ROCKET SCIENCE

# Young people's experience of low-level mental health issues and violence

## Final report by Rocket Science for West Yorkshire Violence Reduction Unit

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# 1. Executive summary

Rocket Science was commissioned by West Yorkshire VRU in November 2021 to research the links between low-level mental health issues and violence amongst young people. The overarching research questions underpinning this research were:

- What is the link between low-level mental health and violence?
- What are the key risk factors and do these differ by demographic groups?
- Which types of interventions can break the link between low-level mental health and violence?
- How do low-level mental health issues affect contact with the criminal justice system?
- What are the practitioner training needs for youth workers and mental health practitioners?

In order to address these research questions, we undertook an extensive evidence review to understand the issues, and then conducted consultation with young people, parents, youth workers and teachers. This was done using a mix of surveys, focus groups, workshops and interviews.

The key findings from this research were:

- Mental health issues are a growing issue among young people, with data showing that they particularly affect girls in their teens
- They have increased over the past years due to COVID-19: the loss of routine, lack of school structure, social isolation, and prolonged uncertainty are key factors
- Presentation and interpretation of mental health issues differs between boys and girls, likewise their experiences of violence are likely to be different
- Reports of mental health issues, and of involvement in violence, are more common in teens than younger children
- Risk and protective factors are broadly similar for both mental health and for violence and include family situation, lack of engagement with school, ACEs, special educational needs and being NEET
- Experiences of violence exacerbate mental health issues, and people with mental health issues are more likely to be victims of violence as they are more vulnerable; in the case

of serious mental health challenges, a reputation for violence can make it harder for these young people to access support services

- School pressures, social pressures, family life, and the impact of social media and their online life are all identified as being key factors impacting young people's mental health
- Almost all the young people being referred to support services are girls; boys are facing the same challenges of social isolation and loss of routine, but don't seem to be reporting problems or accessing services
- Low-level mental health issues can lead to violent outbursts or misbehaviour through a frustration response and poor emotional regulation skills
- Young people with low-level mental health issues are more vulnerable to peer pressure and to being targeted by gangs
- Young people, their parents and youth workers would like more activities to be available, particularly sports and activities that can help support wellbeing and prevent or reduce exposure to negative peer influences
- Access to activities and support is inconsistent across West Yorkshire; availability, transport and cost of activities were the main barriers to taking part
- For specific mental health services (e.g. CAMHS), waiting lists and limited sessions were cited as problems for access, and many low-level issues are below the threshold for referral to CAMHS
- Schools often offer mental health and wellbeing support but their time and resources are stretched; there is increasing pressure on schools to do more: education, mental health support, family and community support
- Sport is a big source of support for young people, but available sports were usually football and rugby; this focus on sport may reduce opportunities to access support for girls
- Training for practitioners working with young people, including teachers, does offer specific content on supporting young people's mental health; there is little standardisation of training required beyond the need for safeguarding
- Senior leadership teams have a big influence on the ethos of a school and its treatment of mental health and violence; most schools and staff are supportive of CPD and training on mental health and supporting young people, though levels of interest vary between individual teachers

- High quality training is available, but resources are stretched, and teachers are stressed so time and budget are the barriers to access
- Some schools have recruited staff specifically for wellbeing and pastoral care, as it is too much to expect teaching staff to do this in addition to their educational roles.

In order to address these issues, we are suggesting the following core preventative and early intervention actions:

- Schools to embed mental wellbeing support (with additional resources to support this)
- More meaningful activities available outside of school
- Engage girls in hobbies and activities
- Improve transport links, and ease of access to transport (including cost)
- Fundamentally, support needs to be long term, and consistent.

# 2. Introduction and context

Rocket Science was commissioned by West Yorkshire VRU in November 2021 to research the links between low-level mental health issues and violence amongst young people. Following a phase of desk research and the production of a detailed evidence review, the second phase of the research involved consultation with a range of stakeholders. This report summarises the key findings from the evidence review, presents the results of the consultation, discusses the issues raised, and finally suggests calls to action for tackling this issue.

The overarching research questions underpinning this research were:

- What is the link between low-level mental health and violence?
- What are the key risk factors and do these differ by demographic groups?
- Which types of interventions can break the link between low-level mental health and violence?
- How do low-level mental health issues affect contact with the criminal justice system?
- What are the practitioner training needs for youth workers and mental health practitioners?

The key findings from the evidence review (detailed in full in section 8, Appendix) were that mental health issues are increasing among young people, particularly following the COVID-19 pandemic. Mental health issues are particularly prevalent among girls in their teens. Presentation and interpretation of mental health issues differs between boys and girls, likewise their experiences of violence are likely to be different. Boys are more often the perpetrators of violence and girls more often the victims. Reports of mental health issues and of involvement in violence are more common in teens than younger children.

Low-level mental health issues are known to impact various aspects of young people's lives and their outcomes, with their attainment and their social interactions both affected. Those with poor mental health are thought to be more at risk of violence (as victims and perpetrators) though the links are complex. Having experienced violence also puts young people at increased risk of poor mental health, and in the case of serious mental health challenges, a reputation for violence can make it harder for these young people to access support services.

Risk factors for both mental health issues and for violence are generally the same and overlap. A lot of the risk comes from family situation, lack of engagement with school, ACEs, and other specific vulnerabilities, such as special educational needs and in older young people being NEET.

Training for practitioners working with young people, including teachers, does offer specific content on supporting young people's mental health. There is less training available on supporting young people who present challenging behaviours including violence. There is little standardisation of training required, beyond the need for safeguarding training.

The evidence review indicated a range of research questions to be further explored through the consultation with young people, parents, youth practitioners and teachers. These are:

- Which settings are appropriate for interventions e.g. schools, youth clubs, mental health services?
- Which types of practitioners or combination of practitioners should be involved in interventions?
- Which training and support do varying types of practitioners (including those working in the criminal justice system) need to support young people's mental health?
- What are the advantages and disadvantages of one-to-one, peer group and family-based interventions?
- How can risk factors be effectively identified early in a child's life?
- How do interventions need to differ depending on a young person's circumstances e.g. at risk of violence, early signs of violence, in contact with the criminal justice system etc?

Building on the overarching research questions, and the findings and evidence gaps from the desk research, the consultation phase of the research focused specifically on the impact of mental health issues in young people, how and where they get support; and the mechanisms by which young people are drawn into violence, and the links to mental health within this.

The consultation explored these questions through focus groups with young people, interviews with youth practitioners and teachers, and surveys with young people, parents, and youth practitioners.

In addition, further mapping of the training of youth practitioners and teachers was conducted to better understand this complex situation. Youth practitioners and teachers were asked about their training, and what barriers or challenges they faced in accessing what they needed.

The format of this report is as follows:

- Section 3 explores young people's mental health, including the impact of the COVID-19 pandemic
- Section 4 explores the how violence is experienced by young people and the links with mental health
- Section 5 details both the availability and types of support that exist for young people and their mental health and to prevent violence, as well as the types of support thought to be needed
- Section 6 outlines the current training provisions for supporting young people with their mental health, and the opportunities and barriers that youth practitioners experience in accessing training
- Finally, section 7 summarises the key findings from the research and recommends some calls to action for how to address mental health in young people and break the links to violence, using preventative measures and early intervention.

# 3. Young people's mental health

Mental health is of growing importance and is now a large feature of schools' concerns including the training available for staff (see section 6), as well as a focus in school lessons, influenced in part by the inclusion on the mandatory PSHE curriculum, and generally in response to recognising the rise in mental health challenges in young people.

Schools are particularly well-placed to notice the existence of, and impact of, those low-level mental health issues, which may not yet reach a threshold of severity to warrant the intervention of more formal mental health support services. This also puts them in a position to respond to low-level issues, offering support and ideally avoiding the situation becoming worse. However, this is one of many priorities that schools face with increasing demands and static or falling budgets and finite time to spend with their young people.

Schools are also a potential source of many common stressors that can challenge young people's wellbeing, and while they have a duty of care to support their young people, many of the exacerbating factors that can cause issues are outside of their control.

## 3.1 Experience of low-level mental health issues

The experience of low-level mental health issues in young people was explored through both surveys and in focus groups and interviews.

### Prevalence of low-level mental health issues

Young people were asked "How common do you feel mental health issues are amongst your peers?". This question aimed to gain a perception of the prevalence of low-level mental health issues, rather than relying on figures showing only diagnoses of more serious mental health issues.

Youth practitioners surveyed were asked "To what extent are you concerned about the prevalence of low-level mental health conditions amongst the young people you work with?", again aiming to identify specifically low-level issues rather than formally diagnosed conditions.

Table 1 shows that out of 150 young people surveyed, 85% reported that mental health issues among their peers were somewhat common or very common. Likewise, of the practitioners surveyed (see Table 2), 92% reported having concerns about the prevalence of low-level mental health conditions among the young people they work with.

**Table 1 "How common do you feel mental health issues are amongst your peers?"**

| | Count | Percentage |
|---|---|---|
| Very common | 81 | 54% |
| Somewhat common | 47 | 31% |
| Somewhat uncommon | 10 | 7% |
| Very uncommon | 12 | 8% |
| Total | 150 | 100% |

**Table 2 "To what extent are you concerned about the prevalence of low-level mental health conditions amongst the young people you work with?"**

| | Count | Percentage |
|---|---|---|
| Very concerned | 28 | 56% |
| Somewhat concerned | 18 | 36% |
| Somewhat unconcerned | 3 | 6% |
| Very unconcerned | 1 | 2% |
| Total | 50 | 100% |

These concerns among young people and practitioners also reflect data on the prevalence of poor mental health in young people, particularly teenage girls, seen in data shown in the evidence review (Appendix section 8.2.2), as well as gaining increasing attention in the press[1].

Focus groups with young people across three schools and one youth club also asked about the prevalence and experiences of mental health among young people. Young people understood what mental health and wellbeing were and they highlighted that a lot of young people their age were experiencing low-level mental health issues for a number of reasons. They

[1]Gregory, A, (2022). Thousands of girls as young as 11 in England hiding signs of 'deep distress'. *The Guardian* 28th February 2022. Link. Accessed 20 March 2022.

particularly highlighted the pandemic, difficult relationships, dislike for school, friendship problems and engagement with school and exam pressures. In particular they also talked about the transition from primary to secondary school being disrupted by COVID-19 and the impact this had on Year 7/8 students, who transitioned during periods of prolonged lockdowns and home-schooling. They were also aware of the disruption to exams and the effect this has had with older age groups, who went through exams or were preparing for them in a time of high disruption.

## Pressures and concerns

The particular pressures and concerns that faced young people were fairly consistent across the young people, parents, and practitioner surveys – although the order of priority of these impacts varied.

When asked to choose the top three main worries for young people, the survey results showed that for young people themselves the main source of pressure was to do well in education or work, followed by loneliness or isolation, and then family life – shown in Table 3.

**Table 3 "What do you think are the main worries for young people?"**

| | Count | Percentage of respondents |
|---|---|---|
| Pressure to do well in education or work | 106 | 71% |
| Pressures associated with social media or life online | 48 | 32% |
| Family life | 52 | 35% |
| Friendships or socialising | 48 | 32% |
| Loneliness or isolation | 60 | 40% |
| Uncertainty about the future | 39 | 26% |
| Financial or money worries/pressures | 37 | 25% |
| Worries about crime or safety | 8 | 5% |
| Other (please specify) | 5 | 3% |
| *Respondents* | *150* | |

A survey with parents asked "What do you see as the main factors impacting your child(ren)'s mental and wellbeing?". The free text responses to this question were coded to match common themes, and the top 10 most commonly cited factors impacting their child or children's mental health are shown in Table 4.

**Table 4 "What do you see as the main factors impacting your child(ren)'s mental and wellbeing?"**

| Issue | Count of parents who mentioned this |
|---|---|
| Negative peer influences | 9 |
| Social media | 9 |
| Social isolation | 8 |
| COVID-19 | 7 |
| Lack of support/poor quality support | 7 |
| School/exams | 5 |
| Climate/environment | 3 |
| Quantity of demands | 3 |
| Lack of confidence | 2 |
| World affairs/war | 2 |

School or exam pressure, and pressure to succeed were less noted by parents than by young people, cited by five out of 34 parents, though when combined with a more general pressure of a high number of demands on them, it was mentioned by 8 parents. The impact of negative peer influences and social media were most commonly identified by parents, though also the impacts of COVID-19 and particularly of social isolation or a loss of social skills following the pandemic were a very close second.

Youth practitioners who responded to the survey, shown in Table 5, also did not cite pressure to do well in school or work as the top pressure on young people. Instead they identified social media and life online as having bigger impacts on young people's mental health, followed by family life and then friendships or socialising.

It is clear from these young people, parents, and practitioner perspectives that there are serious concerns about young people's mental wellbeing, and that they are under a large

amount of pressure, and that school, family and social life (both in-person, and through social media and online influences) are all key factors in the wellbeing of young people. Likewise, social skills, social isolation and the impacts of COVID-19 cannot be ignored.

**Table 5 "What do you think are the main factors impacting young people's mental health and wellbeing?"**

| | Count | Percentage of respondents |
|---|---|---|
| Pressure to do well in education or work | 13 | 26% |
| Pressures associated with social media or life online | 40 | 80% |
| Family life | 28 | 56% |
| Friendships or socialising | 27 | 54% |
| Loneliness or isolation | 19 | 38% |
| Uncertainty about the future | 14 | 28% |
| Financial or money worries/pressures | 4 | 8% |
| Worries about crime or safety | 0 | 0% |
| Other (please specify) | 2 | 4% |
| *Respondents* | *50* | |

Interviews with school staff echoed many of these key themes of the pressures and concerns.

*"Higher up in the school it's the pressure of exams, the loss of resilience from not being in schools [due to lockdowns], and then depending on their home life. It's hard to be person-centred because of so much going on. There are lots of young people and little time to get to know them all."* – Careers advisor

School staff working with young people acknowledged that the pressures of exams was common across all the young people, but also that there were varying impacts depending on whether the young people had a stable home life and supportive parents/carers who were engaged in their children's education. They reflected that this family engagement, or lack of engagement, could make a difference to the young people's wellbeing as well as to their school aspirations and attainment.

The impact of COVID-19 and its associated lockdowns and disruption were also cited repeatedly, and this is discussed further below.

## 3.2 Rising mental health issues and the impact of COVID-19

One theme that was repeated throughout the consultation, particularly by teachers and other youth workers, was the impact that COVID-19 has had on the mental health of young people.

The rising prevalence rates of low-level mental health issues were identified in the evidence review (see Appendix section 8.2.2), and data from NHS Digital, shown in Table 6, shows that as well as rates rising overall during the COVID-19 pandemic, rates for girls are much higher than for boys in their teens.

**Table 6 Percentage of young people showing "probable disorder" on the SDQ, by age, gender and year**

| | 2017 | | | 2020 | | | 2021 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Age 6-10 | Age 11-16 | Age 17-19 | Age 6-10 | Age 11-16 | Age 17-19 | Age 6-10 | Age 11-16 | Age 17-19 |
| All | 9.9% | 13.3% | 10.1% | 15.4% | 17.6% | 17.7% | 17.1% | 17.7% | 17.4% |
| Boys | 12.5% | 12.3% | 7.0% | 18.6% | 15.3% | 8.7% | 21.9% | 15.6% | 10.3% |
| Girls | 7.2% | 14.3% | 13.4% | 12.2% | 20.1% | 27.3% | 12.0% | 19.8% | 24.8% |

Source: Mental Health of Children and Young People in England, 2021: Wave 2 follow up to the 2017 survey, NHS Digital, Table 1.2: Mean SDQ scores and mental health of child or young person by age and sex, 2017, 2020 and 2021

There were several specific areas that caused this increase in anxiety and reduction of wellbeing:

- Disruption to normal routine and loss of structure of the 'normal' day due to home-schooling
- Loss of support structure through less contact with friends or teachers, particularly the loss of face to face contact
- Social isolation due to lockdown and restrictions on meeting up
- Lots of change and often very rapid change with very short notice

- Unpredictability, e.g. rules and restrictions changing at short notice and details not being clarified in good time
- The impact of the pandemic itself – including health anxiety, usually for loved ones rather than for themselves
- Different and changing boundaries and expectations
- Worse impacts for those with less structure or support at home
- Worse impacts for those with additional needs, e.g. special educational needs; unstable family situations.

School staff and other youth workers were keen to highlight that young people are on the whole extremely resilient, but that in this case for many young people, the extreme challenges they faced were beyond those levels of resilience.

It was also noted that for many young people, a lot of the wellbeing concerns emerged when they started coming back to in-person attendance in schools, with a loss of social skills and confidence for interacting with their peers and for being in large crowds.

*"[They have] struggled with coming back into school and getting them back into a routine has been difficult – kids who attended school during COVID [e.g. children of key workers] had the routine so they kept balanced, it's the ones who were at home were quite isolated and have struggled coming into big crowded spaces."* - School teacher

While teachers identified that traditionally the Year 7 transition from primary school and the Year 9 age group choosing their GCSE options were particularly key for young people and their wellbeing, they also noted that the current cohort of Year 8s was feeling lasting effects from having gone through the transition into secondary school in the midst of pandemic, with lockdowns and home-schooling, as well as short notice changes to their routine (particularly the unpredictability of home-schooling vs classroom schooling) and a very high amount of uncertainty and lack of stability and routine.

