



# 11-15 years

## Missed opportunities: children and young people's mental health

Developmentally, adolescence is a period characterized by considerable flux and transition as young people leave their childhood behind and navigate towards incremental independence, striving to create a unique identity separate from parents and carers. It is also a period when peers become more important influences. We now know that it is a period of significant neurodevelopmental change for most children, characterized by the second most dramatic period of structural change in brain architecture after infancy (e.g. rapid pruning as well as significant change in the volume of grey matter). These dramatic neurodevelopmental changes often affect adolescents' judgment and perceptions:

- Increasing their likelihood of sensation-seeking and taking risks;
- Decreasing sensitivity to social cues;
- Decreasing consequential thinking.

(Johnson, *et al.*, 2009).

Changes don't begin to stabilize again until the mid-twenties when finally young adults are left with a fully formed adult brain (Johnson, *et al.*, 2009). It is within this context that we also see many risk taking behaviours increasing. Furthermore, although adolescence and adulthood are a period of maximum physical health, it is also the peak period for the development of first mental health problems (Silva, 1990; Jones, 2010).

### Prevalence of mental health difficulties

During secondary school years, national prevalence studies show that 12% of children meet the criteria for diagnosis of any type of mental health condition. As with primary school years, boys are the most likely to have a diagnosable condition during these years and conduct problems dominate.

- 7% of young people (mostly boys) have conduct disorders (as opposed to 6% in under 11 year olds).
- 5% meet the criteria for a diagnosable emotional condition (increasing from 2.4% in earlier childhood). These conditions are more common among girls.
- 1.4% meet the criteria for hyperactivity (as opposed to 1.6% in the earlier age group).
- 1.4% meet the criteria for other less common conditions such as autism (0.8%) and eating disorders (0.4%).

(Green, *et al.*, 2005).

Although very small in number (and not tracked in previous child and adolescent mental health prevalence surveys) some young people in this age band are at risk of developing very early signs of severe mental illnesses such as psychosis from the age of 14 onwards. Psychotic conditions generally involve some degree of:

- Loss of contact with reality;
- Personality or unusual behavioural changes;
- Confused thought;
- Difficulty with social interaction;
- Impairment of day to day activities.

(National Collaborating Centre for Mental Health, 2009).

Those developing first symptoms at an earlier stage in life face greater impairment compared with those developing psychosis during adult years. They also face poor educational and employment outcomes, poor physical and mental health and reduced life expectancy (Hollis, 2000; NICE, 2013). Some groups of young people are at higher risk of developing psychosis than others. For example, 5% of young people in the youth justice system were identified with psychotic symptoms (Chitsabesan *et al.*, 2006). Psychosis is also associated with earlier and heavier cannabis use particularly if there is a family history of psychosis (Moore, *et al.*, 2007; McLaren, *et al.*, 2010).

Girls are more likely to have emotional problems than boys, particularly post-traumatic stress disorder (PTSD), agoraphobia,

generalised anxiety and panic attacks. Boys are more likely to present with conduct disorders during these years as well as being much more likely to have autistic and hyperactivity conditions (Green, *et al.*, 2005).

Sample sizes in research have historically been small for young people from BME groups and it is difficult to get a reliable picture of prevalence patterns from previous national psychiatric prevalence data. This gap in knowledge is important. The most robust evidence we have on trends for this age band emerge from analysis of the Millennium Birth Cohort who sampled larger numbers of children and families from BME communities using the Strength and Difficulties Questionnaire. The most recent sweep of these data focused on children aged 11 in 2012 and revealed that children classified as mixed heritage had the highest likelihood of meeting the criteria for diagnosable-level mental health problems followed by white children (Morrison Gutman, *et al.*, 2015). Indian children were noticeably less likely to meet the threshold for a diagnosable mental illness.

These patterns are significant as they provide the most robust data we have so far on disparities in BME childhood mental health. Furthermore, they raise some challenging systemic and developmental questions as despite having lower rates of diagnosable mental health problems (and therefore conduct disorder) than other children at this age, black boys during the same period were most likely to be excluded from school (Office of the Children's Commissioner, 2012) and also in young adult years have a higher chance of developing a severe mental illness (McManus, *et al.*, 2009).

### **Eating disorders**

Eating disorders are not just about food, weight, vanity or willpower. They are often driven by distress, anxiety, stress and cultural pressures. Eating disorders are serious and potentially life threatening mental illnesses, in which a person experiences severe disturbances in eating and exercise behaviours because of distortions in thoughts and emotions, especially those

relating to body image or feelings of self-worth (Brooks, *et al.*, 2011; National Eating Disorders Collaboration, 2014).

Perhaps counter-intuitively, according to national prevalence studies, boys aged 11 to 15 were more likely than girls during these years to meet the criteria for a diagnosis of a severe eating disorder (mirroring a pattern also apparent during middle childhood). This may be because the peak age for diagnosable level eating disorders in girls typically emerges just after this 11-15 age band. It may also be because numbers presenting with this type of condition are very small and figures may, therefore, not be accurate.

Body image satisfaction has been one of the factors noted during this age group as a protective factor in relation to emotional wellbeing and eating disorders (Brooks, *et al.*, 2011). The Health Behaviour in Schools survey noted that during early adolescent years, satisfaction with body image varied by gender. So for boys, having a higher BMI led to a more positive body image whereas for girls having a lower BMI leads to a more positive body image. Body image satisfaction also significantly deteriorates over time - particularly for girls. So by the age of 15, despite around three quarters of girls in Scotland having a BMI in the normal range, 55% were dissatisfied with their body image.

Other surveys since 2011 also point to an increasing preoccupation, particularly on the part of young women, with appearance (GirlGuiding, 2014; GirlGuiding, 2015; The Children's Society, 2015) with the occasional study pointing to a possible deterioration in female adolescent mental health (Sweeting, *et al.*, 2010). Good quality data are currently unavailable to help make full sense of all of these contradictory findings. There is an urgent need to get better quality information to make better sense of trends; the next child and adolescent mental health prevalence survey will hopefully provide more reliable data by 2018 and, if it is repeated at seven year intervals, thereafter.

## Self-harm

Self-cutting is the most common form of adolescent self-harm. However, self-poisoning accounts for around 90% of cases referred to hospital (Hawton & James, 2005). Other forms of self-harm at this age include burning and punching, usually resulting in relatively minor injury (Hawton & James, 2005). Self-harm is often a coping mechanism for stress or a way to release feelings that may be overwhelming (Hawton, *et al.*, 2002). Other reasons for self-harming behaviour include self-punishment and using it as a way to escape or to gain a sense of control. Once self-harm begins it can be difficult to stop as it can become addictive. When a person inflicts pain on themselves, the body responds by producing endorphins. This natural pain reliever gives a temporary relief. This physical pain can be easier to stand than the emotional pain that led to the self-harm. However, engaging in self-harm can itself lead to more negative feelings such as shame and embarrassment which in turn causes more self-harm (Hawton & James, 2005).

Self-harm is often hidden because young people fear judgement or feel shame about their actions (YoungMinds, 2012). For this reason, it is difficult to get an accurate record of self-harm prevalence mostly due to secrecy and inadequate monitoring (Bowen & John, 2001).

The average age of onset for self-harm is reported to be between 12 and 14 years of age (Nock, *et al.*, 2009) and the majority of people who self-harm are aged between 12 and 25 years old, with risk rising with each year until mid to late adolescence (Hawton, *et al.*, 2012; Mental Health Foundation, 2006). There are very mixed reports on rates of self-harm in this age group. In the mid-2000s, reported rates of ever self-harming for this age group varied significantly depending on age, ranging from 7%-14% (Hawton & James, 2005). A more recent English survey focusing solely on self-harm among 15 year olds noted 22% of young people reporting ever having self-harmed (Brooks, *et al.*, 2015). Also, in the last national child and adolescent psychiatric survey, young people's self-reported rates of self-harming appear around three times higher than parental



reports (Green, *et al.*, 2005). However, findings and surveys also suggest that rates of self-harm vary internationally, fluctuate over time and may currently be increasing. For example, in the later age band covering 16-25 year olds, the UK witnessed a twofold upturn in self-harming between 2000 and 2007 (McManus, *et al.*, 2009).

Many studies show girls in this age group being three times more likely to self-harm than boys (Hawton, *et al.*, 2002). However, there remains ongoing debate as to whether young females have greater propensity to self-harm than young males with more recent evidence suggesting greater equivalence between genders (Kerr, *et al.*, 2010). Commentators argue that male self-harm often remains under the radar because it involves different forms of activity (such as self-hitting, engaging in fighting as a release for emotional distress or even substance misuse) which gets overlooked in traditional surveys (Kerr, *et al.*, 2010). Young males who self-harm have also been noted to face higher risk of suicide (Hawton, *et al.*, 2003).

Young South Asian females in the United Kingdom seem to have a particularly raised risk of self-harm. Intercultural stresses and related family conflicts may be relevant factors in this instance (Hawton & James, 2005).

Risk factors for self-harming also appear to operate at a number of levels. Some of these include:

- Low self-esteem;
- Family neglect and abuse;
- Conflict in families or in significant relationships;
- Loss including a significant intimate relationship ending;
- Exposure to trauma;
- Persistent bullying or peer rejection;
- Worries and pressures related to school work;
- Contagion/ links with peers who engage in similar activity (particularly attachments to Goth or other alternative youth subcultures promoting self-harm);
- Difficulty making friends;

- Sexual problems;
- Early starting conduct disorder;
- Alcohol and drug abuse;
- Poor physical health;
- Poor communication skills;
- Underlying mental illness such as depression, anxiety, psychosis.

(Bancroft, *et al.*, 1977; NICE, 2004; Hawton & James, 2005; Young, *et al.*, 2006; Klonsky & Moyer, 2008; Hawton, *et al.*, 2012).

Young people in this age group with a diagnosable mental health condition have been shown to be at much greater risk of self-harming. For example:

- Those with a diagnosable emotional condition were ten times as likely to self-harm or attempt to kill themselves (based on parent reports) and five times more likely to self-harm (based on their own report).
- Those with a diagnosable conduct disorder were nine times as likely to self-harm or kill themselves (based on parent report) and four times as likely to harm, hurt or kill themselves (based on their own report).
- Those with a diagnosable hyperactivity condition were six times as likely to harm or kill themselves (based on parent reports) and four times as likely to harm, hurt or kill themselves (based on their own report).
- Those with autistic conditions were 13 times as likely to harm, hurt or kill themselves compared with children without any mental health condition.

(Green, *et al.*, 2005).

There is also a strong relationship between the likelihood of self-harm and the number and type of adverse events that a person reports having experienced during the course of their life. Particular risks highlighted include having suffered multiple victimisation and, in particular, sexual abuse (affecting more girls than boys) (Hawton, *et al.*, 2002).

### **Risk of suicide**

Adolescent and young adult men are more at risk of suicide because they are much less likely to disclose difficulties and seek help/treatment

due to shame, stigma and fear of seeming vulnerable, (Chandra & Minkovitz, 2007) and are more likely to use fatal self-harm methods (McManus, *et al.*, 2009).

