advantages in responding early to the very first signs of poor child mental health (Patel *et al.*, 2007; Bonin *et al.*, 2011). This is particularly important with persistent early behavioural problems (Moffit & Scott, 2008). Simple evidence-based parenting programmes for children from 3 to 11 years have been shown to result in improvements not only in children's outcomes but also parental mental health (NICE, 2013). There is evidence that programmes work best with children with higher severity of need (Hutchings *et al.*, 2007; Reid *et al.*, 2010) and have equally positive impact across a broad age range and gender (de Graaf *et al.*, 2008; NICE, 2013) but that programmes need to be implemented well to guarantee positive results (Centre for Mental Health, 2012).

The importance of multiple risk factors and behavioural problems

Strong evidence exists linking multiple risk factors and adverse childhood events with behavioural problems/poor mental health. Longitudinal studies have expanded our knowledge of clustering risk factors with rates of severe behavioural problems increasing exponentially for each accumulated risk factor. In one study, boys with five or more risk factors were almost 11 times more likely to develop

conduct disorder than those with none, while girls with five or more risk factors were 19 times more likely to develop severe behavioural problems than those with no risk factors (Murray *et al.*, 2010). Intervention at the earliest sign of sustained patterns of poor behaviour can prevent further disadvantages stacking up. However, experiences of risk are dynamic; children may move in and out of as they mature, requiring those in routine contact with them in schools and in other settings to be alert to changes and to take prompt action to mobilise engaging support when risks accrue.

School-based interventions to improve outcomes for high risk girls

Studies further highlight the potentially important contribution of schools in changing the lives of vulnerable girls (and not just through academic attainment). There is good evidence from long-term studies of links between social and emotional wellbeing and academic attainment (Masten & Coatsworth, 1998; Weissberg & Greenberg, 1998; Eisenberg, 2006; Guerra & Bradshaw, 2008). The best school-based social and emotional interventions are noted to result in an 11% shift in attainment levels (Durlak *et al.*, 2011); essentially this means that a child who is 16th in the class in terms of attainment will move up to 5th place. Programmes such as Promoting Alternative Thinking Strategies (PATHS) in schools have a good record of preventing violence and offending (as well as a range of other positive outcomes for girls' wellbeing and life chances) (SRU, 2012).

Conduct problems and older young people

An overview of the literature generally suggests that although we should intervene as early as possible to prevent the escalation of risk factors for gang involvement in a child's life, it is also never too late. Comprehensive programmes focusing on multiple risk factors such as multi-dimensional treatment fostering (MDTF) (for those young women requiring placement outside their family home), functional family therapy (FFT) and multi-systemic therapy (MST - an intensive therapeutic approach focused on empowering families to address the risk

factors which sustain problematic behaviour) all have a good record of improving outcomes for older vulnerable females and should be commissioned and used more extensively with young people at risk of crime and gang involvement (Lee *et al.*, 2012; NICE, 2013).

Violence prevention programmes

Numerous international league tables have sought to identify and draw together the most effective programmes for reducing youth violence, aggression and broader behavioural problems (Lee *et al.*, 2012; Office of Justice Programs, 2012; Blueprints for Healthy Youth Development, 2012 - 2013; SRU, 2012). Since young men are at greater risk of involvement in violent behaviour and criminality, most programmes have been designed with the male majority in mind. A minority have been tested for impact on mixed gender populations. Programmes designed exclusively for females are even rarer and the vast majority have not been effectively evaluated (Zahn *et al.*, 2008).

Gender-specific gang interventions

The majority of literature on girls in gangs advocates the importance of developing a gender-informed treatment model to improve outcomes. Studies suggest essential elements of effective programmes for girls include the following:

1. Programmes should be provided in a safe and nurturing environment (including single-sex space) conducive to therapeutic change; exiting gangs particularly relies on interventions that prioritise young women's safety (e.g. risk assessing exit strategies and providing safe housing).

2. Programmes should include content which reflects both the risk factors and the realities of their daily lives, including:

   - A multidisciplinary, comprehensive, holistic and solutions-focused approach to addressing the multiplicity of girls' risks, strengths and experiences (including physical and sexual health and risk taking, practical difficulties, parenting support, experiences of

victimisation, aspirations, mental health, preparation for work, substance reliance).

- interventions promoting self-esteem, healthy assertive behaviour and self-reliance to build resilience against future victimisation.

- mental health interventions which potentially incorporate treatment for trauma.

3. Programmes for females should foster respectful and positive relationships as an important lever for promoting change when working with young women. Relationships are particularly influential for young women both as a way in to risky activity and as a way out. For example, we know that:

- Young women in the criminal justice system have been described as searching for positive relationships that they didn't find at home; they were most disappointed in youth justice and probation staff who only focused on enforcement, on failures and on mistakes.

- Positive female role models are critical to girls' healthy development and are often a proxy for dissatisfying family relationships; mentors should reflect the racial/ethnic and cultural backgrounds of females seeking to move away from gangs.

