Public Health England

The mental health needs of gang-affiliated young people

A briefing produced as part of the Ending Gang and Youth Violence programme

CPH CENTRE FOR PUBLIC HEALTH
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WHO COLLABORATING CENTRE FOR VIOLENCE PREVENTION

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Executive summary

- Research is beginning to expose the high burden of mental illness faced by young people involved with gangs. Gang members are at increased risk of a range of mental health conditions including conduct disorder, antisocial personality disorder, anxiety, psychosis and drug and alcohol dependence (section 2)
- The links between gang-affiliation and poor mental health can operate in both directions. Poor mental wellbeing can draw young people to gangs while gang involvement can negatively impact on an individual's mental health (section 3)
- Violence is an inherent part of gang culture and gang members are at increased risk of involvement in violence as both perpetrators and victims. Long-term exposure to violence is associated with psychological problems including depression, conduct disorders and post-traumatic stress disorder (section 3)
- Poor mental health and gang-affiliation share many common risk factors, often relating to young people's early life experiences and the environments in which they grow up. The more risk factors young people are exposed to the greater their vulnerability to negative outcomes (section 4)
- Girls involved with gangs can be particularly vulnerable to mental health problems resulting from sexual and intimate partner violence (section 5)
- Preventing the development of risk factors and promoting mental wellbeing in young people requires a life course approach that supports parents and families and encourages healthy development from the very earliest stages of life (section 6)
- Programmes such as home visiting, parenting programmes, preschool programmes and school-based social and emotional development programmes can protect children from the risk factors for gang involvement and poor mental health, including parental stress, exposure to violence and behavioural problems (section 6).
- Evidence-based, relevant, accessible and non-stigmatising community interventions should be available in gang-affected areas to promote health and emotional wellbeing, support recovery from mental illness and help young people move away from harmful gang-related activities (section 7)
- Gang-affiliated young people may experience particular barriers to engaging with mental health and other services. Novel approaches are required, including the provision of holistic support in young peoples' own environments and the use of key workers or mentors who are able to build trusting relationships with young people involved with gangs (section 7).
- Effectively addressing the relationships between gang-affiliation and poor mental health requires a strong, collaborative approach that co-ordinates services across a wide range of organisations. Health services, local authorities, schools, criminal justice agencies and communities all have an important role to play in promoting healthy social and emotional development in children and young people and ensuring vulnerable young people affected by gangs and poor mental health receive the support they require

1. Introduction

Preventing gang-related violence is a major government priority in England. While only a minority of young people are involved with gangs, gang members account for disproportionate levels of crime in affected communities and are at increased risk of involvement in violence as both perpetrators and victims. An area that is often overlooked in work to prevent and address gang violence is the strong relationship between gang-affiliation and mental health. Gang-affiliated young people are disproportionately affected by mental health difficulties. Poor mental health can attract young people to gangs and be a barrier to gang desistance. Equally, involvement in, or association with, gang-related activities can damage mental health and worsen existing problems. Poor mental health has serious impacts on young people's personal and social development and can affect all areas of life including education, employment, peer and intimate relationships, health-related behaviours and vulnerability to violence and crime. Supporting mental wellbeing in vulnerable young people is therefore a multi-agency interest and is fundamental to preventing gang-related violence.

This briefing aims to support partners, particularly in Ending Gang and Youth Violence areas,[a] to understand and address the mental health needs of gang-affiliated young people. It outlines the extent of mental illness in gang members, the relationships between gang-affiliation and poor mental health and the shared risk factors that contribute to both. It emphasises the need for a life course approach to prevention[1] that addresses risk factors, promotes resilience in young people and provides appropriate support for vulnerable young people. Research on the effectiveness of interventions to prevent gang-affiliation and improve mental health in gang members is still largely absent. However, the briefing summarises evidence of the types of interventions that can protect children from antisocial behaviour and poor mental health and treat mental illness in vulnerable young people. Providing a holistic raft of coordinated, appropriate and evidence-based services to children and families throughout the life course is an integral part of a comprehensive approach to preventing gang-related violence.