While these factors have influenced all young people, the cohort who went through a transition during the height of the uncertainty are still noticeably less settled and more disruptive than their peers. This was noted by staff in both mainstream provision and alternate provision schools.

One person interviewed, whose role focused on wellbeing support in schools, commented that she had observed that awareness of, and support for, mental health and wellbeing had been improving over recent years. She noted that mental health issues were increasing among young people, but that the support was also improving – although that was not being reflected in the data due to the scale of the rise in issues.

## 3.3 Summary

- Mental health issues are a growing issue among young people. They have increased over the past years due to COVID-19. Mental health issues are worst for teenage girls. The loss of routine, lack of school structure, social isolation, and prolonged uncertainty are thought to be the key factors
- School pressures, social pressures, family life, and the impact of social media and their online life are all identified as being key factors impacting young people's mental health
- Almost all the young people being referred to support services are girls. Boys probably are also having problems, facing the same challenges of social isolation and loss of routine, but don't seem to be reporting problems or accessing services.

# 4. The link between mental health and violence

This section of the report looks at the links between low-level mental health issues and violence, and explores the mechanisms by which young people may be drawn into violence, or crime and contact with the criminal justice system. It also considers the risks and exacerbating factors that can influence young people. It draws on research from both survey data and from the in-person consultation with young people, and practitioners.

## 4.1 Potential ways in which low-level mental health issues can lead to experience/perpetration of violence

There were two key ways in which mental health and violence were linked – particularly regarding the perpetration of violence. Firstly, that young people with low-level mental health issues were more likely to lash out or act in anger in ways that they otherwise might not. Secondly, that having low-level mental health issues put young people at risk of peer pressure or even grooming, leading to increased chances of becoming involved in crime, including violent crime, thereby being simultaneously victims of child criminal exploitation and potentially perpetrators of violence, depending on the nature of their involvement.

*"If you're feeling sad or depressed the smallest thing can make you want to hit someone."* – Year 8 boy

*"Frustration and lack of empowerment are key causes of violence in young people: Young people acting violently or destructively is almost always because they're trying to communicate a problem but they don't know any other way of doing so."* – Youth mental health support worker

Young people were asked in a survey "To what extent do you agree that violence is a concern for young people living in your local area?", two thirds (66%) of them either strongly agreed or somewhat agreed, shown in Table 7.

When asked "To what extent do you agree with the statement that having low level mental health issues (such as mild to moderate presentations of anxiety, depression and some eating disorders) increases the likelihood of a young person being violent?", 69% of them either agreed strongly or agreed somewhat (see Table 8).

**Table 7 "To what extent do you agree that violence is a concern for young people living in your local area?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 30 | 20% |
| Somewhat agree | 69 | 46% |
| Somewhat disagree | 39 | 26% |
| Strongly disagree | 12 | 8% |
| Total | 150 | 100% |

**Table 8 "To what extent do you agree with the statement that having low level mental health issues increases the likelihood of a young person being violent?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 36 | 24% |
| Somewhat agree | 67 | 45% |
| Somewhat disagree | 38 | 25% |
| Strongly disagree | 9 | 6% |
| Total | 150 | 100% |

When asked "To what extent do you agree with the statement that having low level mental health issues (such as mild to moderate presentations of anxiety, depression and some eating disorders) increases the likelihood of a young person being a victim of violence?", 81% of young people said they agreed or strongly agreed (shown in Table 9). This reflects the understanding from the evidence review that mental health issues are a key risk factor for people becoming victims of violence than of perpetrating violence, including being groomed and exploited to take part in criminal activity. It is also known that experiencing violence can lead to poor mental health. The response from staff and services can also influence the way in which mental health and violence are perceived, with young people with a history of offending finding it more difficult to access support for mental health. See Appendix section 8.3.3 for further discussion of these links.

**Table 9 "To what extent do you agree with the statement that having low level mental health issues increases the likelihood of a young person being a victim of violence?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 53 | 35% |
| Somewhat agree | 68 | 45% |
| Somewhat disagree | 25 | 17% |
| Strongly disagree | 4 | 3% |
| Total | 150 | 100% |

When asked to provide an explanation for these beliefs about the relationship between mental health and violence, the responses were varied and nuanced.

Many young people were keen to stress that people with mental health issues were much more likely to be the victims of violence than the perpetrators, and that they may even be suffering with mental health issues due to violence in their past or present. However, many also articulated that low-level mental health issues could lead to violence through uncontrolled emotions and frustration. Several young people noted that people with poor mental health were more likely to be targets of abuse or bullying, and that there were many contributing factors influencing a person's wellbeing, of which violence was only one part.

Likewise, during the focus groups, young people discussed lowered emotional resilience, and how feeling sad or depressed could make people more likely to lash out in anger about something. They talked about their own experiences of feeling angry and lashing out in response to bad days or negative experiences with their peers.

They also identified that a lack of confidence or poor self-esteem made it harder for young people to say no to peer pressure, which could lead to involvement in anti-social behaviour or minor crime.

> ""*If they're not confident – they have to go along with it to be popular.*" - young person from a group of year 9/10s

While the young people consulted in focus groups did not specifically highlight a direct link between low-level mental health issues and criminal exploitation and gangs, they did observe

that gangs were sometimes a problem in some areas of West Yorkshire. In particular they talked about postcode wars, knife crime and drug dealing, and the influence of "Olders" (older youths) on "Youngers" (younger teens and pre-teens). This was often discussed in relation to conversations about peer pressure, and that lower self-esteem and less self-confidence made young people more at risk of that peer pressure, as well as deliberate targeting and grooming by gangs for criminal exploitation.

When youth practitioners were asked in a survey "How significant is the link between a young person's mental health and their experience of being a victim or perpetrator of violence?" (Table 10), 90% thought that this was somewhat or very significant. When asked to explain their reasons for this understanding, the responses were varied.

**Table 10 "How significant is the link between a young person's mental health and their experience of being a victim or perpetrator of violence?"**

| | Count | Percentage |
|---|---|---|
| Very significant | 26 | 52% |
| Somewhat significant | 19 | 38% |
| Somewhat insignificant | 5 | 10% |
| Very insignificant | 0 | 0% |
| Total | 50 | 100% |

Issues around victims of violence having increased experiences of mental health issues were highlighted much more by practitioners than they were by young people, reflecting their broader experience of the issue. This was particularly the case when explaining the impact of domestic abuse and experiences of trauma in young people. Additionally, that young people with mental health issues could in fact be targeted victims of predators due to their vulnerability.

Practitioners did highlight that frustration and lack of emotional regulation could lead to violent outbursts but did not particularly associate this with more severe violent crime.

## 4.2 Direction of links

The links go both ways. Young people from both surveys and consultations were more aware of the influence of mental health on violence, while practitioners in surveys highlighted the role of violence and trauma on young people's mental health.

It is clear however that there is a lot of cross-over between the direction of these links and also the additional surrounding factors.

One young person talked about having anger management issues and even committing criminal damage on the house of someone in retaliation, following racist bullying and an act of violence committed against him in school. This incident led to police involvement, though it was dealt with without prosecution, thus preventing that young person from entering the criminal justice system. (See section 5.2 for more discussion on preventing contact with the criminal justice system.)

## 4.3 Risks and exacerbating factors

The risks and protective factors identified in the evidence review were broadly similar for both mental health and violence in young people. These are shown in Table 11 and Table 12.

**Table 11 Risk factors for poor mental health in children**

| Area of life | Risk factors |
|---|---|
| Lifestyle | Body image; Coronavirus; Drugs and alcohol; Internet and social media; Puberty; Sleep |
| Home and family | Child abuse and neglect; Home environment; Poor parental mental health; Parental substance misuse; Poverty and unemployment; Young carers |
| School | Absenteeism; Academic and exam stress; Bullying and cyberbullying; Leaving school and future plans; Peer pressure; Relationships and belonging; School exclusion; Transitions |
| Vulnerable children | Autistic spectrum; Child criminal exploitation; Children with additional needs; Disability and illness; Discrimination; Gender diversity; LGBTQ+ |

| | |
|---|---|
| | children and young people; Looked-after children; Refugee and asylum seeker children |

**Table 12 Factors putting children and young people at risk of crime**

| | |
|---|---|
| Individual risk factors include: | Exposure to crime, behavioural problems, low commitment to school |
| Family risk factors include: | Having four or more siblings, experience of being mistreated, family conflict |
| Community or school risk factors include: | Overall school performance, high rates of school exclusions, high availability of alcohol and drugs |
| Society risk factors include: | Wider social and economic injustices, including discrimination and institutional bias |

Practitioners highlighted that violence and trauma were key factors influencing mental health. There was also an understanding that protective factors of self-esteem and confidence were important for avoiding becoming involved in violence. One group of young people in particularly highlighted that they themselves felt happy that they could say no to peer pressure if they were being asked to get involved in something they knew to be bad (including anti-social behaviour and violence). They did however highlight their belief that the majority of their peers would not have this ability and identified lack of confidence to say no to peer pressure as a key risk to becoming involved in violence.

A member of school staff who worked to support ethnic minority young people for whom English was an additional language highlighted that there were also factors particular to the ethnic minority groups that she worked with.

*"[Mental health] is dismissed in the home life and the community. There's not a support system for mental health in young people in ethnic monitory groups."* – support worker for speakers of English as an additional language.

This member of school staff also highlighted that she was aware of increasing incidents of boys hitting their mums, usually lashing out through frustration. She observed that there was a particular challenge when working with ethnic minority groups as there are sometimes

problems culturally, for example saying mental illness is someone being "possessed with spirits" rather than acknowledging it as a health issue with support available.

Other risks and exacerbating factors included violence at home, with the young people exposed to this not always realising that it is unusual and not common to every home.

A youth mental health support worker also criticised a lack of awareness or understanding by teachers for the underlying causes behind 'bad' behaviour in young people, and called for better understanding so that these young people could be provided with support instead of punishment, thus breaking a link that can lead to violence and sometimes criminal behaviour.

*"A lot of the behaviour classed as anti-social [in young people] is often because they've got a condition that they haven't had diagnosed, and things where the teacher also doesn't have training and if the kids aren't understood, then they're not being naughty but it's things like they might be hungry, or from an abusive home, they want attention because there's a reason but they don't know how to ask. I am amazed by how many teachers don't seem to understand that kids aren't trying to be naughty, but it's that there's something else going on for them. Teachers should be better at seeing and understanding what's going on with their kids."* – Youth mental health support worker

## 4.4 Summary

- Low-level mental health issues can lead to violent outbursts or challenging behaviour through a frustration response and poor emotional regulation skills
- Young people with low-level mental health issues are more vulnerable to peer pressure and to being targeted by gangs
- Experiences of violence exacerbate mental health issues, and people with mental health issues are more likely to be victims of violence as they are more vulnerable
- Home life can impact mental health and influence experiences of violence.

# 5. Services and support

Access to services and support within West Yorkshire varies depending on numerous factors, particularly location. Types of support available do not always match the needs or wishes of young people. Practitioners highlighted the need for more funding and to be able to provide consistent, long term support for young people. The services and support discussed ranged from wellbeing support and diversion from negative influences, such as sports, hobbies, to formal mental health support such as counsellors in schools and child and adolescent mental health services (CAMHS).

## 5.1 Current access to services and support within West Yorkshire

Young people were asked in a survey "To what extent do you agree that you have access to the services, information and activities you need to be able to look after your mental health and wellbeing?". The responses are shown in Table 13.

**Table 13 "To what extent do you agree that you have access to the services, information and activities you need to be able to look after your mental health and wellbeing?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 42 | 28% |
| Somewhat agree | 64 | 43% |
| Somewhat disagree | 26 | 17% |
| Strongly disagree | 18 | 12% |
| Total | 150 | 100% |

Forty-three percent of the young people said they somewhat agreed and a further 28% said they strongly agreed that they did have access to this. They were also asked how their access to these services and support could be improved. Their free text responses were coded and grouped by themes, and this summary is shown in Table 14. The main themes emerging from these responses were that young people wanted more information about the support and services available to them, with high quality support available.

**Table 14 "How could this be improved?"**

| Suggested improvement | Count of respondents who said this |
|---|---|
| Awareness/promotion of services | 14 |
| More support | 9 |
| Easier access to support services | 7 |
| Better quality of support | 6 |
| Less stigma around needing mental health support | 6 |
| Less pressure for academic performance | 5 |
| Lower/no threshold for getting support | 5 |
| Support in schools | 5 |
| Free access to support | 5 |
| Clubs outside of school | 3 |
| Shorter waiting lists | 3 |
| Teaching about mental health in schools | 3 |
| Confidentiality | 2 |
| Easier access | 2 |
| Allowing coping mechanisms, like listening to music | 1 |
| Emergency service always available | 1 |
| It can't | 1 |
| Less homework (reducing pressure) | 1 |
| Listen more to the needs of young people | 1 |
| More checks on wellbeing | 1 |
| Student support networks | 1 |
| Support for school work | 1 |

In a survey, most parents disagreed that their child or children had access to the services and activities they needed to look after their mental health and wellbeing, shown in Table 15. Although this was a small sample size, it is interesting that this did not align with the results from the young people's survey, where most of the respondents agreed that they did have access to services and support. The difference in perception may reflect differing priorities for what types of support are needed.

**Table 15 "To what extent do you agree that your child(ren)'s have access to the services and activities they need to look after their mental health and wellbeing?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 4 | 12% |
| Agree | 8 | 24% |
| Disagree | 18 | 53% |
| Strongly disagree | 4 | 12% |
| Total | 34 | 100% |

Practitioners were asked in a survey "To what extent do you agree young people have access to the support/resources they need to look after their mental health and wellbeing?" (Table 16). Their responses were split much more than those of young people – 38% said that they somewhat agreed, while another 38% said they somewhat disagreed. They were also asked how this could be improved, shown in Table 17, and their coded and grouped answers showed that as with young people, they felt that improved awareness, and also faster, easier access to support were needed.

**Table 16 "To what extent do you agree young people have access to the support/resources they need to look after their mental health and wellbeing?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 4 | 8% |
| Somewhat agree | 19 | 38% |
| Somewhat disagree | 19 | 38% |
| Strongly disagree | 8 | 16% |
| Total | 50 | 100% |

**Table 17 "How could this be improved?"**

| Suggested improvement | Count of respondents |
|---|---|
| Awareness/promotion | 10 |
| Shorter waiting lists | 9 |
| Easier access | 5 |
| Less stigma/more social support to engage | 5 |
| More support activities available | 5 |
| Better funding | 3 |
| Better quality of support | 3 |
| Intervention before crisis point | 1 |

Youth workers, including teachers, identified that access to support for multiple aspects of young people's lives were needed, from formal mental health support, to activities and hobbies that will support their wellbeing, to specific types of support for example for LGBTQ+ young people. Many schools offered some form of wellbeing support, such as school staff with a specific remit to promote and support mental health, rooms or quiet spaces for young people in distress, sometimes on-site access to counselling, and training for staff in how to support mental health needs in their students.

However, teachers and pastoral school staff all emphasised the burden on schools of offering support to young people, their families and the wider community. They are stretched in terms of capacity to deliver support and also have limited resources available.

*"Every year there's more and more onus on schools to support the young people, and their families. And the community. There is more and more put on schools to do this support work."* – School wellbeing lead

One particular example of good provision for support with wide access is the CATCH youth club, based in Leeds. Its location and provision enable it to have high attendance and offer good quality support and activities for young people. In particular it can divert young people away from anti-social behaviour and negative peer influences. However, while practitioners and young people all discussed youth clubs as a potential source of support and services, they are not widely available across West Yorkshire. This reflects a trend across the UK of falling

levels of support for youth services, and a loss of provision. These closures are linked to both funding cuts due to austerity, and in some cases places that closed during the pandemic have not reopened[2] [3].

### 5.1.1 Barriers to access:

The types of support available are inconsistent and vary between schools. There is also a varied amount of support services available for more general wellbeing. Many young people and youth workers talked about sports clubs, but often the provision is location specific and choice can be very limited.

*"In this area in, kids interested in rugby have local community support. But otherwise they don't."* – Wellbeing support worker

There is often limited access to transport, either through availability or cost, which can limit engagement in activities that are not in the immediate area. This is often coupled with a lack of opportunities nearby, particularly in rural towns, or where the young people are interested in something which is not widely available.

Young people at an alternate education provider seemed more pessimistic about the role of school staff or other adults to support and help them with problems, citing specific examples of being let down by support provision – either a limited numbers of sessions with counsellors, not getting education support that had been promised, or generally not having much trust in the adults around them to provide support and be consistently "there" for them. This highlights that young people who have been, or are at risk of being, excluded have worse experiences of support – either not getting this, or it not being of the type and duration needed. However, they are also more likely to need additional support than many of their peers in mainstream schooling.

Disengagement and lack of positive influences can also be a barrier to access to services that could support their wellbeing. For example, young people who are disengaged may lack any frame of reference for joining sports clubs or having specific interests. Young people may lack

[2] YMCA (2020). Out of Service: A report examining local authority expenditure on youth services in England and Wales. Link.
[3] UK Youth (2020). The Impact of COVID-19 on Young People and the Youth Sector. Link.

the money or opportunities to take part in these types of activities, and they may not have role models from family or peers who encourage participation.

