

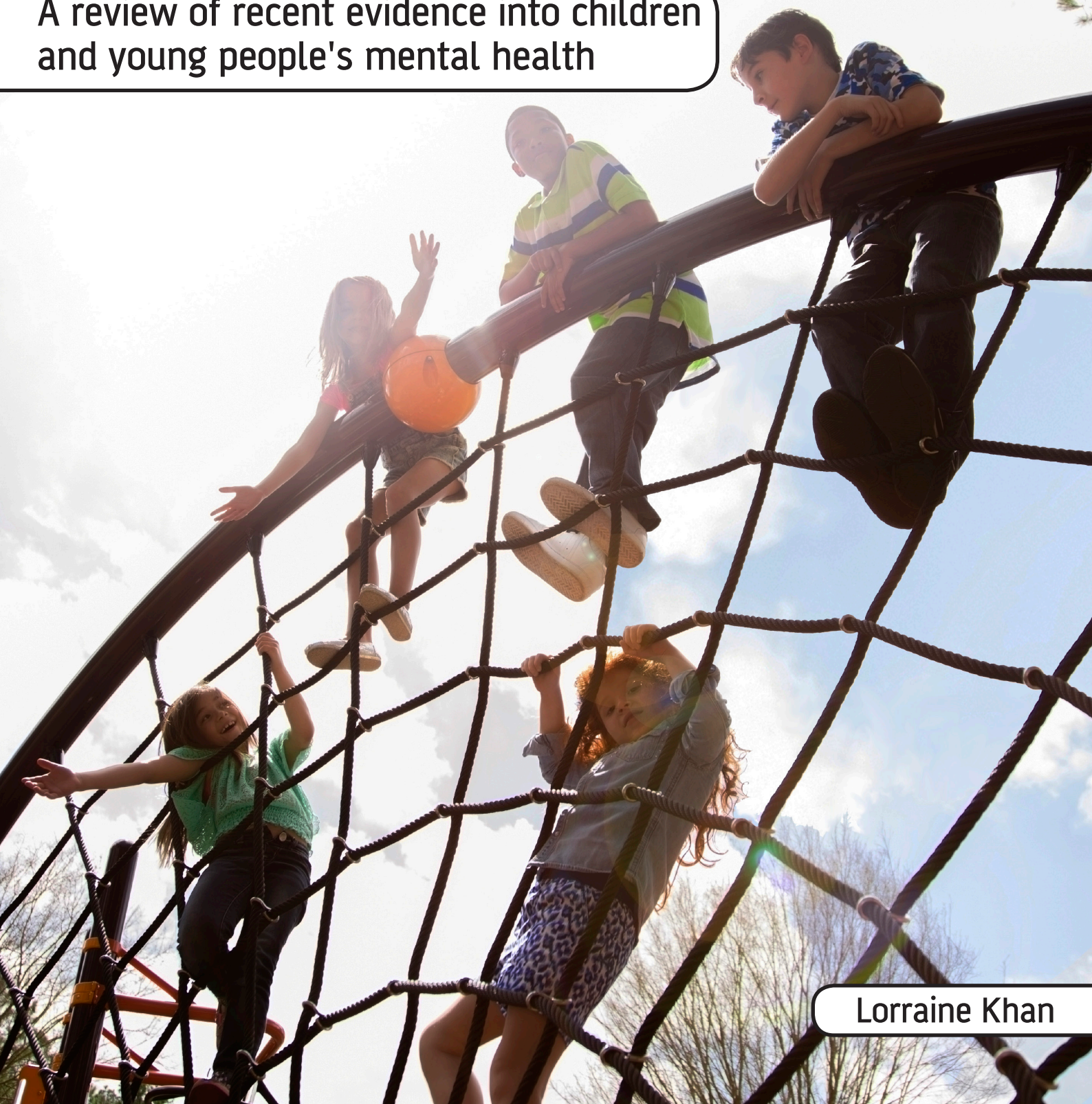
REPORT

Centre for
Mental Health



Missed opportunities

A review of recent evidence into children and young people's mental health



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Executive Summary

Introduction

Mental health problems affect around one in ten children and young people, rising to one in five young adults. Childhood mental health problems are common, damaging, costly and persistent. They cause distress to children, young people and their families and often cast a very long shadow over children's lives.

During childhood and early adolescence poor mental health most commonly presents through severe behavioural problems (mainly affecting boys). From mid-adolescence onwards, emotional conditions (depression, anxiety and self-harming behaviours) become much more common, this time affecting more young women.

There is good evidence on what gives children and young people the best start in life in terms of their mental wellbeing, on the risk factors which compromise healthy emotional and behavioural development, and on the particular children at greater risk due to an accumulation of these risk factors. There is also a clear steer on what works to support children and young people with mental health needs and on the very real difference that can be made to their life chances by intervening at the very first sign of symptoms. Despite this, research suggests a ten-year average delay between the time that young people first experience symptoms and receive help. Furthermore, only a quarter of school-age children with a diagnosable problem receive any intervention at all, despite most parents of these children seeking professional advice. And, when children and families do seek help, they are frequently confused by a maze of largely fragmented services and often face lengthy delays to get the help they need.

There is currently contradictory evidence on whether children and young people's mental health is stabilising or deteriorating, although there are some tentative signs of a decline in young women's wellbeing.

This document seeks to piece together the evidence about children and young people's mental health and wellbeing in the UK, based on

the most recent high quality research. It breaks down findings into four age groups: pregnancy to age 4; children aged 5-10, 11-15 year olds, and young adults aged 16-25.

Access to help

For all age groups, a dominant issue has been the persistent gap between children's needs and their access to help and support, especially early on when difficulties with mental health first emerge. Getting help at the first sign of symptoms is critical, and yet at every age, only a minority of those with diagnosable mental health problems receive help to address them. Stigma can create a 'conspiracy of silence' about mental health difficulties which prevents older children from seeking help or disclosing distress. Poor mental health literacy is another major barrier for parents, children, teachers and other professionals, causing uncertainty about whether there is a need to seek help and prompting delays. Many parents, children and professionals do not know what help is available or how to get it; they find services off-putting, unappealing, frightening or experience lengthy periods waiting to get help.

1. Pregnancy to four year olds

Good mental health and wellbeing in under five year olds is shaped very early on at the first spark of life, and is determined by a complex interplay between genetic make-up and exposure to risks and protective factors in the environment.

During pregnancy, poor maternal mental health, over-exposure to excessive stress hormones and also to some substances (e.g. tobacco and alcohol) can have a toxic effect on a child's brain development and later mental health. After birth, a healthy attachment to a care-giver helps to protect babies from adversity and stress: acting as a 'buffer' with the world outside and slowly helping infants self-regulate in the face of adversity and frustration. For toddlers, positive proactive parenting (e.g. involving praise, encouragement and warmth) and the absence of harsh, rejecting and coercive parenting are

associated with better child mental health and wellbeing.

Infants and toddlers facing greater risk of poor mental health include those whose mothers have untreated mental health problems, whose parents misuse substances, who are subject to maltreatment and neglect, and who live in prolonged poverty. It is the number of risks and their multiplicative effect over time that undermines children's developing mental health (rather than any one particular risk factor).

A range of interventions can help to protect mental health from pregnancy to age five. Most need to be targeted towards families who have the highest risks or children who are showing early signs of distress. They include home visiting programmes for parents facing high risks (such as Family Nurse Partnerships); effective treatment for maternal mental ill health; and group parenting programmes for children with behavioural problems (such as Triple P).

2. Five to ten year olds

During primary school years, family environment, with all its associated strengths and risks, remains an important influence on children's mental health. However, a majority of children also now experience daily exposure to a new and highly significant environment – school. Early educational environments have the potential to provide new, nourishing and potentially protective experiences. But they can also expose children to additional risks. Schools, and the tasks they require of children, can be the context within which difficulties first begin to surface or become entrenched.

Bullying is a major risk factor for poor mental health during primary school years. Being a target of bullying in childhood not only jeopardizes young victims' mental health and wellbeing at the time, but also has significant negative lifelong effects on mental health as well as on a range of other different areas of adult life. And children who are both bullied and bully others face higher risks of poor outcomes in adult life, including imprisonment and suicide.

Most children aged 5-10 enjoy good mental health but just over two children in every primary school class will have a diagnosable mental health condition. Many more will have borderline difficulties. Some children continue to face higher risk of poor mental health due to exposure to serious, prolonged or multiple risks in family and school environments (e.g. maltreatment and victimisation in both home and school). At this age, boys are more likely to have problems which meet the threshold for diagnosis than girls. And for some children in this age group difficulties can further multiply and become entrenched, which in turn raises the risk of poorer life chances.

Schools are one of the few contexts within which universal programmes to prevent mental health problems have been noted to result in population-level improvements, especially during primary school years. To be successful, mental health-promoting and anti-bullying approaches need to be threaded through the entire curriculum and embedded in school culture. Activity needs to be backed up by well-implemented policies, good relationships with parents, whole school training and commitment to being a mentally healthy school, parallel concern for teachers' mental health, swifter identification and good access to both in-house and community resources to ensure timely support.

Many evidence based programmes focus on improving social and emotional awareness and helping young people to improve their ability to self-regulate when faced with worries, frustration and setbacks. Proven programmes (like Social and Emotional Learning) need to be reproduced faithfully, not adapted or dipped into, and delivered by well trained and supervised staff. This can often be challenging for schools preoccupied with prioritising national curriculum targets even if in the longer term, these programmes promote educational attainment.

3. 11 to 15 year olds

Mental health difficulties begin to increase during teenage years. 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; rates of anxiety, depression and self-harm (mainly affecting girls) are also higher. It is also during this age that most early symptoms of adult mental illness (including psychosis) begin, and evidence indicates that if we can limit the length and the recurrence of episodes of mental illness during adolescence, there is a lower risk of problems extending into adult years. Despite this, teenagers tend to be less likely to know when their mental health is deteriorating and feel stigma keenly.

Self-harm is also relatively common in this age group, especially among girls, LGBT young people and those with a diagnosable mental health condition. It is an important risk factor for suicide (particularly if accompanied by depression) among older teenagers.

Some studies have found rising levels of emotional problems and deteriorating life satisfaction among girls in this age group. Recent surveys suggest that girls are concerned about media-driven pressures to be thin, sexual harassment, harmful content online and academic pressures. Many also report being 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 encouraging 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.

Some young people in this age group face a particularly high risk of poor mental health, including:

- Those who are bullied at secondary school;
- LGBT young people (who also face higher levels of bullying);
- Young people who offend or join gangs;
- Those in care or with a parent in prison;
- Young carers;
- Young people excluded from school;
- Migrants and refugees;

- Those with a long term illness/disability;
- Those experiencing family conflict;
- Children in the lowest socio-economic group.

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. This tendency to dislike clinical services presents a difficulty as these health-based interventions (e.g. cognitive behavioural therapy) often have the best chance of helping young people recover from depression, bulimia, trauma and anxiety-related illnesses.

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 mental 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.

4. 16 to 25 year olds

During young adult years, there is a significant increase in self-harm, depression, anxiety and eating disorders, and for the first time diagnosable mental health difficulties are overall more common in young women as opposed to young men. Adolescence and young adult years are the peak age for the first onset of adult mental health problems. This is also the stage at which the effects of childhood abuse and trauma may result in mental health crisis. Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24. It is also at this time that more severe mental health diagnoses emerge, such as psychosis and personality disorders.

Around 20% of 16-25 year olds will experience a diagnosable mental health problem. This stage provides vital opportunities for intervention. There is good evidence that intervening early in the course of many mental illnesses can significantly reduce later impairment – including

for serious illnesses such as psychosis. Yet studies show that many people with mental illnesses fail to receive help for around a decade after first symptoms emerge.

Suicidal thoughts were most likely to be reported in this age band. There was also evidence of a significant increase in self-harm between 2000 and 2007 – mostly affecting young women. This age group is also more likely to screen positive for PTSD with males being more likely than females at this age to have higher rates of trauma symptoms (considered to be linked to higher risk of being violently attacked among young adult males).

Women are the most likely to have an eating disorder but only one in five is likely to be in receipt of treatment; this is despite the fact that poor outcomes have been associated with later presentation to services for anorexia nervosa. The evidence base for effective responses to eating disorders is also still developing.

Groups of young adults with the highest risks of poor mental health include:

- Young adults leaving the care system;
- Young people not in employment, education or training;
- Those in the criminal justice system;
- Homeless young people;
- Some groups of BME young people;
- Early military service leavers.

Young adults as a whole are the most likely age group to develop mental health problems, but least likely to recognise that they have a problem that might benefit from treatment. They are most likely to think that they should handle mental health problems themselves with between a third and just under a half of those with serious mental health difficulties in some studies believing this to be the best course of action. For this age group, friends, digital sources and intimate partners often become frequent sources of help. Once again, males were much less likely than females to seek help, sometimes with tragic results. Those who do seek formal help, or who need continuity of support from early teenage years, can be faced with frustrating gaps between child and adult services which are counterproductive to recovery and progress.

Conclusion

All of the evidence reviewed for this report points to the importance of supporting families and schools to build firm foundations for children's mental health, and of offering effective help for any age at the first signs of difficulty.

Too often, opportunities to offer timely and effective support to children and their families are being missed. Typically, in the ten years many children wait to get help with mental health difficulties, problems become entrenched and (for many young people) escalate until they reach a crisis.

The longer a child is left without help for a mental health problem, and the more often it recurs, the more it is likely to cast a shadow over their entire life. Early high-quality help, offered quickly and combined with ongoing support to prevent problems coming back, is essential. It is never too late to offer effective help to a young person in distress, but the earlier it is offered, the less it is likely to impact on their future health, wellbeing and life chances.

This review has also identified that some children and young people face greater risks of mental health problems than others. Many children face multiple risks that accumulate from early childhood into adolescence and adult life. Especial efforts are needed to support those at greatest risk and look out for the early signs of distress.

The implications of the evidence we have brought together are far-reaching. They point to the need for whole system ownership of and investment in children and families' mental health, from the first spark of life through to early adulthood. They illustrate the importance of raising awareness and mental health literacy among families, schools and young people themselves. And they highlight the importance of making effective help more accessible, more proactive, and more responsive.

Missed opportunities

A review of recent evidence into children and young people's mental health

Key findings from the report



**Three quarters of parents of children with a mental health problem seek help...
...but only one quarter of children receive any support.**



There is an average 10-year delay between young people displaying first symptoms and getting help.

Chapter 1: Introduction

Mental health problems affect around one in ten children and young people rising to one in five in young adults. Children and young people frequently communicate distress through their behaviour, and during childhood and early adolescence poor mental health most commonly presents through severe behavioural problems (mainly affecting boys). From mid adolescence onwards, episodic emotional conditions (such as depression, anxiety and self-harming behaviours) become much more common, this time affecting mainly young women.

Mental health problems are common, damaging, distressing, costly and persistent. They frequently cast a very long shadow over children's lives as they develop and mature. Shifts in children's mental health can be subtle, hidden or prone to being misread, preventing early support when things deteriorate. Even when concerns do surface, a conspiracy of silence often develops about mental health difficulties. Such stigma prevents early open dialogue, hinders help seeking and inhibits effective responses and action about emerging difficulties.

There is particularly good evidence that early starting behavioural (or externalising) problems are persistent with far reaching and costly negative health and social consequences affecting children's life chances as they mature. Despite this evidence, these difficulties are often overlooked or misread.

There is mounting evidence on what provides children and young people with the best start in life in terms of their mental and emotional wellbeing, on the risk factors that compromise healthy emotional and behavioural development, and on children and young people at greater risk of poor mental health due to an accumulation of these risk factors (Davies, 2013; Davies, 2014). There is also good evidence on the real difference that can be made to children's life chances by intervening at the very first sign of deterioration, and on what has the best chance of improving outcomes for those who develop a diagnosable mental health problem (Patel, *et al.*, 2007; Social Research Unit, 2013; Khan, *et al.*, 2015).

Even though most parents of children with a mental health problem seek help and advice, only a quarter of children and young people broadly receive any help (Green, *et al.*, 2005). And when they do seek help, they are confused by the maze of services, often face lengthy waiting periods and are not always happy with the quality, convenience and feel of the help provided (Department of Health, 2015). Furthermore, as young people become adolescents and young adults, despite being one of the highest risk periods for deteriorating mental health and providing significant opportunities for early intervention, they are least likely to seek help for mental health problems at this stage and services are least likely to seek them out (Rickwood, 2005).

This report explores the evidence on what shapes and influences children and young people's mental health as they mature through different stages of their lives. It sets out the evidence we have been able to gather from a range of available sources on what is known about children and young people's mental health in the UK at the present time.

The review was conducted through:

1. A systematic search of bibliographic databases for literature published between 1990 and December 2015 (although a number of publications published up until January 2016 were also included);
2. Internet and website searches for relevant grey or unpublished literature (e.g. Government reports, policy documents/ briefings and third sector reports).

We have divided up the evidence review into four age groups, in each focusing on:

- What we know about trends over time;
- Risk factors for poor mental health;
- The most vulnerable groups;
- What works.

Before that, we explore the main reasons why children of all ages do not get the help they need and the barriers to seeking support for families, children and young people.

Chapter 2: Access to help

In this chapter we explore the main barriers to getting help for children and young people of all age groups, with a particular focus on stigma and mental health literacy, and identify the main sources of help that young people prefer. Figure 1 identifies the main factors that determine whether and how a person seeks help for their mental health.

Stigma and help seeking

Many barriers prevent parents, children and young people accessing help. Over recent decades there has been increasing investigation of the role played by stigma in preventing access to help for those suffering from mental illness.

Stigma emerges from commonly held and dominant attitudes which devalue, discredit or spoil another person’s identity and status in a social context (Goffman, 1963; Phelan, *et al.*, 1997). It involves three important dimensions: lack of knowledge (ignorance), negative attitudes (prejudice) and behaviour (discrimination) (YoungMinds, 2010). To reduce stigma, change has to occur at all three of these levels.

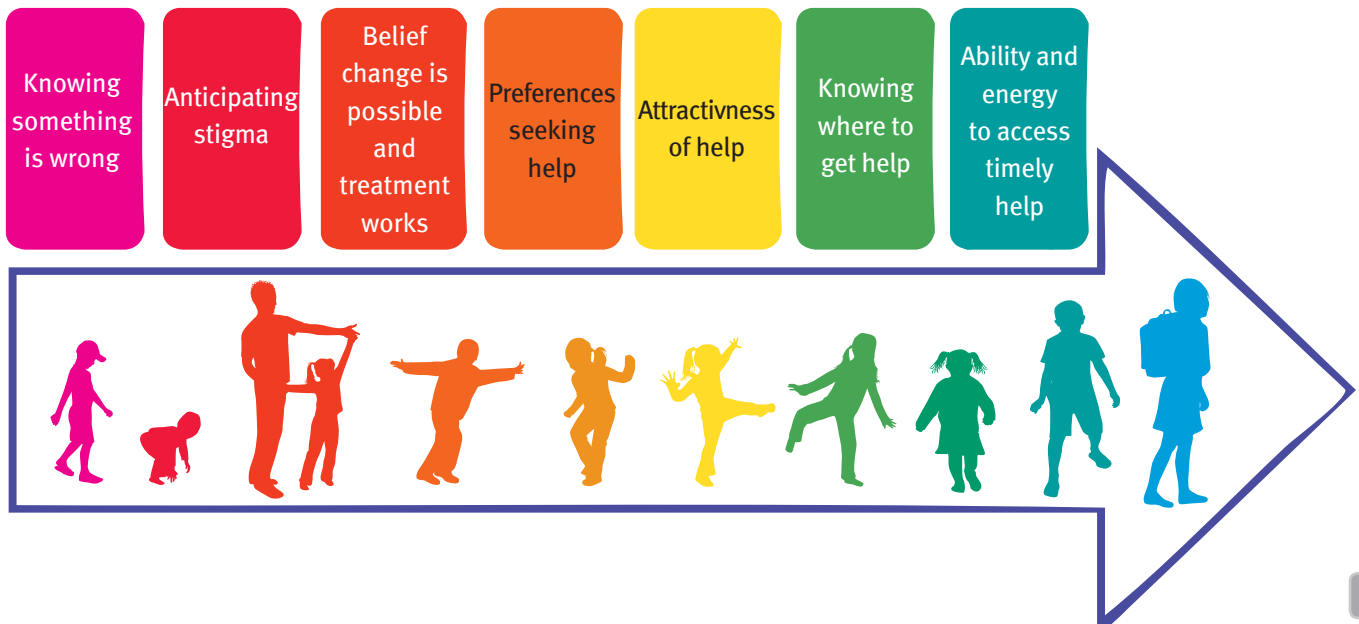
Stigma often harms people with mental illness, diminishes their self-esteem, and deprives them of social opportunities (Corrigan, 2004).

Discriminatory attitudes operate at multiple levels with broader public and community interactions sustained and perpetuated by media images, negative stereotypes (such as ‘people with mental illness are dangerous and unreliable’) and unhelpful attitudes and language (Corrigan, 2004). Stigma can also influence decision-making, affecting policy and funding priorities.

Stigma delays or prevents help seeking as it can make people feel embarrassed or ashamed leading them to hide deteriorating mental health (Clement, *et al.*, 2015). It can also undermine the wellbeing of families, carers and friends making them less likely to seek help on the back of what they have witnessed (e.g. associated stigma) (Mak & Cheung, 2008). There is some evidence that children experience higher levels of stigma than adults with mental illness (Pescosolido, 2007). Young people (particularly young men) have also been noted in studies to have higher sensitivity to stigma associated with poor mental health (Chandra & Minkovitz, 2007; Kranke, *et al.*, 2010). Generally, adolescents with poorer mental health literacy also held more stigmatising views (Chandra & Minkovitz, 2007).

Those who sensed higher stigma around them were less likely to seek help on their own and more likely to keep mental illness a secret due

Figure 1: Factors affecting help seeking in parents, children and young people



to fear of teasing and taunting (Kranke, *et al.*, 2010; Corrigan, 2004). Parental attitudes to mental illness and help seeking appear to have a strong influence on their children's likelihood of seeking help even during late adolescence. Teenagers felt that parents were sometimes reluctant to acknowledge child and adolescent needs for fear of being criticised or blamed themselves (Chandra & Minkovitz, 2007; Hinshaw, 2005).

A range of children and young people are especially sensitive to stigma relating to mental illness. Young men during adolescence and in their early twenties forging adult identities appear more sensitive to stigma, sometimes being concerned at losing social status by being seen as 'weak' (Chandra & Minkovitz, 2007). Some BME children and young people experience high levels of stigma absorbed from wider communities. Their families can also experience significant associated stigma. This shame combines with culturally inappropriate services to reduce seeking help from support services, family and friends (Knifton, 2012). Women with perinatal mental health difficulties also speak of high feelings of stigma, of shame and of feeling as though they were 'not coping' and 'failing' (Khan, 2015a).