The risk of suicide after deliberate self-harm varies between 0.24% and 4.3% and once again is higher for males (Hawton, *et al.*, 2003). NICE guidance also notes that self-harm is a significant predictor of suicide particularly among older teenagers, with 0.5-1% of those admitted to hospital for self-harm taking their own life during the subsequent year (NICE, 2004; Hill, *et al.*, 2011).

Our knowledge of risk factors for suicide following self-harm remains limited. Despite this, the following factors appear associated with elevated risk:

- Being an older teenage male;
- Violent method of self-harm;
- Multiple previous episodes of self-harm;
- Apathy;
- Hopelessness;
- Insomnia;
- Substance misuse;
- Previous admission to a psychiatric hospital;
- Recent experience of a suicide or attempted suicide of a family member or close friend.

(Hawton, *et al.*, 2002).

Studies reveal generally mixed findings and complex associations between bullying and having suicidal thoughts. Some studies illustrated that bullies, who themselves had histories of victimisation, had greater likelihood of suicide risk (Kaltiala-Heino, *et al.*, 1999; Van der Wal, *et al.*, 2003). A key longitudinal study, following children's outcomes over many years, found that experiences of being bullied increased the chances of depression which then became a risk factor for suicide (Klomek, *et al.*, 2008). This means that it is particularly important to be vigilant for signs of depression in young people who are victimized in this way and to intervene in ways that are engaging and have the best chance of working.

### ***Persistence of mental health difficulties***

Between the ages of 11 and 16 we see a rise in the number of children (again mostly boys) presenting with severe behavioural problems. These children divide broadly into two distinct groups. Some have longstanding problems emerging before secondary school age; but there is a larger group who develop more challenging behaviour during adolescent years. Challenging behaviour during adolescence has been linked with dramatic neurological developmental changes which we now know occur at this time. These changes prompt greater risk taking, sensation seeking and reduce sensitivity to social cues (Johnson, *et al.*, 2009). Behavioural changes at this time are also linked to greater investment in peer relationships, 'social mimicry' and frustrations associated with transitioning between childhood and adult years (Centre for Mental Health, 2009).

Behavioural problems largely resolve for these later starters as neurological development stabilises, they find partners, settle in employment and assume other adult responsibilities (Centre for Mental Health, 2009). Late starting behavioural difficulties do not generally carry the same poor long term and multiple risks as those that start earlier in life. It is important, therefore, to differentiate between early and late starters with behavioural problems since these two groups require different interventions to facilitate progress and recovery.

There are less clear-cut findings on the extent to which childhood emotional problems persist into adult years; this requires more investigation. There is evidence that emotional problems that start in childhood or during pre-pubescent years are more likely to resolve. On the other hand, those that begin during adolescent years may be more long lasting. For example, Rutter (2006) noted that 40-70% of teenagers who developed emotional problems during teenage years had symptoms of a major depressive condition. This study also estimated that depressed adolescents had 2-7 times the likelihood of being depressed in adult years. Despite this observation, the lifetime impact of

emotional problems appears less pervasive and also largely less costly than the impact noted for early starting behavioural problems (Centre for Mental Health, 2009).

Attention deficit hyperactivity disorder (ADHD) was formerly thought to be a condition particularly affecting children and young people. However, this is increasingly being challenged as there is evidence that some symptoms persist into adult years for two thirds of children with the condition (although they may become more adept at managing symptoms over time).

## Trends over time

There is currently mixed evidence on the extent to which young people's mental health is improving or declining in the UK over time at this age. Anecdotal reports about rises in adolescent self-harming are confusing and appear to run counter to evidence from ongoing birth cohort studies which largely suggest no very dramatic changes in the prevalence of diagnosable conditions during the 21st century. For example, adolescent conduct problems (mostly affecting boys and young men) were rising up until 2004 but recently appear to have plateaued (mirrored by an overall drop in youth crime) (Collishaw, 2015). Similarly, a recent analysis of the likely prevalence of diagnosable difficulties among 11 year old children in the UK Millennium Birth Cohort also pointed to no overall increase in severe behavioural and emotional difficulties at this age (Morrison Gutman, *et al.*, 2015). However, a small number of other studies have suggested some areas of concern – particularly emotional and anxiety-related conditions affecting adolescent girls (Fink, *et al.*, 2015; Sellers, *et al.*, 2015; Collishaw, 2015).

When considering broader life satisfaction among this age group, the most recent Good Childhood Survey (2015) found self-reported child wellbeing had generally been improving in the UK up until 2007 with some subsequent leveling off up until 2011. Satisfaction with relationships with people in their family, money and possessions, friendships and local police were higher in the UK than international

comparators, while dissatisfaction revolved around life at school and with aspects of themselves particularly 'body, appearance and self-confidence' which were lower than those of international peers (The Children's Society, 2015). Girls in the UK were particularly likely to have lower satisfaction with their appearance than girls of the same age from other countries. Another survey, The Children's World Survey, also highlighted lower levels of subjective wellbeing among children in Great Britain compared with 11 other countries. In this survey children in Great Britain came 9th out of 11 for subjective child wellbeing and 10th out of 11 for dissatisfaction with appearance (Rees & Main, 2015).

Overall, research tracking birth cohort data over time points to no dramatic increases in prevalence in this age band. However, there does appear to be greater use of helpline services and there are concerning increases in some crisis service use. There is continuing evidence that the UK fares worse than other high income countries based on certain 'wellbeing and life satisfaction' comparators. Overall analysis may be pointing to a deterioration in girls' life satisfaction, emotional wellbeing and satisfaction with appearance compared with boys, but clarity on the current state of children's mental health in Great Britain may only ultimately emerge with the forthcoming child and adolescent survey results in 2018.

## Trends in self-harm and suicide

There has been increasing concern about rising self-harm among young people in this age band (particularly young women). Concerns are based on evidence from international school surveys, young people themselves, from teachers, media reports, grey literature, analysis of hospital attendance statistics and other service use data. For example, in 2014, figures were published suggesting not only an increase in the number of calls to child helplines due to self-harm (NSPCC, 2014; Guardian, 2014; National Society for the Prevention of Cruelty to Children, 2015) but also an increase in 10-14 year olds attending A&E for self-harm related reasons during the preceding two years (see

**Figure 1: Number of hospital admissions for self-harm for 10-14 year olds between 2011 and 2014**

	Male	Female	Male	Female	Male	Female
Admissions	483	3367	576	4069	657	5924
Percentage annual change	N/A	N/A	+19%	+21%	+14%	+46%
Percentage change between 2011 and 2014					+36%	+76%

Figure 1) (Health and Social Care Information Centre, 2014). For boys the increase over this time was around 36% and for girls 76%. The Health Behaviour in School-aged Children Survey noted that 22% of 15 year old children reported having ever self-harmed. 32% of girls in this survey reported ever having self-harmed compared with 11% of boys (Brooks *et al.*, 2014). Most who reported self-harming said they had done so once a month. Girls were more likely than boys to report self-harming regularly.

Studies indicate that most children and young people attending an emergency department following an act of self-harm met the criteria for one or more psychiatric diagnoses at time of assessment (Hawton & James, 2005). More than two-thirds were diagnosed as having depression (although within a short period many of these mental illnesses largely resolved (NICE, 2004a)).

Because of secrecy and stigma, it is difficult to build an accurate picture of any shifts in patterns of self-harm over time among children in this age band. Data on self-harming in Great Britain are currently outdated and greater clarity will be available in 2018 when the new national prevalence study is completed. It has been noted that self-harming rates doubled in the age group immediately above this age band (16-25 year olds) between 2000 and 2007 – increases mostly reported by young women (McManus, *et al.*, 2009). However, once again, this data is now relatively old.

It is also difficult to draw conclusions on trends in suicide for this age group due to very small numbers of young people taking this very tragic decision below the age of 15 years. Suicide rates are tracked by the Office for National Statistics from the age of 10 onwards. Suicide is rare at this age. It is also very difficult to track

trends over time due to the very small numbers involved. 13 children between the age of 10 and 15 committed suicide in 2014 compared with 9 young people in 2013 and 12 young people in 2012. Unlike in other age groups, girls and boys between the ages of 10 up until 15 had largely similar rates of suicide and there had been slight increases since 2013 for both genders. Furthermore, an NSPCC helpline said that in 2013/14 there had been an 18% increase in ChildLine counselling sessions about suicide since 2012/13 (NSPCC, 2014).

## Substance misuse

Adolescence is the time when young people are more likely to take risks and seek new sensations. This may lead to experimentation with use of substances such as alcohol and other kinds of drugs (Fuller & Hawkins, 2012). It is also considered a time when substances could potentially have greater impact on young people's brains compared with their effect on adults (Morris & Wagner, 2007).

### Smoking

In 2014, 18% of secondary school children in Great Britain reported that they had tried smoking at least once (22% of pupils had tried e-cigarettes, most of whom were regular smokers). This is the lowest level recorded since data were first collected and continues a steady decline over time from 1996, when 49% of pupils had smoked at least once. Likelihood of smoking increased with age and girls remained slightly more likely to smoke than boys (although boys smoked more cigarettes a week) (Fuller, *et al.*, 2015).

Analysis of older data indicated that young people in this age group with diagnosable mental health problems were more likely to



smoke than children with no diagnosis, and most with a diagnosable condition were likely to start these activities at a younger age than their peers (Green, *et al.*, 2005). For example:

- Children aged 11-13 with an emotional disorder were four times more likely to smoke regularly than children with no emotional disorder; between the ages of 14 and 16 they were twice as likely to smoke regularly.
- Children meeting the criteria for a conduct disorder were ten times as likely to smoke regularly than those with no diagnosable condition between 11 and 13; between the ages of 14 and 16 they were three times as likely to smoke regularly.
- Children with hyperactivity conditions were four times more likely to smoke between 11 and 13, and five times more likely to smoke between the ages of 14 and 16 (although many of those with hyperactivity type conditions would also have co-existing conduct problems).

(Green, *et al.*, 2005).

### **Alcohol**

By far the most common substance consumed by 11-15 year olds (with highest intake in this age band being at 15 years) is alcohol. However, the proportion of 11 to 15 year olds who have ever had an alcoholic drink has been declining in Great Britain since 2003. In 2014, 38% of pupils had drunk alcohol, the lowest proportion since surveys began. Furthermore, the proportion of children abstaining from alcohol has been steadily increasing between 2003 to 2011 (Fuller, *et al.*, 2015).

However, for the 8% of young people who had drunk in the last week, average weekly unit consumption had increased over the last year yet again. Boys and girls were equally likely to drink alcohol. Children and young people from BME communities were less likely to report drinking alcohol. Self-reported accounts of being drunk at least twice in their lives suggested that this had happened to approximately a quarter of 15 year olds in England, and more than a third in Scotland (Brooks, *et al.*, 2011).

Alcohol use has been associated with a range of poorer mental health outcomes for teenagers:

- Pupils with low wellbeing who take other risks (smoking, taking drugs and truancy) were more likely to have drunk alcohol in the last week (Fuller, *et al.*, 2015).
- Alcohol may increase symptoms of depression and the likelihood of other mental health difficulties emerging (Newbury-Birch *et al.*, 2008).
- Drinking as a result of stress or anxiety has been associated with long term and more negative consequences (Institute of Alcohol Studies, 2013).