## 5.2 Touchpoints and opportunities to intervene

Several particular touchpoints and opportunities to intervene were identified particularly by practitioners. There was almost unanimous agreement that early intervention was essential to catch problems and prevent escalation of mental health issues from low-level problems into more serious issues. There was also a strong feeling that teaching emotional resilience and regulation skills was key to preventing violence outbursts in young people who were 'acting out' in order to communicate a particular unmet need.

*"I genuinely believe early intervention is the best option. Supporting young people from tiny tot age with resilience, doing it so it just becomes a norm for them. Helping them to build up the strategies [to cope]. […] Early intervention to learn strategies to build resilience."* -CAMHS practitioner

Practitioners in a workshop agreed that any intervention after a problem had been noticed was not therefore early intervention, and that working with young people before problems arose would be preferable.

*"The term 'early intervention' is a bit of a joke, by the time we have noticed someone acting out, it is just 'intervention'."* -Student welfare officer

It was also highlighted that supporting young people at particular risk was important from an early age, particularly where there were parental mental health issues which were, or could be, impacting the young person.

Practitioners also discussed that some of the highest risk times for young people experiencing mental health issues were around transition points, especially aged 16-18. They expressed concern that it was difficult to help that age group as with waiting lists being long, it may not be possible to get them access to CAMHS before they turn 18, but that until they do turn 18 they cannot be referred to adult mental health services, and so can't join a waiting list for that either. (See section 8.2.2 for more discussion on waiting list times.)

*"Key transition is when you're 17 and a half – there's no point being referred to children services. 16-18 they are independent, finding their feet, drinking, experimenting. It's a really at-risk group."* – Student welfare officer

There was consensus that young people being offered support and activities to occupy their time and teach them positive social skills could help reduce violence by improving wellbeing and also keeping them away from spaces in which they may be more subject to negative peer pressure or exposed to grooming by gangs.

Another key opportunity to intervene was highlighted by a young person at a youth club. He had been involved in crime, and the police became involved. Rather than being prosecuted, he received support for anger management and joined the youth club. He stated that this approach had helped him and that he had much better control of his anger following this course of action. He believed that he would have had a much worse outcome if the police had chosen to prosecute him for this incident instead.

## 5.3 Young people's perspectives on the types of services/activities which help to support their mental health

Young people were asked via survey, "How important are the following in supporting young people's mental health and wellbeing?", and were asked to consider:

- Support from friends
- Support from family
- A positive experience at school
- Sports, creative activities, leisure and hobbies
- Mental health services, e.g. counselling

A summary of the proportion of young people who rated these "very important" or "somewhat important" is shown in Table 18. While 84% of the young people rated "Support from family" as very important, only 49% rated "Sports, creative activities, leisure and hobbies" as very important.

Although, when 'very important' and 'somewhat important' scores were combined, all of these forms of support were considered to be important by most young people (ranging between 87% for mental health services to 95% for support from family).

**Table 18 "How important are the following in supporting young people's mental health and wellbeing?"**

| | Very important | Somewhat important | Very important or somewhat important |
|---|---|---|---|
| Support from family | 84% | 11% | 95% |
| Support from friends | 74% | 21% | 95% |
| A positive experience at school | 71% | 21% | 92% |
| Mental health services, e.g. counselling | 61% | 26% | 87% |
| Sports, creative activities, leisure and hobbies | 49% | 42% | 91% |

It is interesting that formal mental health services are rated the least highly in this combined score, which may reflect either the young people's more limited experience of this compared to the other options or could be reflecting the known barriers to accessing this type of support. In the focus groups with young people, they were aware of long waiting lists and short numbers of support sessions offered through these services.

Through the focus groups, many young people had a clear idea of the things they would do, and sources of support available to them, to help if they felt their mental health was suffering. Young people gave a range of activities out there to help prevent mental health issues and involvement in violence. Many stated that there are interventions within schools and there are some (but not many) after school activities they could participate in to be able to stop them getting involved in gangs and anti-social behaviour. However, most young people said that the opportunities were limited and they would like more availability and a wider choice of things to do. Transport links particularly were mentioned, especially amongst the younger pupils, as a barrier to accessing services.

Sources of support included their families, other trusted adults (specific teachers, sports coaches), friends, and taking part in hobbies or relaxing activities (running, craft activities, spending time with family and pets). However, for some young people, they felt either that

they had no one to talk to or that it would be pointless to ask for help as nothing would be done. Support types mentioned specifically for mental health issues included:

- Games like fidget toys
- Be in a calm room
- A teacher to speak to you who you trust
- Coping methods
- Ways to control your anger
- Fun stuff
- Counsellors
- Mood cards
- Kooth.com (to talk about family problems, drug issues etc)
- Night owl (a confidential support line in West Yorkshire that provides an overnight listening and advice service for children and young people experiencing a mental health crisis).

The young people in focus groups usually felt that where people had hobbies like sports and activities then they would be more able to stay out of trouble and feel more supported. There was no single hobby or activity that was identified as specially being needed but rather a range of different things depending on personal interest. Sport and sports clubs seem to be a big part of the support systems that young people discussed. Sports activities and facilities that young people said they already had or would like to have access to included:

- Boxing sessions
- Football pitch, football training
- Astroturf pitch
- Rugby clubs
- After school clubs and out of school clubs
- Gymnastics
- Skate parks
- Running
- Motorbike riding/motocross.

Non-sport activities that were mentioned included:

- Community centres
- Youth clubs
- Chilling with mates
- Go on buses everywhere (described by several young people as a social activity that groups of friends would do to spend time together).

Many of the young people, particularly boys, identified playing sport (formally or informally) as a key activity that helps them and others like them to avoid negative peer influences that improves their wellbeing and that offers a source of support from trusted adults. It is also known that taking part in physical activity is a good way to boost mental health. However, there is also a known factor that girls are less likely than boys to take part in sport, especially in their teenage years[4]. This could potentially contribute to the reason why mental health gets worse for girls in their teens, as they could be missing out of vital access to sources of mental health and wellbeing support.

## 5.4 Practitioner perspectives on which services or activities are needed/the extent to which they are available

There were two key strands in the discussion with various youth practitioners about what types of services and activities are needed for young people. There was discussion about provision of and access to specific support for mental health and wellbeing, and also about the existence of and access to services that engage young people in positive activities and "keep them off the streets", preventing them from being drawn into anti-social behaviour, crime, and ultimately violence.

*"It used to be a teacher leading safeguarding but now there's so much and they need additional staff to deliver admin and pastoral care. The school are getting no more funding but the demands on time and remit are going up."* – School wellbeing lead

[4] Sport England (2021). Gender. Link.

*"I think something like this [an inclusion support worker] in every school would be good and beneficial."* – Inclusion support worker

*"Not just one-to-one work, a whole school approach, embedded in curriculum, self-esteem. Might be part of, for real small ones, could be a story about someone struggling as part of English. It is bringing it into the everyday and everything. Rather than seeing a therapist and then saying 'there you go, bye', it's engrained in everyday life. Not a taboo subject – it still is in some ways but right from the beginning. I feel it is quite hopeful."* – CAMHS practitioner

*"As a youth worker I believe early intervention is key. Putting support in place before things become entrenched and ingrained. There's something about upskilling people generally in mental health – youth workers need to know lots about lots of things – county lines, substance use but also need to know about mental health."* – Youth services manager

Much of this discussion by practitioners focused on embedding mental health support into everyday activities, having skills in mental health support across all staff working with young people, and teaching it to young people themselves. However, this was balanced against a recognition that resources are stretched and that youth workers, including teachers, already have a large number of skills and content to deliver and that they themselves may even face mental health challenges due to high pressure workloads.

When discussing the activities needed practitioners were aware that there were limited opportunities for hobbies or activities for young people, which increased their exposure to negative peer influences and risk of being drawn into crime or violence.

*"There's no place to go to in the community. They go to the mosque after school but then where else?"* - School support worker for English as an additional language

Negative peer influences outside of school were seen by youth workers, especially teachers, as a big risk factor in exposing young people to violence or crime, and that this could involve them in anti-social behaviour which then could escalate into more serious crime or violence. The impact of gangs and criminal exploitation was also noted, particularly in cities. In smaller towns, gangs were felt to be less of an issue.

## 5.5 Ways of working

The ways of working and delivering services underpinned every discussion around types of services and activities that were, or should be, available. It was felt by young people, parents and practitioners, that the quality and consistency of support were just as, if not more, important than the content of that support service.

*"The teenagers I've worked with that have been involved in violent crime are very disillusioned with services. They don't have support but also feel let down by services. They might have said yeah I've had help but only for 6 weeks. They have been let down by society."* – Student welfare practitioner

The key factors identified particularly by practitioners for how to deliver high quality services to young people included:

- Empowering young people and giving them choice when designing interventions or offering treatments for mental health
- Tailoring approach to individuals
- Longevity of support
- Continuity of the service
- Continuity of the support staff
- Building relationships with young people
- Developing trust between young people and support staff
- Early intervention
- Support for whole families, especially where there are multi-generational issues
- Joined up communication and working between different services
- Using play and play therapies
- Reducing stigma
- Short waiting lists and easy access to high quality support, tailored to the needs of young people.

There was agreement from youth practitioners and teachers that the support offered to young people needed to be high quality, and to meet the specific needs of those young people. Delivering support using a trauma-informed approach would meet these criteria.

While youth workers generally felt they had good skills, adequate training, and knew how to deliver effective support to young people, they cited that the main challenges they faced in being able to offer this support were limited resources, especially time.

*"Everyone is so stretched need more resources and more time."* - Youth mental health worker

*"Youth workers are willing to learn but they are stretched really thin, it is hard for them to have a focus on mental health"* – Youth mental health worker

*"We had a 50 hour timetable over two weeks, we had 5 frees. You're so stressed."* – Youth mental health worker and former teacher

*"Many times I work with young people, and they say what's the point you'll be gone in 6 weeks."* – CAMHS practitioner

*"If you ask anyone in any area, they want continuity of service. We spend hours doing funding bids, and it's a huge time input. People want continuity of service. Something might be helpful to them for 4 weeks or 12 weeks or whatever, but they like to know that if they have difficulties again in the future then that same support is going to be there for them."* – Social prescriber

It is clear that many youth workers are confident that they know how to support young people, but that they are not able to deliver the service they would like due to the limited resources available to them.

## 5.6 Summary

- There is some access to support currently, but it is inconsistent across West Yorkshire
- Young people, their parents and youth workers would like more activities to be available, particularly sports and activities that can help support wellbeing and prevent or reduce exposure to negative peer influences
- Availability, transport and cost of activities were the main barriers to taking part in activities or support
- For specific mental health services (e.g. CAMHS), waiting lists and limited sessions were cited as problems for access

- Schools often offer mental health and wellbeing support, but their time and resources are stretched
- Sport is a big source of support for young people, but available sports were usually football and rugby
- The focus on sport may reduce opportunities to access support for girls.

# 6. Training to support young people's mental health

## 6.1 Current access to training for varying types of practitioners

Youth practitioners were asked "To what extent do you agree that you have accessed all the relevant training to be able to support young people with their mental health and wellbeing?", shown in Table 19. While most somewhat or strongly agreed that they did, 28% disagreed that they had all of the relevant training they needed.

**Table 19 "To what extent do you agree that you have accessed all the relevant training to be able to support young people with their mental health and wellbeing?"**

| | Count | Percentage |
|---|---|---|
| Strongly agree | 10 | 20% |
| Somewhat agree | 24 | 48% |
| Somewhat disagree | 14 | 28% |
| Strongly disagree | 2 | 4% |
| Total | 50 | 100% |

Through the consultation, there was a general consensus that some level of mental health awareness training existed for most youth workers, but that more specialist training or detail on how to deal with more complex mental health situations was less common.

Within schools, teaching and support staff felt that safeguarding training covered mental health. Some staff reported that they felt they had sufficient opportunities for training and that through their continuing professional development (CPD) they were enabled and supported to do training on wellbeing support through online training modules, and via INSET (In-service training) day training sessions. However, many youth workers also highlighted that they went through a large quantity of compulsory training in a short space of time, leaving them with little time to focus on further or more detailed training.

*"As a teacher you have one day for all of the compulsory training, and not much about mental health. It deserves more attention."* – Mental health practitioner and former teacher

*"It is not about recognising mental health, it is about what to do next. Backfill for mental health services that do not exist."* – Youth service manager

One youth practitioner identified that there was a minimum baseline level of mental health awareness that all youth workers should have, citing the high quality Mental Health First Aid training course as the ideal standard. In addition to specific training courses, they also noted that it is important for staff to stay up to date through their regular CPD.

*"Not all staff have accessed up to date training – they've done mental health first aid and then not done anything since."* – Mental health youth worker

Most practitioners agreed that training was available, whether through online modules, in-school training, or other sources. The availability of training was generally viewed to be adequate, though with some barriers to access, discussed in section 6.3.

## 6.2 Training sought but currently not provided

When asked about the types of training that they wanted or needed to better support the young people they work with, most practitioners felt that they had adequate types of training already. However, many felt that they would benefit from more in-depth or more regular training to keep up to date with best practice and emerging trends.

Some cited specific focuses for their own CPD that aligned with their own specialisms and interests, and also that the need for different training changed depending on the needs of the current cohort of young people.

*"There's specific areas I'd like to do and that need can vary depending on the cohort of young people each year. Students' mental health changes all the time so should be more."* – Careers advisor

*"It's never enough. The more we can get the better."* – Safeguarding lead

There was clearly an appetite for staff to learn more where possible, and an enthusiasm for mental health support particularly among the staff members with wellbeing support in their remit.

## 6.3 Barriers and enablers to taking part in training

While the availability of relevant training was felt to be sufficient, the ability to access this was not always as good. Those school staff and other youth workers consulted for the research were predominantly focused on mental health support, and this is reflected in their enthusiasm for the subject. Several did express that the desire to focus CPD on mental health support was variable across teaching staff who did not have this specialism.

One wellbeing lead identified that the senior leadership team within a school were key to promote good training and the importance of mental health support in schools. Without buy-in from senior staff, it would be harder for staff to dedicate time to training for mental health support.

The main barriers for accessing training were the financial cost and time investment needed to attend training courses and dedicate to CPD.

*"Mental health first aid training is expensive."* – Wellbeing lead

*"Not enough time, it's important but everything else is important as well."* – School teacher

While school staff and other youth workers consulted felt that the training available is sufficient, resources are very stretched and there is rarely enough time or money for training. Senior leadership buy-in is an essential driver to promote training.

## 6.4 Examples of good practice

Through the course of the consultation with teachers on the types of training available, some particular examples of good practice were apparent. The following case studies outline approaches to supporting mental health and wellbeing within schools.

Case study: Thornhill Community Academy, Kirklees

*"At Thornhill Community Academy, the health, safety and wellbeing of students is a priority. We recognise the importance of the emotional health and wellbeing of all members of the academy community and don't just look after the academic progress and achievement of students. We have developed an outstanding network of support, advice and care that means that students don't just thrive academically but also emotionally and socially."*[5]

High quality mental health training is provided, including specialist youth mental health first aid training for several staff. Training includes half day or full day courses, and specialist topics including emotion coaching, ACEs, trauma-informed practice, selective mutism[6], bereavement, and other topics as needed. Pastoral care staff do all of the training on supporting wellbeing and mental health. Teaching staff do not do as much mental health specific training, however some want to do this as a specialism, which is supported. Most teaching staff have a general interest in student wellbeing and are supported by pastoral care staff. The wellbeing lead role includes delivering training in school for teaching staff to disseminate key information.

The school use online training providers and platforms, for example The National College[7] and National Online Safety[8] training.

As well as the training for school staff, the school offers practical wellbeing and mental health support. This includes a Student Support Hub with dedicated pastoral care staff, and a wellbeing room. In March 2022, the school received an award for their high quality mental health and wellbeing support.

Case study: Brian Jackson College, Kirklees

*"Brian Jackson College is an Alternative Provision supporting pupils with social, emotional and mental health difficulties."*[9]

[5] Thornhill Community Academy website
[6] A severe anxiety disorder where a person is unable to speak in certain social situations, such as with classmates at school or to relatives they do not see very often. Link.
[7] https://thenationalcollege.co.uk/
[8] https://nationalonlinesafety.com/
[9] Brian Jackson College website.

Staff at Brian Jackson College do a range of training to support the specialist needs of the young people in their care. The online training provider EduCare[10] is used. This provides training across a broad range of topics, including focusing on mental health support for young people. CPD is a key part of staff training. Staff particularly learn about how and why young people react or deal with situations and the psychology that underpins these reactions.

De-escalation training is key and is frequently used if there is an incidence of violence within the school. Staff also learn restraint techniques but these are a last resort only used if physical safety is at risk.

Staff in teaching roles have the usual training and qualification routes, but in addition the induction for staff at the school includes shadowing and on the job training because of the additional demands and needs of the young people in the school.

The focus on support for young people includes boundary setting to give routines and build trust. The support provided by staff is underpinned by school counsellors and a nurture room.