Delays in seeking help not only prevent opportunities for compassionate care, they also hinder critical early intervention for children and young people. This is important as intervening early can reduce symptoms, the impact of poor mental health on development and the likelihood of young people escalating into cycles of distressing and damaging crises (Patel, *et al.*, 2007). By increasing a person's chances of recovery, early intervention can also save considerable costs to society (Knapp, *et al.*, 2011).

A number of interventions show promise in reducing stigmatising attitudes (Jorm, *et al.*, 2010; Evans-Lacko, *et al.*, 2013). Some educational interventions have been noted to have a promising impact on children and young people (Corrigan & O'Shaughnessy, 2007; Rickwood, *et al.*, 2004). Promising educational interventions include videos and slides to address stigmatising attitudes (Pinfold, *et al.*, 2003) – often backed up by interactive

discussion to help reinforce messages (Corrigan & Penn, 1999).

Other interventions build on research evidence which suggests that greater contact with people with mental health difficulties can help normalise mental health distress and break down stigmatising attitudes (Reinke, *et al.*, 2004). Contact has to include specific conditions to ensure that it does not make things worse. For instance, the contact person should present a realistic view of recovery, be of equal status to other participants and be someone they can relate to (Reinke, *et al.*, 2004). They should also not conform to standard stereotypes (Reinke, *et al.*, 2004; Corrigan, *et al.*, 2000; Barlow, *et al.*, 2009; Couture & Penn, 2003).

What is less clear is the extent to which changes in stigmatising attitudes translate into sustained changes in behaviour particularly a reduction in discrimination. Furthermore, although interventions designed to decrease stigma are associated with greater levels of help seeking among those in current or past contact with treatment services, there has not always been increased willingness to seek help on the part of those with no previous history of accessing mental health treatment (Saporito, *et al.*, 2011). These outcomes require further investigation and longer term follow up. Furthermore, reducing stigma is only part of what needs to happen to improve early help seeking.

Mental health literacy and knowledge

Many children and young people describe delaying seeking help for mental health difficulties due to confusion about their deteriorating wellbeing and experiences. They struggle to make sense of what is happening to them. In one study only 15% of young people had adequate mental health literacy, correctly identified depression and recognised the need to get help. Those with a moderate to severe depressive illness had the poorest levels of mental health literacy (Lam, 2014). Other studies indicate that lack of recognition of the significance of symptoms is a major barrier to early help, accounting for seven of the average eight years of delay in seeking help for those with diagnosable emotional conditions (Jorm, 2012).

Parents describe similar challenges when trying to work out whether what they are witnessing in their child is normal behaviour or indicative of poor mental health (Khan, 2014). If professionals in daily contact with children and young people also lack mental health awareness and literacy, then parents approaching them (and we know around three quarters do) can often find themselves in ‘help-seeking dead ends’. For this reason, many interventions targeting stigma also seek to improve mental health literacy in the wider population including families, peers, school staff, GPs and other non-specialist professionals in contact with children. In one study, schools were seen by young people as especially important in helping them seek help. Participants felt that teachers should be more aware of mental health, its effects on school performance and how to help students who may have mental health concerns (Chandra & Minkovitz, 2007; Santor, *et al.*, 2009). Teachers also reported being unprepared to deal with or identify mental health problems (Short, *et al.*, 2009).

Mental health literacy comprises the ability to recognise mental health problems; knowledge and beliefs about risks, causes and effective treatments; and knowledge of how to seek mental health information and services (Jorm, 2000). Such interventions aim to better equip people to recognise when deterioration in mental health occurs and to know how to facilitate early action to prevent further escalation and promote engagement and swift treatment.

It is worth noting that recognising the symptoms of mental health problems plays a much smaller part than might be expected in prompting help seeking in young people (Rickwood & Braithwaite, 1994). A wide range of other factors are also involved including:

- Not knowing that there is help available;
- Not believing that available help will make a difference;
- Being put off by previous or other people’s experiences;
- Willingness and energy to seek help (often undermined by the symptoms of conditions such as depression);

- Finding available help off-putting, unappealing or frightening;
 - Not knowing where to get help;
 - Perceptions that timely help is unavailable.
- (Jorm, 2000; Department of Health, 2015; Rickwood, *et al.*, 2007)

This suggests that interventions to reduce stigma and improve mental health literacy are a good starting point but that action needs to take place at other broader levels to improve access to help for those in distress.

Key sources of support for children and young people’s mental health

Children and adolescents are consistently more likely to confide in and seek help from someone they know and trust – particularly friends and family (often mothers or primary care givers) (Booth, *et al.*, 2004). Prevalence surveys suggest that the majority of parents are proactive in seeking help on behalf of children with a diagnosable illness but seemingly not always able to secure support (Green, *et al.*, 2005). Although important to adolescents, peer relationships can also be unpredictable sources of advice, information and support, particularly if peer mental health literacy is low or affiliations are made with similarly distressed subgroups and cultures promoting health-compromising activities and responses (e.g. such as Goth or Emo culture) (Rutledge, *et al.*, 2008).

Young people are typically fast adopters of new technologies including the internet, and some report turning to online sources about mental health concerns (Griffiths & Christensen, 2006; Cello, 2012). However, online sources and applications can also be highly variable in quality, effectiveness, reliability and safety of advice offered (National Collaborating Centre for Mental Health, 2014). Indeed, some have been noted to worsen mental health difficulties (Robinson, *et al.*, 2014). Although online sources are convenient, popular and hold promise for young people, this is an area where young people need more guidance about reliable sources and where more investment in good quality research is required to ensure that applications and online self-help interventions

consistently produce desired mental health improvements. The National CAMHS Taskforce recommended greater commissioning of organisations providing high quality and well supervised digital support, acting as a guide and a bridge for young people to local services such as kooth.com (Department of Health, 2015).

Young people also favour more familiar and less formal sources of professional help such as teachers or ‘counsellors’ rather than more formal mental health services (and particularly clinic-based help) (Andrews, *et al.*, 1999). However, reluctance to engage with more formal mental health services also presents challenges as other forms of help such as counselling can vary considerably in quality and staff may not be trained in delivery methods offering the best chance of promoting recovery. Some BME communities (such as young African Caribbean males) have particularly high levels of fear and distrust of formal mental health services due to their persistent over representation in the most restrictive forms of psychiatric care (Keating, *et al.*, 2002). This fear has been linked to critical delays in seeking help resulting in excessive levels of crisis later on and generally poorer recovery prospects.

Key messages

- Most parents of children and young people aged 5-15 with a mental health diagnosis seek professional help (Green, *et al.*, 2005).
- Only around a quarter of children and young people and young adults get the help they need (Green, *et al.*, 2005; McManus, *et al.*, 2009). Many seeking help also end up in ‘dead ends’ despite recognition of a need for assistance.
- Many children, young people, families and non-specialist workers do not effectively recognise mental health difficulties. Those with common emotional illnesses took on average just over eight years to get help. For seven of these years, they were unaware of the significance of their symptoms (Jorm, 2012).
- People with mental health problems experience more stigma than those with other health problems (Gale, 2006).
- Stigma deters people from getting help (Clement, *et al.*, 2015; Pescosolido, 2007).
- Children and young people face higher levels of stigma than adults (Rose, *et al.*, 2007).
- Children, young people and families need multiple access points to get the help they need. Schools and colleges are seen by children and young people as particularly important places to help pick up and bridge to required support, but many teachers feel ill equipped to help children and young people in this way (Santor, *et al.*, 2009).
- Young people also say they often use online sources (YoungMinds, 2012; Rickwood, *et al.*, 2007) but worry about the reliability of some of the information they access (Department of Health, 2015).
- Most young people prefer non-clinical sources of support including family members and friends; however, in some instances this preference can mean missing out on early effective help that can make a difference (Rickwood, *et al.*, 2007; Jorm, 2012).
- If young people, families, teachers and other non-specialist professionals recognise mental health problems and have relevant knowledge about risks, causes and effects of treatment, young people are more likely to seek early appropriate help (Burns, *et al.*, 2006; Rickwood, *et al.*, 2007; Swords, *et al.*, 2011; Jorm, 2012).

Chapter 3: 0-4 year olds

Good mental health, wellbeing and cognitive development in under five year olds is shaped very early on right at the first spark of life in the womb and is determined by a complex interplay between genetic make-up and exposure to risks and protective factors in the environment. Mental health terminology, language and labels are used cautiously to make sense of child responses under the age of three since there is much less evidence for persistence of problems. Instead, before the age of three, foetal, infant and child mental health and wellbeing are framed in terms of creating a health-enhancing environment (from pregnancy to early years) promoting optimal neurological, emotional, behavioural and social development.

Conception to birth

Neuroscientific research into foetal and infant development is at an early stage but is adding significantly to our understanding of how good mental health is promoted and compromised (Zeanah, 2012). Foetal and infant development and wellbeing are shaped by multiple contexts ranging from individual genetics, temperament and neurobiology as well as parents, families, culture and class. Each of these contexts transact with each other in complex ways over time. From the moment of conception, a foetus is exposed to a complex psychological and biological context influencing all aspects of their development including cognitive development and mental health architecture. There is increasing evidence of associations between key environmental risks during pregnancy and poorer child mental health later on.

It is becoming clear, for example, that early negative experiences can have significant negative effects on children that persist into childhood and way beyond. Studies note critical periods when a foetus or an infant needs well-regulated health-promoting environments and stimuli to promote optimal neural functioning and to prevent altered brain circuitry and architecture (Shonkoff & Garner, 2012; Shonkoff, 2012). Some neural changes, after exposure to non-ideal environmental influences, appear permanent; with others some recovery is

noted later on (Zeanah, 2012). Research is still very much at an early stage in understanding the brain's potential for recovery following early exposure to risk.

The mother's womb is the first significant environment for a foetus and studies highlight a number of environmental factors shaping optimal foetal wellbeing. An increasing number of studies demonstrate how a mother's experience of significant stress or poor mental health (ranging from mild to moderate conditions such as anxiety to severe mental illnesses) during pregnancy can impact negatively on foetal development (Antonelli, 2014). In the case of severe anxiety, studies suggest that prolonged over exposure to stress hormones in the womb raise foetal heartbeat, over stimulate stress response areas in the brain and alter brain architecture potentially leading to later difficulties regulating emotions and coping with adversity (Field, *et al.*, 2004; Monk, *et al.*, 2003). Resulting neural changes can suppress immune responses, affect learning and memory and can act to turn certain genes 'on' or 'off' at particular locations in the brain (Zeanah, 2012) with long lasting implications throughout life.

Exposure to some substances in the womb have also been noted to have a toxic effect on children's brain development and later mental health. For example, exposure to tobacco in the womb has been linked to greater risk of serious behavioural difficulties later on (and this is even after controlling for other high risk factors affecting poor child mental health such as socio-economic status, parenting quality etc). Studies also indicate that exposure to alcohol and lead at critical developmental times can alter neurological development, potentially reducing cognitive ability and undermining later mental health (Zeanah, 2012).

Birth to eighteen months

After birth, the quality, sensitivity and responsiveness of care-giving becomes central to healthy neural, emotional and behavioural development in many ways.

At birth, infants have highly reactive and volatile systems for reacting to stress. Newborns routinely experience moderate and short-lived stress from both internal (hunger, tiredness) and external sources (e.g. loud noises, pain). A sensitive mother/care-giver acts as an important buffer against early stress, slowly helping moderate the infant's exposure to stress hormones. If all goes well, by two months, as a result of this buffering, the infant's stress system begins to stabilise and by six months infants are slowly learning how to self-regulate in the face of stresses, which is a critical skill (Zeanah, 2012). Without an effective care-giving buffer, infants can once again become over-exposed to prolonged and potentially damaging stress hormones which can affect later ability to self-soothe in the face of adversity. These inability to self-soothe and regulate emotions lie at the root of many later mental health problems.

The quality and sensitivity of moment by moment communication between care-givers and infants is also fundamental to good child mental health. This attunement and 'serve and return' communication involves acknowledging and reflecting back infant responses and has been described as being a critical stimulus for healthy neurodevelopment – almost 'jump starting' brain circuitry (Tronick & Beeghly, 2011).

Attachments between child and care-givers also first form in infancy from the child's need for nurturing, comfort and protection (Bowlby, 1973; Bowlby, 1980). Healthy attachments help to buffer infants against adversity and contribute to an internal working model promoting further the ability to regulate emotion and self-soothe over time. More recent research has highlighted additional core elements of healthy attachment during the first year of life. These include parental interaction being neither overly intrusive nor too passive, but rather in the middle range (Early

Intervention Foundation, 2015) and the ability of parents/care-givers to see their child as an individual with a mind, beliefs, intentions and feelings rather than just a collection of needs (e.g. for food, to be changed, to sleep) (Meins, *et al.*, 2001). As children mature, they are likely to reproduce relationships which match the level of security they experienced as part of their original attachment with their carer (Zeanah, 2012).

When children are inadequately buffered from early environmental adversity, are inadequately stimulated and when their care-giver becomes a source of fear, this can have very long term and damaging effects on a child's mental health extending into adult years.

Twelve months to four years

From the age of twelve months, children continue to experience stepping stones of rapid cognitive, behavioural and emotional development shaped by their environment and mediated through their relationship with their care-giver. Toddlers require ongoing sensitive care-giving for optimal development which provides a safe and secure base from which to start exploring the world and becoming more independent. Having care-givers who encourage and take pleasure in their exploration of the world around them, who engage in sensitive conversational reflections and 'turn taking' further cements positive attachments (Markus, *et al.*, 2000) with play and storytelling further contributing to healthy cognitive development (Zeanah, 2012).

For children to thrive, it is vital that they are not exposed to maltreatment and abuse. In terms of parenting style, the absence of coercive or harsh parenting and the presence of positive proactive parenting (e.g. involving praise, encouragement and warmth) are associated with:

- higher child self-esteem;
- higher social and academic competences in children;
- reduced disruptive behaviour and substance misuse later on.

(Rutter, Giller, & Hagell, 1998) (Gardner, *et al.*, 1999; Denham, *et al.*, 2000; Hutchings, *et al.*, 2007a).

Prevalence of mental health difficulties

Almost all infants and toddlers pass through many transient ‘phases’ which subsequently resolve as part of normal child development (Olds, *et al.*, 1997). For example, most children (70%) take toys away from other children, almost half will push other children to get what they want and a fifth engage in activities such as biting, kicking and fighting (Gardner & Shaw, 2008). Many infants will also experience social anxiety when faced with new situations but generally negotiate fears encouraged by sensitive and positive care-giving and with exposure over time (Gardner & Shaw, 2008).

However, some children get stuck in negative patterns of relating to the world around them which can be distressing for both child and parent/carer (potentially undermining the quality of this key attachment). This can compromise on-going development (Egger & Angold, 2006). At this age, such patterns can include excessive crying, persistent sleeping difficulties or eating problems, severe and repetitive tantrums or obsessive behaviours, very persistent separation anxiety or social isolation and ongoing challenging, hyperactive, disruptive or aggressive behaviour.

Between the ages of 2-5 years, poor child development, mental health or neurodevelopmental difficulties (e.g. attention deficit hyperactivity disorder, autism) tend to be identified through tracking Early Years developmental milestones and also based on the persistence of severe difficulties.

The Early Years Foundation Stage (EYFS) sets standards for learning, development and care of children in England from birth to five years old. Data from these early checks have provided a useful overview of the emotional, social and behavioural health of children in England.

Figures from 2014 Early Year Foundation Stage (EYFS) Profiles collated by health visitors and early years workers indicated that most five year olds show healthy development in terms of social and emotional skills. However a minority do less well than others, and boys tend to lag behind at these earlier stages of child development:

- One in four children (17% of girls and 29% of boys) did not reach the expected level in language and communication skills.
- 13% of girls and a quarter of boys failed to reach the expected level in personal, social and emotional development across the country.

(Department for Education, 2014a).

There is currently little good quality data on the number of 3-4 year olds in the UK who meet the criteria for mental health diagnosis. Neither do we know much about trends in infant and toddler mental health over time. Previous national child and adolescent mental health prevalence surveys have not collected data on under five year olds although children of three years plus are expected to be included in a new UK prevalence survey due to start imminently and reporting back in 2018. Figure 2 summarises best available knowledge on the numbers meeting the criteria for diagnosis in this age group:

Figure 2: Prevalence of diagnosable psychiatric conditions in preschoolers based on a review of prevalence studies (Egger & Angold, 2006)

Type of condition	Percentage range meeting diagnosable rates (%)
Attention deficit hyperactivity disorder	2-6
Oppositional defiance disorder (A form of conduct disorder more commonly found among younger children)	4-17
Any behavioural disorder	9
Any anxiety disorder	9
Any emotional disorder	11-15
Any diagnosable mental health condition	14-26

At this early toddler stage gender differences were not as marked as for children over the age of five years, with girls as likely to get stuck in patterns of problematic behaviour as boys (Gardner & Shaw, 2008). Some studies note particularly high levels of impairment to day to day lives at this age resulting from diagnosable difficulties. Many children at this age also meet the criteria for more than one condition (around a quarter overall but rising to half by the age of five years). Most significant behavioural problems at this age tend to resolve as children move through later developmental stages (Morrison Gutman, *et al.*, 2015). However, where disruptive behaviour was severe and persistent at age three, studies note that around half of children continued to experience problems during school years (Campbell, *et al.*, 2000; Hill, 2002).

Major risk factors

Poor child and adolescent mental health results from a complex interplay between internal factors such as genetics and neurobiology and external influences including parents, families, communities, culture, neighbourhood and economic position.

Research on the biological effect of adversity illustrates how the body's physiological equilibrium can break down under cumulative conditions of chronic stress (called 'allostatic load') (Danese & McKewen, 2012). So the longer a child is exposed to risk, the greater the chance their wellbeing (and other aspects of their health) will be undermined. There is also growing evidence that the timing of exposure to risk may influence later mental health outcomes with some periods of foetal development being more critical than others. Finally, there is strong and varied evidence linking multiplying or 'cascading' adverse experiences in infancy and childhood with a whole range of later physical and mental health problems (Kessler, *et al.*, 2010). If parents face too many stressors (and are unable adequately to buffer infants from adversity, unstable housing, conflict-ridden relationships, family structure, location in a high crime area) infants can be overexposed to stress and stress reactivity systems in the brain can be over stimulated by fight or flight hormones.

This in turn has a 'toxic' effect, weakening and recalibrating children's competency in managing adversity and compromising wellbeing. Children facing multiple stepping stones of risk over their lifetime are those with the greatest risk of poor mental health (Rutter, 1979; Farrington, 1997b; Murray, *et al.*, 2010; Farrington, 1997b).

Exposure to environmental risk does not mean that poor mental health is inevitable. Indeed, children can take very different developmental trajectories even when exposed to similar degrees of adversity and risk. Some children demonstrate greater 'self-righting' tendencies in the face of adversity than others (Hanson & Gottesman, 2012). We are still in the process of fully understanding what influences these different pathways taken by children facing similar degrees of adversity and there is a need for more research in this area. However, exposure to risk does increase the likelihood of children experiencing poorer mental health and should prompt those working with affected families both to mobilise child mental health-promoting responses and to be vigilant for early signs of mental health deterioration.

Maternal mental health difficulties

There are particularly strong associations between poor maternal mental health during the perinatal period and the later development of child mental health problems.

Perinatal mental health problems (which include common mental health conditions such as high levels of anxiety and depressive illnesses as well as more severe mental illnesses such as post-traumatic stress disorder (PTSD) or psychosis) affect between 10% and 20% of women at some point during pregnancy and for the first year after birth. Around 13% to 15% of women experience common mental health problems such as depression and anxiety (O'Hara & Swain, 1996; Heron *et al.*, 2004). Infant development appears particularly sensitive to exposure to poor maternal mental health and high levels of stress during pregnancy and for up to 18 months after birth (Glover, 2014).

Cycles of poor mental health and flat mood can also potentially undermine maternal sensitivity

to and attachment with infants. Fathers/partners are also at greater risk of deteriorating mental illness during the perinatal period decreasing access to compensatory protective relationships (National Institute Clinical Evidence, 2014).

At the present time, identification of pregnant women at risk of or living with poor mental health is inconsistent (Maternal Mental Health Alliance, 2014; Khan, 2015a) with only half of those with a diagnosable difficulty being identified, only half of those identified getting any help, and a minority of these getting effective help (Bauer, *et al.*, 2014). Pregnancy represents a time of considerable change and adjustment and many women are unaware that what they are feeling at this time may not be 'normal'. They can feel confused by their deteriorating wellbeing or may be unwilling to disclose concerns due to high feelings of shame at being judged as 'not coping' (Khan, 2015a). For this reason, it is imperative that there is an equal focus during these important years on maternal, infant and family mental health and emotional wellbeing as well as the physical dimensions of pregnancy and birth. Routine screening is identified as helpful but not if delivered in a mechanical or insensitive manner.

When women proactively approach professionals for help, they describe unreliable, inconsistent and sometimes stigmatising and unsympathetic responses with many practitioners either down-playing maternal concerns or unaware of the added significance of anxiety and mental illness at this important time and its potential to disrupt an infant's healthy neurological development (Khan, 2015a). Furthermore, adult mental health services have often been criticised for insufficient routine consideration of service users as parents whose children's needs might also be affected by their illness without enhanced holistic family support (Ofsted, 2013).

Finally, there is inconsistent availability nationwide of timely psychological therapies for mothers with common conditions, specialist perinatal mental health services (for those with more serious illnesses) and mother and baby units for those in crisis (Maternal Mental Health Alliance, 2014; Khan, 2015a).

Parental substance misuse

Fixation with and reliance on drugs and alcohol also potentially interferes with and undermines a parent or care-giver's sensitivity to an infant's rhythms and needs, compromising the quality of the environment around the child and reducing parental ability to stimulate and promote healthy neurological development and mental health. Parents may also be using substances to manage co-existing mental health difficulties both of which can also impinge on parental sensitivity. They may be using substances to manage their own unresolved attachment problems or mental health difficulties, thereby further amplifying environmental risks affecting child development and mental health (Ofsted, 2013).

Maltreatment, abuse, trauma and neglect

Child maltreatment, abuse (physical, sexual, psychological) and neglect represent a major environmental risk for child mental health and normal biological and psychological development (Cicchetti, 2013). They undermine the quality of parent/child attachment and can also result in parents/care-givers being a direct source of fear (and sometimes terror) for infants, rather than the required buffer against adversity and stress or a source of comfort and safe haven (Shonkoff, *et al.*, 2009). This confusing and distressing situation, where a child both craves and fears contact with their care-giver, is often linked to the development of insecure or disorganised attachment patterns between infant and care-giver (Early Intervention Foundation, 2015). Without additional support, such attachment styles can embed and have long lasting effects linked to later poor mental health and particularly adult personality disorders. Disorganised attachment is often associated with compromised neurodevelopment, an inability to self-regulate/self-soothe, hyper reactivity to stress (setting the stress response system on a "short fuse") and later poor mental health (Zeanah, 2012). Harsh parenting has also been associated with poorer child mental health (Smith, 2004).