Mental health: a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. *World Health Organization*

Gang: a relatively durable, predominantly street-based group of young people who: (1) see themselves, and are seen by others, as a discernible group; and (2) engage in a range of criminal activity and violence. May also have any or all of the following features: (3) identify or lay claim to territory; (4) have some form of identifying structural feature; and (5) are in conflict with other similar gangs. *Centre for Social Justice*

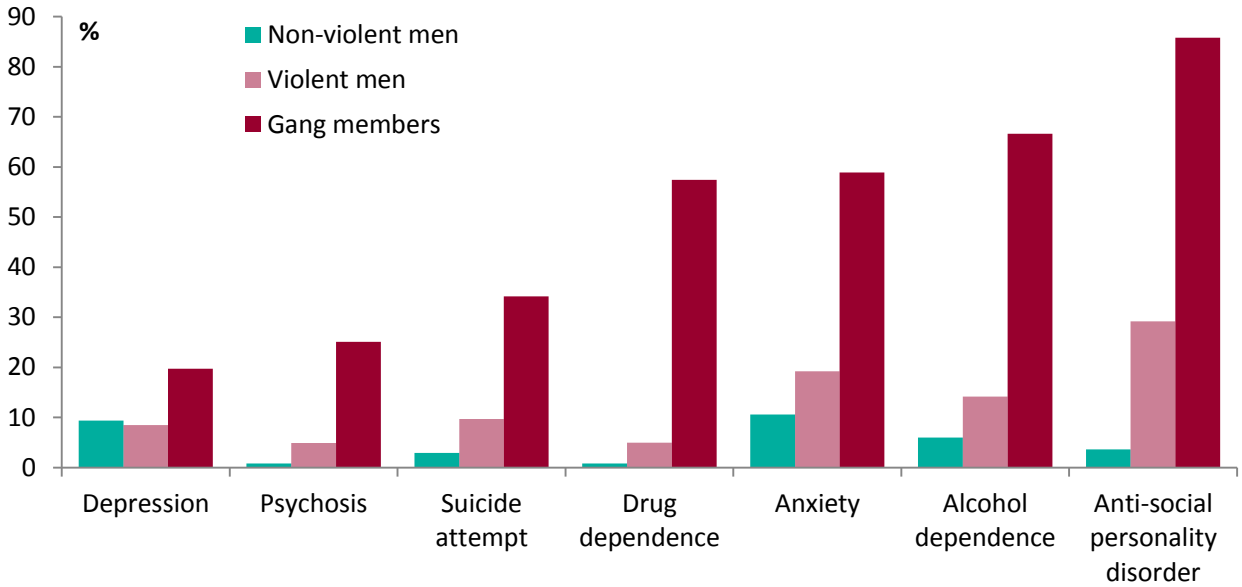
[a]The Ending Gang and Youth violence programme was launched by the Home Office in 2011. It provides targeted support to priority areas to help them respond effectively to gangs and youth violence.

2. The extent of the problem

Research is starting to expose the high burden of mental illness faced by young people involved with gangs in England. Conduct disorder is the most common mental health issue affecting children, which manifests in severe behaviour problems and is particularly harmful to children's life chances when emerging before the age of 12 (see section 4.3). Analysis of data from health screening initiatives with young people (mainly 10 to 18-year olds) at the point of arrest found that almost 40% of those who were gang members (of both sexes) had signs of severe behavioural problems before the age of 12, compared with 13% of general youth justice entrants.[2] Around a quarter had a suspected mental health diagnosis and over a quarter were suffering sleeping or eating problems (compared with less than 10% for general entrants). One in three female and one in ten male gang members were considered at risk of suicide or self-harm.

A study of older males aged 18 to 34 years found that those who were gang members had significantly higher levels of mental illness than both men in the general population and non-gang affiliated violent men (figure 1).[3] Using standardised screening tools, 86% of gang members were identified as having antisocial personality disorder, 67% alcohol dependence, 59% anxiety disorder, 58% drug dependence, 34% suicide attempt, 25% psychosis and 20% depression. After demographic and other factors were taken into account, gang membership was associated with an increased risk of all conditions except depression. The increased prevalence of mental health problems seen in UK gang members is consistent with evidence from the US linking gang-affiliation to conditions including anxiety, mood disorder, conduct disorder, post-traumatic stress disorder and suicide attempt.[4-6]

Figure 1. Prevalence of psychiatric morbidity in male gang-members, non-gang affiliated violent men and non-violent men in the UK (Coid et al, 2013[3])