## 6.5 Summary

Key emerging themes:

- There is increasing pressure on schools to do more: education, mental health support, family and community support
- Pressure and demands on schools have been and continue to increase but it never (or rarely) comes with more time or more funding
- Most schools and staff are supportive of CPD and training on mental health and supporting young people, though levels of interest will vary between individual teachers
- Senior leadership teams have a big influence on the ethos of a school and its commitment to staff training and the treatment of mental health and violence

[10] https://www.educare.co.uk/

- High quality training is available, for example Mental Health First Aid, but higher quality, more detailed training is usually a greater time and financial investment. Easier-to-access training, such as short online training modules, are felt to be adequate but aren't as good as more detailed training
- Resources are stretched, and teachers are stressed, so time and budget are often barriers to access
- Some schools have chosen to have staff specifically for wellbeing and pastoral care, as they feel it is too much to expect teaching staff to do this in addition to their educational roles.

# 7. Conclusions and calls to action

## 7.1 Summary of key findings

A summary of the key findings from the research are:

- Mental health issues are a growing issue among young people, and they have increased over the past years due to COVID-19
- The loss of routine, lack of school structure, social isolation, and prolonged uncertainty are thought to be key factors in the increase in pandemic related mental health issues
- School pressures, social pressures, family life, and the impact of social media and their online life are all identified as being key factors impacting young people's mental health
- Mental health issues are worse for girls than for boys by the time they are in their teens, and almost all the young people being referred to support services are girls
- It is likely that boys are also having problems following the pandemic, facing the same challenges of social isolation and loss of routine, but don't seem to be reporting problems or accessing services
- Low-level mental health issues can lead to violent outbursts or misbehaviour through a frustration response and poor emotional regulation skills
- Young people with low-level mental health issues are more vulnerable to peer pressure and to being targeted by gangs
- Experiences of violence exacerbate mental health issues, and people with mental health issues are more likely to be victims of violence as they are more vulnerable
- Home life can impact mental health and influence experiences of violence
- There is some access to support currently, but it is inconsistent across West Yorkshire
- Young people, their parents and youth workers would like more activities to be available, particularly sports and activities that can help support wellbeing and prevent or reduce exposure to negative peer influences
- Availability, transport and cost of activities were the main barriers to taking part in activities or support
- For specific mental health services (e.g. CAMHS), waiting lists and limited sessions were cited as problems for access

- Schools often offer mental health and wellbeing support, but their time and resources are stretched
- Sport is a big source of support for young people, but available sports were usually football and rugby; the focus on sport may reduce opportunities to access support for girls
- There is increasing pressure on schools to do more: education, mental health support, family and community support. Pressure and demands on schools have been and continue to increase but it never (or rarely) comes with more time or more funding
- Most schools and staff are supportive of CPD and training on mental health and supporting young people, though levels of interest vary between individual teachers. Senior leadership teams have a big influence on the ethos of a school and its treatment of mental health and violence
- Training is available, but resources are stretched, and teachers are stressed so time and budget are the barriers to access
- Some schools now have staff specifically for wellbeing and pastoral care, as it is too much to expect teaching staff to do this in addition to their educational roles.

## 7.2 Future directions to break the link

Breaking the link between mental health and violence looks different for young people who are engaged in schools and other services and those who are disengaged. For young people who are engaged in schools and/or other services, appropriate interventions could include:

- Access to support for low-level mental health issues through existing touch points e.g. schools, sports, youth clubs
- Particular support for year groups most affected by COVID-19
- Focus on targeting activities and hobbies to girls
- Specific activities to build resilience in young people.

Working within schools, youth clubs, and other organised activities, means meeting the young people 'where they are' and integrating wellbeing support into daily activities, with the aim of preventing low-level issues escalating to become more severe mental health issues. This can also teach and foster good emotional regulation skills to prevent violence or escalation of violence and help to develop emotional resilience. Youth clubs in particular can provide vital

opportunities for young people, particularly those at risk of involvement in crime or violence through negative peer pressure or grooming by gangs. They offer a place for young people to go and things to do, usually at low or no cost, and are usually place-based rather than skills-based. This is key for those young people who may not have a specific hobby or interest that they are able to pursue.

Offering a wide range of activities outside of schools creates opportunities for young people to learn these emotional and social skills, boost their mental wellbeing, and can prevent contact with negative peer influences. Offering a range of different types of activities will appeal to a broader range of young people and open up opportunities. Likewise, improved transport access for young people, particularly outside of the main cities, will remove some of the barriers to participation.

For those young people who did not have usual transition points into secondary school, there are known to be issues with social skills and emotional resilience. Targeting support and activities at this group specifically can help them to learn what they missed from that transition, and help to promote recovery from the negative impacts of the pandemic.

Teenage girls are at highest risk of low-level mental health issues and are underrepresented in sports. Yet sports are frequently cited as a key support activity for young people for both mental health and reducing links to violence. Bringing teen girls into sport, or offering alternative activities that appeal to their interests, will help to create the opportunities for them to access wellbeing support.

Building resilience in young people, particularly around self-confidence and aspirations is also known to help protect both their mental wellbeing, and to reduce links with violence. The young people in the consultation who felt comfortable saying no to peer pressure around crime and violence cited their levels of self-confidence as key to enabling them to do this. Focusing on developing these skills in more young people may help break links with violence.

Much of the support for improving mental health and preventing links to violence that was discussed in the consultation was focused on preventative options and early intervention with young people at risk. Working with young people who are disengaged from schools and services may be more difficult to reach with preventative actions. Taking a trauma-informed approach to the delivery of services is key to support young people, especially those who are

already victims or perpetrators of violence. In addition, avoiding school exclusions and instead working directly with these young people to support their needs will help to break the links with violence or crime, and help to prevent contact with the criminal justice system (CJS) and escalating issues. Likewise, where contact with the CJS has already happened, diversion activities (e.g. liaison and diversion services) and providing support for underlying needs (e.g. mental health issues) is likely to have much better long-term outcomes for those young people.

Further ways to break the links between low-level mental health issues and violence also need to consider younger children and future generations, as cycles of mental health issues and violence within households and families are common. Taking a whole-family approach to support activities and working with families and young people from birth can help to foster good wellbeing and improve future life chances.

## 7.3 Improving connection and coordination between services

While many of the suggested activities and ways of working are targeted at individual providers, there are benefits and synergies possible through partnership working across the sector. For example, rather than offering after-school activities themselves, schools could link in with existing providers of sports or other hobbies, and help connect young people to these services. Key actions for improving connects between services are:

- Services (e.g. schools, youth clubs, mental health support) should work to understand the overall support landscape for young people across the area
- Services should work together to share information about opportunities and risks
- Services should be able to connect their young people to each other, to ensure that relevant opportunities are promoted to young people as needed.

## 7.4 Calls to action

There are a number of ways of working that are suggested (i.e. 'how' things are done, rather than 'what' is done), as well as a number of new interventions. These include:

- Delivering support through schools is vital as this is a key point of engagement for most young people, and meeting them 'where they are' is key for providing support

- Enabling schools to expand their support services through increased resources that are ring-fenced for this critical area of activity
- However, schools cannot do everything; high quality support needs to be available in multiple places, particularly offering support and meaningful activities outside of school to prevent or reduce negative peer influences and prevent involvement in crime
- More activities outside of school, with a particular focus on engaging girls in hobbies and activities. Youth clubs that provide high quality support and diversionary activities can reduce the risk of violence. Improving access to activities and transport links (including cost) will remove barriers to participation
- The key ways of working include providing longevity and continuity of support, to enable trusting relationships – particularly for young people who already have issues with their mental health
- For young people accessing mental health services, continuity at the point of transition from children's to adult services is a significant barrier that could be addressed
- Using a trauma-informed approach to design and deliver services will help to avoid re-traumatising young people, and support those who already have experienced trauma, e.g. as victims of violence, and help to protect their mental health and wellbeing.

# 8. Appendix: Evidence review – young people's experience of low level mental health issues and violence

## 8.1 Introduction

Rocket Science was commissioned by West Yorkshire VRU in November 2021 to research the links between low-level mental health issues and violence amongst young people. This evidence review summarises the existing literature on the prevalence of low-level mental health issues in children and young people, and links to violence, in both West Yorkshire and the wider UK. The risk factors and demographic factors that can shape this relationship, and how these change over time are considered, with a view to identifying points in young people's lives that present opportunities for effective intervention.

The review took into account key transition points in young people's lives such as the move from primary school to secondary school, the selection of GCSE subjects in Year 9, and the move into post-16 education or employment.

Rocket Science reviewed evidence from the Idox Knowledge Exchange database, Google Scholar, and third-sector and government websites. The evidence review drew on these various sources of key information and addressed the following research questions:

Overarching research questions

- What is the link between low-level mental health and violence?
- What are the key risk factors and do these differ by demographic groups?
- Which types of interventions can break the link between low-level mental health and violence?
- How do low-level mental health issues affect contact with the criminal justice system?
- What are the practitioner training needs for youth workers and mental health practitioners?

## 8.2 The relationship between low-level mental health issues and violence

### 8.2.1 Research questions

- What is a low-level mental health issue?
- Which low-level mental health conditions are linked to victimisation and perpetration of violence? What is the nature of this connection?
- How does the relationship between low-level mental health issues and violence change throughout young people's lives, from the ages 0-25?
- Which additional factors are likely to impact low-level mental health and/or violence?

### 8.2.2 Defining 'low-level' mental health issues

Defining a low-level mental health issue is challenging as by its very nature, it does not fit easily into diagnostic criteria. Broadly speaking, this covers mild to moderate presentations of common mental health problems, such as anxiety, depression, some eating disorders, and sub-types or related illnesses to all of these (e.g. generalised anxiety disorder, phobias, OCD etc)[11].

Severe mental illness, such as psychosis, schizophrenia, or other illnesses with severe impacts and clear diagnostic criteria would not fall into this category. However, some illnesses may present a grey area: for example, a severe case of depression would not fall into the category of "low-level" while mild and sub-clinical cases of depressive symptoms would. In such a case, it is not the presence or absence of a diagnosis that would define someone has having a low-level mental health problem, but the occurrence and severity of symptoms and the level to which this interfered with their usual activities. Low-level does not mean unimportant, nor that there is no associated risk.

Typical low-level mental health symptoms or indicators can include self-harm, risk-taking and conduct problems[12], as well as anxiety, depression, anger, emotional instability, troubled

[11] National Institute for Health and Care Excellence (NICE) (2011). Common mental health problems: identification and pathways to care. Clinical guideline [CG123]. Published: 25 May 2011. Link.
[12] https://www.hsj.co.uk/mental-health/why-low-level-mental-health-problems-require-a-sophisticated-service-response/7024949.article

relationships, and substance misuse[13]. The Mental Health Foundation[14] lists the most common mental health problems in children, shown in Table 20.

**Table 20 Common mental health conditions in children**

| | |
|---|---|
| Depression | Depression affects more children and young people today than in the last few decades. Teenagers are more likely to experience depression than young children. |
| Self-harm | Self-harm is a very common problem among young people. Some people who experience intense emotional pain may try to deal with it by hurting themselves. |
| Generalised anxiety disorder (GAD) | GAD can cause young people to become extremely worried. Very young children or children starting or moving school may have separation anxiety. |
| Post-traumatic stress disorder (PTSD) | PTSD can follow physical or sexual abuse, witnessing something extremely frightening or traumatising, being the victim of violence or severe bullying or surviving a disaster. |
| Attention deficit hyperactivity disorder (ADHD). | Children who are consistently overactive, impulsive and have difficulty paying attention may have attention deficit hyperactivity disorder (ADHD). |
| Eating disorders | Eating disorders usually start in the teenage years and are more common in girls than boys. The number of young people who develop an eating disorder is small, but eating disorders such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development. |

Low-level mental health issues are likely to be sub-clinical or score as 'mild to moderate' using diagnostic criteria. In contrast to this, access to Child and Adolescent Mental Health Services (CAMHS) is typically available for severe, debilitating and long-lasting mental illnesses[15].

[13] Porteous et al (2015). The Development of Specialist Support Services for Young People who have Offended and who have also been Victims of Crime, Abuse and/or Violence: Final Report. Link.
[14] Mental Health Foundation (2021). What mental health problems commonly occur in children? Link.
[15] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link

Therefore, young people with low-level mental health issues are unlikely to have access to formal mental health support services. This prevents young people from getting support at an early stage, which can lead to a worsening of mental health issues[16]. For those who do access formal support, there can be challenges around transitions from youth to adult mental health services, which often coincide with other key life transitions. CAMHS provide mental health support up to age 16, and adult mental health services start from 18. There is limited formal specialist mental health provision for 16-18 year olds[16] and this provision varies according to local commissioning arrangements[17].

Access to CAMHS can also be difficult, due to the long waiting lists and limited provision, along with delays in recognition of low-level mental health problems in young people, and for parents, carers, teachers and GPs to understand and identify when these issues need to be referred to specialist CAMHS. Barriers to accessing CAHMS also included a delay in parents or carers recognising when help is needed; young people not meeting sufficient criteria to be "ill enough" to warrant specialist treatment; and long waiting lists meaning support is often not received at the time it was most needed[18] [19]. While targets for waiting list times for access to CAMHS do exist, these are often exceeded, with limited staff or funding for provision, and increasing demand for services from young people[20], even before increases in demand associated with the impact of COVID-19[21] [22].

West Yorkshire Combined Authority is covered by multiple NHS Foundation Trusts, who provide wellbeing services including CAMHS: the South West Yorkshire Partnership NHS Foundation Trust (Calderdale, Kirklees and Wakefield); the Leeds and York Partnership NHS Foundation Trust (Leeds); and Bradford District Care NHS Foundation Trust (Bradford). Waiting times from referral to treatment for specialist mental health services are not routinely published for mental health services, but figures for 48 mental health trusts in England were

[16] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[17] Young Minds (2020). Transferring from CAMHS to Adult Mental Health Services. Link.
[18] Crouch et al. (2019). "Just keep pushing": Parents' experiences of accessing child and adolescent mental health services for child anxiety problems. Child: Care, Health and Development, 45, 4, pp491-499. Link.
[19] The Lancet. (2020). Child mental health services in England: a continuing crisis. Link.
[20] Campbell (2019). NHS cancellations of child mental health sessions jump 25%. The Guardian. 11 Nov 2019. Link.
[21] Young Minds (2021). The impact of Covid-19 on young people with mental health needs. Link.
[22] UK Parliament (2021). Children and young people's mental health. Health and Social Care Committee. Link.

made available in January 2022[23] showing the waiting time for a first appointment with CAMHS following a referral. The average varied across England from seven days to 112 days. In South and West Yorkshire NHS Foundation Trust the average waiting time was 23 days, while in Bradford District Care NHS Foundation Trust the average waiting time was 15 days. Data were not available for Leeds and York Partnership NHS Foundation Trust. Proposed new NHS England standards suggest that the waiting time for CAMHS should not exceed 28 days, a target that most of West Yorkshire seems to be meeting on average. However, data were not available on the length of time between the initial assessment appointments and the start of any recommended treatment.

These delays are potentially harmful, not only because of the distress of young people waiting for access to treatment, but also because early intervention in mental health disorders is understood to have a better chance of successful treatment and improved long-term outcomes for patients[24]. Early intervention in this case is often likely to be when symptoms are mild, presenting as low-level mental health problems, and not typically severe enough to warrant a successful referral to CAHMS. Therefore, an opportunity to address mental health problems before they become more serious is being missed, despite evidence suggesting that this early treatment of low-level mental health issues being more successful, and more likely to prevent serious disorders at a later stage.

[23] Tidman, Z (2022). Vulnerable children wait almost three years to access mental health care while others seen in just a week. The Independent, 3 January 2022. Link.
[24] Davey and McGorry (2019). Early intervention for depression in young people: a blind spot in mental health care. Link.

### 8.2.3 The prevalence of low-level mental health issues in children and young people

The prevalence of low-level mental health issues varies by age and gender. The Mental Health and Young People Survey (MHCYP) survey[25] asks a sample of all young people about indicators of likely mental health issues, and therefore can show the prevalence of low-level conditions without need for a formal diagnosis. Percentages of young people scoring as having a 'probable disorder' are shown in Table 21, below.

**Table 21: Young people in England, aged 6-22, scoring "probable disorder" on the Strengths and Difficulties Questionnaire, by age group and gender, data for 2021**

| | Age 6 - 10 | Age 11 - 16 | Age 17 - 19 | Age 20 - 22 |
|---|---|---|---|---|
| | % | % | % | % |
| All | 17.1 | 17.7 | 17.4 | 19.1 |
| Boys | 21.9 | 15.6 | 10.3 | 11.7 |
| Girls | 12.0 | 19.8 | 24.8 | 26.2 |

Source: Mental Health of Children and Young People in England, 2021: Wave 2 follow up to the 2017 survey, NHS Digital, Table 1.2: Mean SDQ scores and mental health of child or young person by age and sex, 2017, 2020 and 2021

Amongst 6–10 year olds, girls have significantly lower prevalence of probable disorders than boys but this trend reverses over time. By the age of 20-22, the rate for girls is more than double that for boys (26% compared to 12%).

Even though there are higher rates of probable disorders all groups in 2020 and 2021 compared to 2017, this pattern is reflected in all three years of data for these age groups (see Table 22). This suggests that opportunities to intervene to promote good mental health at key transition points may differ for boys and girls.

[25] NHS Digital (2021). Mental Health and Young People Survey. Link.