4. Programmes should include evidence-based work with families supporting the longer term resilience of these young women with attention to improving interaction and communication both ways between the parent and the child.

5. Interventions should prioritise outreach approaches and maximise engagement. Marketing, engagement tactics and gang exit pathways need to be creative and co-produced by young people themselves.

(Gross & McCallum, 2000; Bloom & Covington, 2001; Sherman, 2003; Gaarder *et al.*, 2004; Youth Justice Board, 2009; Snethen, 2010; Lynne Scott & Ruddell, 2011)

Every system contact offers an opportunity to improve outcomes for girls in gangs

Finally, effective early intervention requires all services touching families and children (this includes adult-oriented services such as substance misuse, mental health and probation work, as well as educational and children's services) to be familiar with and recognise the implications of risk factors for poor female outcomes (see Table 1) - particularly where multiple risks span a range of domains (Shonkoff & Garner, 2012). Referrers then need clear referral gateways and pathways to mobilise early support.

Conclusion

This study identifies young women with gang associations as a small but significantly vulnerable and troubled group compared to other young women entering the youth justice system. Harsh or neglectful parenting, maltreatment, victimisation and poor relationships appear to have a particular impact on their developmental vulnerability. Furthermore, clustering risk factors spanning multiple domains create a 'toxic' effect increasing the likelihood of persistent behavioural difficulties - the most common mental health problem faced by children.

Nearly half of young women with gang associations on the Centre's database were noted with signs of behavioural problems before the age of 12. Early childhood behavioural problems are associated with an array of poor health and social prospects, particularly if critical opportunities are missed to intervene early and if damaging childhood experiences are later amplified through later gang-related bullying and victimisation.

Our findings suggest that every system that touches the lives of families (including mothers before and after pregnancy) offers opportunities to identify the gender-specific risks undermining the (often intergenerational) prospects of these young women, to strengthen and promote their lifelong healthy development and to save multi-sector costs. Effective responses need to recognise that these young women move in and out of risk across the years; where multiple risks emerge and escalate, evidence-based programmes together with gender-specific programmes should be mobilised.

Young women generally respond best to programmes which are stylistically different to those designed for males; interventions must address relevant aspects of these young women's experiences (such as trauma and victimisation) as well as recognising the importance of positive relationships as leverage for change.

These young women were not difficult to engage at the point of entering the youth justice system. We found examples from sites of positive outcomes being achieved when engaging and empowering multi agency support was wrapped around them focusing on holistic care, safe exit pathways and addressing the damaging psychological legacy of prolonged victimisation.

However, data on referral outcomes still suggest that only a small minority find their way to evidence-based interventions with the best chance of improving their long term outcomes (e.g. MST, FFT, MDTF). Anecdotal reports are of patchy commissioning of these resources (which although sometimes costly in the short term, reap longer term benefits across a range of budgets). There is also evidence that gender-specific programming is generally underdeveloped with insufficient investment as yet in robust evaluation of initiatives. Finally, any action with these young women will also need to link with broader national and local activity to reduce health, social and income inequalities in communities.

Recommendations

1. **All services in regular contact with young people and families should recognise the toxic and undermining impact of both multiple risk factors and prolonged exposure to risk for children's healthy development.**

   All professionals and services in contact with children (e.g. GPs, teachers etc) need training and on-going professional development to improve understanding and practice in supporting healthy child development. This includes workers in services focused mostly on adults of working age.

2. **All services in contact with girls and young women should routinely open a dialogue with young people about whether and how they are affected by gang activity in their communities.**

   Youth workers, social workers, Personal, Social and Health Education (PSHE) workers in schools, voluntary sector providers, health and youth offending workers are all well-placed to raise these issues and signpost or offer support to young people when they need it.

3. **All local authorities with responsibility for conducting Joint Strategic Needs Assessments should identify the number of young women involved in gang activity or who are at risk of it and develop multi-agency strategies to address these risks.**

   Health and Wellbeing Boards, Directors of Public Health and Crime Reduction strategic groups should develop information systems which integrate and analyse information from a range of sources on risks affecting families, children and communities, embedding this shared intelligence in Joint Strategic Needs Assessments.

- All sectors (including health) should proactively contribute to local understanding of young people associated with gangs given the very high safeguarding risks faced by these young people.

- Clear information sharing protocols should be in place between all agencies (including Accident and Emergency and sexual health services) to support work with young people associated with gangs.

4. **Health, social care, education and justice commissioners should all recognise gang membership as a marker for particularly pervasive negative outcomes for young people and communities and take collective action to gather data on prevalence, prevent risk and support those who are involved to exit safely.**

   Clinical Commissioning Groups, children's services, schools and Police and Crime Commissioners should invest jointly in holistic, evidence based and gender-specific interventions for children and young people of all ages to prevent violence and gang membership. These multi sector interventions should:

- Seek to prevent poor outcomes by fostering healthy childhood development, resilience and intervening promptly to mobilise support for families at the first sign of childhood distress. A key shared objective should be to prevent the escalation and multiplication of risk factors in girls.