3. Links between gangs and mental health

The relationships between gang-affiliation and poor mental health operate in both directions. Many of the factors that push or pull young people towards gangs relate to their mental wellbeing, while involvement in gang-related activities can damage mental health. Examples of these relationships include:

Young people with poor mental wellbeing can be drawn to gang-affiliation:

- Gangs may offer a source of support to isolated young people who lack strong family or social relationships. Young people who join gangs often have troubled childhood histories and gang membership may provide a sense of belonging that is central to their social identity[7]
- Fear and anxiety over future victimisation can draw vulnerable young people to gangs due to a perceived need for protection, and can also prevent those involved with gangs from leaving them[7,8]
- Gang activities may appeal to young people with traits such as impulsivity, sensation seeking and externalising behaviours[b] – which can be markers of conditions including attention deficit hyperactivity disorder (ADHD) and conduct disorders[9-11] Children who show these traits may also be actively recruited by gangs[12]
- A certain status may be associated with gang involvement, and individuals with low self-esteem may join gangs to bolster their sense of self-worth[13]

Gang affiliation can negatively impact mental health:

- Gang-involved young people are at increased risk of violence as victims, perpetrators and witnesses.[3,14-16] Exposure to violence and other trauma damages mental health and repetitive exposure is particularly detrimental (see box 1). Sexual violence poses specific risks for females (see section 5.1)
- Gang members may be under extreme pressure to suppress feelings of fear and anxiety, as those that show fear risk being ostracised by the gang.[17] Attempts to avoid certain emotions may simply make them stronger[18]
- Gang activity can increase young people's risks of arrest and conviction.[19] Both potential and actual involvement with the criminal justice system can be anxiety-provoking for young people[20]
- Substance use can increase young people's risks of mental health problems,[21] and alcohol and drug use (particularly cannabis use) can be a key feature of gang life.[22] As well as being a shared recreational activity, substance use may have specific functions in increasing gang members' confidence and numbing emotional stress[23]
- Gang affiliation typically begins in early adolescence; a critical period for psychological development.[24] Gang affiliation can have considerable impact on a young person's adjustment and development during this period of vulnerability

[b]Externalising behaviours are problem behaviours that are directed outwardly, such as vandalism and physical and verbal aggression

Box 1. Gangs, violence and mental health

Violence is an inherent feature of gang life, and can be used for purposes such as achieving dominance, establishing status, avenging perceived disrespect, maintaining group cohesion, accessing resources and regulating drug markets.[25] Young people who join gangs may be put under considerable pressure to perpetrate violence and refusal to do so may result in them being victimised themselves. A UK study found that 90% of male gang members (aged 18 to 34) had been involved in violence in the past five years with 80% reporting at least three violent incidents.[3] Most were found to have violent attitudes and be excited by violence, yet many also feared it. Compared with non-gang members, they were more likely to have perpetrated violence, been a victim of violence and fear future victimisation.

Long-term or pervasive exposure to violence is associated with a range of psychological problems including depression, anxiety, behavioural problems and post-traumatic stress disorder (PTSD).[26-28] PTSD, for example, is a form of anxiety disorder that develops following exposure to an extremely threatening or catastrophic event, such as severe violence. Symptoms include re-experiencing the traumatic event, avoidance of stimuli associated with the trauma, feeling emotionally flat, and increased arousal (eg, difficulty sleeping or concentrating, being irritable, outbursts of anger). It has been suggested that traumatic experiences lead to altered perceptions of safety and uncertainty over the controllability of everyday life, prompting feelings of helplessness and a heightened state of chronic threat.[29] An individual's own violent behaviour may be a common cause of PTSD,[30] with symptoms more pronounced if the person has an emotional attachment to their victim or has some capacity for guilt.[31] Studies have found high levels of PTSD among young offenders, often linked to violent experiences, and that the more violence a young person is exposed to the greater their PTSD symptoms.[32-35] Symptoms of PTSD are particularly pronounced in perpetrators of homicide but may not develop for months or even years after the event, complicating identification and treatment.[36]