**Table 22 Percentage of young people showing "probable disorder" on the SDQ, by age, gender and year**

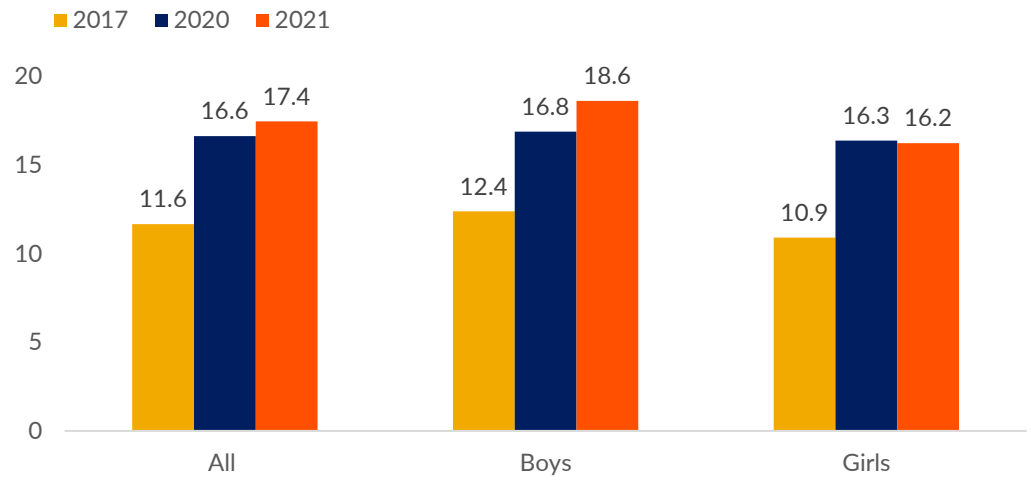
| | 2017 | | | 2020 | | | 2021 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Age 6-10 | Age 11-16 | Age 17-19 | Age 6-10 | Age 11-16 | Age 17-19 | Age 6-10 | Age 11-16 | Age 17-19 |
| All | 9.9 | 13.3 | 10.1 | 15.4 | 17.6 | 17.7 | 17.1 | 17.7 | 17.4 |
| Boys | 12.5 | 12.3 | 7.0 | 18.6 | 15.3 | 8.7 | 21.9 | 15.6 | 10.3 |
| Girls | 7.2 | 14.3 | 13.4 | 12.2 | 20.1 | 27.3 | 12.0 | 19.8 | 24.8 |

Note: the 20-22 age group data was not available for all years, so has been excluded from this table.

Source: Mental Health of Children and Young People in England, 2021: Wave 2 follow up to the 2017 survey, NHS Digital, Table 1.2: Mean SDQ scores and mental health of child or young person by age and sex, 2017, 2020 and 2021

Data for 2020 and 2021 iterations of the NHS Digital MHCYP survey shows much higher prevalence of probable mental health disorders in young people than in 2017, shown in Figure 1. This aligns with other reports on the impact of the COVID-19 pandemic on children and young people's mental health. Research by Young Minds has found that there have been negative impacts in particular for young people with pre-existing mental health issues[26].

**Figure 1 Percentage of young people with a "Probable disorder" for 6-16 year olds, split by gender**




Source: NHS Digital MHCYP survey 2021, Table 1.2: Mean SDQ scores and mental health of child or young person by age and sex, Table 1.2: Mean SDQ scores and mental health of child or young person by age and sex

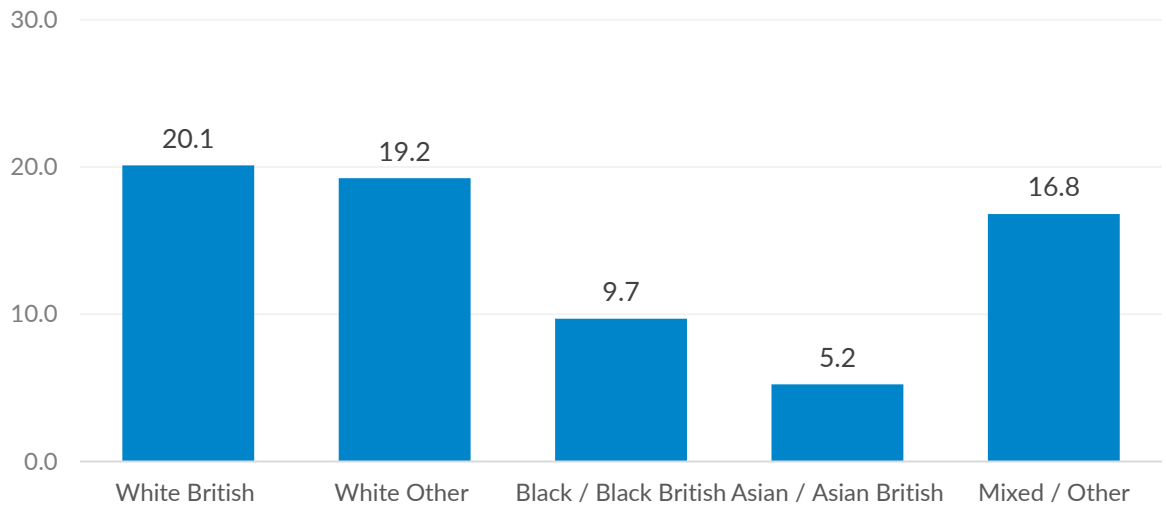
[26] Young Minds (2021). The Impact of COVID-19 on young people with mental health needs. Link.

There are also differences by ethnicity for "probable disorder" scores shown in Figure 2. This shows that probable disorders are less prevalent in Black/Black British and Asian/Asian British children and young people, than for their peers. This could reflect increased stigma around mental health as sometimes reported in Black and Asian adults[27] [28], leading to less reporting of indicators of probable mental health disorders. This unclear pattern indicates a need for further research.

Stigma around mental health in ethnic minority communities is thought to be a limitation in young people both reporting mental health issues, but also in accessing services to support their wellbeing[29] In addition, ethnicity can impact young people's well-being and mental health in diverse, complex and gendered ways[27]. While some existing schemes to reduce stigma around mental health have not been successful in ethnic minority communities, some research indicates that this is due to a lack of targeting to specific communities, and expecting schemes designed primarily for White British communities to be relevant to all sections of the population[30]. Tailored messages with cultural relevance and schemes coproduced with minority communities are expected to work more successfully[30] [31]. However, there are limited examples of this type of scheme being delivered at scale in the UK.

[27] Hamblin (2016). Gender and children and young people's emotional and mental health: manifestations and responses A rapid review of the evidence. National Children's Bureau. Link.
[28] Mentally Health Foundation (2021). Black, Asian and minority ethnic (BAME) communities. Link.
[29] Memon, A. et al (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England. BMJ Open, 6(11). Link.
[30] Knifton (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. Health sociology review. 21(3):287-98. Link.
[31] Race Equality Foundation (2015). Better practice in mental health for black and minority ethnic communities. Link.

Figure 2 Percentage of 6-16 year olds scoring "probable disorder" on the SDQ, split by ethnicity




**Source:** NHS Digital MHCYP Survey, 2021 - Table 1.3d Mean SDQ scores and mental health of child by five category ethnic group, 2021

## 8.2.4 Presentation and symptoms

The ways that low-level mental health problems can manifest vary depending on age and gender.

For young children, aged 3-8, suggested indicators of poor mental health or wellbeing[32] are:

- Repeated tantrums or consistently behaving in a defiant or aggressive way
- Seeming sad or unhappy, or crying a lot
- Afraid or worried a lot
- Gets very upset about being separated from parents/carers, or avoids social situations
- Starts behaving in ways that they've outgrown, like sucking their thumb or wetting the bed
- Has trouble paying attention, can't sit still or is restless.
- Trouble sleeping or eating

[32] Raising Children Network (Australia) (2021). Mental health problems in children 3-8 years: signs and support. Link.

- Physical pain that doesn't have a clear medical cause – for example, headaches, stomach aches, nausea or other physical pains.
- Not doing as well as usual at school
- Having problems fitting in at school or getting along with other children
- Not wanting to go to social events like birthday parties.

Once young people are in their teenage years, they may also exhibit the same signs of poor mental health as adults. The signs and symptoms of poor mental health or wellbeing in older children may include[33]:

- Sudden mood and behaviour changes
- Self-harming
- Unexplained physical changes, such as weight loss or gain
- Sudden poor academic behaviour or performance
- Sleeping problems
- Changes in social habits, such as withdrawal or avoidance of friends and family.

There are key differences in the types of mental health issues that are reported as being experienced by boys and girls. Girls and young women are more likely to be diagnosed with depressive disorders and anxiety disorders, while diagnoses of conduct disorders (the most common mental health problems identified in children and young people) are significantly more prevalent in boys than girls[34].

While all children can display behaviour problems at some stage, where this becomes severe and persisted to the point of disrupting their day to day lives, it is usually then defined as a conduct disorder[35]. These behaviours can be aggressive, destructive, and even violent. Often conduct disorders may be linked to underlying mental health issues or unmet special educational needs, such as poor reading or writing skills that are undiagnosed.

There are also confounding factors in how mental health issues may present themselves, which can make it more difficult to identify low-level mental health issues in young people. In

[33] NSPCC (2021). Signs of child mental health issues. Link.
[34] Hamblin (2016). Gender and children and young people's emotional and mental health: manifestations and responses A rapid review of the evidence. National Children's Bureau. Link.
[35] Royal College of Psychiatrists (2015). Behavioural problems and conduct disorders: for parents, carers and anyone working with young people. Link.

particular, masking behaviours where people may actively try to conform to expected social behaviours even when doing so hides their true feelings and experiences. While seen in both boys and girls, this is more commonly seen in girls, and the difference becomes more marked as children age[36] [37]. Masking behaviours in girls are thought to be influenced by social pressures and structures that teach girls to be 'nice' and to hide or ignore negative emotions[36].

Masking behaviours are also commonly seen in people with autism spectrum conditions (ASC), both girls and boys, for example through mimicking socially acceptable behaviours of other children[38]. This masking behaviour has been shown to use considerable energy to maintain and is itself known to be a contributory factor causing or exacerbating anxiety in people with ASC[38].

### 8.2.5 Types of mental health issues linked to victimisation and perpetration of violence

There are also gendered differences in the presentation of low-level mental health problems, and how these are responded to in different settings. For example, boys are more likely than girls to commit acts of violence, and girls are more likely to be victims, particularly of domestic abuse or gender-based violence[34]. The types of mental health disorders seen in girls and boys has implications for links to violence - emotional problems, particularly anxiety, are more often seen in girls and young women and can lead to internalisation (where distress is directed inwards), while boys and young men are typically more likely to externalise problems, which manifest in 'acting out' (displaying inappropriate and unrestrained behaviour, such as fighting, stealing or having tantrums), which can be linked to conduct disorders and disruptive behaviour[34]. These differing responses can influence the relationship with violence, particularly where 'acting out' manifests as violent behaviour.

These gendered differences in presentation can also influence how the behaviour is recognised by parents, carers and professionals working with young people. Generally, they are better able to recognise emotional problems in girls and behavioural problems in boys. Where children and

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[36] Davis, T. L. (1995). Gender differences in masking negative emotions: Ability or motivation? Developmental Psychology, 31(4), 660–667. Link.
[37] Chaplin, T. M., & Aldao, A. (2013). Gender differences in emotion expression in children: A meta-analytic review. Psychological Bulletin, 139(4), 735–765. Link.
[38] Cage, E., Troxell-Whitman, Z. (2019). Understanding the reasons, contexts and costs of camouflaging for autistic adults. Journal of Autism and Developmental Disorders, 49, 1899–1911. Link.

young people do not conform to gender expectations in the presentation of their issues, these may be overlooked or misunderstood, and therefore not properly addressed. There is also evidence that mental health needs underpinning behavioural problems in children and young people are under-recognised[34].

It is also interesting to note that there is "evidence of gender bias in professionals' recognition of, and responses to, children and young people's experiences of violence and abuse"[39]. This can influence how young people are treated both for prevention of violence or in its aftermath, and also how they are linked into mental health support services.

One of the key mechanisms that can link violence and low-level mental health is a toxic stress response in children exposed to violence, for example living in a domestic abuse situation[40]. When a child or young person is living with some type of adversity (e.g. violence or abuse) over a long period of time, this can lead to a prolonged activation of the stress response systems in the body, such as the production of the hormone cortisol. This toxic stress response interferes with child development and can reshape how a child reacts to other stressful situations. It is a key factor in the relationship between adverse childhood experiences (ACEs) and poor outcomes in later life. It can lead to serious health and mental health problems and depends on severity and duration of the stressful situation, as well as other factors such as genetic predisposition to various risk factors for health outcomes[41]. The link with ACEs is discussed further in sections 8.3.2 and 8.3.5.
As well as being a result of experiencing violence, ACEs are also a strong predictor of perpetration of crime, and particularly violent crime[42]. It is likely that the toxic stress mechanism is also a factor in this relationship, as a child has had interference in their development of appropriate coping responses or socialisation for dealing with high-risk situations in later life[34].

A high proportion of children and young people involved in the criminal justice system and youth offending services experience mental health conditions. Around 40% of a typical youth offending service caseload will have mental health issues, usually linked to ACEs[43]. The link

[39] Hamblin (2016). Gender and children and young people's emotional and mental health: manifestations and responses A rapid review of the evidence. National Children's Bureau. Link.
[40] Harvard University (2018). Toxic Stress. Center on the Developing Child. Link.
[41] Harvard University (2018). ACEs and Toxic Stress: FAQs. Center on the Developing Child. Link.
[42] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[43] Porteous et al (2015). The Development of Specialist Support Services for Young People who have Offended and who have also been Victims of Crime, Abuse and/or Violence: Final Report. Link.

between mental health and violence and is not necessarily straightforward nor is it the same in all cases.

A nationally representative survey of English residents aged 18 to 69 conducted in 2013 found that 47% of individuals experienced at least one of the nine detailed adverse childhood experiences[44]. While now several years old, this survey remains the main source of data on prevalence of ACEs within England. There is limited evidence on which specific types of ACEs are linked to poorer mental health, or the specific types of mental health issues that are associated with ACEs. One study did find that children who had been abused or neglected were four times more likely to be diagnosed with a serious mental health disorder[45]. What is clear is that the more ACEs a person has experienced, the higher their risk of poor mental and/or physical health[44]. Evidence from Scotland assessing the link between ACEs and poorer health in adults, found that adults reporting four or more ACEs were five times more likely to have low mental wellbeing, 14 times more likes to have been a victim of violence in the preceding 12 months, and 15 times more likely to have committed violence themselves. In addition, they were 20 times more likely to have been in prison at some point in their life[46].

It is important to note that while there is a clear relationship between ACEs and poorer health outcomes, this link is associative and not predictive. Some individuals may experience multiple ACEs but maintain good health outcomes throughout life. Both ACEs and poorer health outcomes are also linked to indices of multiple deprivation[47], suggesting that there is a more complex relationship between various factors that can influence the mental and physical health of people from their formative years into adulthood.

[44] Bellis et al (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviours in England. BMC Medicine 12 72). Link.
[45] Chandan et al (2019). The The burden of mental ill health associated with childhood maltreatment in the UK, using The Health Improvement Network database: a population-based retrospective cohort study. The Lancet Psychiatry 6(11), pp926-934. Link.
[46] Scottish Government (2020). Scottish Health Survey 2019: Chapter 8 Adverse Childhood Experiences. Link.
[47] Lewer et al (2020). The ACE Index: mapping childhood adversity in England. Journal of Public Health, 42(4). Link.

### 8.2.6 The prevalence of violence in West Yorkshire

The VRU Needs Assessment, 2021 outlines the incidence of violence across West Yorkshire as follows:[48]:

Violent Crime in West Yorkshire

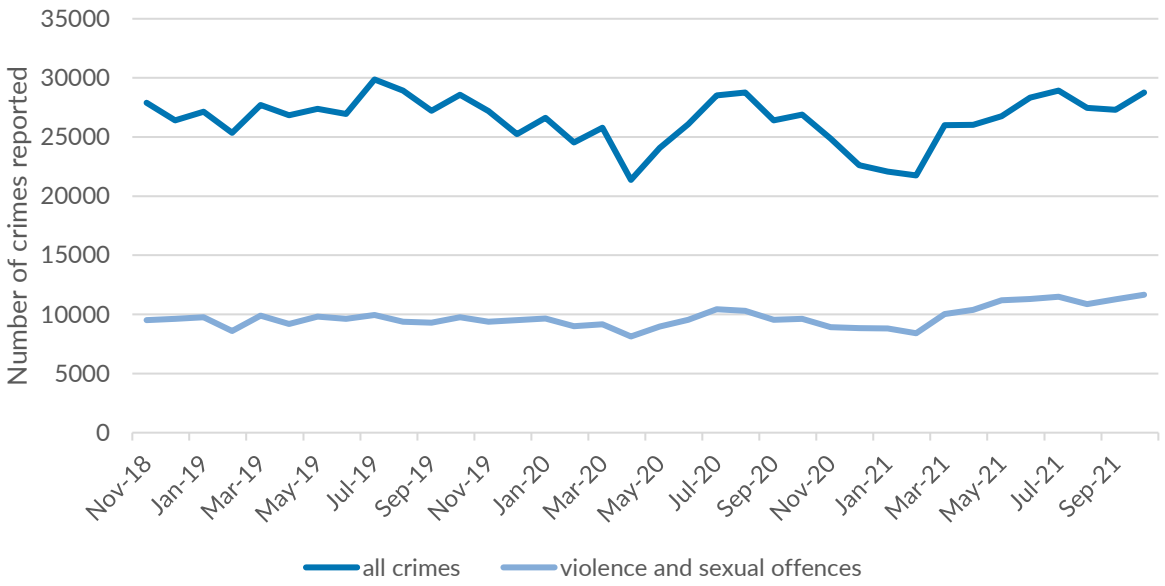
- Crimes of Violence against the Person are more severe in West Yorkshire than the rest of England and Wales. The severity of violence in the region has been increasing steadily since 2012/13.
- West Yorkshire has the third highest rate of knife crime amongst similar police force areas. 42% of knife crime offenders are males aged between 15 and 24.
- West Yorkshire has the third highest rate of gun crime amongst similar police force areas. 94% of gun crime offenders and 99% of victims are male, with those aged 20-24 the most common offenders.
- Most knife and gun crime offences occur in areas of high deprivation.
- Domestic abuse is a major problem in West Yorkshire, with nearly 76,000 incidents recorded in the monitoring period for this assessment. Females account for 75% of victims and two-thirds of victims are aged 20-39. Suspects were mainly male (75%), with two-thirds being aged 21-40.
- Domestic abuse incidents are most often reported between the hours of 3:00pm – 8:59pm Monday to Sunday, with an additional spike at midnight on Saturdays and Sundays.
- Violence with Injury offences occur more regularly in town and city wards, with peaks in offending from 23:00 to 00:00, suggesting a link with increased footfall around the night time economy. An additional peak was seen at around 15:00, potentially linked to after school activities. 75% of victims and offenders are male.
- 100% of homicide offenders in West Yorkshire were aged between 15 and 24.
- Violence in custodial environments emerged as a significant problem, particularly at HMYOI Wetherby, where rates of assault are 8 times the national average for prisons as whole and 19 times the average for West Yorkshire.