There is a significant relationship between mental health problems and regular adolescent use of alcohol. This relationship was stronger for some conditions than for others. For example:

- Young people with emotional problems or with hyperactivity were just under one and a half times more likely to drink alcohol regularly. This increased likelihood was largely not visible before 13 years of age.
- Young people with conduct problems were twice as likely to drink alcohol regularly before the age of 13 and afterwards.

(Green, *et al.*, 2005).

Reasons for drinking during teenage years included pressures to maintain status with peers, to be part of social rituals (with alcohol becoming a social habit) and to increase confidence/mask self-consciousness (Institute of Alcohol Studies, 2013; Fuller, *et al.*, 2015). Activity has also been linked to an 'expanding consumerist alcohol culture' (Institute of Alcohol Studies, 2013). Improved control over alcohol use is linked to family influences and higher parental disapproval during pre- and early teenage years (Institute of Alcohol Studies, 2013; Fuller, *et al.*, 2015).

### **Drug and solvent use**

The prevalence of drug use among 11 to 15 year olds in England declined between 2001 and 2010. Since then this decline has slowed (Fuller, *et al.*, 2015). In 2014, 15% of pupils had 'ever taken' drugs, 10% had taken drugs in the



last year, and 6% had taken drugs in the last month. The prevalence of drug use increased by age and was broadly similar in girls and boys. Children self-identifying as being from black communities were twice as likely as those from white backgrounds to have reported taking drugs in the last year. There were no significant differences between children from other BME communities and white children (Fuller, *et al.*, 2015).

Cannabis was the most frequently tried drug (7% in 2013 compared with 13% in 2001) followed by volatile substances such as glue (3% in 2013 compared with 7% in 2001). 2.5% of young people also said that they had tried legal highs including 2% who had taken them in the last year and 0.9% who had taken them in the last month. 6% had been offered them. Only 1% had tried substances other than these drugs and only 126 children had sought help with drug use in the last year (mostly for cannabis) (Fuller, *et al.*, 2015).

Children in this age group who had truanted from school were more likely than other pupils to say that they took drugs once a month or more, or that they had taken Class A drugs in the last year. However, overall even for this group there had been an incremental decrease in use since 2003 (Fuller, *et al.*, 2015).

### ***The links between drug use and mental health***

The last child and adolescent national mental health prevalence study in 2004 indicated that young people with a diagnosable mental health condition were generally more likely to be using drugs. For example:

- Children and young people with emotional problems were twice as likely to use cannabis; those aged 14 and over were also four times as likely to use amphetamines.
- Children with a diagnosed condition of hyperactivity were four times as likely to use cannabis between the ages of 11 and 13 years. During the ages of 14 to 16 years, these young people were twice as likely to use cannabis, eight times as likely to use solvents and inhalants, and nine times as likely to use amphetamines.

- Between the ages of 11 and 13 years, children with diagnosed conduct disorder were seven times as likely to use cannabis and twice as likely to use inhalants, amphetamines and ecstasy. During the ages of 14-16 they were three times as likely to use cannabis, six times as likely to use solvents and inhalants, and three times as likely to use ecstasy and cocaine. They were also eight times as likely to use amphetamines.

(Green, *et al.*, 2005)

Psychiatric illnesses are highly complex developmental conditions with multiple factors contributing to vulnerability and eventual expression of the illness. For this reason, direct causality between cannabis use and the development of mental illness is still hotly debated. However, there is increasing evidence that cannabis use can significantly increase young people's likelihood of developing mental illnesses such as psychosis, depression, anxiety and suicidal orientation particularly during adolescence and in certain circumstances. The evidence is strongest in relation to psychosis and is less strong for depression and anxiety (Fuller, *et al.*, 2015; National Institute on Drug Abuse, 2015).

For example, it is generally recognised that the likelihood of developing mental illness is increased:

- If young people use cannabis during the critical period of dramatic adolescent neurodevelopment;
- The earlier young people start using cannabis;
- The more often they use the drug;
- If they or a family member has a genetic predisposition to cannabis-related psychosis (noted to result in a sevenfold greater likelihood of risk);
- If they have a history of trauma or child abuse.

(Di Forti, *et al.*, 2012; Chadwick, *et al.*, 2013; Radhakrishnan, *et al.*, 2014; National Institute on Drug Abuse, 2015).

There is also evidence that where someone has developed mental illness, cannabis can undermine chances of successful recovery (Radhakrishnan, *et al.*, 2014).

## Gender differences

A wealth of data indicates that during early years and up until mid-adolescence, boys' development and mental health is consistently worse than that of girls (Department for Education, 2014a; Green, *et al.*, 2005). Furthermore, whereas boys express poor mental health through more long lasting and damaging problems such as externalising behaviours (e.g. behavioural problems), girls express poor mental health more frequently via internalising or emotional problems. As young people approach mid to late adolescence, these trends begin to reverse, with girls seeming as likely to experience diagnosable mental health conditions as boys (although still primarily experienced through emotional problems) (Green, *et al.*, 2005).

Recent data analysing trends over time may suggest that the gender gap is narrowing due to a slight improvement (or at least no deterioration) for boys' mental health and some possible deterioration in girls' mental health and broader life satisfaction. For example, although Fink *et al.* (2015) found overall mental health symptom scores had decreased for boys, they noted an increase in the prevalence of emotional problems among girls – a trend noted earlier by Sweeting (2009) in her study of 15 year old girls in Scotland and reflecting findings from many other countries (Collishaw, *et al.*, 2004; Fichter, *et al.*, 2004; Tick, *et al.*, 2008; Sweeting, *et al.*, 2010). The recent Good Childhood Survey (2015), concerned more with levels of wellbeing and life satisfaction rather than prevalence of mental health conditions, also found girls reporting generally lower wellbeing compared with boys. It revealed other generally increasing gender inequalities, with girls being much less satisfied with their lives. For example, the survey found:

- The gender gap in subjective wellbeing narrowed between 1994 and 2007 but began to widen again, showing deterioration for girls in 2011.
- Girls had lower subjective wellbeing than boys. Highest levels of satisfaction tended to be with home, family and friends, while the lowest levels of satisfaction tended to be with appearance and the future.

- Girls were significantly less happy with their appearance than boys. Dissatisfaction had increased for girls over time and also increased with age.

Increasing pressures on females to be thin also emerge from a number of surveys. Girls see pressures being driven by the media with almost half of 11-21 year olds sometimes feeling ashamed of the way they look (45%), and two in five (39%) opting out of fun activities because they were self-conscious about their appearance (GirlGuiding, 2015). Three quarters of girls and young women aged 13-21 also talked of anxiety about sexual harassment and about its negative impact on their lives:

- One in five 13 to 21 year old girls and young women said they experienced unwanted sexual attention and three in five (59%) experienced sexual harassment in the last year; many didn't feel experiences were taken seriously when reported.
- One in four girls and young women described seeing pictures or videos of girls or women that made them feel uncomfortable (26%), or sexually explicit pictures or videos (25%) (NSPCC, 2015).
- 18% of girls sent 'sexting' messages themselves, 50% knew someone else who had sent such messages and 30% had received them.

(Girls' Attitudes Survey, 2015).

School pressures were also identified as a source of anxiety particularly affecting girls. Academic work was observed to generate worry for schoolchildren of all ages, particularly secondary pupils facing national examinations (Putwain, 2007). In a study which identified 10 dimensions of adolescent stress, four were school-related (stress of school performance, attendance, teacher interaction and school/leisure conflict). The first of these increased significantly with age and was higher among females; all were significantly associated with psychological distress (Byrne, *et al.*, 2007). Although females have out-performed males at school in most Western countries over the last 20 years or so (Johnson, 2008), they were more likely to underestimate their academic ability (Cole, *et al.*, 1999) and show more anxiety and depression before exams (West, *et al.*, 2003).

Finally, recent national surveys of girls' attitudes over the last two years (less robustly designed than some academic surveys described earlier) paint a picture of girls being highly anxious about their mental health. In 2014, three quarters felt that they knew a friend with 'depression', two thirds said they knew someone with an 'eating disorder' and half knew a friend with an 'anxiety disorder'. Findings in 2015 showed that for girls aged 11 to 21, self-harming was one of the biggest health concerns, followed by cyber-bullying and mental illness. Out of 1,574 girls surveyed, nearly half (46%) reported 'having mental health issues', while even more (62%) said they knew someone who'd suffered from a mental health problem. They also talked of high levels of awkwardness at talking about mental health issues, of parents being more concerned about substance use than mental health and of wanting parents to be more proactively concerned about their wellbeing (Girls' Attitudes Survey, 2015).

Given the overall trends and patterns of diagnosable difficulties we have been witnessing in more robustly designed surveys, it is unlikely that all of these 'mental health problems' being described here would amount to diagnosable conditions as this would indicate a very sudden and dramatic deterioration in girls' mental health between the ages of 11 to 21 years in the last two years. It is possible that higher responses reflect a greater awareness of and desire to talk and seek help about emotional distress. It may also indicate lower mental health literacy (e.g. perceiving sub-threshold emotional distress as much more serious and life impairing) or alternatively it could point to deteriorating resilience and coping skills in the face of adversity among this age group.

Whatever the case, young women in Great Britain in this 11-15 age band (and those in the band immediately above) are currently voicing significant distress about their mental health - distress which they seem to experience as impairing in their day to day lives. These findings may also explain why demand for services is increasing. Findings may suggest the need for action at multiple levels to unpick

and understand data and patterns further, potentially addressing toxic environmental pressures affecting girls in this age range, building girls' and young women's ability to self-regulate emotion in the face of adversity (through good quality whole school mental health and wellbeing programmes), and supporting vulnerable young women in need.

Action to improve girls' mental health, however, should go hand in hand with similar action to increase help seeking for and sustain reductions in behavioural problems, more commonly experienced by boys and young men.

## Major risk factors

### *Poverty and inequality*

Some studies have observed associations between widening income inequality and health inequalities in children and adolescents. In Elgar's study (2015), higher national income inequality was linked to more psychological symptoms being reported by children, parents and teachers, and greater polarisation between relatively well off and poorer children in life satisfaction, psychological and physical symptoms. Langton *et al.*'s (2011) overview of longitudinal data, which tracked the mental health of 15 and 16 year olds between 1974 and 2004, also noted an increasing income differential emerging in relation to emotional problems for this age group over time (Langton, *et al.*, 2011). Furthermore, an analysis of a more recent sweep of 11 year olds from the UK Millennium Birth Cohort noted that poverty appeared to have a particularly detrimental effect on the mental health of children in the bottom fifth in terms of family income. Among this group 17% of children presented with diagnosable level difficulties compared to around 10% of children overall and 4% of children from families in the top fifth in terms of family income (Morrison Gutman, *et al.*, 2015). This study noted that this income-related gradient in prevalence had become steeper compared to previous sweeps of this data and appeared steeper among children than among adults.