Although most studies have focused on males, females affiliated to gangs are also at increased risk of involvement in violence and can be particularly vulnerable to sexual victimisation (see section 5.1). Over a 14-month period, the Office of the Children's Commissioner's enquiry into sexual exploitation in gangs and groups identified 2,409 confirmed victims under the age of 18, most of whom were girls.[37] The actual numbers are likely to be much higher. Sexual violence is one of the most severe forms of trauma and its effects on mental health have been widely studied. Exposure to sexual violence can cause multiple long-lasting negative outcomes, including depression, cognitive disturbances (eg, low self-esteem or symptoms of helplessness), panic and anxiety disorders, suicidality and self-harming behaviours.[38] A range of factors can influence the way in which victimisation affects mental health, including individual characteristics, aspects of the assault itself, post-assault disclosures and help-seeking behaviours, and sociocultural norms.[38]

4. Shared risk factors

Mental health and gang-affiliation can also be linked through shared risk factors. A wide range of factors can increase young people's risks of poor mental health[39] and gang-affiliation,[40] and many are common to both. Figure 2 provides examples of shared risk factors that relate to individuals, their relationships, and the communities and societies in which they live. Risk factors tend to have a cumulative impact on negative outcomes, and gang affiliated young people often show a multitude of risk factors across different domains.[41,42] The following sections highlight four examples of important shared risk factors: adverse childhood experiences, attachment insecurity, social exclusion and disadvantaged neighbourhood environments.

Figure 2. Some shared risk factors for poor mental health and gang-affiliation[39,40,43-45]

4.1 Adverse childhood experiences

Adverse childhood experiences (ACEs) are stressful events occurring in childhood that directly affect a child (eg, child maltreatment) or affect the environment in which they live (eg, domestic violence, substance misuse or mental illness in their families). Research is increasingly identifying the lasting damage that early life trauma has on children's developing brains (see box 2). ACEs can have a major influence on children's emotional and social development, increasing their risks of adopting harmful behaviours and suffering poor outcomes in later life.[42,46] A US study found that the more ACEs adolescents had the greater their risks of delinquency, bullying, physical fighting, dating violence, weapon-carrying, self-harm, suicide ideation and suicide attempt.[47] In England, half of adults are estimated to have suffered at least one ACE and 9% to have suffered four or more, with risks of substance use, unintended teenage pregnancy, involvement in violence (as a perpetrator and victim), incarceration and a range of other harmful outcomes increasing with the number of ACEs suffered.[42] ACEs are also strongly related to poor mental wellbeing[48] and conditions including depression, anxiety, PTSD, eating disorders and drug and alcohol dependence.[46,49] For example, 11% of common mental disorders and 17% of PTSDs in England have been attributed to childhood sexual abuse.[49] The NSPCC estimates that nearly a fifth of 11 to 17 year olds in the UK have experienced some form of severe maltreatment in childhood.[50]

Box 2. The impact of early life trauma on the developing brain

A baby's brain grows from around 25% to 80% of its adult size between birth and the age of two, with brain development continuing into early adulthood.[51] The first few years of life are a critical period when billions of brain cells and trillions of synapses are created; far more than are retained into adulthood. Synapses connect brain cells together, sending messages that trigger physical and emotional responses. During brain development, connections that are regularly used are strengthened while those that are not are discarded. If children are raised in safe and nurturing environments, the connections made in their brains can promote traits such as secure attachment, trust, self-worth and self-control, laying the foundations for healthy social and emotional development. However, if children are neglected, abused or exposed to other trauma the world can be a place of uncertainty and fear and brain development can focus on short-term survival, heightening stress responses and dulling emotions.[46,52]
Traumatised children can be overwhelmed when faced with stress (when the 'fight or flight' hormone is triggered), have difficulty expressing and controlling their emotions, struggle to concentrate and lack self-worth.[53] This hampers their ability to communicate effectively, form healthy relationships and succeed at school which in turn can contribute to social isolation, poor mental health and attraction to gangs.