Although not available by age group or gender, the overall crime statistics for West Yorkshire show that violence and sexual offences consistently form over a third of all crimes in West

[48] https://www.westyorks-ca.gov.uk/media/6995/wy-vru-needs-assessment-january-2021.pdf

Yorkshire. Overall crime levels have fluctuated over the past two years, notably they are lower during the two main national COVID-19 lockdown periods in March to May 2020, and December 2020 to March 2021. However, violence and sexual offences remained broadly static, and have been starting to rise over the past six months. This trend has been seen across all five areas, as shown in Table 23.

**Figure 3 Time series of crime in West Yorkshire**




Source: data.police.uk; Crime reported in West Yorkshire, Nov 2018 to Oct 2021. Total of all crimes, and of violence and sexual offences, total for the 5 districts of West Yorkshire Combined Authority
Note: Excludes crimes that fall into the West Yorkshire Police remit, but took place outside of the 5 areas of Bradford, Calderdale, Kirklees, Leeds and Wakefield.

**Table 23 Violence and sexual offences as a percentage of all crimes, from Nov 2018 to October 2021, in the five districts of West Yorkshire**

| | Nov 18 - Apr 19 | May 19 - Oct 19 | Nov 19 - Apr 20 | May 20 - Oct 20 | Nov 20- Apr 21 | May 21 - Oct 21 | Nov 18- Oct 2021 % increase |
|---|---|---|---|---|---|---|---|
| Bradford | 36% | 36% | 38% | 39% | 41% | 42% | 17% |
| Calderdale | 39% | 37% | 40% | 38% | 42% | 42% | 8% |
| Kirklees | 35% | 35% | 37% | 38% | 40% | 42% | 20% |
| Leeds | 33% | 32% | 34% | 34% | 36% | 38% | 15% |
| Wakefield | 36% | 35% | 37% | 36% | 38% | 40% | 11% |
| Total | 35% | 34% | 36% | 36% | 39% | 40% | 14% |

Data published in the VRU Needs Assessment 2021[49], showed that:

- 16,435 Violence with Injury and Rape/Sexual Assault offences were committed against victims under 25 years of age in West Yorkshire between 1st April 2019 – 31st August 2020
- Leeds District accounts for 34% of all offences, Bradford 26% and Kirklees 17%. Wakefield 13% and Calderdale 10%
- The highest prevalence of offending correlates strongly to areas of high deprivation
- Victims of youth violence are 57% female and 43% male
- Less than 3% of offences have offender(s) linked, but where those links exist, offenders are overwhelmingly male (87% male versus 13% female).

**Table 24 Victim age as a percentage of youth violence[49]**

| Victim Age | Male | Female |
|---|---|---|
| Under 10 | 5.1% | 4.9% |
| 10 to 14 | 10.2% | 11.1% |
| 15 to 19 | 13.5% | 20.3% |
| 20 to 24 | 13.8% | 21.0% |

**Table 25 Offender age as a percentage of youth violence[49]**

| Offender age | Male | Female |
|---|---|---|
| Under 10 | 0.0% | 0.0% |
| 10 to 14 | 4.2% | 2.5% |
| 15 to 19 | 35.2% | 5.2% |
| 20 to 24 | 47.2% | 5.5% |

It is also apparent that the proportion of Black, Asian and minority ethnic young people in the youth justice system in England (and Wales) is disproportionately high. Around 20% of young people (aged 0-24) in England and Wales are from a minority ethnic group[50]. However, the proportion of people in the youth justice system who received a youth caution or sentence

[49] https://www.westyorks-ca.gov.uk/media/6995/wy-vru-needs-assessment-january-2021.pdf
[50] ONS (2011). England and Wales 2011 Census. Link.

and were from a minority ethnic group was 29%[51]. This proportion has been increasing year on year. The reasons for this overrepresentation are explored in policy, particularly through the Lammy Review into the treatment of, and outcomes for Black, Asian and Minority Ethnic individuals in the criminal justice system[52]. and its update report[53]. However, how these factors intersect with low-level mental health issues in young people from black and minority ethnic backgrounds is underexplored and offers a direction for further research (see section 8.7.3).

### 8.2.7 Summary

- The prevalence of mental health issues is increasing for children and young people
- Not all mental health conditions become serious enough to enable access to child and adolescent mental health services
- Low-level mental health conditions can have serious impacts on young people, their achievements, and their risks of poor outcomes, including becoming involved in violence
- There is some evidence linking low-level mental health issues and violence, with those experiencing frustration or 'acting out' are more likely to perpetrate violence, but this is not fully understood
- Links between mental health and violence go in both directions: children and young people who have experienced violence are more likely to experience poor mental health and those with poor mental health are more likely to experience violence, as victims or perpetrators
- Boys are more likely than girls to perpetrate violence; girls are more likely to be victims
- ACEs are strongly correlated with poor mental health and with violence.

[51] Ministry of Justice (2021). Youth Justice Statistics 2019/20: England and Wales. Supplementary tables, Table 3.1. Link.
[52] Lammy Review (2017). An independent review into the treatment of, and outcomes for Black, Asian and Minority Ethnic individuals in the Criminal Justice System. Link.
[53] Ministry of Justice (2020). Tackling Racial Disparity in the Criminal Justice System: 2020 Update. Link.

## 8.3 Risk factors and demographics

### 8.3.1 Research questions

- What are the main risk factors for young people with low-level mental health issues becoming victims or perpetrators of violence (or both)?
- How do different low-level mental health conditions present themselves in different age groups of children?
- Does the link between low-level mental health and violence differ by gender, ethnicity, location/part of West Yorkshire? If yes, why is this?
- Are there differences in risk factors for victim and perpetration of violence?

### 8.3.2 Risk factors

Risk factors for poor mental health in young people can be found across multiple aspects of their lives, from lifestyle to home and family and school situations. Table 26 below lists the key risk factors for poor mental health[54]. These same factors can also be protective, depending on young people's circumstances.

There are increased risks where children experience multiple risk factors. Many of these risk factors, as well as poor mental health itself, can make young people more vulnerable to both perpetration and victimisation of violence. For example, children with more risk factors can be targeted by child criminal exploitation (CCE) and involvement in gangs[54]. Being a victim of CCE can in turn have a negative impact on a young person's mental health through the exposure to violence and trauma.

The Department for Education report *Mental health and behaviour in schools*[55] outlines key risk factors and protective factors specifically around mental health issues becoming a problem in school settings or disrupting learning. It states that ACEs are a key risk factor. Transition points are known to be especially high risk for young people and their mental health.

[54] Mentally Healthy Schools (2021). Risks and protective factors. Link.
[55] Department for Education, 2018, Mental health and behaviour in schools, link.

**Table 26 Risk factors for poor mental health in children**

| Area of life | Risk factors |
|---|---|
| Lifestyle | Body image; Coronavirus; Drugs and alcohol; Internet and social media; Puberty; Sleep |
| Home and family | Child abuse and neglect; Home environment; Poor parental mental health; Parental substance misuse; Poverty and unemployment; Young carers |
| School | Absenteeism; Academic and exam stress; Bullying and cyberbullying; Leaving school and future plans; Peer pressure; Relationships and belonging; School exclusion; Transitions |
| Vulnerable children | Autistic spectrum; Child criminal exploitation; Children with additional needs; Disability and illness; Discrimination; Gender diversity; LGBTQ+ children and young people; Looked-after children; Refugee and asylum seeker children |

For young people who may feel they do not 'fit in' elsewhere (including those with learning disabilities, autism spectrum conditions, and ADHD), being part of a gang can provide a sense of belonging and of safety and security or protection[56]. Participation can provide emotional support and wellbeing, as well as damaging wellbeing through engagement in criminal behaviour and the development of unhealthy relationships. Relationships with gangs can also be linked to child criminal exploitation, and may have links to drugs, for example through county lines[57]. Poor mental health is also known to be a driver of knife crime, though the mechanism is thought to be due to the link between both mental health and violent crime to trauma and ACEs. That is that trauma can lead to poor mental health and that this makes young people more at risk of becoming involved in knife crime[58].

[56] Mentally Healthy Schools (2021). Child Criminal Exploitation. Link.
[57] Longfield, A. (2019). Keeping kids safe: improving safeguarding responses to gang violence and criminal exploitation. Children's Commissioner for England. Link.
[58] Grimshaw and Ford (2018). Young people, violence and knives – revisiting the evidence and policy discussions. Centre for Crime and Justice Studies. Link.

### 8.3.3 Victimisation versus perpetration

The type of violence that young people can experience as victims includes domestic violence or abuse, bullying, and involvement in gangs or child criminal exploitation[59]. Poor mental health is one of the factors that can make children more at risk of these, but also experience of these can have a negative impact on their mental health in turn. Poor mental health can be particularly challenging for children known to be perpetrators of violence, as young people who have been labelled as 'offenders' and work with the youth offending team can experience prejudice and find it harder to get treatment through CAMHS because of the stigma of offending, and because mental health professionals are not trained or supported in working with this group of young people[60].

Gender seems to play a role in whether young people are more likely to be victims of violence or to commit crimes, with girls being far more likely than boys to be victims of violence and sexual offences, and boys much more likely than girls to be the perpetrators[61 62]. Teens and young adults are much more likely to be both victims and perpetrators of violence than young children[61].

Partner abuse is a key challenge faced by girls and young women. One study found that 25% of young women (aged over 13) experienced physical violence and 72% experienced emotional abuse in their own relationships[62 67]. There are also concerns that domestic violence perpetrated by young people is increasing, in part due to COVID-19 and the increase in pressure on families as a result of prolonged and repeated lockdowns[63]. The data on this rise are still emerging, and this link is potentially worth further exploration. Lockdowns due to COVID-19 are thought to have increased the frequency and severity of domestic violence, due to correlations between lockdown and calls to helplines, support services and police[64].

The types of crimes that young people from ethnic minorities may experience, particularly as victims, are likely to include those that are not experienced by their white peers. Issues of

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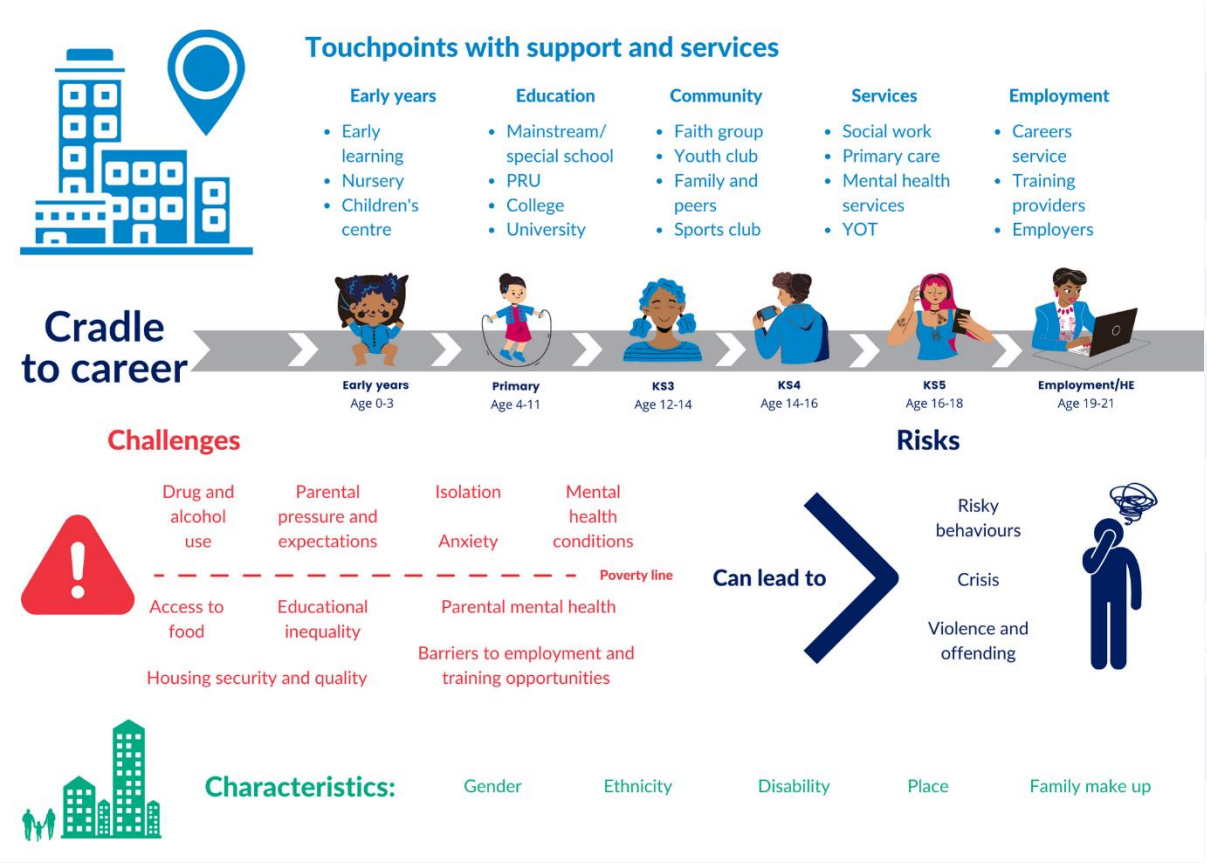
[59] Mentally Healthy Schools (2021). Risks and protective factors. Link.
[60] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[61] https://www.westyorks-ca.gov.uk/media/6995/wy-vru-needs-assessment-january-2021.pdf
[62] Hamblin (2016). Gender and children and young people's emotional and mental health: manifestations and responses A rapid review of the evidence. National Children's Bureau. Link.
[63] WYCA VRU Needs Assessment 2022, tbc.
[64] Havard, T. (2021). Domestic abuse and Covid-19: A year into the pandemic. House of Commons Library. Link.

racism and hate crimes can influence the types of violence that young people might experience[62], and is also a key risk factor for poor mental health in these groups[62].

### 8.3.4 Key transition points

The key transition points in a young person's life can leave them particularly vulnerable to triggers for poor mental health, particularly if their resilience is already low, or if they have additional risk factors making them more vulnerable. These transition points are outlined in the cradle to career framework, shown in Figure 4.

**Figure 4 The cradle to career framework**




Half of all mental health problems have been established by the age of 14, and 75% by the age of 24[65]. They are most likely to affect those aged between 14 and 25[66] and, if they go

[65] Public Health England (2019). Wellbeing and mental health: Applying All Our Health. Link.
[66] NHS Digital (2021). Mental Health and Young People Survey. Link.

untreated for more than 3 to 5 years, the chances of recovery are greatly reduced[67]. Targeting young people at the ages they are most at risk and continuity of care between services is important.

The transition from school and into further education, training or work is often a period of risk for mental health and violence. This change in stability is recognised as a risk for young people's mental health. Being not in education, employment or training (NEET) is a risk factor for both poor mental health and also for child criminal exploitation and for perpetration of crime, including violent crime[68].

For children engaged with CAMHS, this age group is also at risk, because of the transfer to adult mental health services, a point at which many young people are 'lost' in the gap between these services. The formal provision of mental health support for 16-18 year olds also often does not fall into either CAMHS or adult mental health services, and so young people will have only their GP (or private services) to provide any formal mental health support at that age[69]. While some areas may fund CAMHS provision for young people aged 16-18, this is not the norm, and may be limited only to those already receiving treatment. Even where there is a direct transfer from CAHMS to adult mental health services, this transition is frequently problematic, with reports of notes and case histories being lost or miscommunicated, and young people struggling to adjust to different styles of support[70].