There is some evidence that the earlier a child is exposed to neglectful and abusive environments and the later they exit these

circumstances, the worse their mental health and cognitive outcomes. Longitudinal studies of children exposed to extreme neglect and deprivation in Romanian orphanages showed that they experienced much higher risk of poor mental health later on. Risks increased the earlier and longer they were exposed to these settings and in spite of later transfer to predominantly positive post-adoption care. On the other hand infants escaping risk very early on showed greater capacity for recovery and fewer later mental health and developmental problems (Kumsta, *et al.*, 2015). These findings suggest that early and prolonged exposure to maltreatment leads to lifelong persistent physiological alterations occurring in the brain; it also reinforces the importance of intervening early to reduce toxic environments and prevent later poor mental health (Kumsta, *et al.*, 2015).

Poverty

Poor mental health usually has multiple and complex interlinking causes and it is important not to oversimplify the drivers. However, prolonged family poverty and to a lesser extent neighbourhood poverty can play an important role in worsening child and youth mental health (Akee, *et al.*, 2010; Yoshikawa, *et al.*, 2012). The effect of poverty on poorer child and youth mental health is independent of other influential factors such as levels of parental education or ethnicity (Joseph Rowntree Foundation, 2015). It is not just absolute or average levels of poverty that have an important impact on child mental health and emotional wellbeing, but also relative poverty in a society; those societies that have the largest gaps between the richest 20% and poorest 20% tend to have worse child mental health outcomes (Wilkinson & Pickett, 2011; Yoshikawa, *et al.*, 2012). In a study in 2009, Wilkinson and Pickett also identified the UK, Portugal and Singapore as examples of societies with larger gaps between rich and poor compared, for example, with Scandinavian countries (Wilkinson & Pickett, 2009).

Poverty is thought to affect infant mental health through a variety of mechanisms operating at different levels:

- Adults living in deep and persistent poverty are likely to experience and can expose their children to higher levels of stress as a result of general living conditions, reduced opportunities and survival struggles due to economic and environmental insecurity. Such exposure can compromise the neurobiological processes that guide later responses to stress in longstanding ways (Shonkoff & Garner, 2012).
- Poverty is associated with higher levels of poor adult mental health and this in turn can undermine parental energy to be sensitive and responsive carers and their ability to fulfil critical buffering roles which help children deal with stress and adversity.
- Parental poverty, low educational achievement and mental illness have also been associated with higher rates of child maltreatment which is also detrimental to children's mental health (Gilbert, *et al.*, 2009).
- Finally, impoverished families often live in neighbourhoods characterised by poorer day care and schools, higher levels of adversity, stress and violence with fewer opportunities for enrichment or to exit poverty.

The relationship between socio-economic deprivation and the development of serious childhood behavioural difficulties is complex. Parenting can be undermined by poverty and poverty may indeed drive other risk factors such as family conflict and poor maternal mental health (Simons, *et al.*, 1993; Conger, *et al.*, 2002). However, there is equal evidence that positive parenting has potential to act as a protective buffer against the negative effects of poverty (Kim-Cohen, *et al.*, 2004).

What works

Most effective interventions seeking to promote infant and child mental health during early years concentrate on strengthening crucial aspects of the parent/care-giver relationship which we know improve neurological, social, child development and mental health outcomes (e.g. parenting sensitivity, positive attachment and positive parenting techniques). They also seek to reduce health-compromising care-giving and environmental characteristics and stressors (e.g. maltreatment, parental emotional unavailability, harsh parenting, poverty, multiple risk factors).

Interventions seeking to encourage improvements in child mental health can attempt this in three different ways:

1. Through promoting change across the whole population (a universal approach);
2. Through seeking to reduce risks among populations who are known to have higher risks (targeted or selective approaches) including those relating to maternal mental health and to mitigating the effects of poverty;
3. Through seeking to target infants and children at the very first point that they show signs of a diagnosable mental health condition (early intervention or indicated approaches).

Universal interventions

As a general rule of thumb, universal programmes (e.g. population-level preventative programmes such as newsletter awareness-raising campaigns about optimal parenting or making available parenting groups to everyone) have not produced as convincing results so far as targeted strategies (Early Intervention Foundation, 2015).

However, one universal programme shows promise in this respect. The 'Triple P' Positive Parenting approach is a stepped programme of parenting support (ranging from a media campaign reaching the whole population to specialist group work for those with higher chances of reduced parent sensitivity and poorer attachment). This 5-stage programme was

piloted across an entire state in the US (South Carolina), tracking and comparing outcomes for children in the state with a sample of children elsewhere not exposed to the programme (Prinz, *et al.*, 2009). At the conclusion of the trial, overall child outcomes were superior for those children and families exposed to this multi-level pilot programme. Child mental health and wellbeing outcomes were not tracked as part of this research. But there was evidence of sizeable reductions in an important area of risk associated with poorer child mental health – maltreatment (Prinz, *et al.*, 2009).

More recently, a similar multi-level whole population 'Triple P' parenting approach was tested closer to home in Ireland targeting three to seven year olds in Galway (Fives, *et al.*, 2014). This initiative tracked child and family mental health and wellbeing, noting lower levels of mental health difficulties (e.g. conduct problems, emotional problems, ADHD) and improved parental mental health after intervention compared with children and families in neighbouring 'control' counties. Improvements were also almost all sustained at twelve month follow up (Fives, *et al.*, 2014).

At the present time, such whole population programmes have not been tested sufficiently to determine whether results can be consistently replicated. Neither has the initiative yet been fully investigated to assess whether costs of whole population coverage, when compared with savings from improvements, make this a viable approach. These are, nevertheless, initiatives which show good promise and which should be further trialled and evaluated in the UK (comparing outcomes against a comparison group and investigating the economics of such coverage).

This type of universal prevention programme, open to all families, is often favoured because it is considered to reduce stigma for vulnerable parents and families (improving help seeking). However, in practice, making programmes available in this way has not always worked quite as planned. SureStart programmes, made available via Children's Centres in the early 2000s, had an open door policy to all parents in local communities for parenting resources and support. While this open door approach

led to good uptake of parenting support by low risk parents, engagement by high risk parents was limited. Overall evaluation results were mixed with some findings indicating that health and social inequalities had increased and outcomes and risks had deteriorated for some higher risk groups compared with comparison groups in areas without these services (Belsky, *et al.*, 2006; Eisenstadt, 2011). Learning from SureStart highlighted the importance of investing in outreach work to develop strong relationships with and engage under-served parents (Eisenstadt, 2011). Findings also led to Children's Centres being much more targeted towards parents facing higher risk factors for poor child and family outcomes.

Finally, there are some relatively low cost digital whole-population level initiatives currently under evaluation (Early Intervention Foundation, 2015). These programmes should be further researched and monitored to investigate whether they result in sustained improvements to children's mental health.

Interventions targeted at higher risk parents and infants

Research studies indicate more consistent improvements from interventions for children's mental health which target parents with known risk factors compromising children's healthy development (Early Intervention Foundation, 2015). However, although some programmes show promise, results can be somewhat mixed in terms of their ability to prevent later child mental health problems. Generally, more research is required to strengthen knowledge and the evidence base for what works as well as to understand protective factors which enable a child to thrive in the face of adversity.

Some promising interventions targeted at high risk families include:

Parent-Infant psychotherapy: targeted towards children with a history of attachment difficulties and trauma. It aims to support infant mental health through strengthening attachment and parental sensitivity. A recent review of the evidence suggested that such interventions appear promising in their ability to improve infant attachment security in high risk families (Barlow, *et al.*, 2015). Longer term research

tracking longevity of impact and knock-on effects on children's later mental health and wellbeing is required.

Infant massage: this low-cost intervention has no proven impact on infant wellbeing when targeted at all parents and infants but it shows some promise with higher risk parents (with more research advised to understand exact drivers underpinning observed changes). Two studies highlighted that infant massage showed positive impact on maternal depression but only one noted improvements in parent-infant interaction (Early Intervention Foundation, 2015).

Video feedback interventions supporting 'protective' parenting behaviours: brief video-feedback sessions with higher risk families demonstrate good success in producing improved child mental health outcomes for under 5 year olds. These programmes work through helping parents improve their interaction skills, which in turn promote child development. Parents become more skilled in interacting with their young child, experience fewer problems and gain more pleasure from their role as parent (Kersten-Alvarez, *et al.*, 2011).

Home visiting interventions supporting high risk parents: reviews of high quality evidence have suggested inconsistent results from studies tracking the impact of home visiting initiatives designed to support improved parenting with at-risk groups.

The best studied and most successful home visiting scheme has been Family Nurse Partnerships targeting teenage parents. Originally trialled and evaluated over many decades in the United States, they are now being rolled out and evaluated in the UK. These parents and their children have been identified as facing higher adversity across many different domains including higher socio-economic deprivation and poorer intergenerational outcomes (Asmussen, 2011). The intervention, built on a strong relationship with the home visiting nurse, provides intensive outreach for two years after the birth of an infant and places a high premium on engagement skills. It has impressive levels of take-up despite being voluntary, and seeks to support parents

to address multiple risk factors (including practical challenges) whilst also mobilising protective factors in the child and family's environment (e.g. promoting parent-infant sensitivity and attachments). Outcomes have been monitored in the US for this programme now for over 20 years with improvements noted not only in parental outcomes (reduced crime, reduced child abuse, reduced reliance on welfare and reduced neglect, etc) but also in child and adolescent outcomes (significantly improved high school graduations and reduced offending for daughters, improved earnings for young adult men). In order to work well, home visiting nurses receive high levels of training and ongoing supervision (Washington State Institute for Public Policy, 2015). Initial findings from a trial in the UK have so far been less positive (Robling, *et al.*, 2016); however, much of the broader positive impact and multi-sector savings in the US emerged for children and mothers over time, suggesting a priority need for longer term tracking of programme impact.

The programme is set down in a manual (although delivered reasonably flexibly) to ensure that practice remains faithful to the principles which have been observed to work. Such attention to high quality implementation has been shown by research to be vital for a number of programmes to achieve consistent results (Centre for Mental Health, 2012).

Other promising home visiting interventions are currently being piloted by the NSPCC in Glasgow, Sheffield and York and evaluated by the Anna Freud Centre. 'Minding the Baby' involves a two-year home visiting support for parents with mental health and substance misuse difficulties. It has developed a promising evidence base in the United States, improving mothers' sensitivity to their baby's feelings and needs (Olds, *et al.*, 2007). A robustly designed evaluation should provide useful data by 2018 on the programme's transferability into the UK.

Finally, NSPCC are also piloting another programme called 'Parents under Pressure' which has a promising evidence base in Australia of engaging with severe substance-misusing parents to improve parenting and infant mental health and outcomes (Dawe, *et al.*, 2003). This programme is also currently under evaluation in the UK.

Interventions which mitigate the effects of poverty

There are strong indications from a range of studies of the detrimental effect of children's exposure to ongoing deprivation. Interventions designed to address poverty occur at a variety of levels and include broader government led welfare reform and anti-poverty activity (outside the scope of this report). Research does, however, point to some child development interventions (largely trialled and tracked over time in the US) which have resulted in notable improvements to children's outcomes.

The HighScope Perry early childhood education programme was a preschool education programme targeting three to four year olds with African-American single mothers living in poverty. The study followed children up and compared their outcomes with a control group over two decades. The programme aimed to develop children's participatory learning through encouraging them to plan an activity for the day, execute their plan, review progress and then talk through what they had learnt from the activity and process with a supportive preschool practitioner. The programme was supplemented through weekly home visits by preschool staff to parents.

The 40 year follow-up revealed significant gains for those in the intervention group as well as cost savings. Girls involved in this project were 80% less likely to present with cognitive impairment in schools and nearly twice as likely to complete secondary school successfully (although rather surprisingly this did not translate into higher earnings). Boys were much less likely to be involved in crime and were more likely to earn significantly more as adults. Economists have studied this intervention in detail and noted economic returns to society more than ten times the original investment cost (Heckman, *et al.*, 2010).

It was assumed that benefits from the intervention would be related to gains in IQ. However, although IQ increased initially, gains were not sustained and did not appear central to the success of these children. Rather, improvements appeared more linked to the development of softer skills (the cluster of personality traits such as social graces, facility

with language, planning and problem solving skills, personal habits, friendliness, and optimism – commonly known as Emotional Intelligence) that are present in people to varying degrees. Not all attempts to replicate gains from this programme have been successful. Learning from later implementation attempts have suggested that, like Family Nurse Partnerships, to have the greatest impact, such programmes need to be targeted towards those in highly adverse environments rather than being universally on offer to all parents (Heckman, *et al.*, 2010).

Some parenting interventions have also been noted to protect some children despite their exposure to poverty (Kim-Cohen, *et al.*, 2004).

Supporting effective treatment of maternal mental illness

Children of mothers who have experienced poor perinatal mental health have a higher likelihood themselves of developing poor mental health. A simple way of reducing one major risk factor impacting on foetal and infant mental health and wellbeing would be through improved identification and swift support for maternal mental illness. At the present time only around half of mothers with perinatal mental illness get the help they need and very few get reliable help capable of making a difference (Bauer, *et al.*, 2014).

It is essential that poor mental health in mothers and fathers/partners during the perinatal years is monitored with problems identified swiftly through routine screening by sensitive and compassionate universal services (e.g. midwives, health visitors and GPs). Routine health checks during pregnancy and for the year after birth should ensure equal focus on mental and physical health (Khan, 2015a).

There is good evidence of a range of NICE-recommended interventions which have the best chance of improving maternal mental health (National Institute Clinical Evidence, 2014). These should be engaging and easily accessible for families. In the case of mild to moderate mental illness, this will largely involve fast track access to recommended psychological therapies; for those with more severe mental illnesses it is likely to involve access to carefully

monitored use of medication supported by specialist perinatal mental health services with an expert understanding of both child, maternal and family needs at this important time.

Mothers in extreme mental health crises should have access to mother and baby units where recovery can be supported in a psychologically informed environment designed to minimise stress, with support delivered by specialists in mother, baby and family mental health and in attachment for mother and infant.

Finally all those in routine contact with mothers experiencing mental illness should sensitively explore any disruptions in the quality of communication and attachment between mother and infant, making available compensatory support focusing on strengthening the mother-infant relationship where this is needed (National Institute Clinical Evidence, 2014). Effective intervention has the potential to make a big difference and has been shown to save considerable costs over time from reductions in later poor child mental health (Bauer, *et al.*, 2014).

Mothers experiencing perinatal mental health problems have raised concerns about the stigma they feel at ‘not being seen to cope’ when disclosing to some health professionals. They were concerned about the lack of swift access to psychological help as well as a lack of attention paid to the infant/maternal relationship and any disturbance that might have occurred following their mental health crisis. Finally, studies have highlighted a lack of reliability and consistency in provision, and in responses from professional to professional and from area to area, to poor perinatal mental health (Bauer, *et al.*, 2014; Khan, 2015a).

Investment in more consistent and evidence based care for mothers developing poor mental health, improved fast tracking to good quality help, and increased access to interventions to support infant-mother attachment and the emotional wellbeing of infants is an important first step in enhancing child mental health and preventing later mental health problems. The absence of attention to the mother-child relationship when treating poor mental health in women is a striking example of the gap between science and practice, given extensive evidence

of the negative impact of diminished maternal responsiveness on the development of young children (Phillips & Shonkoff, 2000).

Early intervention programmes for severe behavioural problems

Children’s behaviour spans a spectrum and every child at some point will present with some behavioural problems.

Behaviour is a significant communication for children and young people and can often be the primary way in which they communicate distress, stress and developmental frustration. Children who develop severe and persistent behavioural problems are at the most extreme end of the behavioural spectrum and will meet the criteria for the most common childhood mental health diagnosis – conduct disorder. Figure 3 shows the proportion of children at each part of the spectrum.

When children get stuck in patterns of challenging behaviour, it is important to take early effective action to improve their mental health and reduce the chances of them accumulating other risks because of their behaviour (a deteriorating relationship with carers, teachers and friends, school failure).

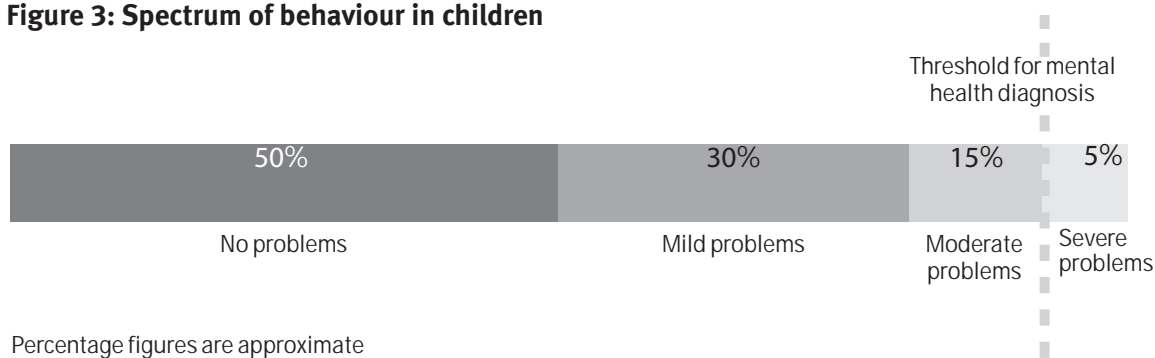
Interventions targeting children with the first signs of diagnosable mental health needs are currently more proven than programmes targeting families or children on the basis of suspected risk factors (Centre for Mental Health, 2012).

Severe and persistent behavioural problems experienced by children under the age of ten

have been identified in longitudinal studies (those following and tracking children’s outcomes into adult years) as a marker for a range of diminished life chances including reduced life expectancy, reduced educational attainment, increased risk of either victimising others or being victimised, and higher risk of almost every mental illness (Fergusson, *et al.*, 2005; Moffitt, 2006; Moffitt & Caspi, 2002). Yet during preschool years, only around 5% of children with symptoms indicative of a diagnosable condition get any help (Kataoka, *et al.*, 2002). One in six new parents approach a medical professional for advice during early months and years, mainly about excessive crying. Most do not get practical help (over and above a diagnosis of the infant experiencing colic) to help families manage prolonged infant distress and wellbeing (Kaley, *et al.*, 2011).

There is consistent high quality evidence for the effectiveness of well implemented group programmes (such as Incredible Years and Triple P level 4 and 5) in promoting positive parenting techniques and in improving children’s behavioural problems between the ages of three and 11 (Barlow, *et al.*, 2002; Centre for Mental Health, 2009; Centre for Mental Health, 2012; NICE, 2013; Parsonage, *et al.*, 2014). Improvements appear greatest for children with more severe needs (NICE, 2010). These positive parenting programmes involve praise, encouragement and affection and minimise negative communications or harsh responses. They can also reduce parental stress and improve parental mental health (Barlow, *et al.*, 2009; Stewart Brown, 2010; Lindsay, *et al.*, 2011). Finally, there are

Figure 3: Spectrum of behaviour in children



Brown, Khan and Parsonage (2012)

indications that programmes can prevent the build-up of cumulative risks over time. For example, reducing child behavioural problems can improve a parent’s relationship with and warmth towards a child and can improve a toddler’s ability to form better relationships with day care staff and with friends in nursery. They also benefit siblings (Barlow, *et al.*, 2010).

Parents who access Positive Parenting programmes generally speak very positively of their experiences and about the impact it has had on their children – although some didn’t know what to expect before they attended. Engagement is encouraged through ensuring that there are practical incentives supporting attendance (e.g. crèches, transport) backed up by good outreaching relationships with facilitators before and during the programme (Centre for Mental Health, 2012).

Parents, preschool workers and reception teachers can track children’s wellbeing and whether it has moved into unhealthy ranges from the age of three years through completion of the Strengths and Difficulties Questionnaire (Goodman, *et al.*, 2000). It has separate subscales for behavioural and emotional wellbeing. In Scotland this tool has been incorporated routinely into early years and nursery care, with well supported encouragement and links for parents from day care settings to evidence based parenting programmes, helping them strengthen protective factors around their child (NHS Education for Scotland, 2014; Renz, 2015). Outcomes are being tracked by NHS Education for Scotland.

Investment in these interventions is considered good value, producing savings of £3 for every pound invested (Parsonage, *et al.*, 2014).

Although programmes have been consistently effective in improving children’s mental health, there are insufficient studies tracking outcomes over the longer term allowing us to evaluate how long improvements last for children.

Seeking help

Studies indicate a range of barriers which deter parents from seeking early help between the ages of 0-5 years. Although mothers go through significant physical changes during pregnancy, they can often be unprepared for changes in their mental health despite the fact that pregnancy and parenthood is a significant life change and adjustment. Mothers can feel that they are failing when they are seen to be ‘not coping’ during perinatal months. They can feel guilty at feeling anything other than joy. Stigma associated with not coping has particularly been identified as an issue among African Caribbean mothers (Edge, 2009).

Mothers also fear that nothing can help them improve their mental health and there is inconsistent knowledge on the importance of maternal mental health for foetal and infant development and mental health. Not all mothers experience or are aware of disruptions to the relationship they develop with their child which is critical to stimulate neurodevelopment and buffer against toxic environmental risks. However, those that do note difficulties are unaware that there is help that can improve attachment and make a difference, and therefore do not seek help (Khan, 2014).

Finally, severe and persistent behavioural problems in children are the most common childhood mental health difficulty, yet they are at best overlooked by professionals and parents. At worst, children are seen as naughty (rather than in need or distress) preventing more positive and sensitive responses most likely to help children move back into healthy ranges. Parents describe being confused and embarrassed when their child’s behaviour is persistently challenging, often feeling that either their child or they are failing. They are also sensitive to subjecting younger children to stigmatising labels. When they do seek help, they often face professionals who don’t hear their worries or who use language and approaches which can often reinforce stigmatising feelings; many professionals are equally unaware of the significance of early starting behavioural problems, and families end up in help seeking ‘dead ends’ (Khan, 2014).

Key messages

- Good mental health and wellbeing in under five year olds is shaped very early on, right at the very first spark of life and is determined by a complex interplay between genetic make-up and exposure to risks and protective factors in the environment.
- During pregnancy, poor maternal mental health, over exposure to stress hormones and also to some substances (e.g. tobacco and alcohol) have a toxic effect on a child's brain development and later mental health.
- After birth, a healthy attachment to a care-giver helps to protect babies from adversity and stress: acting as a 'buffer' with the world outside and slowly helping infants to self-regulate in the face of frustration.
- For toddlers, positive proactive parenting (e.g. involving praise, encouragement and warmth) and the absence of harsh, rejecting and coercive parenting are associated with higher child self-esteem and social and academic competences.
- Infants and toddlers facing the highest risks for poor mental health include those whose mothers have untreated mental health problems, whose parents misuse substances, who are subject to maltreatment and neglect, and who live in prolonged poverty.
- There is a range of interventions that can help to protect mental health from pregnancy to age five. Most need to be targeted towards families who have the highest risks or children who are showing early signs of distress. They include group parenting programmes for children with behavioural problems (e.g. Triple P); home visiting programmes for parents facing high risks (such as Family Nurse Partnerships); and effective treatment for maternal mental ill health.