The most recent UK Good Childhood Survey (2015) noted similar associations between children's perceptions of material inequality and their subjective wellbeing – again with indications of a deterioration over time. Material deprivation was significantly associated with lower wellbeing for children surveyed between the ages of 11 and 15 years. This survey concluded that it was in fact children's views of their relative position in terms of access to material resources that was a key factor influencing levels of happiness. For example, children had higher wellbeing if they had about the same spending money as their friends, but fared less well if below average – particularly if parents were unable to buffer them from awareness of or the effects of increasing financial pressures (The Children's Society, 2015). Interestingly, young people with access to greater than average spending money than friends also had lower wellbeing than those with average wellbeing in this survey (The Children's Society, 2015).

### ***Victimisation, violence and maltreatment***

In 2013/14, the British Crime Survey indicated that children aged 10 to 15 were a particularly high risk group in terms of their likelihood of being victims of violent crime compared with other age bands (Office for National Statistics, 2014). 16% of boys and 9% of girls reported having been a victim of violent crime in this age band. The likelihood of being a victim of violent crime was associated with being male, having a longstanding illness and being younger. Around one fifth of violent incidents experienced by young people resulted in them receiving medical attention.

There are challenges in tracking trends in maltreatment over time across all four UK nations due to the hidden nature of many experiences of abuse, the differences in the way that data are collected and spikes in patterns of disclosure, service use and child protection action following high profile cases (for example after child deaths due to abuse). The NSPCC last completed a review of maltreatment prevalence rates in 2009. It concluded that reports of retrospective child maltreatment disclosed by young adults aged 18-24 were lower in 2009

than in 1998, suggesting maltreatment may be decreasing. However, findings must be seen in the context of an apparent doubling of contact by children with the NSPCC helpline about maltreatment between 2009 and 2014/15. Furthermore, the NSPCC survey still identified a significant minority of children and young people in the UK today who were experiencing severe maltreatment (associated with poorer emotional wellbeing and increased rates of self-harm, suicidal ideation and delinquent behaviour) (NSPCC, 2011).

### ***Bullying in secondary school***

There is now increasing evidence of the impact of bullying both on the mental and physical health of victims during childhood, and on victims' mental health and broader outcomes many decades later (Takizawa, *et al.*, 2015). Being occasionally bullied was associated with higher levels of psychological distress both in young adulthood and also some 40 years later during midlife. Being bullied frequently was associated with a higher chance of experiencing adult mental illness (particularly depression and anxiety) and of being predisposed to suicide. The scale of these difficulties was equivalent to those facing other childhood adversity such as being in local authority care or facing multiple risk factors (Takizawa, *et al.*, 2015). As adults, victims of bullies were also more likely to earn less, have poorer social relationships and to have lower educational achievements.

Estimating the prevalence of bullying is generally challenging as activity is often covert and ill defined. It has also been difficult to establish the extent to which digital culture and cyberbullying has impacted on the prevalence of such victimisation in recent years (Rigby & Smith, 2011). Historically, young men are both more likely to be bullies and are marginally more likely to be bullied than young women. Young men and women may be involved in different types of behaviours with young men displaying more obvious physical hostility and aggression, and young women being more inclined to relational bullying (Wang, *et al.*, 2009). Traditional bullying has also tended to decrease with age during secondary school years (Currie, *et al.*, 2012).

The Health Behaviour in School Aged Children survey probably provides the best source of information on recent bullying time trends in England, Scotland and Wales. It has tracked rates of bullying using similar methodologies since 2002 and repeats surveys every four years. Figures 2 and 3 summarise results for children and young people aged 11-15 in Great Britain, adapted from Chester's international comparison of school aged bullying rates (Chester, *et al.*, 2015).

With the exception of girls in England, trends for occasional bullying had generally decreased in Britain although with some increases in trends during the mid-2000s in Wales.

More frequent bullying was also increasing over time for boys in Scotland and had increased slightly since 2002 for boys in Wales. After marginal reductions in bullying in the mid-2000s for girls in England, rates of frequent bullying appear now to be slightly rising again. Welsh and Scottish girls had experienced

increases in frequent bullying during the mid-2000s but had more recently benefited from slight reductions bringing rates to a lower level than experienced by English girls (Chester, *et al.*, 2015).

For young people of this age, bullying often involved taunting about appearance, sexual victimisation, homophobic or racist comments or bullying about disabilities (GirlGuiding, 2014; GirlGuiding, 2015). Lesbian, Gay, Bisexual and Transgender children in schools were also more likely to experience bullying (Statham, *et al.*, 2012).

Based on the Health Behaviour in Schools Survey data, students who bullied others reported increased rates of health-risk behaviours such as:

- Smoking and excessive drinking (Nansel, *et al.*, 2001);
- Weapon carrying, fighting and being injured through fighting (Nansel, *et al.*, 2003);

Figure 2: Occasional bullying in British secondary schools. Adapted from Chester *et al.*, 2015

% of children aged 11-15 bullied occasionally (once or more) at school in the last couple of months		2001-2 (%)	2005-6 (%)	2009-10 (%)
England	Boys	38	30	27
	Girls	35	27	28
Scotland	Boys	28	27	24
	Girls	30	26	23
Wales	Boys	29	30	30
	Girls	31	32	27

Figure 3: Occasional bullying in British secondary schools. Adapted from Chester *et al.*, 2015

% of children aged 11-15 bullied at least two or three times at school in the last couple of months		2001-2 (%)	2005-6 (%)	2009-10 (%)
England	Boys	14	11	9
	Girls	12	9	10
Scotland	Boys	8	9	10
	Girls	9	10	9
Wales	Boys	9	11	10
	Girls	10	12	8

- Disconnectedness with parents;
- Negative school perceptions (Harel, 1999).

The use of power and aggression in so-called 'playground bullying' may also be an indicator of increased risk of future sexual harassment, marital aggression, broader abusive behaviour (Glew, *et al.*, 2008) and possibly a marker for future delinquency (Ttofi, *et al.*, 2011).

### ***Lesbian, Gay, Bisexual and Transgender young people***

There are currently limited data on the numbers of young people in this age bracket identifying themselves as Lesbian, Gay, Bisexual and Transgender (LGBT). Surveys of young adult populations (aged 16-24 years) generally suggest that around 2.6% of this older age group in the UK identified themselves as LGBT (Office for National Statistics, 2015).

In 2012, Stonewall, in partnership with the University of Cambridge, surveyed 1,600 LGBT young people in British schools (a survey repeated every four years). This study found that:

- 55% of LGBT children and young people reported being subjected to homophobic bullying;
- One in six reported being subjected to physical abuse;
- 6% reported being subjected to death threats;
- Just under half who experience homophobic bullying skipped school because of it; one in seven had skipped school more than six times;
- More than half of LGBT children and young people don't feel there is an adult at school who they can talk to about being gay;
- A quarter don't have an adult to talk to at school, home or elsewhere;
- Seven out of ten LGBT girls and six out of ten LGBT boys had experienced suicidal thoughts; boys from BME communities had the highest rate of suicidal thoughts affecting nearly eight out of ten;
- These children were around three times as likely as other children to have tried to take their own life at some point;

- More than half deliberately harmed themselves, which can include cutting or burning themselves.

(Statham, *et al.*, 2012).

Although Stonewall's surveys in 2007 and 2012 point to a reduction over time in homophobic bullying in schools and some decrease in related distress, findings still point to a highly vulnerable school-age group.

A number of international studies have also found that school-aged LGBT young people experience higher levels of emotional distress than other children, including being twice as likely to have depressive symptoms, suicidal thoughts and to attempt suicide (Safren & Heimberg, 1999; Fergusson, *et al.*, 1999; Ueno, 2005). In a study of transgender youth aged 15-21 a quarter reported a prior suicide attempt (Grossman & D'Augelli, 2007) – although rates are likely to be lower in younger age groups. Young people from some BME communities were noted to disclose to fewer people, have less involvement in LGBT social activities and to face additional harassment (Rosario, *et al.*, 2004).

Attempts to understand drivers for increased suicide in LGBT youth suggest links with broader risk factors for suicidal thoughts and action (such as depression and alcohol/substance misuse). Alcohol was thought to be used by some LGBT youth to numb anxiety and depression associated with concealing sexual identities (Radkowsky & Siegel, 1997). Increased risk of depression in males was particularly associated with ongoing experiences of discrimination on the basis of their sexual orientation (Almeida, *et al.*, 2009). Particular challenges have been noted for LGBT children and young people in rural communities where they have limited access to LGBT peer support networks.

### ***Children and young people who offend***

In 2013/14, 94,960 young people aged between 11 and 17 years were arrested in England and Wales, accounting for around 10% of all arrests. Since the peak in 2007, the number of arrests has reduced by 73%.



Over the last two decades, overall crime has consistently been decreasing (Office for National Statistics, 2015).

Many young people at an early stage of offending are now diverted away from the formal youth justice system (YJS), either being required to make recompense for offences that have occurred or being bridged to early intervention to address needs and risks. Since 2007, there have been 82% fewer young people coming into the formal Youth Justice System as a result of diversionary activity. Furthermore, the number of young people aged 10-17 years in custody has fallen by 70% over the last decade. There has been a 20% drop in the last year (Ministry of Justice, 2016). However, those who remain in the system are considered anecdotally to have more concentrated and extensive needs and difficulties.

Children in contact with the youth justice system aged 10-18 are:

- More likely to present with symptoms of post-traumatic stress disorder (particularly girls and some young people from BME communities) (Chitsabesan *et al.*, 2006);
- More likely to self-harm and many times more likely to commit suicide (Lennox & Khan, 2013);
- More likely to have multiple risk factors largely accumulated over time (Khan, *et al.*, 2013);
- More likely to have speech, language and communication difficulties (possibly linking back to poorer early years development) which will have impeded their education and prompted frustration preventing them from processing information (Bryan, 2007);
- More likely to have severe attachment difficulties and trauma, sometimes predisposing them to explosive anger (Lennox & Khan, 2013);
- More likely to have acquired brain injury (ABI) due to historical trauma to the head – ABI is linked to higher risk of violence resulting from neurodevelopmental damage and suicide risk (Williams, *et al.*, 2010);

- At least three times more likely to have a mental health diagnosis compared with children who don't offend (Hagell, 2002). Often at this age, symptoms are subtle and confusing, frequently masked by aggressive behaviour. At least half in both community and custodial settings have been identified with a diagnosable conduct disorder (Stallard, *et al.*, 2003; Fazell, 2008).

Although boys are roughly three times more likely to offend than girls (just as they are more likely to present with ADHD and conduct disorder diagnoses), girls and young women who offend have been noted to have much higher levels of mental health needs, many more needs, histories of victimisation and broader general health and social vulnerability (Douglas & Plugge, 2006; Khan, *et al.*, 2013; McNeish & Scott, 2014).