Some other forms of support are available to young people in these transition gaps. For example, where support through third sector organisations is targeted at young people, this is typically for those aged under 18, or even under 25, with no limitation on 16-18 year olds[71] [72] [73] [74]. Likewise, some of the many wellbeing and mental health support apps that are commonly available are targeted specifically at young people, for example Clear Fear[75] (designed for ages

[67] Walsham and Sholotan (2016). Young People Count 2016: A collection of data sources about young people. Partnership for Young London. Link.
[68] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[69] Mental Health Foundation (2021). What mental health problems commonly occur in children? Link.
[70] Young Minds (2020). Transferring from CAMHS to Adult Mental Health Services. Link.
[71] https://www.youngminds.org.uk/young-person/
[72] https://www.childline.org.uk/info-advice/your-feelings/mental-health/
[73] https://www.mind.org.uk/information-support/for-children-and-young-people/useful-contacts/
[74] https://www.themix.org.uk/get-support
[75] https://www.clearfear.co.uk/

11-19, or younger children with assistance from a parent or carer) and MeeToo[76] (designed for ages 11-25).

The biggest impact of age on risk factors for mental health and violence are key life transitions[77] [78]. This is usually changing school from primary to secondary for example, but it also includes those children and young people who transition at different times for example due to moving house. Children from Gypsy, Roma and Traveller communities, as well as Armed Forces families and looked after children are all more likely to experience more frequent transitions and so are at greater risk of the potential negative impacts on their wellbeing and life chance[77]. It is estimated that 45% of looked after children in England, aged 5 to 17 years, experience a mental health disorder, 37% have clinically significant conduct disorders, and that 12% have emotional disorders, such as anxiety or depression[67].

Several studies have shown that earlier interventions for mental health are more successful than later ones, and the earlier the better[79] [80]. This suggests that mental health support, and interventions to break links with violence need to be in place throughout children's lives, with support flexible enough to target different age groups, depending on when problems are first identified.

### 8.3.5 Additional factors likely to impact low-level mental health issues and/or violence

As previously explored, there is a very strong indicative relationship between adverse childhood experiences (ACEs) and poor mental health in children and young people (as well as on physical health, and these impacts go on into adulthood as well). This is also discussed further in Chapter 5 below.

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[76] https://www.meetoo.help/
[77] Hamblin (2016). Gender and children and young people's emotional and mental health: manifestations and responses A rapid review of the evidence. National Children's Bureau. Link.
[78] Grimshaw and Ford (2018). Young people, violence and knives – revisiting the evidence and policy discussions. .Centre for Crime and Justice Studies. Link.
[79] O'Moore (2019). Collaborative approaches to preventing offending and re-offending in children (CAPRICORN). Public Health England. Link.
[80] Boyd and Bermingham (2019). Early interventions to reduce violent crime (POSTnote no 599). Parliamentary Office of Science and Technology (POST). Link.

ACEs are often co-indicated with poor mental health in prison and youth offending services[81] [82]. While there is no official definitive list of adverse childhood experiences, the common understanding of these is that they include[83]:

- Verbal abuse;
- Physical abuse;
- Sexual abuse;
- Physical neglect;
- Emotional neglect;
- Parental separation;
- Household mental illness;
- Household domestic violence;
- Household alcohol abuse;
- Household drug abuse; and
- Incarceration of a household member.

As well as factors influencing the likelihood of developing a mental health issue, or becoming involved with violence, there are also demographic risk factors that can put young people at increased risk of poor mental health or victimisation of violence in addition to those described above. LGBTQ+ young people are far more likely to experience mental health issues than their peers, though this is often to do with the social responses to their identities and parental support and affirmation for LQBTQ+ identities is linked with fewer mental health issues[77] [84] .

### 8.3.6 Summary

- The risk factors for both poor mental health and violence are found across lifestyle, home and family life and school situation
- Transitions can be a higher risk time as children deal with the change
- Children who are more vulnerable, (for example with special educational needs, neurodiversity, gender diversity, looked after children, among other factors), are at greater risk of low-level mental health issues and both victimisation and perpetration of violence
- Exposure to violence or victimisation can lead to poor mental health, including domestic violence and child criminal exploitation

[81] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[82] Moline and Levell, (2020). Children's experiences of domestic abuse and criminality: a literature review. Victim's Commissioner. Link.
[83] Public Health Wales (2018). Sources of resilience and their moderating relationships with harms from adverse childhood experiences. Link.
[84] Hamblin (2016). Gender and children and young people's emotional and mental health: manifestations and responses A rapid review of the evidence. National Children's Bureau. Link.

- Perpetration of violence may be linked to involvement in gangs, and/or child criminal exploitation
- Young people known to be 'offenders' (perpetrating crime) can find it harder to access CAMHS, despite being at greater risk of poor mental health
- Victimisation is a predictive factor for perpetration of violence and crime.

## 8.4 Interventions to break links between mental health issues and violence

### 8.4.1 Research questions

- Which interventions exist that break links between experience of low-level mental health issues and violence?
- What are the key factors for programme success?

### 8.4.2 Good practice and success factors

It is recognised that effective mental health interventions can be crucial to improve both the health of people involved, but also to reduce their risk factors for offending behaviour, and to improve their life chances[85]. However, what defines an 'effective' mental health intervention may vary, depending on delivery context, who the funder is, or how the intervention is measured.

Young people often do not engage with mental health services even when this provision is offered[86], and these barriers are thought to be a combination of:

- Not being developmentally and psychologically ready to engage with treatment
- Stigma attached to needing to access mental health services
- Poor past experiences of interventions
- Support being unavailable at the right time or place.

Integrating mental health provision with existing routes such as schools or youth groups that young people currently already engage with may have better success then those delivered elsewhere, as it reduces one of the barriers to engagement[87].

One review of interventions[87] looked at a range of strategies and programme design, and concluded that there is no one single approach that is guaranteed to succeed when working

[85] HM Government (2012). No Health Without Mental Health Implementation Framework. Link.
[86] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[87] Porteous et al (2015). The Development of Specialist Support Services for Young People who have Offended and who have also been Victims of Crime, Abuse and/or Violence: Final Report. Link.

with young people who have mental health needs and have been involved with violence or violent crime (as victims or perpetrators, or both). However, the report did consider the strengths and weaknesses of some particular approaches, a summary of the key types of best practice from this report are shown in Table 27.

**Table 27 Best practice for working with young people with mental health needs involved in crime**

| | |
|---|---|
| Diversionary Initiatives | These are schemes which aim to divert young people assessed as having mental health needs away from the youth justice system at the point of entry, or as an alternative to more traditional community-based offender programmes. These schemes divert young offenders into mental health support services, including for example co-location of CAMHS and YOS. There are mixed results from pilots of these schemes, with some indication that they can reduce recidivism but not necessarily for all participants. |
| YOS/CAMHS based Approaches/Practices | Cognitive Behavioural Therapy<br>If young people are well-engaged, attending sessions and working to achieve their aims, then CBT is consistently associated with positive outcomes including: improved institutional behaviour, better problem solving skills and lower recidivism rates, or longer time to re-arrest (survival analyses).<br>Enhanced Resettlement/Transition Programmes<br>Enhanced transition programmes for young people leaving custody have been shown to be effective in reducing recidivism and outcomes can also be improved for young people with mental health challenges when dedicated, tailored support is provided through transition and afterwards for 18 to 24 months, tapering off towards the end of that time.<br>Mentoring<br>There is evidence to suggest that mentoring type schemes have been used effectively in supporting young victims through the criminal justice process in countries such as Canada, the US and Scandinavia where 'buddies' form the core of child centred justice approaches and are reported to have worked well with young |

| | |
|---|---|
| | children and adolescents, often encouraging active engagement with CAMHS.<br>Enhanced Case Management Practice<br>Focused on young people serving community orders, the YJB in Wales is piloting the development of an Enhanced Case Management Practice Project based on the Trauma Recovery Model (TRM). This has yet to be evaluated in community settings but is strongly grounded in best practice principles from clinical psychology and rigorous previous evaluations of interventions provided to young people who have offended |
| Parenting and Family Interventions | Well managed and sustained family involvement has been found to improve outcomes both for community and secure interventions, with young people who have diverse offending histories. Interventions such as Family Intervention Projects and related strategies central to the government's Troubled Families Initiative are often likely to be working with children at risk of offending and victimisation. There are five criteria identified for what makes a successful family intervention:<br>1. A dedicated worker, dedicated to a family<br>2. Practical 'hands on' support<br>3. A persistent, assertive and challenging approach<br>4. Considering the family as a whole – gathering the intelligence<br>5. Common purpose and agreed action |
| Youth Work/Street based Initiatives | The question of how to better engage young people in mental health services has led to projects which use a youth outreach approach. The evaluation of one such scheme highlighted the benefit of intervening with young people at the moment when they may well be experiencing (physical and mental) trauma and more open to accepting help. Relatedly, the fact that interventions are provided in the community and underpinned by a 'youth-friendly' philosophy is said to make mental health services more acceptable and accessible. |
| Further Elements of Best Practice | Repeated themes that evaluations highlight as key to success include: |

| | |
|---|---|
| | • The importance to young people of feeling respected, being treated with fairness and recognition and that their views are being considered<br>• Good rapport between practitioners, young people and their families which can underpin positive engagement<br>• Coordination and information sharing in multi-agency working. |

Young Minds also identified several key factors for programme success, in interventions aimed at breaking the cycle of violence in young people involved with youth offending services [90]. These factors are:

- Trust and rapport with practitioners
- Meaningful and regular engagement
- Consistency and motivation
- Authenticity in interaction
- Quality relationships
- Availability of practitioners
- Non-judgemental
- Informal/non-clinical settings.

It was also suggested that young people with mental health needs who were involved with youth offending services had better mental health provision when access to mental health services was mandated by the court, using a Mental Health Treatment Requirement (MHTR) as part of a Youth Rehabilitation Order, rather than being offered as a voluntary option. An MHTR also allows mental health services to use funding from probation services or community rehabilitation services, therefore increasing the available funding[88]. Use of MHTR is reportedly low, which could in part reflect confusion over who is eligible and when it is suitable to use them. This includes some unclear guidance on their use for youth offenders[89].
Similarly, training for practitioners in youth justice on mental health and its impacts can have beneficial outcomes for young people with mental health issues involved with youth offending services[87].

[88] National Offender Management Service (2014). Mental Health Treatment Requirements Guidance on Supporting Integrated Delivery. Link.
[89] Scott and Moffat (2012). The Mental Health Treatment Requirement. Centre for Mental Health. Link.

Early intervention has been consistently recognised as a key factor for success in reducing poor mental health, improving outcomes for young people and ultimately reducing the victimisation and perpetration of crime[90] [91] [92]. Schools were identified as a key partner for encouraging early intervention. Interventions often need to be holistic and to work with whole families, not just the individual children and young people, especially where there are issues of ACEs and multi-generational issues with mental health or violence[87].

### 8.4.3 Evidence for successful interventions

The Youth Endowment Fund have a detailed review of the evidence relating to preventing children and young people from involvement in violence[98]. The findings from their evidence review identified some approaches with supporting evidence of success as:

- Whole-family interventions
- Parenting training
- Therapeutic Foster Care
- Developing social and emotional skills
- Cognitive behavioural therapy (CBT)
- Restorative Justice Conferencing
- Anti-bullying programmes
- Situational approaches
- Policing approaches

### 8.4.4 Summary

- Early intervention has better chance of success for both mental health and for breaking cycles of violence or offending

[90] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[91] Boyd and Bermingham (2019). Early interventions to reduce violent crime (POSTnote no 599). Parliamentary Office of Science and Technology (POST). Link.
[92] Spencer et al (2019). Vulnerable adolescents thematic review (report for Croydon Safeguarding Children Board. London Borough of Croydon. Link.

- Whole family involvement may be necessary, especially where there are intergenerational issues with mental health and/or violence
- Young people may be reluctant to engage with mental health services for various reasons and therefore providing support through their existing touchpoints such as schools or youth groups may be more successful
- Mental health needs and past experiences of violence, crime, or abuse should be considered when dealing with perpetration of violence in youth offending services
- Further research is needed to understand what types of interventions are most successful for breaking the links between low-level mental health issues and violence, and the nuance of 'what works' in this sector.

# 8.5 Contact with the criminal justice system

## 8.5.1 Research questions

- How is low-level mental health currently considered when a young person has initial or ongoing contact with the criminal justice system e.g. in sentencing or signposting to support?
- What are the key touchpoints and opportunities to intervene to prevent young people from entering the criminal justice system, or to exit from the criminal justice system?
- How does this fit with the key transition points identified in the Cradle to Career framework?

## 8.5.2 Mental health in the criminal justice system

The risk factors for youth crime, shown in Table 28[93], overlap with those for mental health.

**Table 28: Factors putting children and young people at risk of crime**

| | |
|---|---|
| Individual risk factors include: | Exposure to crime, behavioural problems, low commitment to school |
| Family risk factors include: | Having four or more siblings, experience of being mistreated, family conflict |
| Community or school risk factors include: | Overall school performance, high rates of school exclusions, high availability of alcohol and drugs |
| Society risk factors include: | Wider social and economic injustices, including discrimination and institutional bias |

[93] Youth Endowment Fund (2020). What Works: Preventing children and young people from becoming involved in violence. Link

Within the CJS there is a definite prevalence of mental health issues, including low level mental health conditions. A study of the adult prison population in Wales[94] found that:

- 45.9% of prisoners had served a sentence in a young offenders institute (YOI)
- 91.2% of prisoners who had served a sentence in a YOI had at least one ACE and 60.0% had four or more
- Prisoners with four or more ACEs were 4.2 times more likely to have spent time in a YOI than prisoners with no ACEs.

The same survey also found that ACEs were also an indicator specifically for violent crime. It was also recommended that better training about mental health, and integration with mental health services could improve outcomes for young people involved with the CJS.

> *"Improved awareness, support and evidence-based training for criminal justice professionals can also improve the experience of people with mental health problems accessing the criminal justice system as either a victim or a witness."*[95]

Comparable statistics for the English prison population are not available, but it is thought that while around 10% of the adult prison population are receiving mental health treatment, around 70% are estimated to have a mental health need[96]. In Scotland, adults reporting four or more ACEs were 20 times more likely to have served time in prison at some point in their lives[97].

In the youth justice system, marginalised groups are overrepresented in the youth justice system[98]. This includes:

- Black, Asian and Minority Ethnic children and young people,
- Children with special educational needs,
- Looked-after children,
- Children receiving Free School Meals.

This also links to groups particularly at risk of poor mental health. Despite the increased prevalence of mental health issues in young offenders, this group can find it difficult to access CAMHS due to

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[94] Ford et al (2019). Understanding the prevalence of adverse childhood experiences (ACEs) in a male offender population in Wales: The Prisoner ACE Survey. Link.
[95] HM Government (2012). No Health Without Mental Health Implementation Framework. Link.
[96] House of Commons Justice Committee (2021). Mental Health in Prison. Link.
[97] Scottish Government (2020). Scottish Health Survey 2019: Chapter 8 Adverse Childhood Experiences. Link.
[98] Youth Endowment Fund (2020). What Works: Preventing children and young people from becoming involved in violence. Link.

lack of training, limited provision, and stigma[99] . Likewise, being NEET is also a risk factor for both poor mental health and involvement in the CJS and/or perpetration of violence[99].

As discussed in section 8.2.5, 40% of a typical youth offending service caseload will have mental health issues, usually linked to adverse childhood experiences (ACEs)[100].

### 8.5.3 Transition points and key opportunities for intervention

As with mental health, transition points can present a particular risk as they can create instability in a young person's life, and disrupt the protective factors around them, and affect their resilience. In terms of specific evidence for contact with the CJS, the main transition point in terms of violence and offending is the 16-18 year old transition into adulthood. This is older than the key transition points for risk of mental health issues and behavioural issues (see section 8.3.4), and may indicate that issues not dealt with through early intervention can become more serious and escalate to crime and violence as the young people get older.

Young people who are more vulnerable due to transitions will also be more at risk of child criminal exploitation (CCE) and child sexual exploitation (CSE), which may not be easily identified and recognised by the CJS[101]. Young people may not always know, or feel able to disclose, that they have been victims of CCE, which can make it difficult to explore this if they come into contact with the CJS[102].

There are differences in types and availability of support services for children and young people for both their mental health and when they are in contact with the CJS, which can create issues in transfer from child to adult services. In addition, this transition is linked with changing levels of parental support or expectations, which can increase young people's vulnerability to mental health issues and violence as the support structures change[103].

[99] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[100] Porteous et al (2015). The Development of Specialist Support Services for Young People who have Offended and who have also been Victims of Crime, Abuse and/or Violence: Final Report. Link.
[101] Mentally healthy schools (2021). Child Criminal Exploitation Link.
[102] Just for Kids Law (2020). Excluded, exploited, forgotten: Childhood criminal exploitation and school exclusions. Link.
[103] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link

Getting mental health support mandated through court orders can be more effective than relying on the standard provision of CAMHS for young offenders[104]. The report identifies that the official channels for support rely heavily on the voluntary sector to provide support and practical interventions to support young people and to prevent offending or reoffending. However, it recognises that these voluntary schemes are also often very precarious because of their funding situations.