Chapter 4: 5-10 year olds

During middle childhood, children's developing mental health continues to be sensitive to family environmental risk and protective factors; however, during this period most children in this age group also experience daily exposure to a new and highly significant environment – school. Early educational environments have the potential to provide new nourishing and potentially protective experiences promoting a child's mental health; but they can also expose children to new risks as they venture independently into new social settings. Schools, and the tasks they require of children, can also be the context within which children's mental health or neurodevelopmental difficulties first begin to surface or become entrenched. For children who come from less than optimum home backgrounds and neighbourhoods, school environments can redress risk factors providing a turning point and compensatory protective factors (Gross, 2008).

Broadly speaking, children's mental health appears to deteriorate over time and as they accumulate risks. An analysis of longitudinal data collected on children in English primary schools pointed to a degree of unpredictability and fluctuation in levels of wellbeing experienced by children during these school years. Although most children experienced improvements in wellbeing between the ages of eight and ten, 2% of children had persistent poor wellbeing during this entire time frame. Furthermore, another 6% of children also suffered deterioration in wellbeing from previously average or higher levels (Gutman & Feinstein, 2008). Gutman and Feinstein's (2008) research noted general continuity between patterns of risk and protective factors and risky behaviours at age eight compared with age ten. For example:

- Eight year olds who talked to their teacher, liked school and expressed satisfaction with their friends were more likely to be happy with all these aspects of their school lives at age ten.
- Children who were bullied at age eight were also more likely to be bullied at age ten.

- Children with behavioural problems at age eight were more likely to persist with these patterns at age ten, talked less to their teachers, liked school less, and were less satisfied with their friendships (Gutman & Feinstein, 2008).

For a minority of children, negative experiences and behaviours appeared not only to continue but also multiplied during these years leading to cascading risks and cementing negative experiences and trajectories (Posner, *et al.*, 2000; Gutman & Feinstein, 2008).

Prevalence of mental health difficulties

Overall, around 8% of children will have a diagnosable mental health problem during middle childhood. At this stage in life, boys are more likely than girls to have a diagnosable mental health difficulty. The last national survey (2005) indicated that:

- The most common diagnosable mental health difficulty (affecting around one in 20 or 5% of children in this age group) is conduct disorder – or severe and persistent behavioural problems.
- Just over 2% of 5-10 year olds had a diagnosable anxiety-related or depressive illness (with the majority presenting with anxiety-related conditions).
- Just over 2% (again mostly boys) presented with diagnosable hyperkinetic conditions – difficulties which significantly impair attention and hyperactivity.
- Just under 2% presented with other diagnosable difficulties such as autistic spectrum conditions (1%), tic conditions (0.1%), eating disorders (0.3%) and mutism (0.1%).
- Based on parental report self-harming has historically been rare at this age (estimated to affect around 2% of children in 2004, although reliable data for this age group are lacking and there has been growing anecdotal concern about self-harming starting earlier with children being influenced by friends and siblings).

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

Broadly speaking, girls were marginally more likely to present with emotional problems (including generalised anxiety, post-traumatic stress syndrome and separation anxiety) than boys. On the other hand boys were twice as likely to present with severe behavioural problems, nearly seven times as likely to present with hyperactivity and attention-related problems and 19 times as likely to have autistic spectrum conditions (Green, *et al.*, 2005).

Conduct disorder is the most common mental health problem affecting children in this age group. The school environment can often be the first place that such difficulties gain wider attention having previously been contained within the family unit. There is robust evidence that difficulties reaching diagnosable levels before the age of secondary school significantly undermine children’s life chances across a range of domains (Fergusson, *et al.*, 2005). These children also have a higher risk of suffering from almost all adult mental illnesses (Kim-Cohen, *et al.*, 2003; Rutter, *et al.*, 2006). Half of these children will continue to face elevated risk of multiple poor outcomes without

effective early intervention (Centre for Mental Health, 2012).

A recent study noted a significant overlap between children excluded from school and those with symptoms of conduct disorder (Cole, 2015). However, the health dimensions of their behaviour can often be overlooked or inconsistently considered with proven responses used patchily to de-escalate risk (Khan, 2014; Cole, 2015). Primary school exclusions present a particularly important opportunity to use evidence based approaches to improve children’s outcomes. Over the last year we note slightly higher numbers of permanent primary school exclusions (albeit that this group will be a small sample) mainly due to aggression directed at teachers or other children (Department for Education, 2015). This trend requires ongoing monitoring as it may reflect reduced resources or tolerance in schools for supporting and managing children with conduct problems, or on the other hand, reduced access to effective interventions such as NICE-recommended early parenting programmes.

Figure 4: Poorer life chances for children with conduct disorder

NEGATIVE OUTCOMES

2 x MORE LIKELY TO LEAVE SCHOOL WITH NO QUALIFICATIONS



6 x MORE LIKELY TO DIE BEFORE AGE 30



3 x MORE LIKELY TO BECOME A TEENAGE PARENT



8 x MORE LIKELY TO BE ON THE CHILD PROTECTION REGISTER



4 x MORE LIKELY TO BE DEPENDENT ON DRUGS



20 x MORE LIKELY TO END UP IN PRISON



Parsonage *et al.*, (2014)

Between a quarter and a third of children with a diagnosable mental health condition had more than one diagnosable mental illness. In the case of conduct disorders, over half in this age group had more than one diagnosis.

Children’s mental health and wellbeing falls across a spectrum. We know a lot about the impact that conduct disorder at this young age has on children’s lives and adult life chances (Centre for Mental Health, 2009) but there is less clarity on patterns of persistence with diagnosable emotional conditions. There has also been far less research on the outcomes faced by those with difficulties falling just below clinical cut-off points who may nevertheless face considerable and ongoing challenges in their lives.

Trends over time

There has been a mixed picture emerging on the state of children’s mental health during middle childhood with no clear evidence of any strong trend.

Comparison of previous national surveys and birth cohort studies generally suggest deterioration in children’s mental health between the late 1970s and the millennium. Thereafter, at least for children in middle childhood, mental health appeared to plateau or possibly even improve. For this age group, this trend has been consistent regardless of gender and applies particularly to behavioural conditions but also in some cases to emotional problems (Green, *et al.*, 2005; Maughan, *et al.*, 2008; Bor, *et al.*, 2014; Sellers, *et al.*, 2015; Morrison Gutman, *et al.*, 2015).

Sellers (2015) compared prevalence rates of seven year olds in a number of past and current surveys and longitudinal studies. Analyses focused on children living in England, Scotland and Wales and compared parent- and teacher-completed Strengths and Difficulties Questionnaires – a tool considered to provide a reliable proxy for identifying children within clinical ranges (Goodman, *et al.*, 2000). Despite concerns and anecdotal fears of mounting distress and increased demand for services (Sourander, *et al.*, 2008), Sellers did not find increases over time in the prevalence of mental

health diagnoses in the 2008 cohort. In fact findings pointed to overall improvements in child mental health over a ten year period for almost every diagnosable condition. Reductions in symptoms were present for boys and girls, although the scale of improvement for seven year old boys was greater than for girls. A more recent study, focusing on the same cohort at the age of 11 years again revealed no overall increase in the prevalence of diagnosable conditions as they moved towards early adolescence (Morrison Gutman, *et al.*, 2015).

Sellers (2015) speculated that these possible decreases in the prevalence of primary school children’s mental health problems may be due to:

- Overall reductions in absolute family poverty and income inequality since it peaked during the late 1990s;
- Increased early intervention (e.g. understanding of perinatal issues and increased investment in early years and evidence based parenting programmes during the mid-2000s).

These observed improvements should of course be considered with caution. More good quality investigation is needed to conclude on these trends. Furthermore, improvements may not persist into adolescence and a small number of studies suggest deteriorations in mental health as children approach middle adolescence – particularly in relation to emotional problems and among girls (Collishaw, *et al.*, 2010; Sweeting, *et al.*, 2010). There is also now some indication that child poverty and income inequality may be worsening in Britain in recent years with particular impact noted on children and young people (Joseph Rowntree Foundation, 2015). The planned 2016/17 child and adolescent mental health survey will provide a more reliable and up to date analysis across time from which we will be able to draw conclusions.

Major risk factors

Risk and protective factors (both temperament-based and environmental) continue to interact during primary school years, building on children's early experiences and influencing their wellbeing. Over time, wellbeing can be shaped by carer, family structure, teachers, school context, peer groups and neighbourhood level factors in both positive and negative ways. There is a wealth of high quality evidence which suggests that if risk factors accumulate and persist over time, this can be highly detrimental to a child's mental health and wellbeing (Aguilar, *et al.*, 2000; Appleyard, *et al.*, 2005).

Children with warm and supportive relationships with parents/carers have better socio-emotional adjustment including lower levels of behavioural problems (Bronstein, *et al.*, 1996). Indeed, the quality of parenting (particularly harsh parenting and lack of supervision) accounts for 30-40% of severe and persistent poor behaviour in children (Patterson, *et al.*, 1989).

As with early childhood, studies show that some parental characteristics and circumstances have greater likelihood of compromising children's mental health than others.

Parental mental ill health

In 2008, roughly two million children in the UK were estimated to live in households where at least one parent had a mental illness (Parrott, *et al.*, 2008). Most parents with mental illness are responsive and sensitive parents and children will be unaffected by parental mental illness (SCIE, 2011). However, poor parental mental health is one of the most consistent and potent risk factors for the development and persistence of diagnosable mental health problems in children (Leinonen, *et al.*, 2003; Hosman, *et al.*, 2009). Studies suggest, for example, that between a third and two thirds of children whose parents have mental health problems will experience emotional and behavioural difficulties themselves (Social Exclusion Unit, 2004). Mothers are generally more likely to be diagnosed with poor mental health than fathers (SCIE, 2011).

The association between parental and child mental health is complex. Influences are likely to be bi-directional (e.g. parents' poor mental health affects children's mental health, but also a child's poor mental health affects a parent's mental health).

The relationship between parent and child mental health is also likely to be linked to a range of interacting biological, social and environmental factors including:

- The child's temperament;
- The impact of parental illness on family resources and stability (particularly employment or increasing exposure to poverty);
- The impact of mental illness on the quality of parental relationships;
- The extent to which parental mental illness affects their sensitivity and responsiveness, child attachment, parent-child interaction and parents' ability to buffer children from cumulative stress and adversity;
- The consistency of positive parenting.

This does not mean that those with poor mental health are poorer parents (Hosman, *et al.*, 2009). But poor parental mental health may intermittently undermine critical carer sensitivity and energy to adopt authoritative/positive parenting, with affected parents cycling between states of wellness and poor mental health (Hosman, *et al.*, 2009). Families with parents affected by mental illness are also more likely to experience poverty, unemployment and associated survival and financial stresses which we know also impact on family cohesion and child mental health (Zeanah, 2012). Poorer child outcomes may equally be linked to the cumulative impact of all of these events (Donga, *et al.*, 2004; Hillis, *et al.*, 2001) as well as straitened financial circumstances more commonly affecting those living with diagnosable conditions.

Parents reliant on drugs and alcohol

There is generally poor knowledge on the number of children living with a parent who misuses substances (Ofsted, 2013). In 2002, roughly a million children were estimated to be living in a family with a problem drinker parent

(Tunnard, 2002). Estimates also suggested that around 200,000 adults were receiving treatment for substance misuse problems, of whom one third were parents and had children living with them (Ofsted, 2013).

Studies indicate that children of parents who misuse substances are more likely to experience poorer emotional, psychiatric and behavioural outcomes (Hogan, 2003), to have a higher likelihood of reliance on substances themselves (Christensen & Bilenberg, 2000) and to face a range of other physical and educational problems (Conners, *et al.*, 2001). As with poor parental mental health, it is as yet unclear whether poorer child mental health outcomes can be isolated and attributed directly to parental substance misuse itself or are linked to other aspects of disadvantage (Fals-Stewart, *et al.*, 2004; SCIE, 2004). This requires more investigation. Research also shows, as with mental illness, that the impact of substance misuse can be mitigated by a second parent, or care by extended family involvement and early community support (Sawyer & Burton, 2012).

Maltreatment, abuse and neglect

Definitions of maltreatment generally include:

- Physical abuse;
- Sexual abuse;
- Psychological or emotional abuse;
- Neglect.

Increasingly, both witnessing and experiencing intimate-partner violence is being regarded as a form of child maltreatment.

Securing accurate data on the number of children affected by child maltreatment is challenging with most official information significantly under-recording prevalence (MacMillan, *et al.*, 2003). For example, there is generally a tenfold discrepancy between the number of children officially recorded as maltreated by child protection agencies and rates reported by victims or children (Gilbert, *et al.*, 2009). Indeed, one international study identified that only 5% of children who were physically abused and 8% of those who were sexually abused had reported contact with child protection services (MacMillan, *et al.*, 2003). Recent analysis of data collected through the Children’s Commissioner estimated that only one in eight children who had been sexually abused came to the attention of statutory agencies (Children's Commissioner, 2015). Another study indicated that even children who were in contact with child protection services reported six times more abusive experiences compared with official records (Everson, *et al.*, 2008). Most children don’t disclose sexual abuse until after the age of 18, yet most children reported initiation of abuse at around the age of nine (Children's Commissioner, 2015).

Lack of accurate data on experiences makes it particularly difficult to track trends over time. Despite these challenges, there is some indication that overall maltreatment may be slightly decreasing over time although reporting rates for some forms of abuse are rising (NSPCC, 2011). Figure 5 sets out the estimated levels of different types of abuse.

Figure 5: summary of prevalence rates for child maltreatment (adapted from Gilbert *et al.*, 2009)

Type of abuse (self-report)	Ranges identified (%)	Girls	Boys
Physical abuse	5-35	Not available	Not available
Any sexual abuse	15-30	15-30	5-15
Childhood sexual abuse (penetrative)	Not available	5-10	1-5
Non-contact sexual abuse	Not available	15-30	5-15
Neglect	6-12	Not available	Not available
Severe neglect	1-10	Not available	Not available
Psychological abuse	4-9	8-9	4
Exposure to Intimate Partner Violence	8-25	Not available	Not available

Many children will experience more than one type of abuse. Overall, girls are marginally more likely to experience overall maltreatment during childhood and they are significantly more likely to experience sexual abuse (Gilbert, *et al.*, 2009) although during early years and primary school years the number of male and female victims of abuse remain relatively equal (Children's Commissioner, 2015). Disabled children were also noted to have a significantly elevated risk of experiencing maltreatment compared with non-disabled children (31% versus 9% in one study) (Gilbert, *et al.*, 2009).

Mixed heritage children were at higher risk of experiencing maltreatment even after controlling for other risk factors for abuse and neglect, such as socio-economic deprivation (Gilbert, *et al.*, 2009).

80% or more of maltreatment is perpetrated by parents or parental guardians. In the case of sexual abuse, there is mixed evidence on the most likely perpetrators. The NSPCC found that known adults (including parents, guardians and non-resident adults such as neighbours or family friends) were the most frequently reported perpetrators of adult perpetrated contact sexual abuse (NSPCC, 2011). Gilbert *et al.* (2009) found that sexual abuse was more likely to be perpetrated by acquaintances or other relatives (Gilbert, *et al.*, 2009). Men have been noted as much more likely than women to perpetrate sexual abuse whilst women were more likely to be responsible for neglect (Sedlak, *et al.*, 2010). Parental risk factors for maltreatment have been identified as poverty, parental mental health problems, low educational achievement, parental alcohol and drug misuse and parental exposure to maltreatment as a child. Community environment has also been associated with poorer outcomes resulting from maltreatment (amplifying family and individual risk factors). Adverse features of community environment affecting children's outcomes included high crime, low social cohesion and informal mechanisms of social control (Jaffee, *et al.*, 2007).

Child maltreatment has lifelong consequences for children. Studies reveal strong associations between all experiences of maltreatment

in childhood and poorer emotional and behavioural health including anxiety, depression, post-traumatic stress, suicide, self-injury, dissociation and severe and persistent behavioural problems (Lanktree, *et al.*, 2008). Maltreatment is also linked to increased explosive anger and aggression and risk taking (use of drugs and alcohol, age inappropriate sexual behaviour and crime) (Lanktree, *et al.*, 2008; Gilbert, *et al.*, 2009; NSPCC, 2011). In 2006, the World Health Organisation (WHO) called for greater public health prominence to be given to this important risk factor affecting children's outcomes (Gilbert, *et al.*, 2009).

Longitudinal studies tell us that child maltreatment can have a very long-lasting impact on children's ability to regulate their emotions and behaviour with effects persisting into adult years. Such experiences also increase the chances of school failure, risky substance misuse and sexual behaviour, employment difficulties, lower income, obesity and criminal behaviour (Gilbert, *et al.*, 2009).

More work is needed to understand whether exposure at any one particular time in childhood is more damaging than at any other (for example, to what extent infant neurodevelopment is affected by early maltreatment and to what extent infants can recover). There is some evidence that the earlier risk is escaped, the more children benefit across a range of developmental domains (Kumsta, *et al.*, 2015). There is also evidence that exposure to ongoing, severe and cumulative maltreatment is highly detrimental to children's mental health and wellbeing with effects not only in middle childhood and adolescence (e.g. exacerbating behavioural and emotional regulation) but also linking to young adult suicide risk and adult depression (Gilbert, *et al.*, 2009).

Children experiencing prolonged and multiple abuse had higher risk of subsequent victimisation. Findings suggest that risks of victimisation ripple out and multiply during a child's life course - moving from victimisation by parents/care-givers to include abuse by perpetrators outside the home and in non-familial relationships (e.g. victimisation by bullies, sexual exploitation, intimate partner violence) (Finkelhor, 2008; Finkelhor, *et al.*,

2009). In this respect, research highlights the need to intervene early before early child mental health difficulties embed and cascade into other spheres of their life (Gilbert, *et al.*, 2009).

Domestic violence

12% of under eleven year olds have reported exposure to domestic violence or intimate partner violence (NSPCC, 2013). In reviews of research studies, partner violence was associated with child trauma, high levels of family stress and higher likelihood of children experiencing severe behavioural problems and anxiety. They were also at elevated risk of depression and alcohol use in adult years (Gilbert, *et al.*, 2009). There is some debate (and a need for further investigation) as to whether intimate partner violence on its own is responsible for poor mental health outcomes or whether effects are reliant on and amplified by exposure to other forms of maltreatment and risk factors (Gilbert, *et al.*, 2009). For example, around a third of children affected by domestic violence were also the direct victims of child physical abuse (Hamby, *et al.*, 2010).

Exposure to family breakdown, conflict and bereavement

There is also some evidence that children who have experienced family breakdown, conflict or bereavement have poorer mental health than those not exposed to these experiences (Green, 2005). For example, children living with a lone parent who had been widowed, divorced or separated had almost a twofold higher risk of experiencing diagnosable emotional difficulties; bereaved children were approximately one and a half times as likely to be diagnosed with ‘any disorder’ (Fauth, *et al.*, 2009).

Bullying

Exposure to bullying in school is a major risk affecting children’s mental health and wellbeing. Studies show that children who have been bullied have higher prevalence of poor mental health and also face a range of other persistent adverse outcomes across their life course.

Bullying often begins as children enter school and forge broader social relationships during

infant and primary school years. Prevalence rates for bullying vary considerably depending on definitions used and how questions about frequency of experiences are framed. One in three children say they have been bullied at some point in their lives and around 10-14% report longer term bullying of more than six months’ duration (World Health Organization, 2012). Between 2% and 5% of children are bullies and a similar number are both bullies and victims in childhood and adolescence (Wolke & Lereya, 2015). Current evidence suggests that rates of cyberbullying are not higher than rates of traditional bullying but this requires ongoing investigation; reports also suggest significant overlaps between the two forms of bullying (Wolke & Lereya, 2015).

Being bullied by other children is the most frequent form of abuse experienced by children – much higher than abuse by parents or other adults (Radford, *et al.*, 2013).

Studies indicate that victims of peer aggression have:

- Generally lower self-esteem than non-victims;
- Higher levels of social isolation;
- Greater risk of health problems (particularly young female victims);
- Higher rates of mental health problems.

(Kumpulainen, *et al.*, 1998; Hawker & Boulton, 2000; Wolke, *et al.*, 2001).

Children and young people also describe experiences of bullying affecting their sleep and undermining concentration, academic performance and family and social relationships. Some of those who had been cyberbullied reported higher levels of aggression and behavioural problems at school including lower attainment, reduced attendance and getting into trouble (Hamm, *et al.*, 2015).

Among girls aged 7-12, one in four in a recent survey said they had been bullied because of their appearance (25%) (Girls’ Attitudes Survey, 2014).

Evidence increasingly confirms that being a target of bullying in childhood, and particularly frequent bullying, has pervasive negative effects on children’s mental and physical health, and

social, educational and economic development which seem to persist for at least four decades (Takizawa *et al.*, 2014). In the US, based on these findings, calculations suggest that prevention of bullying could result in lifetime savings of over 1.4 million dollars per person (Masiello, *et al.*, 2012; Wolke & Lereya, 2015).

Children do not all fit into polarised categories of being either bullies or victims; some are both victims and perpetrators simultaneously (Wolke & Lereya, 2015). Indeed, many studies found that experiences of bullying and victimisation increased the probability of engagement in later bullying (Barker, *et al.*, 2008).

Children and youths who were both victims and perpetrators were noted to be much more common at primary school stage and to have far poorer life chances (Haynie, *et al.*, 2001). Bully-victims felt less safe at school, felt uncared for by teachers, had lower self-esteem, had more suicidal thoughts and later on in life had greater risk of attempting suicide (Patchin & Hinduja, 2010; Patchin & Hinduja, 2011; Patchin & Hinduja, 2012).

Although not all children who bully go on to offend, bullying during middle childhood has been noted to increase the chance of later criminal activity particularly self-reported violent offending, weapon carrying and arrests (Hinduja & Patchin, 2010; Ybarra & Mitchell, 2004). Bully perpetrators also have the highest risk of suicide during young adult and adult years (Klomek, *et al.*, 2010). These risks were quite independent of the risk that any child with early starting behavioural difficulties might have of increased offending (Fergusson, *et al.*, 2014).

Gutman and Feinstein's study (2008) tracked an incremental two-year deterioration during primary school years in the frequency with which bullies talked to their teachers, liked school and were satisfied with friendships – findings which supported the likelihood of poor behaviour worsening over time due to escalating negative experiences (Posner, *et al.*, 2000). Other studies have also pointed to bullies having low school bonding and academic competence (Haynie, *et al.*, 2001).

There is mixed evidence on the gender split of bullying and peer victimisation. Boys are

noted as more likely to be bully/victims than girls (Pellegrini & Long, 2002) and also to be involved in more face to face and direct bullying (Bongers, *et al.*, 2004; Wolke, *et al.*, 2001). Some studies indicate girls favour more indirect and psychological aggression (Salmivalli, *et al.*, 2005).