4.2 Attachment insecurity and poor caregiver bonds

Attachment refers to the lasting emotional bonds that individuals form with other people. The bonds that children develop with their primary caregivers in early life can strongly influence their future relationships. When caregivers are consistently available, sensitive and responsive to a child's needs, the child learns they can depend on the caregivers, giving them a secure base from where they can explore the world. This type of secure attachment can guide their expectations and emotions in future relationships. However when caregivers are unreliable, unresponsive or abusive, different attachment patterns emerge characterised by avoidance, resistance, fear or distress.[54] These children build up a very different picture of the world – one which often fails to meet their needs and questions their ability to meaningfully impact on their surroundings or engage with others.[55] Attachment insecurity and poor parental bonds have been linked to adverse outcomes including conduct problems and delinquency, violence (particularly intimate partner violence) and poor mental health.[55-58] They are often cited as a driver of the 'need to belong' that attracts young people with troubled backgrounds to gangs.

4.3 Conduct disorders

Conduct disorders are mental health disorders diagnosed in childhood that are characterised by repetitive and persistent antisocial, aggressive or defiant behaviour. These emotional and behavioural problems have major impacts on a child's life outcomes, particularly when they emerge before secondary school years.[59] Children with early onset conduct disorders are at increased risk of problems including low

academic achievement, substance misuse, violence, incarceration, and adult mental illness.[59-61] Around half of children with early onset conduct disorder suffer severe problems that last into adulthood.[9] Early behavioural problems are also a risk factor for gang involvement and a marker of prolonged gang membership.[2,41,62] Problematic behaviour in childhood is often a marker of internal distress and conduct disorders are thought to emerge through an interplay of genetic, environmental and social factors.[63] They commonly co-exist with other mental health problems such as ADHD, depression and anxiety.[64] In England, around 5% of children aged 5 to10 have a conduct disorder, with boys and children from disadvantaged backgrounds disproportionately affected.[65] For further information on conduct disorders see[60] and section 7.1.

4.4 Social exclusion

Social exclusion is typically defined by a lack of participation in mainstream social, cultural, economic and political activities.[66] For young people, it is often thought of in terms of relationships with peers. Peer rejection can have a major impact on adolescents, who can place great value on the approval of their peer group. Social exclusion in young people has been linked to depression, anxiety, loneliness, low self-esteem and social withdrawal,[67] and such adverse effects can persist into later life.[68] Links have also been found between social exclusion and aggressive behaviour.[69] More broadly, young people who feel excluded by mainstream society may show disregard for its rules, contributing to a willingness to break laws and perpetrate violence. Being socially excluded may also encourage young people to seek social support from 'alternative' groups, such as gangs.

4.5 Disadvantaged neighbourhood environments

The neighbourhood in which young people grow up can have an important impact on their capacity to develop and thrive. Living in a disadvantaged neighbourhood featuring gangs, high crime levels and easy access to drugs increases young people's risks of associating with delinquent peers, being exposed to community violence and becoming involved in crime.[70,71] Fear of gangs, violence and crime can impact on mental health and draw young people to join gangs for the perceived protection they offer.[7] Young people living in disadvantaged neighbourhoods may also experience feelings of hopelessness; holding negative expectations about their future and abandoning long term goals in favour of short term gain.[72] This may contribute to antisocial and risky behaviours, including violence.[73] Some evidence suggests that males experience more severe feelings of hopelessness than females.[74] Disadvantaged neighbourhoods may also affect young people's wellbeing through proximal influences such as institutional resources (eg, quality of schools, health facilities, employment opportunities), social norms (eg, parenting practices, family functioning) and levels of social cohesion, community organisation and social control.[75]

5. Specific population groups

5.1 Women and girls affiliated with gangs

Gender roles can shape an individual's experience of life in a gang. Females may be affiliated to gangs as members in their own right or as girlfriends, relatives or friends of gang members. While some female gang members are active participants in serious crime and violence,[2] UK research has exposed widespread sexual abuse of gang-involved females, with reports of girls being seen as sexual objects or entertainment for gang members and subjected to severe sexual assault, coercion and degradation.[76] For many gang-affiliated girls, exposure to violence begins at home.[77] Girls with limited family support may be attracted to gangs or gang-affiliated men for status and protection,[78] yet those who have grown up with abuse and domestic violence may be conditioned to tolerate abuse.[79] In gang culture, power and violence are used to maintain status and structure and gangs can operate under the belief that it is appropriate to control women. Girls may accept sexual exploitation as a condition of gang membership and view violence as normal within intimate relationships; therefore not recognising their abuse or viewing themselves as victims.[76] Research has shown that sexual abuse in the context of gangs is rarely reported.[76]