As previously outlined, adolescents who offend will include not only those who become involved in antisocial behaviour for the first time during adolescence, but also some children who have had longstanding problems with challenging behaviour. Those with early starting and persistent behavioural problems have some of the worst adult health and social outcomes and have the greatest chance of getting stuck in patterns of prolific offending as adults (Farrington, 1997b; Loeber and Farrington, 2000; Fergusson, *et al.*, 2005). Yet there are currently few processes in place to help identify and prioritise this group. This is important as these two groups are likely to benefit from largely different recovery and rehabilitative approaches – with later starters requiring support with adopting adult responsibilities and earlier starters needing more intensive holistic and multi-system focused support. Centre for Mental Health's research (based on screening completed at the point of arrest with 12,000 young people) indicated that around 13% of YJS entrants had severe behavioural problems before the age of 12; however, this increased to 40% among higher risk groups, such as boys and girls in gangs, children with care histories and those excluded from school (Khan, *et al.*, 2013).

### Children and young people in gangs

Due to the covert nature of gang activity, it is difficult to build an accurate picture of the prevalence of gang involvement among young people. The only robust data we have date back to the 2004 British Crime and Justice Survey which reported gang-membership rates in the UK of around 6% in 2004 for those aged between 10 and 19 years (Sharp, *et al.*, 2006). There is growing evidence that both young women and young men involved in gangs have higher chances of diagnosable difficulties and poorer general mental health than other young people (Coid, *et al.*, 2013). Centre for Mental Health found that young people involved in gangs had multiple vulnerabilities and risk factors (and on average had three times more risk factors than general YJS entrants; Khan, *et al.*, 2013). Girls in gangs in this study had by far the most severe and multiple health and social vulnerabilities compared with other groups screened as they entered the Youth Justice System.

US research (2001) indicated that an accumulation of risk factors predisposed young people to get involved and remain in gangs. 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 (Hill, *et al.*, 2001). 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. Centre for Mental Health's research also noted that young men in gangs in the youth justice system were between two and four times more likely than other youth justice entrants to face a range of challenges including:

- Early starting behavioural difficulties;
- Having witnessed domestic violence;
- Having been excluded from school;
- Having self-harmed;
- Having used drugs;
- Having been physically abused;
- Having a parent with mental health or substance misuse difficulties;

- Having experienced sexual abuse;
- Having been a victim of bullying.

Girls involved in gangs in the youth justice system were noted with greater severity and many more risk factors and vulnerabilities than any other group. On average, they 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. 40% were identified with behavioural difficulties before the age of 12 (which are rarer for girls). Girls also faced significantly higher risk of victimisation compared with other girls entering the system both in the past but also then seemingly perpetuated through gang membership (including violence and non-consensual and sometimes routine sexual abuse) (Khan, *et al.*, 2013).

Some young women are also highly fearful of retaliation if they move away from gang activity and require geographical re-location and wraparound care to re-establish new lives and promote their safety. Having a family member (or intimate partner) involved in gang activity is a risk factor for female involvement (Khan, *et al.*, 2013).

Parenting difficulties and poor relationships were particularly strongly associated with female gang membership. Compared to other girls in the justice system, female gang members were:

- Five times more likely than other girls who offended to report that they had a parent in prison;
- Five times more likely to report having been bullied;
- Four times more likely to have a sibling involved in antisocial behaviour;
- Three times more likely to have a parent who misused substances and had mental health issues;
- Three times more likely to have experienced physical abuse and witnessed domestic violence;
- Three times more likely to have self-harmed or have a risk of suicide, and to have a suspected diagnosable condition.

(Khan, *et al.*, 2013).

Risk factors for gang membership operate at multiple levels ranging from individual risk factors (such as temperament and inclination towards sensation seeking) to family risk factors (such as girls having a relative involved in gang activity) but also linking to community, neighbourhood and societal influences. For example, there is evidence that gangs are more likely to emerge in societies with widening social inequalities where young people face barriers to assuming adult responsibilities and accessing opportunities (Department of Health, 2012). For some young people seeking to exit gangs, legitimate opportunities rarely match the short term gains of gang activity and this can be a huge challenge in terms of recalibrating their expectations. Many have developed 'street skills' but lack formal qualifications to help them take steps towards a more legitimate life.

Gangs and increased risk of violence are often associated (although not exclusively) with more urban settings. US studies (Garbarino, *et al.*, 1991; Garbarino, 1995; Flannery & Huff, 1999) highlight how prolonged exposure to stressful and unsafe neighbourhoods and dangerous environments can often result in near combat-stress like behaviours and borderline post-traumatic stress symptoms. Garbarino *et al.* (1991) also observed that for young people with temperament-based risk factors, who were not sufficiently buffered from excessive and continuing stress during childhood and who were also exposed to persistent maltreatment and unsafe communities, there was an elevated risk of children being in a state of constant hyper vigilance and alertness to danger often prompting overreaction in the face of perceived threat (Garbarino, *et al.*, 1991; Garbarino, 1995). This type of prolonged stress and hyper vigilance can be toxic to children's neurodevelopment and developing mental health. We also know that early experiences of trauma can be stored deep in primitive parts of the brain (the amygdala) sometimes resurfacing later when presented with similar triggers and then prompting exaggerated, disproportionate and explosive anger, emotion and overreaction which bypass control by rational parts of the brain (Charney, *et al.*, 1993; Flannery & Huff, 1999).

### ***Children with parents in prison***

There is a strong association between parental imprisonment and adverse outcomes for children of all ages. The emotional and physical reactions to the loss of a parent to prison have been likened to grief felt at bereavement (King, 2002). However, imprisonment does not always elicit the same sympathetic or supportive responses so normal outlets for grieving can be denied (Robertson, 2007). Furthermore, often the remaining parent becomes overwhelmed with survival and can overlook children's hidden needs (Eurochips, 2006).

Studies suggest that children of prisoners are twice as likely to have mental health problems during their life course (Nacro, 2005; SCIE, 2008). They are also around three times more at risk than their peers of committing antisocial or delinquent behaviour with 65% of boys with a convicted parent going on to offend (Social Exclusion Unit, 2002). Girls with a parent in prison were also particularly noted to have higher risk of gang involvement and multiple vulnerabilities and needs (Khan, *et al.*, 2013).

There are limited data on the number of parents in custody. In 2009, it was estimated that around 200,000 children in England and Wales were identified as having a parent in prison at some point (Ministry of Justice, 2012). At the time, this was over three times the number in care and over five times the number on the Child Protection Register. Prisoners' families face high levels of stigma with nearly three quarters missing out on local help despite having multiple needs (Centre for Mental Health, 2013). They are often considered a 'hidden group' in local service provision with historically poor national and local accountability for the wellbeing of prisoners' children and families (SCIE, 2008). More research is needed on the experiences of children and young people with a parent in prison.



### **Children in care**

Looked After Children make up 0.6% of children in the UK. There were 68,840 looked after children as of 31 March 2014, a marginal increase of 1% compared to 31 March 2013 and an increase of 7% compared to 31 March 2010. The number of looked after children has increased steadily over the past five years and it is now higher than at any point since 1985 (Department for Education, 2015). Numbers of children within the child protection system have increased in all four nations since 2002 – with the steepest increase in England. Around half of children are taken into care primarily due to experiences of maltreatment or neglect (Department for Education, 2014).

There is increasingly powerful evidence that maltreatment (physical, sexual or emotional abuse, neglect, exposure to family violence) is highly damaging to an infant's developing emotional architecture and development, particularly if persistent and clustered together with other risk factors (e.g. socio-economic deprivation, poor or intermittently sensitive parenting). Early over-loading of a child's stress response system can have a range of adverse, lifelong effects on learning and on a child's ability to regulate emotions and behaviour (Shonkoff & Garner, 2012).

Children raised in highly threatening environments can also have overdeveloped skills in detecting threat. Although these skills are functional in highly volatile home environments, they become much less helpful as young people move into arenas where threats are lower. Children taken into local authority care are likely to have faced the most severe forms of childhood maltreatment and children who enter care later (having remained for longer in abusive settings) and those who stay in care for longer face the greatest risk of poor outcomes and have more challenging needs (behavioural difficulties, problems with schooling) (Biehal, 2007).

Prevalence studies of looked after children and young people indicate that around 40% meet the threshold for conduct disorder (Ford, *et al.*, 2007). A minority of young people (around 10%) enter group homes; their outcomes are

the worst of all of those in the care system. Children raised in residential homes have the very highest rates of mental health problems, with approximately three quarters meeting the criteria for a psychiatric diagnosis (Luke, *et al.*, 2014). Many children in care also have more than one mental health diagnosis (Ford, *et al.*, 2007).

Centre for Mental Health data analysis of 10,000 young people at the point of arrest found that children with current looked after status were 15 times more likely than other children to have contact with the Youth Justice System. Compared with their peers in the YJS who had not been in care, they were also:

- Around twice as likely as other youth justice entrants to:
  - be homeless
  - have experienced domestic violence
  - have histories of self-harm/suicide attempts
  - have a suspected diagnosable mental health condition
  - have run away
  - have developmental difficulties (such as autistic spectrum conditions or ADHD)
  - have sleeping/eating problems
  - have sexual health problems
  - have a diagnosable physical health problem
  - have early starting behavioural difficulties (a predictor of a range of poor adult outcomes);
- Three times as likely to have poor social relationships;
- Three and a half times as likely to be involved in sexually harmful behaviour;
- Four times as likely as other youth justice entrants to have histories of sexual exploitation.

Many of these children also had multiple vulnerabilities which we know increase the chances of poorer mental health and life chances (although the number of vulnerabilities was not as great as those experienced by young people identified with gang involvement).

Children who end up in the care system already have a cluster of risk factors for poorer

outcomes; many will have had previous traumatic experiences. A critical principle of care for Looked After Children is bringing relationships to the heart of all that is done in the care system (Luke, *et al.*, 2014). It should be the role of the care system to provide compensatory stability through consistent, safe and reliable relationships/attachments and to bolster protective factors around a child so that they are able to recover and move forward from experiences of maltreatment, trauma, poor attachment and instability. Based on what is understood about the impact of maltreatment on children, child trauma and attachment difficulties, any help supporting recovery should be trauma and attachment informed.

Evidence reviews recommend high quality, evidence based care-giving with multi-dimensional interventions targeted:

- Directly towards supporting the child;
- Indirectly (through the carer or those around the child);
- Focused on the system surrounding children (school/college and social worker)

(Washington State Institute for Public Policy, 2015).

A good example of this type of intervention is multi-dimensional fostering treatment (Washington State Institute for Public Policy, 2015). The Care Review (2013) also highlighted that foster carers who were warm and sensitive, who were committed to the child and who were clear about what they expected of them were more likely to be successful.

Ironically, rather than providing stability, literature and national reviews have noted that the experiences of Looked After Children are in fact highly variable and characterised by damaging impermanence. The more instability children experience in care placements, the poorer their behaviour and outcomes; the worse their behaviour becomes, the more their placements breakdown (Luke, *et al.*, 2014).

Group homes have been described as ‘turbulent environments with rapid turnover’ (Berridge, *et al.*, 2012). They are noted to vary significantly in the quality of the environment they offer dependent on the manager and the quality of

their interaction with staff (Sinclair & Gibbs, 1998; Hicks, *et al.*, 2009). There is little good quality evidence on what an effective group home might look like, although the development of a psychologically and trauma informed environment would appear critical. Furthermore, these settings are dealing with a highly damaged group of young people and yet the workforce is not always sufficiently therapeutically expert to support children.