The evidence on likelihood of victimisation by gender presents a less clear picture. Boys tend to score generally higher on victimisation scales but some studies indicate no gender differences (Rose & Rudolph, 2006) and still others show the reverse is true (Veenstra, *et al.*, 2005).

Bullying historically has been noted to decrease with age (Smith, *et al.*, 2001); but findings may pre-date increased opportunities emerging through digital culture. The frequently repeated General Health Questionnaire in Schools, however, which should by now be capturing some impact of cyberbullying, does not indicate overall increases in bullying in the UK. Indeed, there is evidence that bullying (reports of ever being bullied and experiences of regular bullying) in England and Wales decreased between 2001 and 2010. In Wales experiences of regular bullying increased by 15% between 2001 and 2006 but then subsequently decreased by around 15% between 2006 and 2009/10. However, for boys in Scotland, there has been a 5% increase in bullying since 2006.

Children with disabilities or long term physical health conditions

Children with learning disabilities have been noted to face or be living with higher levels of mental health difficulties compared with those without such disabilities. They are:

- 33 times more likely to have an autistic spectrum condition;
- Eight times more likely to have attention deficit and hyperactivity condition;
- Six times more likely to have a conduct disorder;
- Four times more likely to have a diagnosable emotional mental health problem;
- Three times more likely to have psychosis as they move into adolescence/early adult years;
- Nearly two times more likely to have a depressive disorder.

(Emerson & Hatton, 2007).

Children with physical disabilities also appear more likely to experience victimisation (GirlGuiding, 2014).

Children with chronic physical health problems and disabilities are also noted to be twice as likely to have diagnosable mental health difficulties as other children (Hysing, *et al.*, 2007).

What works?

Universal programmes in schools to prevent poor child mental health

Ordinarily, programmes targeted at all children are overall less effective and cost effective than those targeted at children in higher risk groups or presenting with early symptoms. However, schools provide a rare context within which universal programmes have been noted to result in moderately sized improvements to whole child population mental health, but with particularly notable gains for higher risk children (Weare & Nind, 2011).

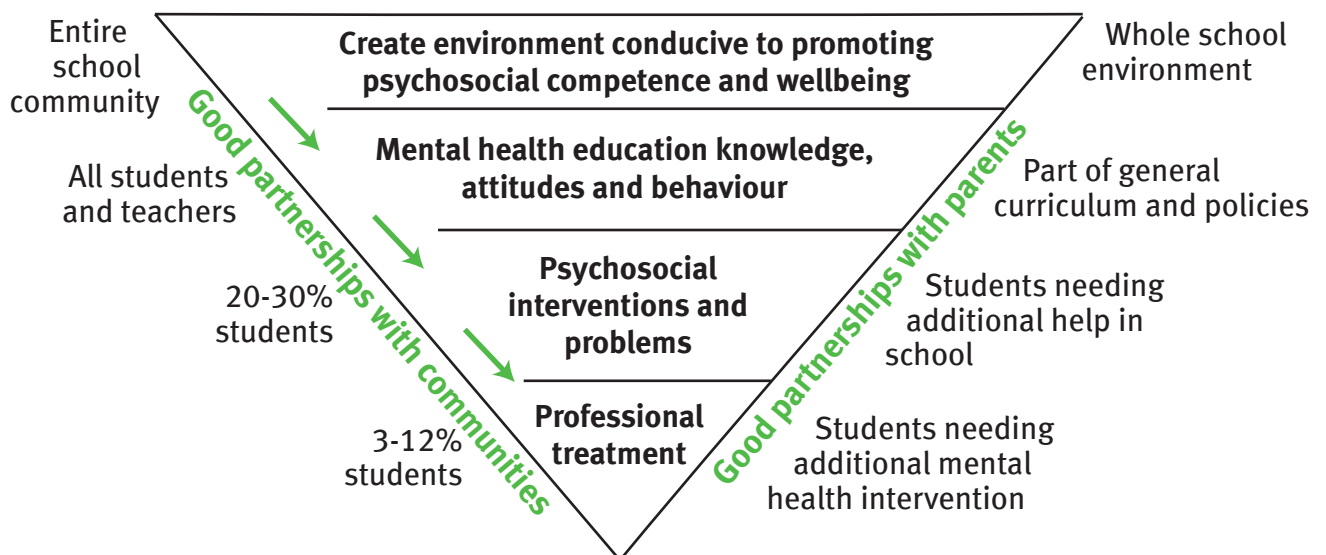
Many evidence based social and emotional learning programmes focus on improving social, emotional and academic competencies (see Figure 3), helping young people to regulate behaviour and emotions when faced with worries, frustration and setbacks. Programmes such as PATHS and the Good Behaviour Game (described opposite) appear so far to have greater proven effectiveness during primary

school years (Washington State Institute for Public Policy, 2015). Proven programmes must form part of a Whole School Approach to promoting mental health and wellbeing and should be reproduced faithfully (not adapted or dipped into). Programmes should be delivered by well trained and supervised staff (Durlak & DuPre, 2008); they often fail because of poor quality implementation or ineffective delivery. These universal programmes also work best when complemented by access to targeted programmes for those with higher needs (see Figure 6).

The World Health Organisation’s Whole School Approach (see Figure 6) sets out a framework for whole school cultural change and intervention promoting children’s mental health.

To be successful, mental health promoting and anti-bullying approaches need to be owned by all school staff, threaded throughout the curriculum and embedded in school culture. They should be backed up by policies, good links with parents and outside agencies, swift action to support wellbeing and whole school staff training and commitment to promoting children’s mental health and wellbeing (Weare & Nind, 2011). Faithful delivery of school-based programmes can be challenging for schools preoccupied with prioritising national curriculum targets, even if in the longer term they promote educational attainment (Durlak & DuPre, 2008).

Figure 6: Whole School Approach to mental health (adapted from Wyn *et al.*, 2000)



Examples of effective universal programmes supporting healthy emotional, behavioural and social wellbeing

Classroom based **Social and Emotional Learning (SEL)** programmes are noted to be effective in promoting better mental health in children and better educational outcomes, and to be cost effective (Durlak & DuPre, 2008; Knapp, *et al.*, 2011; Washington State Institute for Public Policy, 2015). To be effective they must form part of a broader Whole School commitment to promoting mental health and emotional wellbeing (Durlak & DuPre, 2008). It also takes time for the impact of such programmes to pay dividends, often with secondary schools benefitting from primary school intervention (Durlak & DuPre, 2008).

SEL programmes are designed to promote the development and application to learning of social and emotional skills that have been classified under the five domains of Goleman's (1995) model of emotional intelligence. These domains include self-awareness, self-regulation (managing feelings), motivation, empathy, and social skills. At the school level, SEL is characterised by the following principles:

- Being underpinned by clear planning focused on improving standards, behaviour and attendance;
- Building a school ethos that provides conditions to promote social and emotional skills;
- All children are provided with planned opportunities to develop social and emotional skills;
- Adults are given opportunities to enhance their own social and emotional skills;
- Staff recognise the significance of social and emotional skills to effective learning;
- Pupils who would benefit from additional support have access to small group work;
- There is a strong commitment to involving pupils in all aspects of school life;
- There is a strong commitment to working positively with parents and carers;
- The school engages well with other schools, the local community and wider services.

The **Good Behaviour Game (GBG)** is a two-year classroom management strategy targeted at six to eight year olds and designed to improve aggressive/disruptive classroom behaviour and prevent later conduct problems/antisocial behaviour. The programme, delivered to all children in this age band, costs around £100 to deliver per child but with savings now noted over time of more than £50 for each pound invested in the programme. Across a whole school population, benefits and savings could be substantial (Washington State Institute for Public Policy, 2015). Two trials of this programme are currently under way – one in England and another in the Republic of Ireland.

The **Promoting Alternative Thinking Strategies (PATHs)** curriculum is one example of an effective classroom social and emotional learning (SEL) programme. It is adapted for different age groups and can be initiated from preschool years and continues through to the age of 13. The primary school version aims to create an environment that helps young children from three to six years develop better self-control, self-esteem, emotional awareness, basic problem-solving skills, social skills, and friendships. The curriculum provides teachers with systematic, developmentally-based lessons, materials, and instructions for teaching their students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. SEL skills have been shown to improve school attainment and prevent and reduce the development of emotional and behavioural problems (Durlak & DuPre, 2008; Washington State Institute for Public Policy, 2015).

Although there is good evidence internationally about the effectiveness of these programmes in supporting improved emotional and social skills, successful results have not consistently been replicated in the UK. An attempt at national rollout and implementation in late 2000 produced very mixed results and overall had a negligible impact in terms of improving children's mental health and wellbeing. It was speculated that this lack of success in the UK was linked to excessively speedy rollout on a large scale, inconsistency and lack of quality control in the way they were implemented, lack of time to generate the required whole school culture and restricted time and resources, all of which international research has noted affect successful reproduction (Humphrey *et al.*, 2010).

A more recent evaluation by the University of Manchester also concluded that PATHS had not resulted in any immediate gains specifically in terms of educational attainment (Humphrey *et al.*, 2015). However, a report investigating broader health and wellbeing benefits from the trial is due imminently. It should also be noted that many of the benefits from these programmes do not tend to surface until later in a child's school career (Durlak & DuPre, 2008) requiring longer term follow-up which has not been planned as part of this recent PATHS trial. When implemented well, systematic evidence reviews suggest that for every pound invested, savings can be expected of around £5 (Washington State Institute for Public Policy, 2015).

Bullying interventions in schools

Overall, bullying interventions produce inconsistent results. Some anti-bullying interventions have been noted to result in at least a 30% reduction in bullying in schools (Olweus, 1994), while others have no effect or even seem to increase the amount of bullying (Farrington & Ttofi, 2009). Many school based bullying programmes have struggled consistently to produce or replicate positive results. For example, in one review of the evidence only 4 out of 10 programmes evaluated reduced bullying. Furthermore, even the most successful programme to date, the Olweus Programme developed in Norway, has

been unable to consistently replicate initial positive results (Vreeman & Carroll, 2007; Roland, 1993).

Key features increasing the likelihood of reductions in bullying include:

- That programmes should include clear and explicit guidance on how to implement and reproduce them successfully;
- That programmes should not just be stand-alone classroom level activities; rather, they should address the systemic and environmental risks related to bullying - anchored in a whole school cultural commitment (including teachers, students, support staff and parents) to developing and publicising policies, monitoring playground interactions, and addressing and reducing bullying.

(Vreeman & Carroll, 2007; Farrington & Ttofi, 2009).

More research is currently required into understanding:

- Differences and overlaps between cyberbullying and traditional bullying;
- Effective anti-bullying approaches and programmes (particularly those targeted at cyberbullying);
- Critical variations in implementation affecting programmes previously demonstrating promise.

Since bullying can often form part of a larger spectrum of conduct problems, evidence based parenting programmes may also be effective as a first port of call supporting parents of children who bully during primary school years (National Institute for Health and Care Excellence, 2013). Bully victims, who face the worst outcomes as they progress to adulthood, may also require broader assessment for underpinning risk factors such as family victimisation, maltreatment or trauma followed up with appropriate trauma-informed treatment (Duncan, 1999).

Prevention of self-harm

Self-harm is rare at this age but is generally a means to release emotional pressure when this becomes overwhelming. As such it is closely linked to difficulties in regulating emotions. Depression (commonly associated with self-harming) is rare at this age.

Effective programmes have not yet been developed to prevent self-harming behaviours in children and young people (Khan, *et al.*, 2015). There may also be concern in schools about talking about self-harm during primary school years due to some evidence of a risk of ‘contagion and mimicry’ with this type of activity. There are, however, some signs that self-harm may be increasing during teenage years (and particularly by the time young women reach mid to late adolescence) (McManus, *et al.*, 2009). Greater clarity will emerge from the planned child and adolescent psychiatric morbidity survey. Given that self-harming is distressing, highly damaging and costly, this may be an area requiring urgent continuing research and development.

If self-harming has increased, more research may be required to investigate effective interventions. There may be a particular case for longer term high quality follow-up of outcomes for children receiving Whole School SEL and counselling interventions, with particular attention paid to longer term impact on mental health and later risk of self-harming.

Evidence based parenting interventions

Although there is robust evidence of the damaging effect of early starting behavioural difficulties on children’s life chances and mental health prospects (see Figure 4 on page 27), there is also a good indication of what works to improve the mental health of these children and lower future risks. NICE-recommended positive parenting programmes (Triple P, Incredible Years or Webster Stratton, Strengthening Families, Strengthening Communities, Parent Management Training - Oregon model, Families and Schools Together etc) must be effectively implemented to have the best chance of producing positive change. For example, this means ensuring that they:

- Are targeted at families who need them;
- Are facilitated by well trained and supervised staff;
- Place a premium on keeping parents engaged.

These programmes have an excellent record of helping children move back into healthy behavioural ranges. They help improve children’s self-regulation, settle behaviour and reduce family stress through teaching positive parenting techniques. They also have a proven ability to reduce parental mental health problems. They have been successfully tested with diverse ethnic groups (National Institute for Health and Care Excellence, 2013; Centre for Mental Health, 2012).

Programmes work best when targeted at parents of children with the highest levels of need (Centre for Mental Health, 2012). There is some evidence that gains are sustained over time; however, more research is required extending the length of follow up for children and families who have benefitted from these programmes. Programmes are exceptionally good value producing savings over time of at least £3 for every pound invested. Initial savings benefit schools (who often have to employ more frontline resources to manage children with challenging behaviour). The greatest savings occur later on in the justice system. Savings also accrue for social care and for the NHS (Parsonage, *et al.*, 2014). One of the challenges with such programmes is that commissioners who benefit most do not currently invest in them.

Centre for Mental Health found that there was rarely sufficient delivery of NICE-recommended parenting provision to meet likely levels of clinical need for local children (Centre for Mental Health, 2012). Since the last audit of provision in 2010, it is also difficult to assess the extent to which continuing cuts to Local Authority provision and to Children’s Centres have further compromised availability. When such programmes are available, they are also frequently not targeted at those with the most severe needs who can benefit most from this type of help (Centre for Mental Health, 2012).

Some charities have attempted to extend the reach of such services particularly through

Troubled Families and school contracts. In Scotland, there is a major initiative to make parenting programmes more systematically available in nursery settings for children showing vulnerability. Children are routinely screened to assess their wellbeing as part of health visitor and nursery activity with encouragement to link up with support for those in clinical ranges (NHS Education for Scotland, 2014).

Individual parenting programmes

One-to-one positive parenting support programmes such as 'Helping The Non-Compliant Child' (which involves a therapist observing a parent and child through a two-way mirror and coaching the parent) are also effective despite generally higher delivery costs (Washington State Institute for Public Policy, 2015; National Institute for Health and Care Excellence, 2013). These programmes are best reserved for the small percentage of children and families who are least likely to engage with group programmes, have complex and multiple needs, and struggle most engaging with group programmes (Centre for Mental Health, 2012).

Children with attention deficit hyperactivity disorder (ADHD)

Only about a third of children diagnosed with ADHD have this condition on its own, with most of the remaining two-thirds also having some form of conduct disorder (Centre for Mental Health, 2014). For these children, NICE-recommended parenting programmes should form part of wider evidence-led approaches focusing on broader environmental risks surrounding a child (such as classroom strategies, medication etc) (National Institute for Health and Clinical Excellence, 2008; Khan, *et al.*, 2015). Behavioural Parent Training (BPT) for children with ADHD also shows some promise in supporting parents to work with teachers through developing psycho-education and behaviour management techniques (Washington State Institute for Public Policy, 2015).

Children with anxiety

Various forms of Cognitive Behavioural Therapy (CBT) have demonstrated effectiveness

in reducing anxiety in children and young people aged 7-12 years. Examples of effective programmes include Coping Cat and the Australian version Coping Koala.

CBT for anxiety is based on the idea that anxiety is a learned response that can be unlearned. It addresses problematic thoughts and behaviours related to anxiety. Strategies include understanding and managing negative thoughts, skills development, managed exposure to triggers for anxiety, role-playing, positive reinforcement and relaxation training.

Support can be delivered through group programmes involving children or alternatively involving parents. These interventions are good value and effective. Estimated savings range from £10 (for parent groups) to £30 (for child groups) for every pound invested (Washington State Institute for Public Policy, 2015).

Skills can also be delivered through one to one sessions with children or with parents (although the latter appears less effective). One to one CBT with children of this age results in improvements producing savings of around £6 for every pound invested.

The Coping Cat CBT programme has recently been piloted in the UK for children with both autism and anxiety with promising results (Washington State Institute for Public Policy, 2015).

Children with depression symptoms

Depression is rare among 5 to 10 year olds. However, a group programme targeted towards children on the cusp of this age group (aged ten and eleven) with depressive symptoms has produced strong evidence of ability to reduce symptoms. It is good value and has been shown to produce measurable savings of around £8 for every pound invested (Washington State Institute for Public Policy, 2015).

Children who have experienced trauma

Trauma can result from one event, multiple events, or a series of them. These events can cause children to see the world as dangerous and can alter their ability to function. A child may experience anxiety, fear of death, panic, powerlessness, prolonged sleep problems,

anger and deep sadness. When trauma is a result of violence perpetrated by a parent/ care-giver they trust, it becomes overwhelming and can cause a child to be in a constant state of anxiety. This, of course, interferes with the child's ability to trust or to invest in and sustain relationships.

After experiencing trauma, a child may have recurring nightmares, flashbacks, cope by avoiding things associated with the disturbing experience or may exhibit angry or challenging behaviour in the face of any stressful situation triggering a reminder.

There are currently few proven interventions for trauma in children. One intervention showing measurable improvements for children in this age group with symptoms of trauma is **Eye Movement Desensitisation and Reprocessing (EMDR)**. EMDR is effective and well supported by research evidence for treating children with symptoms accompanying Post-Traumatic Stress Disorder (PTSD) and associated feelings of guilt, anger, depression and anxiety. The goal is to reduce the long-lasting effects of distressing memories through controlled exposure and by developing more adaptive coping mechanisms. The therapy uses an eight-phase approach that includes having the child recall distressing images while receiving one of several types of alternative sensory input, such as side to side eye movements or hand tapping.

Again, these programmes show good effectiveness and cost effectiveness. They are noted to be more effective with simple rather than complex trauma suggesting that there is real benefit in intervening early before a child begins to experience an accumulation of complex adversity or before risk of multiple victimization (Washington State Institute for Public Policy, 2015).

Children with eating disorders

Although eating disorders span a spectrum, most children do not develop conditions that meet the criteria for an eating disorder until teenage years. Despite the anecdotal concern over girls developing unhealthy attitudes about body image at an earlier age than in the past, few programmes have been targeted at this age group. Universal prevention programmes have not so far been able to demonstrate effectiveness in addressing risk factors or in preventing severe problems later on (Pratt & Woolfenden, 2002). This is an area for further research and development.

Children with autism

There is generally poorer quality evidence of what works to support children and young people with autism mainly due to insufficient investment in higher quality research. There is emerging evidence that interventions focusing on social communication and developing social skills have positive outcomes for children with autistic conditions. Interventions facilitated by speech and language therapists and involving the carer/parent and child show some promise in improving social communication of young children (NICE, 2013). For young children there is also evidence that peer-mediated play sessions (where a child with autism plays with a typically developing peer) may improve social interaction with other peers (NICE, 2013). More investment is required in testing out promising programmes to see if encouraging results can be replicated consistently.

Seeking help

Most parents with a child aged 5-15 who meets the criteria for a common mental health diagnosis will seek professional help and advice for their children (Green *et al.*, 2005). This ranges from 73% for parents with a child with diagnosable emotional difficulties to 95% for a child with hyperactivity. Most will approach a teacher; the remainder GPs. A few also approach other members of their family. For most common diagnosable conditions, only around a quarter of children and young people get the help that they need (Green, *et al.*, 2005). Furthermore, one study indicates that on average there is a ten year delay between first experience of symptoms and getting help (Kessler, *et al.*, 2005) which is worrying given evidence about the critical importance of intervening early to improve chances of recovery (Patel, *et al.*, 2007; Knapp, *et al.*, 2011).

Parents whose children had emotional problems were less likely to identify that their child had a diagnosable mental health difficulty: many sought help believing that symptoms were associated with physical health, developmental or behavioural problems. Lower identification rates are assumed to be because emotional problems are more subtle in presentation and less readily observable than other conditions such as hyperactivity (Green, *et al.*, 2005).

Children with conduct problems face similar challenges getting the help they need but for different reasons. Three quarters of parents of a child with a diagnosable conduct problem approach a professional (mainly teachers or less frequently a GP) with concerns about their child's behaviour, and two thirds correctly recognised that their child might have a mental health problem. Despite this, only a quarter of children received help (Green, *et al.*, 2005).

In 2010, Centre for Mental Health investigated some of the drivers for this lack of access to appropriate and early help for children with childhood conduct problems. Many professionals and some parents tended to perceive children with behavioural difficulties as predominantly naughty rather than seeing behaviour as a communication of distress or 'need'. This prevented, or led to delays

in, accessing help. Access was not helped by some specialist CAMHS having explicit exclusion criteria for children with behavioural problems (Centre for Mental Health, 2012). There appeared an apparent reluctance in some local areas to accept that severe and persistent behavioural problems were in fact a diagnosable mental health condition in their own right even though they are our most common and life-damaging childhood mental illness (Green, *et al.*, 2005).

Finally, access was hampered by the complexity of local pathways. Many evidence based interventions for these children were not provided by specialist CAMHS but commissioned instead by local authorities. Neither parents, teachers, nurses nor GPs understood the maze-like pathways to get help and many areas lacked a clear central gateway for help when a child had worrying yet unclear needs (Khan, 2014). Furthermore, systems often felt fragmented so that if a parent got turned down by one agency there was no follow-up action to link families up with alternative sources of help. This often meant that families, children and young people found themselves ricocheting for many months around the system (Department of Health, 2015). Some of these barriers have been highlighted by the recent national CAMHS Taskforce and there is now a national ambition to improve access to services through the development of Transformation Plans (Department of Health, 2015).

Almost all parents of a child with ADHD sought professional help because they were concerned about their child's emotions, concentration or behaviour and most recognised that their child had one if not more co-existing mental health difficulties. Children with hyperactivity were most likely to receive specialist treatment through mental health services (52%) and special educational services (37%). Nearly half also accessed primary care services such as GPs, nurses and paediatricians (Green, *et al.*, 2005).

Almost all parents of children with autism approached professionals for help and a larger proportion of these children were referred on to more specialist help. For example, around half of children with autistic conditions had accessed

special educational needs services in schools or specialist mental health services. Over a third also accessed specialist physical health services such as community paediatricians (Green, *et al.*, 2005).

Eating disorders appeared rare in this age group in the 2004 survey. Because of the very small numbers of children with these conditions, there is little evidence on the extent to which they or their parents either seek or receive help.