- Provide early and engaging responses to young women drawn into gang membership helping them exit safely and gain access to gender-appropriate services supporting their progress and effective recovery (e.g. safe housing, sexual health services and engaging mental health services etc).

5. **Local Safeguarding Boards should actively monitor and review local prevalence information on gang activity and membership.**

   Given their exceptionally high safeguarding risks, females in gangs warrant particular attention and monitoring from Safeguarding Boards. Safeguarding Boards should also ensure that multi sector information sharing protocols are in place and work effectively to support collaborative working to safeguard young people associated with gangs.

6. **NHS England should commission point of arrest liaison and diversion services which are gender-sensitive and recognise the deleterious impact of gang membership on children's health and social outcomes.**

   The National Operating Model for point of arrest health screening and diversion services must include gang membership as a significant marker of multiple poor health, social and safeguarding outcomes.

   Point of arrest liaison and diversion services should recognise that first contact with the police and with YOTs provide a critical opportunity to identify both gang involvement and the multiple health and social risk factors underpinning membership.

   They also need a reliable and holistic health screening tool to help consistently, accurately and swiftly identify mental health, speech and language/neurodevelopmental needs and behaviours prompting fuller assessment when necessary. No comprehensive screening tool currently exists to support holistic health screening. Any tool should also be child, gender and culturally sensitive.

7. **The Youth Justice Board and the Home Office Violence Prevention Unit should continue and extend work to produce tools, training materials and initiatives for youth services and YOTs on gender-specific practice.**

8. **YOTs and probation services should work in close partnership with voluntary sector services working with gangs to create engaging and safe spaces and services for highly vulnerable young women.**

9. **The Government should ensure that the statutory duty on the Secretary of State to reduce local health inequalities translates into meaningful and measurable local action.**

   Studies have shown that inequality is more important in predicting violence and gang membership than poverty itself. This is thought to be linked to factors such as poor social trust and relationships in unequal societies.

10. **Academic institutions should prioritise research and development into effective responses to the needs of young women involved in gangs.**

    Current priorities for research include:

    - To develop gender-sensitive and validated screening tools for young women at risk of gang membership to help prompt schools, youth services and YOTs to respond early to risk.

    - To develop programmatic knowledge of what works for young women involved in gangs. This should include solid evaluation of the broad impact of initiatives with particular attention to the longer term economic benefits of interventions for young women. The high degree of risk identified in these young women suggests scope for adapting/trialling an intensive person-centred wraparound programme (adopting models similar to Multisystemic Therapy or Family Nurse Partnerships) specifically focusing on turning around the lives of gang-associated women.

    - To crystallise the core components of what make any gender specific programmes work so that these can be effectively replicated in different communities.

Data for the figures

Data for Figure 1: family based risk factors and vulnerabilities (%)

| | Percentage vulnerabilities | | | |
	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Parental imprisonment	2	2	9	10
Family conflict	20	28	39	60
Neglect	10	13	29	43
Sibling involved in anti-social behaviour	6	7	18	26
Parent with mental health or substance misuse problem	9	11	17	33
Physical abuse	2	4	7	13
Young carer	1	2	2	5

Data for Figure 2: child protection and safeguarding histories of those screened at the point of arrest (%)

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Current looked after child status	9	13	10	18
Previous looked after child status	11	13	15	15
On a child protection plan	11	12	13	28
Experience of foster care	4	8	13	20
Homelessness	4	5	15	10

Data for Figure 3: abuse / victimisation / social connectedness (%)

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Poor relationships	10	12	29	53
Victim of bullying	7	9	13	36
Witnessing / experience of violence in the home	7	10	19	26
Victim of sexual abuse	2	6	4	19

Data for Figure 4: school performance (%)

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Poor school performance	15	17	47	59
School exclusion	11	11	34	28

Data for Figure 5: Behaviour problems under the age of 12 years (%)

General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
13	13	38	39

Data for Figure 6: risky behaviours

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Running away	5	8	17	35
Violence / aggression	20	23	53	62
Drug misuse	15	13	51	38
Alcohol misuse	10	16	25	39
Involvement in sexually risky or harmful behaviour	2	3	3	16

Data for Figure 7: Mental health and emotional wellbeing (%)

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Identified with susp[ected mental health diagnosis	9	11	24	26
Sleeping or eating problems	7	11	27	30
Significant event affecting wellbeing (such as bereavement)	9	13	18	30
Suicide or self-harm risk	6	12	10	30

Data for Figure 8: Neuro-developmental difficulties (%)

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Learning disability	7	6	20	15
Speech and communcation problems	4	2	11	3
Acquired brain injury	1	1	3	0
Developmental difficulty	3	2	11	10

Data for Figure 9: Physical health (%)

	General youth justice entrant	Female entrants	Boys in gangs	Girls in gangs
Dentistry problems	2	2	9	9
Eyesight problems	2	3	2	9
Hearing problems	1	1	2	1
Diagnosable physical illness	2	3	2	4
Sexual health problems	4	9	9	31

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