### ***Children who run away***

There are limited studies detailing the prevalence of mental health difficulties among young runaways although some of the findings for this group will be similar to those of homeless young people. One US study noted that homeless and runaway teenagers were at least twice as likely to have a diagnosable mental illness and six times as likely to have more than one diagnosable mental health condition. They were also at much higher risk of sexual exploitation (Whitbeck, *et al.*, 2004; Smeaton, 2013).

### ***Young Carers***

The term Young Carer includes children and young people who provide regular and ongoing care and emotional support to a family member who is physically or mentally ill, disabled or misuses substances. Previous research has found that the person receiving care is often a parent, but can be a sibling, grandparent or other relative (Becker, 2000). 10% of young carers care for more than one person (The Children's Society, 2013).

A young carer becomes vulnerable when the level of care-giving and responsibility to the person in need of care becomes excessive or inappropriate for that child, risking their emotional or physical wellbeing or educational achievement and life chances (ADASS and ADCS, 2009). In 2013, ONS data suggested that 166,363 children and young people were caring for their parents, siblings, and other family members compared to 139,000 in 2001 (The Children's Society, 2013). This is thought to be an underestimate of the true number of young carers with some sources estimating that

rates could be four times higher than official estimates. ONS statistics indicated that nearly 15,000 children and young people under the age of 17 years were providing more than 50 hours of care a week (Office for National Statistics, 2013). Marginally more girls were thought to be young carers than boys, and more than 15% of young carers were thought to be from ethnic minorities. 30% are supporting parents with mental health problems (Dearden & Becker, 1998). The average age of young carers in three large surveys was 12 years. However, recent ONS data pointed to an 80% rise in young caring responsibilities among 5-7 year old carers (Office for National Statistics, 2013). This increase is of concern as we know that caring responsibilities have an impact on health and social outcomes and also that young carers have been found to provide more care as they grow older. Older children are also less likely to utilise the support of young carers' projects (SCIE, 2005). Typically, caring can be a long-term commitment (Dearden & Becker, 2004). Given that children now remain in the family home much longer (Office for National Statistics, 2014), young carer status and responsibilities may now increasingly affect 16-25 year olds as well.

Surveys of young carers found substantial numbers reporting stress, anxiety, low self-esteem and depression (Frank, *et al.*, 1999; Dearden & Becker, 2000; Banks, *et al.*, 2001). Some research studies have found that they often feel concerned and anxious about their parent's welfare when they are not there to help look after them (Thomas, *et al.*, 2003; Aldridge & Becker, 2003), especially if a parent has mental health problems and is at risk of self-harming (Dearden & Becker, 2004). Other studies also found that substantial numbers reported mental health and related problems, such as eating problems, difficulty in sleeping, and self-harm (SCIE, 2005). Around 5% identified missing school because of their caring responsibilities with one in three of those missing school doing so at least once or twice a month (The Children's Society, 2013). Other key facts include:

- Young carers live in households which have an average income £5,000 less than

families without a young carer.

- Young carers are more likely to live in a household where no adults are in work.
- Young carers between the ages of 16 and 18 had a much greater chance of being not in education, employment or training (NEET). Of these, 75% had been NEET at least once (compared with 25% of all young people) and 42% had been NEET for six months or more (compared with 10% of all young people).

(Audit Commission, 2010).

Only small numbers of young carers tend to be identified or assessed for support and they are generally considered to be hidden from view (The Children's Society, 2013). Reasons for this include blurred boundaries of responsibility between adults and children's services; a lack of awareness among many professional groups about young carers' needs and concerns; young carers' own lack of awareness of their entitlements; and their reluctance to seek formal help (SCIE, 2005). Anecdotal reports also suggest that many Young Carer projects are patchily available and have been subject to continuing cuts.

### ***Children excluded from school***

Education is one of the strongest predictors of good health; the more schooling people have the better their health is likely to be. More formal education is consistently associated with lower death rates (Molla, *et al.*, 2004). School exclusion can often be a life-changing decision and experience. It often adds to already accumulating risks in a child's life.

There is debate between educationalists and mental health specialists regarding the extent to which the behaviour of excluded children reflects any underpinning mental health diagnosis (Cole, 2015). The most common reason (affecting a third of children) for permanent exclusion is persistent disruptive behaviour. This description of the reasons behind many exclusions significantly overlaps with conduct disorder symptoms (Cole, 2015). Studies also indicate that:

- The most common age for exclusion is between the ages of 13 and 14 years.



- Boys were four times more likely to be excluded than girls (reflecting a similar pattern of gender distribution found in childhood and early adolescent mental health problems).
- Children from low income families (eligible for Free School Meals) were around four times more likely to receive a permanent exclusion.
- Black Caribbean boys are three and a half times more likely to receive a permanent exclusion compared with white boys (Cole, 2015) despite fewer at this age meeting the criteria for a diagnosis with conduct disorder (Green, *et al.*, 2005).
- Travellers of Irish heritage and Gypsy Roma young people were at higher risk of exclusion.
- Children with a diagnosable mental health condition have much higher likelihood of being excluded (Green, *et al.*, 2005).
- Two thirds of children permanently excluded also have Statements of Special Educational Needs (Cole, 2015).

(Department for Education, 2012; The Office of the Children's Commissioner, 2012).

A further common health problem associated with school drop-out and exclusion is substance use. Teenage pregnancy is a particularly common manifestation of conduct disorder in adolescent women, and in addition has historically been associated with school dropout (Brindis & Philliber, 1998).

Official school exclusions have been reducing since the early 1990s and were reduced by financial incentives made available to schools in 2012/13 to avoid exclusions. The Office of the Children's Commissioner's review (2012) noted a trend for unofficial exclusions in schools. Furthermore, there has also in the last year been a marginal increase in primary school exclusions (although this will involve very small numbers) (Department of Education, 2015). Moreover, academies have been observed to exclude more children than other schools. Alternative educational provision for excluded children can be variable in quality despite often supporting children with multiple and complex mental health, developmental, social and educational needs.

Effective action to prevent and reduce exclusions should start early in primary school with a focus on preventing the development of behavioural problems through early intervention to support those with first signs of unhealthy behaviour and to reduce the multiplication of risk factors. Studies suggest that effective action to reduce school exclusion relies on multi-faceted strategies combining educational and public mental health approaches (Freudenberg & Ruglis, 2007). There is some evidence that early high quality nursery care (promoting softer social and emotional learning skills such as planning, conscientiousness, problem solving and task reviewing) resulted in improved school engagement, school completion and graduation rates among very high risk groups – particularly among girls and young women (Heckman, *et al.*, 2010; Schweinhart, 2005).

Schools provide an ideal setting to identify risk of school exclusion early and to link up with good quality SEL and parenting interventions. Well implemented mentoring programmes targeted towards supporting vulnerable children have also been noted to improve school engagement and behaviour (WSIPP, 2015).

Whole school approaches promoting good behaviour and mental health in primary school and secondary school are considered vital factors in helping reduce poor pupil mental health and poor behaviour (Weare & Nind, 2011). Positive relationships with a key adult are also considered an important protective factor in terms of healthy behaviour, mental health and child/youth development (The Centre for Community Child Health, 2000).

Good relationships between teachers and pupils are also important as well as having access to good quality counselling and mentoring in schools (Gutman & Vorhaus, 2012; Rickwood, 2005; Rickwood, *et al.*, 2007). As children get older then more intensive interventions such as Multi Systemic Therapy and Functional Family Therapy (described later in this report) may also have a role to play in reducing teenage conduct problems and antisocial behaviour affecting school progress (WSIPP, 2015).

### ***Migrant and refugee children and young people***

There remains a lack of clarity about the extent of mental health need among migrant and refugee populations in the UK. This is largely due to poor quality collection of data on health status and service access (Henley & Robinson, 2011). It is also because migrating populations are in themselves a highly heterogeneous population whose decisions to migrate can be prompted by many different ambitions, needs and circumstances and who often have very different socio-economic circumstances, pathways and pre-migration experiences prior to arrival in the UK (Stevens & Vollebergh, 2008). For some children and young people, migration may have been an economic choice. For others, decisions to migrate may have been prompted by experiences of war or victimisation.

Migration is deemed to be intrinsically stressful for a range of reasons mainly due to challenges in adapting to life in a different country – a problem known as acculturative stress. Clear links have been made between acculturation difficulties and mental health. Acculturative stress can include:

- Loss of broader family networks, friends, customs and surroundings;
- A need often to start from scratch and sometimes a loss of previous social status;
- Discrepancies between old standards, expectations and values and those in new communities;
- Economic stresses;
- Intergenerational stresses linked to different rates of acculturation experienced by family members;
- Experiences of discrimination, restricted opportunity and victimisation in new communities which has been linked to poorer psychological functioning in children.

(Fazel, *et al.*, 2012).

The impact of migration and refugee status on children's mental health is highly dependent on the extent to which they are exposed to or buffered from multiple, severe, harmful and

stressful experiences and risk factors in their early life, during pre-migration years, during their migration journey and once in their new residence (Stevens & Vollebergh, 2008). As is the case with other areas of children's mental health, the more persistent their exposure to risk, trauma and stress and the broader range of risks they face, the more detrimental the effect and the more likely experiences are to overwhelm natural resilience. Some refugee children experience persecution of family members, disappearances, deaths and deprivation (Berman, 2001). Yet despite often challenging histories and circumstances, there is also evidence of good levels of resilience among migrant and refugee children with the majority adjusting to their new circumstances (Henley & Robinson, 2011).

Although good quality data remain elusive, there is general consensus that the prevalence of post-traumatic stress disorder and other mental health problems is higher in refugee children than in host country populations (Thomas & Lau, 2002; Slodnjak, *et al.*, 2002). This remains the case even when studies control for other factors such as socio-economic status (Fazel & Stein, 2003). There is also evidence that these children and young people are more likely to have more than one mental health difficulty (Fazel & Stein, 2002; Pumariega & Rothe, 2005).

The most commonly reported diagnosable difficulty affecting refugees is PTSD, affecting around 10% of children and young people with refugee histories and which studies cite as being at least twice as high as among non-refugee children. There is also evidence of the enduring nature of experiences of PTSD among these children. A range of longitudinal studies highlighted that PTSD symptoms were still present some 12 years after resettlement (Almqvist & Brandell-Forsberg, 1997; Sack, *et al.*, 1999).

Studies note evidence of higher levels of depression (although not anxiety) among refugee children, young people and young adults – again with evidence of very longstanding persistence of problems and a higher prevalence of psychosis, grief reactions, conduct disorder, aggression and hyperactivity

(Tousignant, *et al.*, 1999; Leavey, *et al.*, 2004; Ehntholt & Yule, 2006). Refugee children also reported higher numbers of sub-threshold symptoms such as:

- Somatic complaints;
- Irritability;
- Withdrawal;
- Sadness and grief;
- Suicidal ideation;
- Self-harm;
- Problems with peers;
- Problems with attention, sleeping and eating.

(Almqvist & Brandell-Forsberg, 1997; Tousignant, *et al.*, 1999; Montgomery & Foldspang, 2005).