Research priorities

Generally, there has been insufficient investment in mental health research compared with other areas of health. More research and development should be encouraged in child mental health in the following areas for this age group:

- Research and development into effective anti-bullying initiatives, self-harm prevention programmes and eating disorder prevention programmes, including good quality longitudinal tracking of outcomes for children benefitting from interventions. Research into eating disorders is increasingly pinpointing heritable risks as well as environmental risks driving the development of these illnesses. There is scope, therefore, to develop and test targeted programmes for higher risk groups in the future and evaluate the impact of programmes through longitudinal follow-up.
- There is a need for more analysis of birth cohort data unpicking those factors promoting resilience in children at risk of poor mental health (e.g. Centre for Mental Health is continuing to work with the Centre for Longitudinal Studies in this area of investigation).

Key messages

- School is a unique and critical environment touching the lives of almost all children which has the ability either to build on or redress early life experiences.
- If schools are mental health-promoting environments (adopting a whole school approach, proactively monitoring mental health and wellbeing, addressing bullying effectively, encouraging healthy relationships and school connectedness, having good links with effective local specialist support and parenting programmes, commissioning good quality counselling services and social and emotional learning programmes), they can help mobilise critical protective factors which can counter earlier experiences, reduce toxic cumulative risk and build children's resilience.
- School is one of the few settings where there are proven effective interventions targeting the entire school population which are effective in reducing children's chances of developing future mental health difficulties.
- Where schools are not psychologically informed environments (with poor management of bullying, dismissive of poorly connected/attached children, insufficient focus on children's wellbeing, poor linkage to support), children's mental health not only suffers but so does their attainment.
- Because of the length of time children spend in schools and the number of parents approaching teachers for help, these settings have considerable potential to pick up children's poor mental health early.

Chapter 5: 11-15 year olds

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.

(Adams, 2004).

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 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 7) (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).

Figure 7: 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%

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 8 and 9 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):

Figure 8: 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 9: 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

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);
- 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, 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 (YJS) 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, 2013a). 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, 2013a). 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.

Chapter 6: 16-25 year olds

Adolescence and young adult years are considered a peak age for the first onset of adult mental illness. Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24 (Kessler, *et al.*, 2005; McGorry, *et al.*, 2007). Diagnosable conditions which occur at this age produce high levels of enduring impairment which can snowball over time and increase the odds of suffering life course disadvantage – this includes school failure, unstable employment, poor family and social functioning (McGorry, *et al.*, 2007). There is now strong evidence that common mental health conditions that first emerge in adolescence have a higher chance of persistence into young adult years if not quickly treated and contained – particularly for women. For example, around half of young men and two-thirds of young women went on to have at least one further episode in young adult years after suffering an episode of adolescent diagnosable depression and anxiety. However, for those with a single episode in their teens lasting less than six months, persistence into adult years was much lower than those with longer lasting illness or recurrent episodes of ill health (Patton, *et al.*, 2014). This study points to the critical importance of containing and reducing any period of illness during adolescence through prompt and reliable early intervention and also of preventing the recurrence of episodes of illness during this important time.

Evidence suggests that 60% of disability experienced by those aged 15-34 years is caused by mental illness; as such, it represents a major burden of disease for this age group and should be a health improvement priority (Halfon, *et al.*, 2012; Whiteford, *et al.*, 2013). International evidence from high income countries also points to a broad increase in young adult psychological distress and depression during the recession between 2008 and 2011 (Collishaw, 2015) although we are currently lacking up to date data on trends over time for this age range.

The weight of evidence indicates that it is not too late for interventions to have a positive effect during teenage and young adult years; intervening early in the course of many mental illnesses can significantly reduce life-course impairment (Patel, *et al.*, 2007). Yet very few young adults get early help that has the best chance of making a difference and on average it will be 10 years after the first onset of symptoms before they access help (Kessler, *et al.*, 2005). This points to significant missed opportunities to change the trajectory of mental health outcomes and alter the life chances of vulnerable adolescents.

Services for teenagers and young adults also create gaps and involve imperfect handovers between child, adolescent and adult systems. This can result in young people losing support at a time when they face the greatest risks in terms of their wellbeing, mental health and risk taking and need the most help (McGorry, *et al.*, 2013). Furthermore, gaps in support at this time mean that services back away from young people at the time that they are also least likely proactively to seek help from services (McGorry, *et al.*, 2013).

Overall, at any one time around 20% of young people in this age band experienced a diagnosable mental illness during mid adolescence to young adult years (McManus, 2007). However, studies also suggest that around 60% of 9-21 year olds are likely to fulfil criteria for one diagnosable mental health condition at some point during this entire age range (Copeland, *et al.*, 2011).

Prevalence of mental health problems

Depression and anxiety

The adult psychiatric morbidity survey completed in 2007 indicated that 16% of young people aged 16-24 met the criteria for diagnosis with a common mental health condition such as depression and anxiety (the peak period for presentation with such conditions was between 45 and 54 years) (McManus, *et al.*, 2009). Data also highlighted that:

- Women were more likely than men to present with diagnosable common mental health conditions during this age band (21% versus 12%).
- There was little variation between males from white, black and south Asian communities; however, women from south Asian communities were noted to have a higher likelihood of presenting with a diagnosable common mental health problem (although small sample sizes made it difficult to draw reliable conclusions).
- People living in households with the lowest level of income had a higher likelihood of having a common mental health condition compared with those living in the highest income brackets (McManus, *et al.*, 2009).

Post-traumatic stress disorder (PTSD)

The overall prevalence rate for a diagnosis of PTSD among adults was 3% (McManus, *et al.*, 2009). However, it was much higher in young people and adults aged 16 to 24 years with 5% of young men and 4% of young women likely to screen positive for PTSD (McManus, *et al.*, 2009).

These high levels were attributed to evidence that young men in this age band were more likely to have exposure to violent assault, an occurrence associated with higher likelihood of developing PTSD symptoms (Nicholas, *et al.*, 2007; McManus, *et al.*, 2009).

Men and women of all ages from black communities were more likely to have experienced trauma, to have a higher likelihood of PTSD symptoms and to screen positive for current PTSD. And black men were much more likely to screen positive for PTSD than women (McManus, *et al.*, 2009). The reasons underpinning this finding were not explored but may again be related to a higher likelihood of men from BME communities living in urban

and more deprived settings with higher risk of experiencing victimisation and violent assaults. There has been no reliable breakdown of prevalence for those with migrant or refugee experiences in the last national adult psychiatric survey.

Self-harm

Reports of self-harm were highest for young people of both sexes in the 16-24 age group ranging from 9% disclosure in face-to-face responses and 12% in self-completed responses. The overall average across all age ranges was 5%. Half of those who had self-harmed also said that they had attempted suicide at some point in their life (McManus, *et al.*, 2009). Figure 11 shows the number of hospital admissions in England for self-harm among 15-19 year olds between 2011 and 2014.

Trends over time for this age group suggest that while hospital admissions for self-harm have remained largely stable for young males between 2011 and 2014, female self-harming has increased by around 30% in the same period with the largest jump occurring between 2012/13 and 2013/14.

Fewer men (35%) than women (53%) received psychological help after self-harming. In a qualitative study of this age group, young people generally talked about a ‘conspiracy of silence’ which locked them into isolated distress searching among a maze of variable sources (often online) for help (YoungMinds & Cello, 2010). They talked of experiencing high levels of stigma and wanting more open dialogue with, and less negative judgment from, family, friends, educational staff and professionals. GPs, teachers and parents also talked of having high levels of nervousness about how to open up conversations safely and support young people appropriately with addressing self-harming behaviour (YoungMinds & Cello, 2010).

Figure 11: Hospital admissions for self-harm for 15- 19 year olds between 2011 and 2014

2011-2012		2012-2013		2013-2014	
Male	Female	Male	Female	Male	Female
4,405	12,010	3,745	12,600	4,189	15,515

Suicidal thoughts

13% of 16-24 year old men and 22% of young women in the most recent national adult psychiatric morbidity survey reported suicidal thoughts with around a third reporting that they had attempted suicide at some point. Reported rates of suicidal thoughts in the last year were higher for young men and women in this age band than in any other age group during adult years (McManus, *et al.*, 2009).

Suicidal thoughts were more commonly disclosed by white men and women and least common among South East Asian men. Men were more likely than women to take their own lives. Suicide was twice as likely in households with low income compared with those in households with the highest income (McManus, *et al.*, 2009). The national suicide prevention strategy identified unemployment as a known risk factor for suicide (Department of Health, 2012).

National statistics (2016) on completed suicides in 2014 indicate that 4.2 in every 100,000 15-19 year olds and 9.2 in every 100,000 20-24 year olds took their own lives in 2014. Overall, these rates represented a very marginal increase compared with 2013 rates for both age ranges. Suicide remained much more common among young men than among young women. Although suicide rates had remained largely stable for young men when comparing trends during 2013 and 2014, rates for females in both age ranges appeared to have increased (although conclusions on trends are difficult due to the small numbers of young women affected). Suicide represented a leading cause of death for both men and women aged 20-34 in England and Wales (Office for National Statistics, 2015).

On a more positive note, young adults were the most likely of all age groups to have sought help after a suicide attempt (70% compared with 50%). There had also been a notable improvement in rates of help seeking since 2000 among young men – pointing to the significant potential to achieve improvements in help seeking among this age group (McManus, *et al.*, 2009).

Confusingly, in the 2007 national survey (McManus, *et al.*, 2009), women reported more

lifetime suicide attempts than young men (which runs counter to what we know about completed suicide events which are more common among males). The explanation offered for this contradictory finding is that men are more likely to be successful in their first suicide attempt (McManus, *et al.*, 2009).

Groups at higher risk of suicide include:

- Men;
- Those in lower income groups;
- Young people in the criminal justice system;
- LGBT young people;
- Young people with a history of self-harm;
- Young people with a history of abuse;
- Young people with untreated depression;
- Young people with a history of early conduct problems;
- Young people with a family member or peer who have died from suicide;
- Those with painful or physically disabling illnesses, including chronic pain;
- Those misusing alcohol or drugs.

(McManus, *et al.*, 2009; Department of Health, 2012).

High risk events are noted as:

- The loss of a job;
- Debt;
- Living alone, becoming socially excluded or isolated;
- Bereavement;
- Family breakdown and conflict including divorce and family mental health problems;
- Imprisonment;
- Harassment.

It can often be a combination of these factors that leads to suicide (Department of Health, 2012).

Psychosis

Psychoses represent a group of major psychiatric conditions characterised by significant disturbances and alterations in people's perceptions, thoughts, mood and behaviour. They include conditions such as schizophrenia, affective psychosis and bipolar disorder. Young people in this age band are less

likely to meet the criteria for a full diagnosis with psychosis compared with older age groups. However, this age band is the peak period for first onset of psychotic symptoms. During early onset years, symptoms are more subtle and easier to miss. However, there is good evidence that early treatment at this stage can change the severity, level of impairment experienced, likelihood of recurrence and course of the illness (Bottlender, *et al.*, 2003) (Harrigan, *et al.*, 2003). Early intervention can also prevent later crisis and costs (Knapp, *et al.*, 2011).

Some young people are at higher risk of developing psychotic illnesses. These include those:

- With a relative suffering from psychosis;
- Using cannabis during adolescence
- Who experienced certain childhood and adult adversity (such as sexual, physical, emotional abuse, bullying and neglect);
- With reduced household income;
- Living in highly urban environments;
- With migration histories.

(Arseneault, *et al.*, 2004; McManus, *et al.*, 2009).

Psychotic illnesses are more common among men in the 16-24 age group than women. Conditions are also more prevalent among men from black communities than men from white communities with black African Caribbean males being around five times more likely than average to present with the symptoms of psychosis.

Adult attention deficit hyperactivity disorder (ADHD)

ADHD was previously considered a condition solely affecting children and mostly boys. However, long term studies have shown that around one in six children will continue with symptoms impairing their day to day functioning in adult years (Faraone & Biederman, 2006; McManus, *et al.*, 2009). National surveys of adults also suggest that ADHD may be more visible among young adult women in this age group than in childhood/early adolescence (McManus, *et al.*, 2009). Symptoms are also most visible between the ages of 16 and 24 and decrease (or get easier to manage) with age.

During adult years, symptoms appear slightly different with hyperactivity decreasing but inattention, disorganization, and impulsivity affecting functioning both at home and at work. People who are 'economically inactive or unemployed' are more likely to screen positive for ADHD (McManus, *et al.*, 2009). Adult ADHD can result in failure in education and college, high job turnover, higher car accidents, increased likelihood of poor relationships and divorce and higher reliance on substances (McManus, *et al.*, 2009). Those with ADHD frequently have higher rates of other disorders including anxiety, substance misuse and personality disorders. Eight out of ten will have two other co-existing disorders, yet the same proportion of people with adult ADHD are not in contact with treatment or support services (McManus, *et al.*, 2009).

Specialist mental health services for adults with ADHD are now increasing but knowledge of what works is still emerging. For example, many ADHD medications have not yet been licensed with adults. Other recommended interventions include support for co-existing conditions and psychosocial interventions helping sufferers understand and manage the impact of their symptoms on their lifestyle thus reducing instability. Cognitive behavioural interventions and family therapy appear promising (McManus, *et al.*, 2009).

Eating disorders

Eating disorders rank among the 10 leading causes of disability among young women (Mathers, *et al.*, 2000) and anorexia nervosa has the highest mortality rate of all mental health conditions (Millar, *et al.*, 2005; Zipfel, *et al.*, 2000). There is mounting evidence of increasing demand on high cost crisis placements when young people slip into crisis as a result of eating disorders (Health and Social Care Information Centre, 2014); by the time they enter inpatient settings there is also evidence of significant impairment to their day to day lives with recovery taking longer (Pro Bono Economics & Beat, 2012).

Eating disorders exist across a spectrum. When severe and persistent, they reach the threshold for mental health diagnosis and include

conditions such as anorexia nervosa, bulimia or non-specific eating disorders (eating disorders which are severe but do not share clear common characteristics with anorexia and bulimia). Non-specific eating disorders and anorexia almost always start in teenage years and are most commonly identified in young people between the ages of 16 and 24 years. Bulimia starts slightly later (Fairbairn & Harrison, 2003; McManus *et al.*, 2009).

Eating disorders are noted as being between three and ten times more common among young women than men (Health and Social Care Information Centre, 2014). In the last adult national psychiatric morbidity survey, very severe symptoms were observed in 5% of young women and 2% of young men (McManus, *et al.*, 2009). Unlike other mental illnesses, there is much less of an association between eating disorders and low household income.

British data indicate that only two out of ten people with diagnosable level needs were receiving treatment and support (McManus, *et al.*, 2009). This is worrying as there is good evidence that conditions tend to worsen with age and that later presentation for help worsens outcomes – particularly for anorexia.

Risk factors for eating disorders include:

- Being female;
- Being adolescent or in young adult years;
- Living in a western society;
- A family history of:
 - depression
 - eating disorders
 - substance misuse
- Family discord (particularly low contact, high expectations, high conflict);
- A history of sexual abuse;
- Critical comments about body image;
- Occupational/recreational/social pressure to be thin (e.g certain sports or professions where there is pressure to self-evaluate through weight);
- Low self-esteem;
- Perfectionism (particularly for anorexia);
- Anxiety;
- Early menarche;
- Obesity (especially for bulimia).

(Fairbairn & Harrison, 2003).

Evidence increasingly points to a combination of genetic susceptibility together with exposure to environmental risk driving the development of eating disorders (Fairbairn & Harrison, 2003). However, the genetic branch of eating disorders research is in its infancy. More research is required to understand the interplay between genetics, environmental risk factors and more recently identified early neurodevelopmental risks linked to birth complications and trauma during pregnancy and childbirth.

Environmental risk factors are considered to include social norms about thinness and the importance that women pursue beauty (instead of or as well as securing interpersonal or vocational success) to affirm their sense of femininity (Rodin, *et al.*, 1985). Both the yearly Girlguiding's Girls' Attitudes Survey (covering girls and young women aged 7-21 years) and the Good Childhood Survey (collecting data on young people up until the age of 18) point to worrying increases in girls' preoccupation with appearance as well as pressures to be perfect or thin (Girls' Attitudes Survey, 2014 & 2015) in recent years.

Personality disorders

Personality disorder is an umbrella term for a range of mental health conditions. It describes a rigid and enduring pattern of personality traits which deviate markedly from those accepted in an individual's culture, which persist across a range of different contexts, which can severely impair the social, interpersonal and occupational functioning of those affected and which often cause distress to others. These patterns often start early.

Generally personality disorders can result in:

- People feeling overwhelmed by stress and negative feelings leading to unpredictability, emotional volatility (including excessive anger and sometimes intimidation), self-harming, high demands, overdosing, anxiety or substance misuse to manage emotions;
- An inability (in the case of antisocial personality disorder) to acknowledge and respect the rights and boundaries of others;
- Avoiding or prompting rejection from other people, creating social isolation;

- Difficulties feeling empathy and building stable relationships with others including families, children, peers and professionals.

Because of the lack of agreement over the definition of personality disorders, national studies often struggle to reliably identify prevalence rates. Furthermore, the label ‘personality disorder’ is controversial and not always clearly defined, often covering a series of diagnoses. Not everyone accepts their existence or their legitimacy as diagnoses. For many years, these conditions were deemed untreatable, although greater confidence has now emerged as to how people can be supported to live with and manage their conditions in the longer term.

Two examples of well-known personality disorders include antisocial personality disorder and borderline personality disorder.

Antisocial personality disorder

Antisocial personality disorder is characterized by a long-standing pattern (starting in youth) of disregard for other people’s rights, often involving violation of those rights. Those with antisocial personality disorder can present as arrogant, have unrealistic perceptions of their potential achievements and often lack empathy and remorse concerning the rights, feelings, and suffering of others. Symptoms often significantly impair the lives of those affected as well as causing damage to others, including:

- Failure to conform to social norms;
- Persistent deceitfulness;
- Impulsivity or failure to plan ahead;
- Irritability and aggressiveness, as indicated by repeated physical fights or assaults;
- Reckless disregard for safety of self or others;
- Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations.

Antisocial personality disorder (ASPD) has been identified in 1.7% of young adult men. (McManus, *et al.*, 2009). There is some evidence that these young men are more likely than average to end up in the criminal justice system and particularly in custody (Singleton, *et al.*,

1998). However, the relationship between ASPD and crime is not straightforward with broader community studies estimating that only 47% of people with the condition had significant arrest records. Instead, those with this condition often experienced histories of aggression, school failure, unemployment, unstable interpersonal relationships, and substance reliance (Robins & Regier, 1991; The National Collaborating Centre for Mental Health, 2010). Such experiences often lead to a lack of stability and experiences of multiple crises. Adults with ASPD have lower than average life expectancy, including higher levels of suicide (The National Collaborating Centre for Mental Health, 2010).

Some continuity is observed between children presenting with early starting conduct disorders (and also with severe forms of disorganised attachment associated with severe maltreatment) and the development of later ASPD (Fergusson, *et al.*, 2005; National Institute for Health and Care Excellence, 2013). Around 25-40% of children with early starting conduct disorder go on to experience ASPD during adult years (Zoccolillo, *et al.*, 1992), and indeed current diagnostic criteria for antisocial personality disorder require a conduct disorder diagnosis before the age of 15. However, diagnostic guidance advises strongly against labelling young people with a personality disorder before the age of 18 years partly because adolescence can be a period of such dramatic emotional, behavioural and neurodevelopmental change. However, neither is it helpful to children, young people, families and communities to adopt a policy of providing no support (purely watching and waiting to see what happens) when behaviours, distress and harm associated with emerging personality disorders are left to fester, impairing young people’s lives during critical years and often resulting in later damaging and expensive crises. In practice, many of the behaviours that prompt later diagnosis during young adult years have been persistent and distressing beforehand, with children, parents and victims frequently struggling to get early intervention. In these early stages of adolescence the condition is often referred to as emerging personality disorder.

Borderline personality disorder

Borderline personality disorder (BPD) is four times as likely to be diagnosed in the 18-34 age band compared with other adult age groups. It is also more commonly diagnosed in women aged 18-34 years (1.4%) as opposed to men (0.3%) (McManus, *et al.*, 2009). It is characterised by high levels of personal and emotional instability and self-destructive behaviour which seriously undermines people's ability to forge and maintain healthy relationships and achieve stability in their day to day lives (Skodol, *et al.*, 2002; McManus, *et al.*, 2009). Self-harm and suicidal behaviour is common with 60-70% attempting suicide at some point in their life and an estimated suicide rate of around 10% for those experiencing the condition (Oldham, 2006). As well as the severe impairments faced by the person affected by BPD, the diagnosis is also associated with significant financial costs to the NHS, social services and wider society. The annual cost of personality disorders to the NHS was estimated at approximately £61.2 million in 1986 (Smith, *et al.*, 1995).

Most people diagnosed with borderline personality disorder no longer meet the criteria for diagnosis five years later. There is some evidence that they get better at managing the impact of their symptoms over time. However, a small number of young people will face ongoing and serious impairment throughout their life as a result of the condition (National Institute for Health and Clinical Excellence, 2009).

Borderline personality disorder emerges from a complex interrelationship between genetic predisposition and exposure to environmental risk (National Institute for Health and Clinical Excellence, 2009). Many young people with borderline personality disorder have experienced some form of childhood trauma or serious attachment difficulty with their care-givers. Histories often include exposure to physical abuse (71%), sexual abuse (68%), parental substance misuse and witnessing serious domestic violence (62%) (Herman, *et al.*, 1989). Indeed, some have argued that BPD should be seen as a delayed form of PTSD. The unstable, non-nurturing family environment is considered a key mediator of abuse and for the development of later personality disorders (Zweig-Frank, *et al.*, 1991; Bradley, *et al.*, 2005).

Women with borderline personality disorder often take multiple pathways from early experiences of abuse and trauma towards generally unstable lives and vulnerability in society, often remaining under the radar until they slip into crisis (McNeish & Scott, 2014). Crises and vulnerability can include self-harming, substance misuse, victimisation through interpersonal violence, prostitution etc. Estimates suggest that around a fifth of women in prison fulfil criteria for borderline personality disorder (Singleton, *et al.*, 1998).

Substance misuse

Alcohol use

The most recent national survey focusing on the drinking patterns of 16-24 year olds pointed to an overall decline in alcohol consumption between 2005 and 2013 with most of the change being driven by changes in young adult behaviour (Office for National Statistics, 2013b). In 2013, young adults (aged 16 to 24) were just as likely to be teetotalers as those aged 65 and over (27%). Between 2005 and 2013 there was a rise of over 40% in the proportion of young adults who said that they did not drink alcohol at all. In contrast, when young adults did drink they remained the most likely group to have binged. Four out of ten young adults who drank alcohol in the week before interview exceeded eight units for men and six units for women on at least one day. Women were more likely to be teetotalers than men although the steepest rise in teetotal behaviour had been among men in this age group (Office for National Statistics, 2013b).

Drug use

Young people aged 16 to 24 years were the most likely age group to have used an illegal drug in the last year with around 19% reporting use. This is more than double the average rate of use among all other age bands. Between 2012/13 and 2013/14 there had been an increase of roughly 3% in the numbers of young people reporting using drugs in the last year. There was also a slight increase in frequent drug use. However, these figures were both lower than in 1996. Overall, cocaine, ecstasy, LSD and ketamine use had increased between 2012/13

and 2013/14. Levels of use of any illicit drug more than once a month on average in the last year were higher among men than women, among those who went to pubs or nightclubs more often and among those who lived in more deprived areas (Office for National Statistics, 2013).