### 8.5.4 Summary

- As with mental health, there are key risk factors for involvement with the CJS, including parental involvement in crime, family conflict, bullying or abuse, and difficulties at school or poor attainment.
- The same vulnerabilities are often encountered here, with ACEs a strong predictor of perpetration of crime including violent crime, involvement in youth offending services, and offending in adulthood
- Young people who are NEET are more likely to be at risk of perpetration of crime, and also of poorer mental health
- Young people at risk of poor mental health may be more at risk of child criminal exploitation, which can be missed during their contact with the CJS
- While all transitions increase the risk of poorer mental health and vulnerability to exploitation, violence, and perpetration of crime, it is the transfer from youth to adult services for offenders that is particularly noticeable in terms of contact with the CJS. This transition age is known to correlate with perpetration of crime
- Court mandated provision of mental health services can be a good mechanism for ensuring young people engage with mental health support, and can provide funding for mental health from other sources within CJS funding, via MHTR, which otherwise might not be available for providing mental health support.

[104] Grimshaw and Ford (2018). Young people, violence and knives – revisiting the evidence and policy discussions. .Centre for Crime and Justice Studies. Link.

## 8.6 Practitioner training needs

Training provision for youth practitioners and teachers on issues of mental health and violence is mixed, and while resources exist, access to training may vary depending on local context and settings.

Teachers have responsibility in school and formal education settings to address safeguarding issues and deliver the Personal, Social, Health and Economic (PSHE) education curriculum. In addition to safeguarding duties, schools and other youth workers have some responsibilities under Prevent legislation around extremism and radicalisation of young people.

### 8.6.1 Research questions

- Which types of training do practitioners working with young people need to effectively:
    - Equip young people to protect their mental health
    - Identify when a young person is in need of specialist support
    - Identify mental health-related risk factors for violence
    - Break the link between low-level mental health issues and victimisation and/or perpetration of violence
- How do these training needs differ by practitioner type? (Mental health practitioners, youth workers, teachers etc.)
- What type of training do various practitioners currently receive?
- Is there a gap between training need and provision?

### 8.6.2 Availability and access to training

While various training and guidance sources are available (see section 8.6.3), outside of limited legal duties (around Prevent[105] and safeguarding) there is little to dictate the amount or types of training that youth practitioners undertake on mental health and risk of violence. Teacher training and CPD expectations can create space (and hopefully budget) for teachers to engage with training, but the expectations and requirements on the types or content of training are likely to vary by school context. Schools will ideally provide the training and support relevant to the issues and risk factors applicable to their students. This is not mandated, so it requires a competent and willing leadership

[105] Department for Education (2015). The Prevent duty: Departmental advice for schools and childcare providers. Link.

team within the school and sufficient resources to source and provide relevant training for their staff (see section 8.6.3 for more detail on the training on mental health, PSHE, and safeguarding).

There is some criticism that teachers are increasingly asked to provide more and more support – in terms of safeguarding, recognising mental health issues and other problems in children, and providing support where needed[106]. This is done without much in the way of additional resource and may or may not be with adequate training.

> *"The pressure school systems are under and the quality of the training teaching staff receive was felt inadequate for identifying mental health problems and learning difficulties and was a concern."*[106]

Even for specialist practitioners working with young offenders, there are gaps in training provision.

> *"In terms of gangs, some professionals expressed the view that they felt inadequately trained to work with girls who are experiencing sexual exploitation and with the boys who are or have been involved in exploiting them."*[106]

Training should include the understanding that children can display problematic behaviour and behave disruptively in classroom environments[106]. A lot of the resources and training that are aimed at classroom settings (including the examples listed above from NSPCC[107]) deal with how to recognise signs of mental health issues or how to talk to young people about mental health, but there is little guidance aimed around how to approach violent behaviours and find help for the root causes of the problem, which could include mental health issues and/or ACEs. Young people can be labelled as 'trouble makers' or 'problem children' which can then shape how they feel about themselves but also how they're dealt with by youth practitioners, offender services and mental health practitioners.

### 8.6.3 Training available for youth practitioners

Youth practitioners are required to know their key duties of safeguarding including recognising and responding when children make disclosures about abuse or neglect. Training and guidance are

[106] Young Minds (2013). Same old...: the experiences of young offenders with mental health needs. Link
[107] https://learning.nspcc.org.uk/training

available on this from several sources. There is official government guidance on safeguarding[108] and training is provided by local authorities and charities, for example the NSPCC[109].

### 8.6.4 Mental health training

Department for Education guidance exists on mental health, a key document is the Keeping Children Safe in Education[110], as well as specifically "mental health and behaviour in schools"[111],

Youth charities also provide training guidance and support for teachers and other youth workers for supporting children with their mental health, and also for recognising when a child may be struggling with their mental health[109].

There is little mention in these resources however, about the perpetration of violence, or discussion of how to respond to young people who are displaying violent behaviours where this might be a symptom of their current mental wellbeing.

The key exception here is that there is some guidance from Mentally Healthy Schools[112] on risk factors for child criminal exploitation. This is one of the key mechanisms by which at risk young people might become involved with violence and violent crime, both as victims and perpetrators.

There is also increasing awareness of the approach of using trauma informed practices in schools, in order to help children and young people as issues start to develop, and in order to prevent them becoming problems[113]. This allows schools to support children and young people who suffer with trauma and/or mental health problems, in order to overcome barriers to learning. The organisation Trauma Informed Schools UK provide training for school staff, from more general courses, to detailed training for designated mental health needs, to a diploma in trauma and mental health informed schools and communities.

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[108] HM Government (2018). Working Together to Safeguard Children. Link.
[109] https://learning.nspcc.org.uk/training
[110] Department for Education (2021). Keeping Children Safe in Education 2021: statutory guidance for schools and colleges. Link.
[111] Department for Education (2018). Mental health and behaviour in schools. Link.
[112] Mentally healthy schools (2021). Child Criminal Exploitation Link.
[113] Trauma Informed Schools UK (2022). What is a trauma and mental health informed school? Link.

### 8.6.5 PHSE and mental health

In terms of engagement with children on issues of mental health the PSHE curriculum is a key driver. The Health and Relationships aspects of this are compulsory in all schools. which includes mental health, and also the relationships aspect includes promoting healthy relationships, which could include content on assertiveness within relationships, dealing with peer pressure (including peer pressure to commit crime) etc. However, the detail of this part of the curriculum is not prescribed, meaning not all children and young people will get the same level or type of education on these issues, and teachers may or may not be required to have knowledge of them, depending on each school's approach.

- The 'Health' and 'Relationships' aspects of PSHE are now compulsory in all primary schools. For secondary schools the compulsory aspects are 'Health' and 'Relationships and Sex Education (RSE)'[114] [115]
- Health includes mental health and wellbeing, physical health (including healthy lifestyles and first aid). Relationships- or Relationships and Sex Education - includes learning about safe, healthy relationships, including understanding consent and negotiating life online[114]. These provide opportunities to incorporate issues around violence as well as mental health
- The PSHE Association provide guidance on teaching a comprehensive PSHE offer, including MH in PSHE, guidance for teachers, and example lesson plans etc[114]

Despite the limited mandatory requirement for PSHE in schools, it has nonetheless been proven to improve life chances and academic success when delivered well[115] . Evidence suggests that there is a positive impact on physical and psychosocial health, which in turn is shown to improve the chances of educational attainment, and that again is a factor in improving health and wellbeing. There is therefore the opportunity for a virtuous circle to form[115]. However, this relies on the quality of the PHSE curriculum and its delivery, which can be hard to measure objectively. By making a commitment to teaching a comprehensive PSHE curriculum, above and beyond the basic requirements, it may lead to improved wellbeing, attainment, and therefore improved life chances for young people. The extent to which this can combat any external risk factors, such as ACEs, is unknown, but good mental and physical health, and good educational attainment are known to be protective factors for both mental health and perpetration of violence.

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[114] The PSHE Association (2021). Guidance and lessons teaching about mental health. Link.
[115] Department for Education (2015). Personal, social, health and economic (PSHE) education: a review of impact and effective practice. Link.

### 8.6.6 Safeguarding training

Schools, childcare providers and other youth practitioners have a duty of care to young people, to keep them safe from violence, whether this is in the form of bullying, abuse, neglect or even radicalisation. Safeguarding policies and practices are essential to ensure that young people are kept safe, and risks and vulnerabilities can be identified. Some of these key safeguarding policies and guidance sources are:

- Guidance on Prevent[116] identifies PSHE lessons in schools as a key route to discuss controversial topics, and to help teach emotional resilience
- Safeguarding comes with statutory guidance for schools (and other education settings), including training, policies and procedures[117]
- Local authorities offer guidance and training for teachers and youth workers on safeguarding requirements, and will set out the procedures for reporting safeguarding concerns
- Additional guidance and training is also available from third parties, e.g. the NSPCC guidance on safeguarding has tailored information for specifically for youth groups and health workers[118]
- Training can include online or face to face options, and generally with lower cost options for online learning, and higher cost for in-person courses
- The NSPCC training on issues like bullying, abuse, neglect, etc: all focus mainly on victimisation rather than perpetration
- Healthy relationships learning is recognised as important for young people to avoid abuse and mental health problems, but the link between these two is not explored[119]
- Government guidance on safeguarding acknowledges that "mental health problems can, in some cases, be an indicator that a child has suffered or is at risk of suffering abuse, neglect or exploitation"[120] and flags this as something that teachers are well placed to look for, but that only a trained mental health practitioner can diagnose a mental health problem. It does state that signs of a mental health issue are something to look for when considering safeguarding.

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[116] Department for Education (2015). The Prevent duty: Departmental advice for schools and childcare providers. Link.
[117] HM Government (2018). Working Together to Safeguard Children. Link.
[118] https://learning.nspcc.org.uk/training
[119] PSHE Association (2019). Why PSHE Matters. Link.
[120] HM Government (2018). Working Together to Safeguard Children. Link.

### 8.6.7 Summary

- Training, guidance and best practice exist on issues around mental health, and on violence, especially supporting victims of violence. However, there is less support and training available on the intersection between mental health and the perpetration of violence
- Although training and guidance exist, there is no clear pathway through different training options for youth practitioners, nor any standard way of gauging the levels of training different practitioners might require. There is no requirement for schools to be consistent with each other in the training that education staff have, nor any clear 'steer' from any central organisation on what the training needs might look like.

# 8.7 Conclusions

## 8.7.1 Key findings

This evidence review looked at several core areas of evidence around these broad research questions:

- What is the link between low-level mental health and violence?
- What are the key risk factors and do these differ by demographic groups?
- Which types of interventions can break the link between low-level mental health and violence?
- How do low-level mental health issues affect contact with the criminal justice system?
- What are the practitioner training needs for youth workers and mental health practitioners?

Key findings are as follows:

### Prevalence of low-level mental health issues including demographic differences in presentation of low-level mental health issues

- Mental health issues are a reality for an increasing number of children and young people, but not all mental health conditions become serious enough to enable access to child and adolescent mental health services (CAMHS)
- Boys are more likely than girls to perpetrate violence; girls are more likely to be victims, and there is also some difference in how boys and girls present symptoms of mental health issues and how these are interpreted socially.

### Impact of low-level mental health issues on young people's lives

- Low-level mental health conditions can have significant impacts on young people, their achievements, and their risks of poor outcomes, including becoming involved in violence, either as victims, perpetrators, or both
- There are links between low-level mental health issues and violence, and those experiencing frustration or 'acting out' are more likely to perpetrate violence
- Young people known to be 'offenders' (perpetrating crime) can find it harder to access CAMHS, despite being at greater risk of poor mental health.

## Risk factors for mental health issues and for violence

- The risk factors for both poor mental health and violence are found across lifestyle, home and family life and school situation. ACEs are strongly correlated with poor mental health and with violence, and victimisation is a predictive factor for perpetration of violence and crime. In addition, poor mental health itself can be a risk factor for violence
- The links go in both directions: children and young people who have experienced violence are more likely to experience poor mental health and those with poor mental health are more likely to experience violence, as victims or perpetrators
- Children who are more vulnerable, (for example with special educational needs, neurodiversity, gender diversity, looked after children, among other factors), are at greater risk, and for all children and young people transitions can be a higher risk time as they deal with the change.

## Violence, crime, and the criminal justice system

- Experiences of adverse childhood experiences (ACEs) is a strong predictor of perpetration of crime including violent crime, involvement in youth offending services, and offending in adulthood. Exposure to violence or victimisation (including domestic violence and child criminal exploitation) can lead to poor mental health
- Young people who are NEET are more likely to be at risk of perpetration of crime, and also of poorer mental health. Perpetration of violence may be linked to involvement in gangs, and/or child criminal exploitation, and more vulnerable young people (e.g. with mental health issues, special educational needs, neurodiversity, gender diversity, looked after children, etc) are more at risk of CCE, and CCE can be missed or misunderstood during contact with the criminal justice system
- While all transitions increase the risk of poorer mental health and vulnerability to exploitation, violence, and perpetration of crime, it is the transfer from youth to adult services for offenders that is particularly noticeable in terms of contact with the CJS. This transition age is known to correlate with perpetration of crime
- Court mandated provision of mental health services can be a good mechanism for ensuring young people engage with mental health support, and can provide funding for mental health from other sources within CJS funding, through MHTR, which otherwise might not be available for providing mental health support.

### Practitioner training needs

- Training, guidance and best practice exist on issues around mental health, and on violence, especially supporting victims of violence. However, there is less support and training available on the intersection between mental health and violence
- Although training and guidance exist, there is no clear pathway through different training options for youth practitioners, nor any standard way of gauging the levels of training different practitioners might require. There is no requirement for schools to be consistent with each other in the training that education staff have, nor any clear 'steer' from any central organisation on what the training needs might look like.

## 8.7.2 Risk and protective factors

Overall, it seems that protective factors are key for reducing poor mental health and improving resilience against violence and crime. These key risk factors and protective factors are summarised below (see Table 29), and can will inform consultation design in the later stages of this research. While these factors cannot directly predict or prevent vulnerability of any individual young person to mental health issues or involvement with perpetration of violence, they do provide a starting point to understand how communities can develop targeted support for those young people who might be more at risk.

One key aspect of the initial research questions remains unclear in the evidence: the relationship between ethnicity, mental health and violence. The data present a contradictory picture with lower reported rates of mental health issues in young people from ethnic minority groups, but overrepresentation in the youth justice system (see section 8.2.6).

There is unclear evidence for the underlying causes behind these data differences, with some suggestions around stigma in reporting mental health issues, or accessing primary care for mental health support. There also may be protective factors in minority ethnic groups, for example where cultural practices provide support networks for young people, for example through family relationships. In the case of overrepresentation of ethnic minority groups in the youth justice system, there may also be indicating a lack of culturally informed services, or of institutional racism, if these differences are reflecting different treatment of ethnic minority young people compared to their White peers. The nuance of how mental health impacts young people from ethnic minority groups, particularly where these young people are in the CJS, remains an underexplored intersection in the literature, and would benefit from further study.

Table 29: Risks and protective factors for young people for both mental health and violence

| | Risk factors | Protective factors |
|---|---|---|
| Individual factors | Exposure to crime, behavioural problems, low commitment to school | Wanting to help others, a belief in moral order, having a sense of confidence in your ability, being resilient |
| Family factors | Having four or more siblings, experience of being mistreated, family conflict | Good family management, stable family structure, a close relationship with at least one parent |
| Community and school factors | Overall school performance, high rates of school exclusions, high availability of alcohol and drugs | A strong sense of local community, high academic achievement, low crime rates |
| Societal factors | Wider social and economic injustices, including discrimination and institutional bias | |

### 8.7.3 Directions for future consultation

The evidence review has indicated a range of research questions to be further explored through the upcoming consultation with young people, youth services and practitioners. These are:

- Which settings are appropriate for interventions e.g. schools, youth clubs, mental health services?
- Which types of practitioners or combination of practitioners should be involved in interventions?
- Which training and support do varying types of practitioners (including those working in the criminal justice system) need to support young people's mental health?
- What are the advantages and disadvantages of one-to-one, peer group and family-based interventions?
- How can risk factors be effectively identified early in a child's life?
- How do interventions need to differ depending on a young person's circumstances e.g. at risk of violence, early signs of violence, in contact with the criminal justice system etc?

## 8.8 Glossary of terms

- ACE Adverse Childhood Experience
- ADHD Attention deficit hyperactivity disorder
- ASC Autism spectrum conditions (sometimes referred to as autism spectrum disorders, ASD)
- CAMHS Child and Adolescent Child and Adolescent Mental Health Services
- CYPMHS Children and Young People's Mental Health Services
- CJS Criminal Justice System
- CCE Child Criminal Exploitation
- CSE Child Sexual Exploitation
- GAD Generalised anxiety disorder
- MHTR Mental Health Treatment Requirements
- NEET Not in employment, education or training
- PSHE Personal Social Health and Economic education/curriculum (see also RSE)
- PTSD Post-traumatic stress disorder
- RSE Relationships and sex education (see also PSHE)
- SEN Special educational needs
- SEND Special educational needs and disabilities
- YOI Young Offenders Institute
- YOS Youth offending services

**Project team:**

**Dr Laura McGinty, Consultant**
Laura.McGinty@rocketsciencelab.co.uk

**Cherri Blissett, Director**
Cherri.Blisset@rocketsciencelab.co.uk

**Offices:**

**London**
T: 0207 253 6289

**Edinburgh**
T: 0131 226 4949

Newcastle
T: 07887 67 34 07

**www.rocketsciencelab.co.uk**