In terms of responses, these should be trauma informed and there is a need for careful collection of mental health related data and trauma histories with this being done only once trust has been established (Henley & Robinson, 2011). Families should be involved in early discussions (as they may have spent years protecting their children) but thereafter, when trust has been established, it may be helpful to talk separately to children (who often push down their own feelings to protect their parents) (Henley & Robinson, 2011).

School is seen as an important environment to help bolster and build up protective factors and to identify problems requiring further support. To effectively promote the wellbeing of migrants and refugees, schools should have in place well monitored and implemented whole school anti-bullying, anti-harassment and anti-racism policies and practice with a curriculum that encourages children to recognise and confront racism in themselves and others (although more research is required on effective anti-discriminatory interventions in schools) (Henley & Robinson, 2011). Schools should also have good pathways to proven trauma interventions such as CBT for trauma and Eye Movement Desensitisation and Reprocessing therapy (Washington State Institute for Public Policy, 2015).

### ***Sexually exploited young people***

The scale of sexual exploitation experienced by young people in the UK is unclear but thought to affect 6-15% of under 16 year olds, the majority of whom are girls (Cawson, *et al.*, 2000; Radford, *et al.*, 2013). Recorded cases are thought to represent a small fraction of those actually affected (Health Working Group Report on Child Sexual Exploitation, 2014) with more than one in three not informing an adult either due to shame or fear of reprisals on their family (Radford, *et al.*, 2013). Four out of five children who experienced contact sexual abuse from a peer also did not tell anyone else about it (Radford, *et al.*, 2013). Nine out of ten victims of child sexual exploitation were girls. The average age of identified victims was 15 years and abuse had often taken place over a prolonged period (Health Working Group Report on Child Sexual Exploitation, 2014).

Barnardo's found four main models of exploitation:

- The **inappropriate relationships model** – usually a sole perpetrator who may be older and who has inappropriate financial, physical or emotional power over a child;
- The **boyfriend model** – the perpetrator befriends and grooms a child into a relationship;
- The **peer exploitation model** – a child is groomed often by same sex friends into sexual relationships;
- **Organised/networked sexual exploitation** – children are passed through networks sometimes over geographical distances. This can involve sex/drug parties and also exploited children recruiting others.

(Health Working Group Report on Child Sexual Exploitation, 2014).

In terms of the risk factors faced by these young people:

- Many had histories of multiple risk factors including previous physical and sexual abuse, learning disabilities, experiences of domestic violence and problematic parenting (including parents who suffered from poor mental health or with reliance on alcohol) (Scott & Skidmore, 2006);

- Half had histories of going missing (and in fact had a tenfold greater chance of runaway history);
- Just under a quarter were in care;
- Two thirds were not attending school.

(Jago, *et al.*, 2011).

A number of health difficulties were also identified including:

- 41% having substance misuse problems;
- 32% self-harming;
- 39% with suspected sexual health problems;
- 73% suffering with some PTSD symptoms;
- 57% suffering with depression;
- Over half presenting with separation and anxiety disorder.

(Health Working Group Report on Child Sexual Exploitation, 2014).

Furthermore, experiences of child sexual abuse and exploitation have not only been linked to multiple poor adult health and social outcomes, they have also been noted to increase the likelihood of developing emerging personality disorder in late adolescence and young adult years (Zanarini, 2000).

Effective action and interventions should include:

- Early identification of girls at risk to reduce multiplying risks and strengthen protective factors;
- Improved awareness of early indicators of abuse among multiple stakeholders (including among families, police, Accident and Emergency);
- Good quality gender-sensitive risk assessment;
- Multi-agency coordinated activity;
- Good information-sharing;
- Swift action;
- Highly engaging outreach activities to build trust with young victims and families;
- Child and gender centred approach – understanding consent and the impact of sexual violence/intimidation;
- Robust safeguarding procedures;
- Recognition that girls may not see themselves as victims or act as victims;
- Routine mental health screening and good links to engaging trauma and attachment-informed interventions (EMDR and CBT for trauma).

(Health Working Group Report on Child Sexual Exploitation, 2014; Washington State Institute for Public Policy, 2015).

### Other risk and protective factors

The recent Good Childhood Survey (2015) highlighted a range of other factors impacting on children and young people's mental health and wellbeing. These included:

- Happiness was much more associated with the amount of choice a child had.
- Children who played sports or active games most days were half as likely to have low wellbeing than those who never did so.
- Having 'enough friendships' was associated with better child wellbeing. A very small number of children reported having no friends and their average life satisfaction was three to four times lower than other children. Children in frequent conflict with friends also had lower than average wellbeing (even after household income and gender were taken into account).
- Children who had been bullied were three times as likely as other children to have lower life satisfaction and four times as likely to have lower average levels of happiness as children who were never bullied. Bullying had most impact for this age group when perpetrated by non-siblings.



## What works?

### *Interventions in secondary schools promoting good mental health*

As with primary schools, research findings point to the importance of whole school approaches in secondary schools creating a health-promoting environment, securing commitment from the whole school workforce to support children's mental health and threading social and emotional learning throughout the curriculum (Clarke, *et al.*, 2015).

Some universal SEL programmes are developing good evidence for promoting better mental health outcomes, coping skills and reducing risk taking for this age group (Clarke, *et al.*, 2015). For example, 'Positive Action' is a school-based programme aimed at improving both social and emotional learning and the school climate. Positive Action consists of a detailed curriculum of approximately 140 short lessons throughout the school year from ages 11 to 14 years. The 'Whole School Climate' approach is reinforced in the classroom curriculum and includes training and professional development, coordination of resources, programme promotion and incentives for positive behaviour. It has demonstrated an array of positive effects over time, mostly in relation to substance misuse, reducing early sexual activity, improving school attendance and test scores, reducing exclusions, and in the short term reducing major depressive and anxious symptoms (however, gains were not sustained in mental health at the follow-up stage) (Washington State Institute for Public Policy, 2015).

UK-developed programmes, such as the UK Resilience Programme, have shown some early stage and promising results in reducing emotional problems (although not behavioural difficulties) (Clarke, *et al.*, 2015).

Mindfulness, which involves learning therapeutic and meditative approaches to dealing with stress, has also been tested as a universal approach in schools with very early promise (Clarke, *et al.*, 2015).

### *Other school-based whole population social development programmes*

A number of other whole-school programmes are also credited with improving broader health-related outcomes such as reduced later substance misuse, reduced teenage pregnancy, later initiation of sexual activity, reduced crime and increasing employment prospects thus reducing poverty (which is so closely linked with poorer mental health). These tend to be targeted at those just starting secondary school and include:

- Linking the Interests of Families and Teachers (LIFT);
- Seattle Social Development Project;
- Raising Healthy Children;
- Caring school community;
- Life Skills training.

(Washington State Institute for Public Policy, 2015).

In 2013, Barnardo's adapted the Life Skills Training project for some schools in Northern Ireland as part of the Big Lottery Fund's Realising Ambition programme. To date, almost 3,000 pupils have participated in this initiative. All the above programmes are relatively cheap and for every pound invested are noted to produce savings ranging from £5 to £50 (Washington State Institute for Public Policy, 2015).

### *Community programmes seeking to develop resilience in children*

The Headstart programme, sponsored by the Big Lottery, is currently seeking to build mental wellbeing in children transitioning to and in secondary schools aged 10-15 years in up to 12 locality sites. This programme of work will be evaluated. Although we know much about the risk factors undermining children's mental health and wellbeing, we know much less about what helps some children thrive or remain resilient in the face of multiple adversity. At the current time programmes which seek to boost resilience are largely not well proven or tested and are based on a large degree of guesswork (Davies, 2014). More research is required using data from longitudinal studies allowing us to

pinpoint what factors promote resilience at this age. This will then hopefully allow for the development of more effective programmes building capacity in and around children and young people. Findings from the Big Lottery Headstart programme will also further develop learning in this field.

### **Mentoring**

For some time, there has been mixed evidence on the effectiveness of mentoring. Effect sizes from the intervention have generally been modest but with huge variations across different programmes and different sub groups studied. Greatest effectiveness (in terms of reducing aggressive behaviour) is noted when targeted at children and young people facing the greatest adversity and disadvantage – but even across these populations results have varied. Some positive outcomes have been noted with effects for some programmes extending a year or more beyond the end of the youth's participation in the programme (Rhodes, 2008).

Good quality school-based mentoring programmes are now beginning to prove effective in improving school connectedness and performance as well as reducing crime, school behavioural problems and substance misuse from the age of 14 onwards (Washington State Institute for Public Policy, 2015). To be effective they should replicate the characteristics of programmes with a strong evidence base and need to be well implemented to ensure that they reproduce these features faithfully (Rhodes, 2008). The most effective mentoring programmes recruit adult volunteers, school staff, or well supported secondary school students. Community-based organisations liaise closely and coordinate with school staff and provide mentors with training and oversight. Effective programmes include the US national Student Mentoring Program, Big Brothers Big Sisters, Project CHANCE, and SMILE (Washington State Institute for Public Policy, 2015).

### **Conduct disorders in adolescence**

A number of interventions have good effectiveness in supporting children's recovery as well as being very good value in this age group, including:

- **Aggression Replacement Therapy (ART)** is a group cognitive behavioural-based programme helping aggressive adolescents (aged 12-18) self-regulate and adopt more positive behaviour. It is rarely available in the UK despite proven effectiveness. It is facilitated by trained practitioners and can take place in a range of environments, from schools to youth justice settings. This programme is good value as well as effective. Every pound invested in the programme saves about £22 in costs to society based on observed and now well replicated improvements (Washington State Institute for Public Policy, 2015).
- **Functional Family Therapy (FFT)** is a family programme targeting young people aged 11-18 who are at risk of entering or already in youth justice settings. FFT works with family behaviours seen to maintain problematic behaviour, supports more effective family communication, trains family members to negotiate effectively and helps establish clear rules about privileges and responsibilities. Every pound invested in this programme saves about £12 in costs to society based on anticipated improvements (Washington State Institute for Public Policy, 2015).
- **Multi-systemic therapy (MST)** is an intensive home based programme aimed at families with children aged 12-17 who are at risk of or who have a history of arrest. It is also effective in supporting children who are misusing substances with their recovery. It is practical in focus and empowers parents with skills and resources needed to address difficulties that arise in raising teenagers. It empowers young people to cope with family, peer, school and neighbourhood problems. MST involves approximately 60 hours of contact over four to six months and despite its intensity is calculated to produce savings of around

two pounds for every pound invested from benefits (Washington State Institute for Public Policy, 2015).

### **Anxiety and depression**

There are many cognitive behavioural interventions which work very effectively to improve the recovery of young people suffering with anxiety and depression. In the case of depression, swift access to these programmes is essential because of its role as a risk factor for suicide. These programmes are described in greater detail in the chapter on five to ten year olds and have been proven to be effective up until the age of 18 years.