The number of drug related deaths by poisoning had marginally decreased for under 20 year olds (from 53 to 46) and remained largely stable for 20 to 29 year olds (from 413 to 415) compared with the previous year. There had been a fourfold reduction in drug related deaths for under 20 year olds since the late 1990s and a halving of rates for those aged 20-29 years whereas drug related deaths in older age groups were continuing to rise (Office for National Statistics, 2014).

What works?

Depression and anxiety

Common mental health conditions such as depression and anxiety should be managed through a process of good quality initial assessment to determine risks, and through stepped care. Evidence suggests that less complex conditions, where risk of harm is low, can be supported through evidence-based psychological therapies provided through Improving Access to Psychological Therapies (IAPT) services (now available from 16 years onwards), self-help CBT support, physical activity groups (in the case of depression) or group and individual CBT. Young people in this age range are often less happy to approach highly 'clinical feeling services' (DH, 2015). They may, therefore, favour seeking psychological support and counselling from Youth Information Advocacy and Counselling services (YIACs) as highlighted by the recent CAMHS Taskforce Review (Department of Health, 2015).

For young people with more persistent or severe problems, more intensive CBT and/or medication (for over 18 year olds) should be available. Referral to specialist mental health services would normally be for young people with depression who are at significant risk of self-harm, have psychotic symptoms, require complex multi-professional care, or where an

expert opinion on treatment and management is needed (National Institute for Health and Care Excellence, 2005; National Institute for Health and Care Excellence, 2009; National Institute for Health and Care Excellence, 2013; National Institute for Health and Care Excellence, 2014).

Post-traumatic stress disorder

As for under-16 year olds, Eye Movement Desensitisation Therapy and trauma focused CBT is effective for teenagers and young adults (Washington State Institute for Public Policy, 2015). A meta-analysis of studies also points to the effectiveness and good value of PTSD Prevention Following Trauma – an intervention which is delivered in the first weeks and months after a trauma, before a diagnosis of PTSD can be made. Interventions involve five to ten hours of individual therapy combining education on effects of trauma, relaxation, and exposure (Washington State Institute for Public Policy, 2015).

The last adult survey indicated that just under 30% of those screening positive with PTSD were in receipt of treatment – however, most were receiving medication rather than interventions likely to promote recovery (McManus, *et al.*, 2009).

Suicide prevention

More research and development are needed to establish effective preventative initiatives and treatment for young people at risk of suicide. Depression is one of the most important risk factors for suicide. Early identification followed by prompt, compassionate and effective treatment of depression is particularly important and has a major role to play in preventing suicide across the whole population (Department of Health, 2012). Reducing reliance on substances is also critical. Good crisis management plans should involve families and should facilitate swift access to crisis care in the event of any escalation of poor mental health (Department of Health, 2012).

Multi agency post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, and health and care settings (Department of Health, 2012).

Men are much more likely to hide emotional problems and avoid seeking help for emotional distress than young women (Rickwood, *et al.*, 2007). They are also much less likely to approach primary care services (Department of Health, 2012). This presents a major challenge when seeking to prevent suicide. Supporting wider awareness in non-clinical settings among those in contact with young men (for example in educational, employment or job centre settings and through raising awareness in friends and partners) or encouraging more creative and more male-friendly ways of accessing help is an important developmental piece of work.

Psychosis

Early identification continues to be important at this early adult stage. Effective early intervention approaches involve medication but also holistic care from multi-disciplinary teams supporting broader psychosocial recovery (Knapp, *et al.*, 2011). For those recovering from psychosis, placement in employment backed up by specialist mental health support during this transitional adjustment (Individual Placement and Support schemes) has also proved to have a positive effect on people's mental health as well as representing good value for money (Washington State Institute for Public Policy, 2015).

Borderline personality disorder

The core effective principles of working with young people with borderline personality disorder include:

- Placing a premium on flexible engagement and developing an optimistic and trusting relationship;
- Adopting a multi-disciplinary approach to supporting the young person according to their needs;
- Working in partnership with young people; supporting them actively to problem solve, find solutions and co-create crisis management, recovery, multi-agency and holistic plans;
- Paying especial attention to managing transitions and endings in relationships carefully; this includes transitions from

youth to adult services as well as internal changes in support workers and exit planning.

(National Institute for Health and Clinical Excellence, 2009).

A number of treatment interventions show early stage promise for people with BPD including:

Dialectical Behaviour Therapy (DBT) is a NICE-guidance recommended cognitive behavioural therapy-based intervention for those with BPD at particular risk of self-harm (Dimeff & Linehan, 2001). It seeks to reduce the incidence of unwanted behaviours and improve regulation of emotions. It includes mindfulness skills, taken from Buddhist meditation practice. DBT has also been extensively researched and has a proven efficacy.

Mentalisation-based treatment and related approaches were developed by the Anna Freud Centre and are informed by early attachment theory recognising how problems experienced in relationships with carers in infancy and childhood can over stimulate neural stress responses with long lasting effects on people's destructive and self-destructive behaviours, and their ability to regulate their mood and emotions. Strong relationships with workers aim to help those affected improve the quality of their relationships and their understanding of other people's internal states and feelings, work towards life goals and help regulate responses in the face of negative responses and stress. It has been evaluated and is demonstrating promising early results (National Institute for Health and Clinical Excellence, 2009; Durcan, 2015).

Adolescent Mentalisation-Based Integrative Treatment (AMBIT) is an adolescent version recognising the particular challenges faced by young people with conduct and emerging personality disorders in vulnerable groups who have often accumulated multiple challenges across the life course. Rather than offering a health clinic-based approach (unpopular with this group and resulting in low engagement with support) it seeks to skill up workers in day to day contact with these young people (youth offending workers, probation, youth workers, substance misuse workers) to deliver mentalisation-based approaches providing

background supervision and consultation and, if things get stuck and if the young person agrees, three way problem solving sessions involving a consultant therapist (Durcan, 2015).

Structured Clinical Management (SCM) involves regular counselling sessions, practical support, advocacy and case management. Like MBT it has been shown to be effective with people diagnosed with BPD. It has been evaluated and is demonstrating promising early results (Durcan, 2015).

Multi Systemic Therapy and Functional Family Therapy (MST), for those under the age of 18 years meeting the criteria for conduct disorder and with emerging personality disorder, is an intensive in-home programme aimed at families with children and young people aged 12-17. It seeks to empower parents with the skills and resources needed to address the difficulties that arise in raising teenagers and to empower young people to cope with family, peer, school and neighbourhood problems. Functional Family Therapy is a family intervention targeting young people aged 11-18 years at risk of entering youth justice settings. It assesses the behaviours in families which sustain problematic behaviours, supports more effective family negotiation and communication, and helps families set clear boundaries and skills.

Antisocial personality disorder

The evidence for treatment of antisocial personality disorder in adult life remains limited, outcomes of interventions are modest (NICE, 2010) and the work can be challenging for practitioners. There is emerging evidence for a multi-agency approach with practitioners supported via local expert networks and focusing on helping young people manage the knock-on effects of their condition to maintain stability. Effective management of and work with young people with antisocial personality disorder includes the following activities:

- Developing an optimistic and trusting relationship;
- Good quality assessment by staff specifically trained in managing risk and supporting people with ASPD;

- Paying attention to frequently missed secondary mental health conditions and ensuring access to proven interventions;
- Delivering group based cognitive behavioural interventions which address impulsivity, interpersonal difficulties and antisocial behaviours;
- Using approaches which incentivise improvements in substance use through positive rewards and reinforcement (contingency management approaches);
- Good quality supervision and consultation for staff supported by regional forensic expert networks;
- Brokering multi agency care;
- Ensuring that there is effective continuity of support (placing a premium on effective handover and transitional engagement).

The most effective interventions, however, are those offered at an earlier stage to help children and young people with conduct disorders, such as Functional Family Therapy, Multisystemic Therapy and (for younger children) teaching parents positive parenting techniques (Khan, *et al.*, 2015; National Institute for Health and Care Excellence, 2013).

People with ASPD are small in number and easy for local commissioners to overlook when considering the broader local population's requirements. However, when people with personality disorders escalate into crisis the costs can be very high. But because these costs are poorly tracked and affect multiple agencies, intensive projects seeking to reduce people's chances of escalating into crisis often receive inconsistent funding particularly when budgets are under pressure.

Eating disorders

The evidence base for what works to reduce the risk of young people developing eating disorders and for intervening early remains in its infancy. In particular, interventions seeking to prevent the development of eating disorders have shown very inconsistent results. At best some programmes have been able to demonstrate a positive impact on reducing risky attitudes associated with eating disorders; however, it has not been possible to track

whether interventions actually have any knock-on effect to prevent later high risk behaviour. This is mainly because programmes have been targeted at universal female populations (Pratt & Woolfenden, 2002). As we understand more about groups at higher genetic risk for eating disorders, there may be some benefit in targeting and evaluating the impact of interventions more specifically for those at greater risk.

Family Therapy, particularly the Maudsley Family Therapy approach, appears the most promising intervention for adolescents with a diagnosable eating disorder (National Institute for Health and Care Excellence, 2004b). Despite a recent review of the evidence generally pointing to no notable improvements at the immediate conclusion of family-based therapy, moderate improvements in recovery did emerge six months after treatment had concluded compared with comparison groups (Couturier, *et al.*, 2013). More research is required to develop the reliability of this intervention with longer term follow up.

Self-help resources and CBT delivered over six months are considered effective for adults with bulimia with an adapted version recommended for under 16 year olds (National Institute for Health and Care Excellence, 2004b).

Given the significant impairment that often follows the development of a diagnosable eating disorder, more research is required to understand who may be at greater genetic risk of developing disorders. This research needs to go hand in hand with efforts to develop and test out preventative programmes with higher risk groups.

Groups at higher risk of poor mental health

Some young people in this age band face higher risk of poor mental health compared with their peers.

Care leavers

Every year around 10,000 16-18 year olds leave foster or residential care in England. Local authorities must support care leavers until they are 21 years old (or 25 if they are in education or training).

Young people in care have often had difficult lives. Without comprehensive wraparound support they can face greater likelihood of multiple poor outcomes as adults. For example:

- 62% of care leavers were originally taken into care because of neglect or abuse.
- Only half of children in care have emotional health and behaviour that is considered normal and this has changed little in recent years.
- Care leavers are five times more likely to self-harm in adult years (National Audit Office, 2015).
- 25% of those who are homeless have been in care at some point in their lives.
- 22% of female care leavers became teenage parents.
- 49% of young men under the age of 21 who had come into contact with the criminal justice system had a care experience.
- In 2013-14, 41% of 19 year old care leavers were not in education, employment or training (NEET) compared with 15% for all 19 year olds.
- Only 6% of care leavers were in higher education compared with one-third of all 19 year olds.

(National Audit Office, 2015).

Despite facing greater life challenges than young people who have not been in care, care leavers often failed to get the support they needed to help them negotiate critical transitions to adult independence. For example, while half of young people in the UK were living

with their parents at the age of 22 in 2013, a third of young people aged 16 or over left care before their 18th birthday. Many care leavers felt that they left care too early despite the introduction of legislation supporting continued support up until the age of 21. Care leavers also wanted:

- Support from personal advisors up to the age of 25, whether or not they are in education or training;
- More support for those in prison;
- Better housing, employment training and financial support;
- More access to apprenticeships for care leavers.

(The Care Leavers' Association, 2013).

Young people not in employment, education and training

The most recent Youth Index 2015 (The Prince's Trust Macquarie, 2015) highlights that young people not in employment, education and training have poorer wellbeing than other young people in this age band. The survey also suggested that young people's confidence in the future (often linked to employment and the

successful adoption of adult responsibilities) was at its lowest point for seven years. Furthermore, a University and College Union study (2014) found that:

- A third of young people not in education, employment or training had suffered from depression.
- Young people out of work and training also had higher levels of anxiety than other young people in employment.
- Nine out of ten wanted to work or be in education or training but a third felt they had 'no chance' of ever getting a job and 40% felt that they had 'no part in society'.
- 37% rarely left their home.
- More than 70% said that with the right support they could contribute a lot to the country although they needed advice and support about their options and help to boost their confidence.

(Simmons, *et al.*, 2014).

Furthermore, the most recent Joseph Rowntree Foundation (2015) poverty report noted that families with children, as well as young people and young adults, were most likely to have been affected by recent housing benefit, housing

Transitions between child and adult services

Young people and young adults are at most risk of developing mental illness at the point when they are most likely to experience multiple gaps and a lack of continuity between youth and adult mental health and social care systems (Department of Health, 2009; McGorry, *et al.*, 2013).

For young men, adolescent years are also the time when they are least likely to approach services and acknowledge vulnerabilities (Chandra & Minkovitz, 2007). One study tracking people from child mental health services to adult services noted that up to a third of teenagers are lost from care during transition and a further third experience an interruption in their care (Singh, *et al.*, 2010). In many cases, adult mental health services were not vigilant in looking for, or being responsive to, the less clear cut, more subtle and less crisis orientated emerging mental health problems synonymous with young adults' needs. This is worrying given that there is still good evidence at this age of the benefits of intervention during the very early stages of presentation with early symptoms.

Better designed services and commissioning systems which minimise service gaps at this crucial time are urgently required and are now being piloted in some local areas (e.g. Birmingham and Norfolk & Suffolk). Youth Information, Advice and Counselling Services (YIACS), provided by the voluntary sector (e.g. Youth Access) also seek to straddle gaps in transitional mental health care in local health and social care services (Department of Health, 2015).

market and welfare changes. Although marginal overall increases in poverty were noted in the UK over the last year, this younger age group was thought to be facing significantly more straitened financial circumstances increasing their social exclusion (Joseph Rowntree Foundation, 2015).

Young adults in the criminal justice system

The peak years both for developing mental illnesses and for offending span mid-adolescence to the mid-twenties (McGorry, *et al.*, 2013; Centre for Mental Health, 2014). Adolescents and young adults in the criminal justice system have poorer mental health than other age groups who offend (Singleton, *et al.*, 1998).

Nearly all young adults in the criminal justice system face multiple social, educational, psychological, health and economic challenges (Social Exclusion Unit, 2002). Many have experienced cumulative social and psychological stress and adversity, maltreatment, violence, trauma and poor attachments with parents and carers (Bretherton, 1992; Revolving Doors Agency, 2010).

From the age of 16 onwards, these young people face multiple transitions, disrupted support worker attachments and many barriers which prevent successful rehabilitation, undermine recovery from poor mental health and hamper independent living (Centre for Mental Health, 2014).

In terms of their mental health:

- Nine out of ten young people in custody have been found to suffer from a diagnosable mental health condition and eight out of ten suffer from at least two (Singleton, *et al.*, 1998).
- Young adults in custody aged 18 to 20 account for 18% of all self-harm incidents although they represent 9% of the population in custody (Ministry of Justice, 2013).
- 52% of newly sentenced prisoners were permanently excluded from school (Stewart, 2008).

- 40% of young women in custody and 25% of imprisoned young men reported having suffered violence in the home (Stuart & Baines, 2004).
- 29% of young women in custody reported having been sexually abused in childhood (Farrant, 2001).
- A quarter of young adults thought they would leave prison with a drug problem (HM Chief Inspector of Prisons for England and Wales, 2011).
- Fewer than half of young people in custody knew where to get help with accommodation, drug treatment or continuing education when they left prison (Centre for Mental Health, 2014).

Criminal justice systems tend to be organised around the needs of predominantly male offender populations rather than catering for the needs of females. Yet females in the criminal justice system have been noted to have more severe and broad ranging vulnerabilities with backgrounds frequently characterised by trauma (Scott and McNeish, 2014).

Homelessness and social housing

Over half of all people seeking help with homelessness are under 25 years old. However, official figures only capture a fraction of actual need with many young people temporarily staying in other people's homes, in insecure settings or living rough. In 2011, the University of York published an estimate of the scale of youth homelessness in the United Kingdom (based on 2008/9 data) which was felt to amount to roughly 80,000 16-24 year olds (Quilgars, *et al.*, 2008). Although estimated rates of youth homelessness decreased nationally between 2006 and 2009, improvements have not been sustained since and there is some indication that rates have been rising since the last estimate in 2013 (Platts, 2015). For example, in the last four years the number of young people sleeping rough in London has more than doubled (CHAIN, 2014). Recent changes to benefit allowances and shortages of affordable housing for young single people have particularly affected younger people.

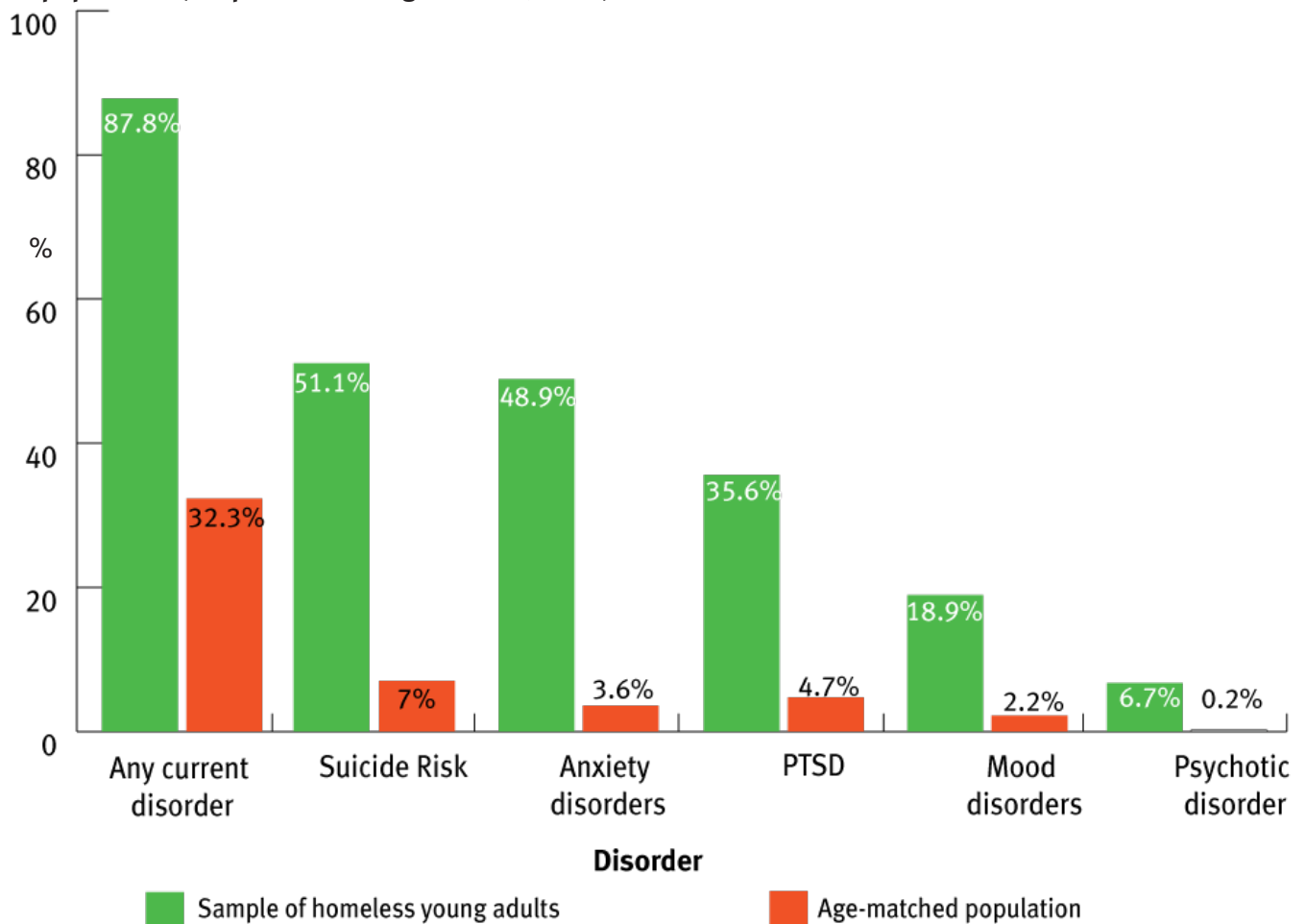
Homelessness is highly stressful. Studies generally show large variations in the proportion of homeless people who have mental health problems. However, most studies indicate that homeless young people have much greater likelihood of suffering from mental illness compared with other young people (see Figure 12) (Hodgson *et al.*, 2014). Studies also suggest that between four and nine out of ten young homeless people meet the criteria for a diagnosis (Hodgson, *et al.*, 2013). Mental health problems sometimes precipitated young people’s homelessness; but homelessness also undermined mental health and wellbeing. Homeless young people were also more likely to be reliant on substances (Hodgson, *et al.*, 2013).

One study also noted that only 30% of homeless young people had accessed any form of mental health service and only 10% accessed substance misuse services. This was despite two thirds having visited their GP in the three months prior to one survey and a quarter having been to A&E (Hodgson, *et al.*, 2013).

Overall one in five young people who became homeless had been forced to leave their family home (CHAIN, 2014). The risk of becoming homeless was greatest for those who had experienced multiple disadvantage including disrupted family background, trauma, violence in the home, institutional history, poor socio-economic status and poor health (Social Exclusion Unit, 2004). Young women were more likely to declare themselves as being statutorily homeless and were also more likely to be homeless as a result of physical or mental illness or after fleeing violent relationships. Young men were less likely to be declared statutorily homeless and more likely to cite relationship breakdown, substance misuse and leaving an institution such as care, prison or hospital as a trigger for homelessness (Quilgars, *et al.*, 2008).

Among those facing greater risk of homelessness are care leavers, drug and alcohol users, asylum seekers and refugees, and lesbian, gay, bisexual or transgender (LGBT) people. In a survey of 16-22 year olds who were

Figure 12: Prevalence of psychiatric disorders among homeless people compared with the general population (adapted from Hodgson *et al.*, 2014)



LGBT one third became homeless because of non-acceptance by their family. Often the full extent of their need was ‘invisible’ in homeless settings due to insufficiently sensitive screening for sexuality (Dunne, *et al.*, 2002).

Trusting relationships with key staff who supported access to resources which facilitate independent living and skills was identified as important for homeless young people (Quilgars, *et al.*, 2008). However, those providing services for homeless young people talked of low confidence in providing basic emotional support for young people within the generic housing and homelessness sector, and struggles in accessing specialist mental health support due to waiting times or gaps between child and adult services. A lack of integration between services also meant that many young people fell through the gaps between multiple sectors and between child and adult services.

There are significant gaps in knowledge of what works well for young homeless people (Quilgars, *et al.*, 2008). There is generally considered to be insufficient investment in pre-crisis prevention activities such as conflict resolution or parenting initiatives. Inadequate emergency accommodation and affordable ‘move-on’ housing are often lacking. Even when available, emotional and practical support may be poorly coordinated. Evidence suggests that young people experiencing homelessness need high quality relationships with a significant adult, support from ‘floating workers’ offering life skills, tenancy management/budgeting skills and opportunities to access employment to support recovery (Mental Health Foundation, 2006; Quilgars, *et al.*, 2008). There may also be some benefit in testing out with young people a promising approach known as ‘Housing First’ which is beginning to show positive results with adults with poor mental health (Boardman, 2016). Housing First sees stable accommodation both as an essential human right and as a core health intervention. The consistent principles of the Housing First model also include:

- Providing immediate housing without the need to go through a series of intermediary stages to prove ‘housing readiness’;
- An emphasis on choice and on permanent housing;

- Providing access to flexible, respectful, voluntary, person-centred and open-ended support as part of the core offer. (Boardman, 2016).

Finally, there is some indication from research tracking trends in child and adolescent mental health over time of increasingly powerful links between adolescent emotional difficulties and living in social housing. The association between family poverty (and to a lesser extent neighbourhood poverty) and child/youth mental health is strong (Huston, *et al.*, 2003; Akee, *et al.*, 2010; Morrison Gutman, *et al.*, 2015). Observed increases in emotional problems among adolescents living in social housing were thought to be related to higher rates of exposure to environmental stress and adverse events; increased maternal distress and family stress; and income inequality among those without opportunities for social mobility (Langton, *et al.*, 2011). Some Arm’s Length Management Organisations have recognised these higher needs and the benefits to landlords of supporting child and parental mental health (Centre for Mental Health, 2012).

Young people in the Armed Forces

Young people in the Armed Forces community experience mental health problems at broadly the same rate of prevalence as other groups. They are most likely to experience depression, anxiety and particularly alcohol misuse problems (Fear, *et al.*, 2009; Iversen, *et al.*, 2009). Recently there has been greater focus on the prevalence of post-traumatic stress disorder (PTSD) among UK military personnel, although prevalence rates among those returning from Iraq appear relatively low (between 4–6% compared with 8–15% experienced by US counterparts) and are broadly comparable with community rates. Similar rates of mental illness are also found between ex-Service personnel and their still serving equivalents (Sundin, *et al.*, 2010).

However, some particular patterns, problems and challenges are noted in the literature outlining the particular experiences of those with mental health needs in the Armed Forces community and their patterns of access to mental health interventions.

Based on a comparison involving small samples, overall UK veterans appear no more likely than non-veterans to have mental health difficulties (Iversen, *et al.*, 2010; Iverson, *et al.*, 2011). However, female veterans in one study appeared more likely to present with suicidal thoughts and male veterans were more likely to present with violent behaviours than non-veterans (Woodhead, *et al.*, 2011). Relative to other service personnel, the following groups have been identified with poorer mental health in the Armed Services community:

- Early service leavers;
- Those deployed to Iraq or Afghanistan with pre-Service vulnerabilities;
- Those exposed to high levels of combat in Iraq or Afghanistan;
- Reservists;
- Younger male ex-Service personnel (under the age of 24 years); this age group has higher rates of suicide than their general population equivalent.

(Iversen, *et al.*, 2009; Fear, *et al.*, 2010; Harvey, *et al.*, 2011; Buckman, *et al.*, 2012; Woodhead, *et al.*, 2011a; Woodhead, *et al.*, 2011b).

Early service leavers have been particularly noted to have poorer mental health than others in the Armed Forces (Buckman, *et al.*, 2013). There was evidence that common mental health problems, PTSD, fatigue and multiple physical symptoms were more prevalent compared with other veterans after adjusting for other influential variables. Early Service Leavers were also more likely to be younger, female and to have higher rates of exposure to childhood adversity (Buckman, *et al.*, 2013).

Having mental health problems is also acknowledged as a recognised risk factor for leaving service early. Military personnel with mental health problems are more likely to leave service compared with those with no problems or with physical health problems, and are at risk of poorer post-service outcomes (Garvey Wilson, *et al.*, 2009; Fear, *et al.*, 2009; Buckman, *et al.*, 2013).

In terms of stigma and seeking help there is evidence that:

- Armed Service personnel do not always know where to go (Iverson, *et al.*, 2011).
- Stigma and lack of trust or confidence in providers of mental health services represent significant barriers to seeking help in serving personnel (Britt, 2000; Langston, *et al.*, 2007; Rona, *et al.*, 2004; Greene-Shortridge, *et al.*, 2007). For example, admitting a psychological problem was experienced as much more stigmatising than admitting a physical health problem among soldiers returning from Bosnia (Britt, 2000). Some stigma has been associated with a reluctance to disclose vulnerability in a profession which sets great store by physical and psychological resilience in the face of adversity. Some stigma is also linked to fears of being blamed by their employer and that disclosure may have a negative impact on careers (Britt, 2000; Langston, *et al.*, 2007; Iverson, *et al.*, 2011).
- There are mixed findings regarding the likelihood of those in the Armed Services seeking help. One study noted an overall treatment rate of 13% for a sample of UK Armed Forces personnel, around half that found for the general population (Iversen, *et al.*, 2010). However, other studies indicated that serving personnel and veterans were no less likely to seek help than non-veterans, although there were some indications of personnel delaying seeking appropriate help and treatment thereby reducing opportunities for early intervention and better recovery (Iversen, *et al.*, 2010; Iverson, *et al.*, 2011; Woodhead, *et al.*, 2011a). Just under a quarter (23%) of personnel with alcohol problems had sought professional help, compared with 50% among those suffering with depression and anxiety (Iversen, *et al.*, 2010). Common treatments included medication and counselling/psychotherapy (Iversen, *et al.*, 2010).
- When Armed Forces personnel with a mental health problem seek help, there is evidence that they prefer informal support through a spouse or friend (between 73–85%). Regulars and Reservists did not differ in their help-seeking behaviours.

BME young people

There is longstanding evidence of persistent mental health inequalities affecting young adults and adults from some BME communities (Keating, *et al.*, 2002; Street, *et al.*, 2005; Afiya Trust, 2011) – particularly young African Caribbean men. This is despite cross cultural prevalence studies suggesting that rates and patterns of diagnosable mental health problems are broadly comparable and stable across different ethnic groups and evidence that children largely start on a level playing field in terms of their mental health (Weisz, *et al.*, 1997). In the past, poor quality prevalence data on BME children and adolescents has hindered understanding of mental health trends among these populations over time – sample sizes for national prevalence studies have been too small to draw reliable conclusions (Green, 2005). A recent analysis of eleven year old children in the Millennium Cohort (which oversampled those from BME communities) sheds some light on patterns of mental health over time indicating that at this age, white boys and mixed heritage young people are most likely to present with diagnosable difficulties closely followed by boys classified as black. For girls, those classified as being of mixed heritage were most likely to present with a diagnosable difficulty. Indian boys and girls were least likely to have diagnosable difficulties (Morrison and Gutman, 2015).

However, by the time children from some UK BME communities reach adult years, sizeable increases can be observed in prevalence of some mental health diagnoses (particularly PTSD and psychosis diagnosis rates), in the severity and length of mental illness and in the way that formal mental health and other systems respond to those from some BME communities compared to white British counterparts (Keating, *et al.*, 2002; McManus, *et al.*, 2009). Despite lower rates of diagnosable conduct disorder than white adolescent males, they were also much more likely during teenage years to be over represented among higher risk populations (e.g. in local authority care settings, those excluded from school or in the youth justice system) and to access mental health care through criminal justice pathways rather than via primary healthcare (Keating, *et al.*, 2002; Afiya Trust, 2011).

The drivers for these persistent inequalities remain the subject of ongoing debate and are attributed to a medley of factors including greater exposure to persistent economic deprivation, social exclusion, institutional racism, misinterpretation of cultural differences and social cues, cultural insensitivities, poor design of mental health services, high stigma and fear preventing early intervention and leading to greater likelihood of presenting in crisis (Keating, *et al.*, 2002; Afiya Trust, 2011).

Over the years, many initiatives have attempted to drive changes in the system and improve mental health outcomes for BME communities. However, these have so far failed to result in system-wide sustainable and culturally sensitive adaptations. Culturally sensitive initiatives for young people focused on early intervention and prevention therefore remain patchily available, and have failed to attract investment in research and development to build their evidence base and scalability. And yet, there is evidence that good quality early support can both prevent poor mental health and life chances as well as promote more effective recovery (Patel, *et al.*, 2007). Creating less stigmatising, more culturally acceptable, better branded and more accessible strength-based early support for at-risk BME communities must be a central priority as well as ensuring that such services are routinely available on a national scale.

Other groups covered in earlier age bands and who continue to possess higher risk of poorer mental health at this stage include:

- Young people in gangs;
- Migrants and refugees;
- Young Carers.

Seeking help

Teenagers and young adults are most likely to develop mental health problems but least likely to recognise that they have a problem that might benefit from treatment (Jorm, 2012).

As young people pass through adolescence they become incrementally less reliant on parents and have greater need for autonomy and independence. At this time in their life, they are more likely to believe that they should be

able to handle problems themselves (Wilson & Deane, 2001; Wilson, *et al.*, 2005) with between a third and just under a half of those with serious mental health difficulties in some studies believing this to be the best course of action (Andrews, *et al.*, 1999; Gould, *et al.*, 2004).

Furthermore, studies suggest that the particular mental health difficulties more commonly experienced by adolescents and young adults (e.g. depression, anxiety and substance misuse) tend to increase social withdrawal, making it more likely that a young person will keep their distress to themselves. This is particularly the case with suicidal behaviour where studies of young adults and adolescents found that the more suicidal a person felt the less likely they were to seek help (Deane, *et al.*, 2001; Wilson, *et al.*, 2005).

Likelihood of seeking help at this age is also influenced by:

- Lack of belief that seeking help will make a difference;
- Lack of faith in formal services;
- Previous poor experiences of help;
- Fears about confidentiality.

(Rickwood, *et al.*, 2007).

Young adults are most likely to seek help from those they trust and know (Rickwood, *et al.*, 2007). As with younger teenagers, friends continue to be an increasing source of support for those in late adolescence (Booth, *et al.*, 2004) (Rickwood, *et al.*, 2007). However, some studies have indicated that peers were least likely to encourage linkage with professional support for those suffering from potentially serious conditions such as depression (Kelly, *et al.*, 2006; Dunham, 2004).

There were mixed results concerning the role of the internet in supporting mental health for this age group. Some studies highlighted the importance of online information, websites, social media sites, blogs etc. (Burns, *et al.*, 2009; YoungMinds, 2012), while other studies have suggested that face to face support still remains the preferred mode of help for young people (Bradford & Rickwood, 2014).

For young adults, intimate relationships become an important source of support – particularly for men – with partners often exerting a strong influence on men to seek professional support (Cusack, *et al.*, 2004).

Furthermore, although adolescents and young adults are increasingly self-reliant, the influence and views of parents still remain important even among this age group. Most students still identified parents as a source of support (Rickwood, *et al.*, 2007). Other studies have also pointed to the impact that negative parental reactions or stigmatization can have on help seeking at this age, particularly for men (Cohen, *et al.*, 2009). This study found that while some parents of 17-24 year olds were supportive of their children with mental health conditions, others discouraged or actually prevented young people from getting the help they needed (Cohen, *et al.*, 2009). These family responses were related to a lack of understanding of mental health issues, negative attitudes about mental health treatment, and concerns about the part of people outside the family. Finally, surveys of young people that use case scenarios show that accurate recognition increases rapidly from early adolescence to the mid-20s and is associated with their parents' ability to recognise correctly (Wright, *et al.*, 2005; Wright, *et al.*, 2007).

Gender, mental health literacy and help seeking

Men were generally noted to have lower mental health literacy than women as well as being less sensitive to peer wellbeing and less likely to air their problems with peers (Wilson & Deane, 2001; Burns & Rapee, 2006; Rickwood, *et al.*, 2007; Mojtabai, 2007). Men were also noted to experience higher levels of self-stigma concerning mental health and emotional wellbeing. More traditional views on masculinity and concerns about showing vulnerability were seen to be in direct conflict with help seeking (Galdas, *et al.*, 2005; O'brien, *et al.*, 2005). Young adult men have also been particularly noted to have less positive attitudes to mental health treatment (Rickwood & Braithwaite, 1994; Gonzalez, *et al.*, 2005; Chandra & Minkovitz, 2007) than women. In an Australian study of 3,092 young adults aged 15-24 years, 39% of males and 22% of females reported low

intentions to seek help from formal services for personal, emotional or distressing problems and 30% of males (compared with only 6% of females) reported that they would not seek help from anyone at all (Donald, *et al.*, 2000). In practice, adolescent and young adult males are also significantly less likely to actually seek professional help (including psychological therapies) than females (Chandra & Minkovitz, 2007; Bowers 2013). Low help seeking rates for males at this age are particularly worrying given their comparatively higher rates of suicide. However, young women are more likely during this age group to experience poor mental health (McManus, *et al.*, 2009).

The capacity for self-referral was seen to develop over adolescence, as independence and autonomy from parents increased, although parents do continue to play a significant role, particularly until young people are financially independent. Parental attitudes have also been associated with gender differences in patterns of help seeking. One study found that more boys and young adult men cited perceived parental disapproval as a reason why they might be more unwilling to use mental health services (Cohen, *et al.*, 2009). The same study found that older adolescents who did turn to parents for mental health issues were more likely to seek formal mental health support than those who turned to friends.

Key messages

- In young adulthood, there is a significant increase in self-harm, depression, anxiety and eating disorders, all of which for the first time begin to affect young women more than young men. It is also at this time that we first begin to see more severe mental health diagnoses emerge such as psychosis and personality disorders.
- Three quarters of adults with a diagnosable mental health problem will have experienced first symptoms of poor mental health by the age of 24. Poor mental health represents a major disease burden for this age group and should be a health improvement priority.
- Teenage and young adult years continue to provide vital opportunities for intervention among those facing or living with poor mental health. Intervening early in the course of many mental illnesses can significantly reduce life course impairment. Yet very few young adults get early help that has the best chance of making a difference and they are the least likely to seek help – particularly males.
- For young adults with common mental health problems (depression and anxiety), cognitive behavioural programmes have the best evidence of supporting recovery. CBT is also effective for young adults who have suffered trauma. For young people with emergent psychoses, early identification and holistic intervention supporting recovery is highly effective.
- Women are the most likely to have an eating disorder and only one in five are likely to be in receipt of treatment; this is despite the fact that poor outcomes have been associated with later presentation to services for anorexia nervosa. The evidence base for effective responses to eating disorders is also still developing.
- A small proportion of young adults are affected by a group of mental health conditions known as personality disorders. While these are rare and highly controversial diagnoses, people living with them can feel overwhelmed by stress and negative feelings, have difficulties in forming relationships, end up in frequent, distressing and costly crises, and become very isolated.
- Support for young adults with personality disorders needs to be based on building trusting and optimistic relationships, on working in partnership with young people, and on managing transitions to maximise continuity (for example at age 18).
- Young people who have been in the armed forces have a similar prevalence of mental health problems to other groups, but they face particular challenges in seeking help, for example because of stigma, fears about reduced career progress or a lack of knowledge of where to go for support.

- Young adults as a whole are the most likely age group to develop mental health problems but the least likely to recognise that they have a problem that might benefit from treatment. Their difficulties are less likely to be spotted by parents or teachers.
- Where young adults do seek help, it is often from peers, parents or online information rather than from formal services. Young men are particularly unlikely to seek help, sometimes with tragic results.
- There is good evidence that the impact and burden of poor mental health during adult years can be reduced if, during adolescence, you intervene to reduce the duration of episodes of mental illness and to prevent its re-occurrence during these vital years.

Chapter 7: Conclusions

Diagnosable mental health difficulties are common among children, young people and adolescents and, if left untreated, can cast a significant shadow over their life chances. Shifts in children's mental health are often subtle, confusing, hidden or can be misread, preventing early support and compassionate responses when things deteriorate. Even when concerns do surface, a 'conspiracy of silence' often develops. This prevents early open dialogue, hinders help seeking and inhibits effective responses and action about emerging difficulties.

There is mounting evidence on what gives children and young people the best start in life in terms of their mental health and emotional wellbeing, on the risk factors which compromise healthy emotional and behavioural development, and on the particular children at greater risk due to an accumulation over time of these risk factors (Davies, 2013; Davies, 2014).

All efforts should be made to help parents provide the optimum environment to support their children's mental health from the very first spark of life. Supporting parental mental health, preventing exposure to chronic and excessive stress (including the impact of prolonged exposure to poverty), promoting positive parenting approaches and reducing maltreatment should be priorities.

There is also good evidence on the real difference that can be made to children's life chances by intervening at the very first sign of deterioration in children's mental health and on what has the best chance of improving outcomes for the one in ten children who develop a diagnosable mental health problem (Patel, *et al.*, 2007; Social Research Unit, 2013; Khan, *et al.*, 2015).

Well supported whole school and Social and Emotional Learning approaches and efforts to reduce bullying are also pivotal to helping children develop firm foundations for good mental health and to facilitate prompt identification and access to help.

The weight of evidence on what works also clearly suggests that it is never too late to intervene during teenage and young adult years. There is for example good evidence that if teenage episodes of poor mental health can be promptly supported with high quality and engaging support, reduced in length and prevented from recurring during these crucial years, mental health prospects during adult years can be significantly improved.

Even though most parents of children with a mental health problem seek help and advice, only a quarter of children get any intervention (Green, *et al.*, 2005) and there is an average delay of a decade between first symptoms emerging (when opportunities for limiting damage are highest) and treatment eventually being accessed. And when children and families do seek help, they are confused by the maze of services, often face lengthy waiting periods and are not always happy with the quality, convenience and feel of the help provided (Department of Health, 2015).

As young people become adolescents and young adults, despite being one of the highest risk periods for deteriorating mental health and providing significant opportunities for early intervention, they are most sensitive to mental health stigma and are least likely to seek help for mental health distress at this stage (Rickwood, 2005). Improving timely, engaging, proactive, accessible and high quality help in universal settings such as schools, youth and online communities would appear an important priority.

Efforts are also required to reduce stigma associated with poor mental health among children and young people and to normalise early help seeking. As with some physical health problems, a key message for mental health should be 'be aware of your mental health compass' and 'seek advice promptly at first concerns of any persistent downturn in wellbeing or behaviour'.

School staff, primary care workers, youth workers and those in routine contact with children and families need support in understanding the first signs of poor mental health and in knowing how to link children with good quality help. Routine tracking of wellbeing in schools would raise its importance as an essential building block for healthy child development and would enable earlier help preventing damaging cascades of risk as children and families battle on unsupported under the radar.

There is currently a very mixed and confusing picture from the evidence on the current state of children and young people's mental health over time. Increases in distress and demand for help have been noted by some specialist child and adolescent mental health services, schools, youth helplines and voluntary sector providers (NSPCC, 2014; Ford, *et al.*, 2015; Hutchings, 2015). Year on year increases have been reported in hospitalisations particularly for self-harm and eating disorders (Health and Social Care Information Centre, 2014; BBC News, 2014). But the reported deterioration in children and young people's mental health emerging from anecdotal and service use data have not always been reproduced in independent and higher quality studies tracking changes over time.

For example, at least for younger age groups, since the mid 'noughties', there has been some evidence of a plateauing in what had been previously deteriorating rates of poor mental health. Improvements have particularly been noted in relation to conduct disorders (mirrored by an overall drop in later crime). In some instances, among this younger age group, slight improvements in child mental health have even been noted. But recent evidence suggests that poverty exerts a more pronounced impact on children's mental health than that of adults, and finds increasing inequalities between the mental health of children in the highest income band and those in the lowest (Morrison Gutman, *et al.*, 2015).

On the other hand, high quality comparisons of time trends in adolescent and young adult mental health have suggested that emotional difficulties may in fact have been

increasing during the noughties – particularly for young women. This trend is to an extent backed up by broader surveys exploring other dimensions of teenage wellbeing which have also pointed to widening gender inequalities and particularly a deterioration in young women's life satisfaction, school-related anxiety, experiences of sexual harassment, body image pressures and wellbeing compared with young men. But some other factors linked to adolescent mental health appear to be improving – with alcohol use decreasing, crime rates falling, suicide and drug related death rates marginally declining, bullying decreasing and substance use stabilising since the mid noughties. Clarity will only finally emerge on these time trends with findings from the new child and adolescent psychiatric morbidity survey in 2018.

Other overarching concerns also emerge for young people and young adults' future wellbeing with these age groups appearing to be worst affected by emerging income inequalities, unemployment, social security changes and housing difficulties.

What is clear from the evidence is that children and young people's mental health and wellbeing must be a bigger priority. It is one of the major health burdens affecting this largely healthy age group, yet it can often remain hidden and be left to fester. Too often it prompts uncompassionate reactions and gets overlooked and unsupported, with responses underfunded and under researched.

Mental health research is also underfunded compared to other areas of health research. This evidence review has also highlighted the importance of investing in further research to investigate poorly understood issues and seek solutions. Priorities for future research include:

- More high quality testing of innovative programmes so that we can be sure that they have the best chance of promoting positive outcomes and at the very least don't make things worse;
- More research and development in programmes seeking to prevent and address bullying and self-harming behaviour in young people and the development of eating disorders;

- Improved testing of the longer term effects of programmes seeking to prevent or intervene early with children and young people with diagnosable mental health difficulties;
- More analysis of longitudinal data from the birth cohort studies which allow us to gain greater understanding of what promotes resilience in children and young people in the face of adversity;
- More research into the prevalence of BME child and youth mental health problems and how to ensure access to effective and culturally sensitive interventions;
- Greater research into interventions that can buffer children from the worst effects of poverty which appears to have a particularly undermining effect on their mental health.

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Missed opportunities

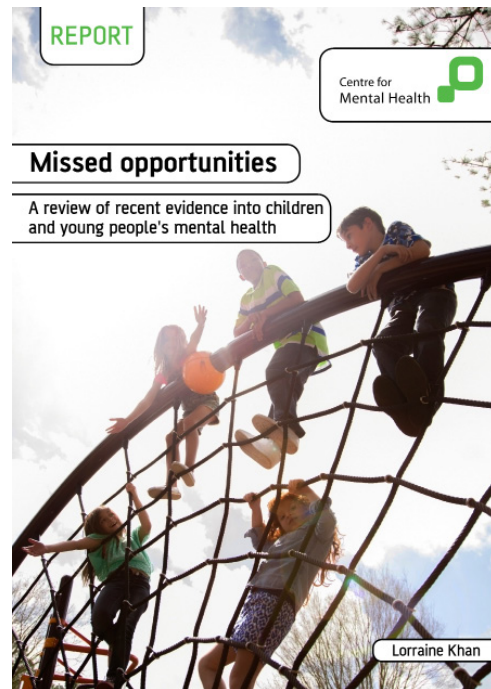
This is a chapter from the report **Missed opportunities: a review of recent evidence into children and young people's mental health** by Lorraine Khan. For the full report, or the reference list, please visit www.centreformentalhealth.org.uk/missed-opportunities

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