### **Psychosis**

Although much rarer than emotional or conduct disorders, a very small proportion of young people at risk of developing psychosis will present with the first very subtle symptoms from the age of fourteen onwards. People experiencing psychosis generally exhibit some personality changes, confused thought patterns and a loss of touch with reality. In the initial stages of illness, symptoms can be more subtle with a risk that they are missed or misinterpreted. Yet there is now good evidence that preventative intervention through Early Detection Services with those at enhanced risk (broadly those with subtle symptoms and with an enhanced family risk) at this very early stage using CBT can prevent the onset of illness or change the course and severity of the illness and its impact on a young person's life (National Institute of Clinical Excellence, 2014). Early Detection services involve provision of CBT, medication, and contact with support workers and psychiatrists.

Early Intervention services will be explored in the next age band when the peak period for the development of psychosis arises.

### **PTSD**

Children and young people in this secondary school age band can benefit from those trauma treatments described earlier for younger children.

### **Interventions for self-harm**

NICE guidance reinforces that self-harm should always be taken seriously as an expression of distress in children and young people (NICE, 2004). One in eight young people who self-harm are hospitalised and inpatient placement usually occurs where there are very high risk factors or physical health concerns. All young people who have self-harmed in a potentially serious way should be assessed either by a child and adolescent psychiatrist or a specialist mental health worker, psychologist, psychotherapist, or psychiatric nurse. Yet half of those who attend an emergency department are not offered or do not wait for a psychosocial assessment (NICE, 2004). Many other children and young people do not disclose self-harm.

A recent review of the evidence noted very limited robust evidence on which interventions can reliably prevent or reduce deliberate self-harm and suicide (Glenn, *et al.*, 2015). Some promising programmes had also been unable to replicate initial gains reliably with other groups of young people (Ougrin, *et al.*, 2015). Glenn's study also noted little difference between outcomes for the most promising interventions (CBT, Family Behaviour Therapy, Interpersonal Behaviour therapy and psychodynamic approaches). On the other hand it did note a number of core features of effective interventions across all promising interventions including:

- Targeting relationships or interpersonal functioning – with particular sensitivity to strengthening attachments;
- Intervening within the family and involving families and parents closely;
- Skills training particularly for improving regulation of emotion/stress and problem solving;
- Being intensive - (i.e., greater number of weekly contacts and longer length of treatment – particularly important immediately after release from hospital) (Goldston, *et al.*, 1999);
- Targeting risk factors and unhelpful behaviours (including alcohol and drug use) which are associated with self-harming or suicidal thoughts;

- If school problems, particularly bullying, are prominent, liaison with the school is considered critically important (NICE, 2004a).

Interestingly, so far there is little evidence that pharmacological or more narrow treatment of depression on its own can reduce broader risk (Asarnow, *et al.*, 2011; Gibbons, *et al.*, 2012). Neither is there evidence for the use of dialectical behaviour therapy with adolescents, although trials are currently continuing for this therapy (Glenn, *et al.*, 2015). It is of concern that some media and social media exposure and interventions have been noted to worsen risks of suicide promoting a contagion or social mimicry effect with other young people (Sisask & Varnik, 2012).

Young people who self-harm talk about a desire to discuss their difficulties in a non-judgemental setting (YoungMinds, 2012). For this reason, facilitating access to a high quality community or school counselling, or through easier access to good quality digital counselling services may be an effective way forward in the absence of better quality evidence. This type of non-clinical feeling counselling can be popular with young people (Rickwood, *et al.*, 2007), can often be easily accessed, can bridge transitions between youth and adult services, can help differentiate which children need more intensive and systematic support, and often actively help to maintain support and contain risk among young people waiting for specialist and more systemic interventions.

There is an urgent need for more research and development in preventing and treating self-harm and suicidal orientation. First of all, research indicates that there is a need to separate out the impact of interventions based on improvement in suicidal behaviours and self-harming outcomes in order to draw more nuanced conclusions on what works (Glenn, *et al.*, 2015). There may also be benefit, for example, in evaluating the longitudinal impact of good quality primary school counselling and social and emotional learning programmes on later emotional self-regulation, self-harming (including eating disorders) and suicidal outcomes. This type of longer term tracking of

impact is important to improve knowledge on effective prevention.

There is a lack of clarity on effective prevention programmes for self-harm, eating disorders and suicide for this age group. Successful testing and replication of preventative programmes are particularly important for girls in the context of evidence of increasing prevalence rates during young adult years and potentially deteriorating mental health over recent years. We also have insufficient knowledge on the complex factors which lead one child in adversity to develop or maintain resilience, beating the odds, while another suffers deteriorating mental health and wellbeing.

## Seeking help

Evidence suggests that:

- Young people in this age group aren't always aware when their mental health is deteriorating (Gulliver, *et al.*, 2010) e.g. because of poor mental health literacy.
- Young people in this age group are highly self-reliant when coping with mental health difficulties (Rickwood, *et al.*, 2007; Gulliver, *et al.*, 2010).
- Young people in this age group favour informal sources of support such as friends or family (Burns, *et al.*, 2006; Jorm, *et al.*, 2007).
- Young people in this age group experience stigma, shame and embarrassment about mental health difficulties strongly (Gulliver, *et al.*, 2010). During adolescence, they are more susceptible to negative environmental perceptions of mental health in their family, in their peer group, in the media or in their school environment, becoming more secretive and backing away from disclosure and seeking help (Kranke, *et al.*, 2010).
- Young people in this age group largely do not know where to get help for emotional problems. In one local area, despite most secondary schools having some form of counselling provision, most children and teachers did not know about it - with nine out of ten young people being unaware of provision in same sex schools (St Albans Youth Council and Youth Connexions, 2012).



- Young people in this age group lack faith in formal services (Jorm, 2012) and are less likely to seek help if they have had bad experiences or held negative beliefs about services (Rickwood, *et al.*, 2007).

Evidence also suggests that even those with the most severe symptoms are unlikely to seek help (Zachrisson, *et al.*, 2006). Those suffering from depression and at risk of suicide are least likely to seek help and have the greatest chance of going unnoticed (Rickwood, *et al.*, 2007). Trusted relationships and faith in the confidentiality of discussions are generally critical facilitators for young people seeking help (Gulliver, *et al.*, 2010).

Young men tend to be more reluctant to seek help than young women with one study in Australia highlighting that a third of young men would not seek help from anyone at all (as opposed to 6% of girls) (Donald, *et al.*, 2000).

Parents and carers generally remain important detectors of distress for children in this age group although many feel awkward and unconfident in opening up conversations (YoungMinds, 2012). Young people who were self-harming were also put off disclosure by their parent's discomfort, feelings of failure and fear (YoungMinds, 2012). On a more positive note, most parents of a child with a diagnosable disorder would approach schools or a GP for help, but frustratingly, their children generally do not get the help they need (Green, *et al.*, 2005).

Seeking support online was a popular tool for many young people – but again with concerns from young people and in the literature about the variability, unreliability and sometimes harm experienced while seeking help in this way (Rickwood, *et al.*, 2007; YoungMinds, 2010). Many young people have also been noted to prefer face to face contact (Rickwood, *et al.*, 2007).

Although young people favoured access to informal, family and peer support, there was some concern in the literature that friends and family do not always have the capacity to spot deterioration early and to know what to do. For example, most young people supporting

a friend with depression were unlikely to approach an adult about their concerns (Jorm, 2012). Without additional support peers may not always have the experience, knowledge or maturity to take on an advisory role. This is particularly troubling with serious conditions such as depression where delays in accessing high quality treatment can increase the likelihood of suffering longer term illness or possibly tragic outcomes such as suicide (Jorm, 2012). However, studies also point to the crucial role that friends and families can play in terms of providing social support and encouraging and facilitating formal help seeking (Rickwood, *et al.*, 2007).

If approaching a professional, just under half of young people would approach a teacher or member of school staff, highlighting the critical gateway that schools can play with this age group. Generic counselling services tended to be preferred by children and young people to more formal mental health, clinical services or cognitive behavioural approaches (Jorm, *et al.*, 2008). There is less clarity about why this might be in existing research. It may be because clinical services can be less likely to be relationship driven (which is of great importance to young people), school based, familiar and convenient. This greater tendency to dislike clinical services presents a challenge as some clinical approaches (such as CBT) often have the best chance of supporting recovery with depression, bulimia and anxiety related illnesses. Furthermore, counselling services can be of variable quality and are not all sufficiently resourced to develop evidence based approaches. Young people generally value help that is genuine, warm, confidential, non-patronising, built on strong relationships and with co-produced solutions (Rickwood, *et al.*, 2007).

Future education and developments about mental health aimed at this age group may benefit from taking into consideration the preferences of young people to seek help from their peers, and focus on encouraging young people and peers to seek adult assistance when they are worried about the wellbeing of a friend (Kelly, *et al.*, 2007).

### ***Vulnerable groups and help seeking***

Vulnerable and higher risk groups can often be even more cautious about engaging with formal services because of attachment difficulties, negative previous experiences and learnt distrust. These young people require support based on patient outreaching engagement and strong relationships (Sainsbury Centre for Mental Health, 2010; Lennox & Khan, 2013; Department of Health, 2015).

Some innovative models of holistic support are now developing to improve access for vulnerable groups. These include:

- The Anna Freud Centre's Adolescent Mentalisation Based Integrative Treatment approach;
- Safer London's work with vulnerable young women – but also more generally with young people involved in gangs and offending in London;
- Initiatives such as The Integrate Movement (TIM) working with under-served young people such as gang members, young people who offend and some BME young men. Approaches are highly engaging, co-produced, focused on holistic recovery and involve an approach called 'Street Therapy' (Zlotowitz, *et al.*, In press).

### **Key messages**

- During secondary school, one child in eight will have one or more mental health conditions at any time. The number of children (mainly boys) with severe behavioural problems is higher among this age group. Self-harm is also relatively common, especially among girls, LGBT young people and children with a diagnosable mental health condition.
- Some studies have found rising levels of emotional problems among girls in this age group. Media-driven pressures to be thin, sexual harassment and harmful content online, and school pressures generate anxiety for girls, and many report being very worried about their mental health or that of their friends.

- Misuse of alcohol, smoking and drug taking are all associated with poorer mental health in this age group. There are very positive signs that alcohol and substance misuse have been decreasing over the last decade; however, for those who continue, reliance and binge drinking may be getting worse creating greater inequalities between high and low risk children and young people.
- Young people in this age group largely don't know where to get help for emotional problems. They also feel stigma strongly. This can lead them to be more secretive about difficulties, which prevents essential early help. Many favour informal sources of support such as friends and family. Seeking support online is also a popular tool for many young people – but again with concerns from them and in the literature about the variability, unreliability and sometimes harm experienced while seeking help in this way.
- If approaching a professional, just under half would approach a teacher or member of school staff. Generic counselling services tended to be preferred to more formal mental health, clinical services or cognitive behavioural approaches.
- Young people generally value help that is genuine, warm, confidential, non-patronising, that co-produces solutions and builds on strong relationships.
- Whole school approaches that create a health-promoting environment and secure the commitment of the entire school workforce have been found to promote the best outcomes, to improve coping skills and to reduce risk-taking.



## Missed opportunities

This is a chapter from the report **Missed opportunities: a review of recent evidence into children and young people's mental health** by Lorraine Khan. For the full report, or the reference list, please visit [www.centreformentalhealth.org.uk/missed-opportunities](http://www.centreformentalhealth.org.uk/missed-opportunities)

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