Sexual and intimate partner violence can make girls affiliated to gangs particularly vulnerable to mental health problems (see box 1). Girls may also be more vulnerable to the psychological impacts of witnessing violence.[80] Females can place stronger emphasis on interpersonal relationships, experience greater impacts from violations of trust, and face gender-specific anxieties such as unintended pregnancy or the potential placement of children into care.[81] Trauma-based mental health services may be particularly important for female gang members, along with gender-sensitive responses that acknowledge the importance of positive relationships and improved self-esteem as an exit from crime and violence (see box 8). Front-line agencies that work with young women and girls should be aware of the risk indicators of gang association and gender-based violence, understand the additional complexities that this presents, and provide holistic support that addresses the multiplicity of girls' experiences, risks and needs.[82]

In several gang-affected areas, the Home Office has funded young people's advocates to enable direct support to young women who have been victims, or are at risk of sexual violence by gangs. It is also funding training for advocates and other professionals (such as independent sexual violence advisors and independent domestic violence advisors) on sexual, domestic and gang-related violence, including dealing with trauma and self harm.

5.2 Lesbian, gay and bisexual gang members

Little is known about the involvement and experiences of sexual minorities in gangs, yet sexual minority youth can be vulnerable to mental health problems and risk factors for gang involvement such as bullying and social isolation. Those who experience homophobic bullying and harassment in schools and communities may choose to 'fight back'.[83] School bullying victimisation has been associated with delinquent behaviour, gang membership, violence and weapon carrying,[84-86] as well as mental health problems including anxiety and depression.[87] Within a macho and misogynistic gang culture, gay and bisexual gang members (particularly gay males) may feel unable to disclose their sexuality through fear of victimisation from fellow or rival gang members. They may also be involved in the perpetration of violence against people from sexual minority groups if such acts are initiated by the gang. This may be accompanied by feelings of conflict and guilt, as well as anxiety and fear of being 'exposed'. In treatment and intervention, it is important for professionals to recognise the potential for gang members to be from a sexual minority group.

5.3 Black and minority ethnic (BME) gang members

The ethnic composition of gangs typically reflects that of the local area. However, BME communities are often exposed to higher levels of discrimination (including unwanted police attention such as stop and search strategies)[62] and disadvantage,[88] which can affect risks of gang membership and poor mental health. There are also ethnic variations in the use of primary care and mental health services in the UK. Some studies suggest patients from some BME groups have higher rates of in-patient admission to mental health services yet are less likely to be referred to specialist services by their GP.[89] BME communities are also 40% more likely than white Britons to access mental health services via a criminal justice gateway.[90] With many gangs situated in BME communities, this raises implications for intervention such as the need for culturally competent practitioners, improved early intervention models focused on building young people's resilience, involvement of BME communities in service development, effective and non-stigmatising community engagement, and cultural adaptations within programmes (eg, the Race Equality Foundation's Strengthening Families, Strengthening Communities programme).[91,92]

5.4 Immigrant populations

Little is known about the involvement of immigrant youth in gangs in England. However, the issues that some immigrant youth may face pre (eg, exposure to war) and post migration suggest they may be at increased risk of gang involvement and poor mental health. Some immigrant youth may form gang-related alliances based on shared experiences, social isolation and a perceived need for protection.[12] Individuals may also suffer a range of psychological stressors and challenges in adapting to life in a different

country – a problem known as acculturative stress.[93] Coming from different cultural, socioeconomic and linguistic backgrounds, immigrant youth may struggle to establish social connections and experience stereotyping and discrimination[94] which can affect access to education, employment and social activities. Clear links have been made between these difficulties and mental health.[95] Mental health risks are increased when acculturative stress is accompanied by economic stress (eg, in deprived communities).[96] While immigrant populations are not a homogenous group, professionals that engage with gang-affiliated youth should be aware of the potential for psychological distress resulting from experiences prior to immigration, as well as acculturative stress.

5.5 Gang members in custody

The 1997 Psychiatric Morbidity Survey found that 95% of young offenders (aged 16 to 20) in prison settings showed evidence of at least one of five mental disorders (personality disorder, psychotic disorder, neuroses, hazardous drinking and drug dependence).[97] In the US, incarcerated gang members have been found to have more mental health problems than non-gang affiliated prisoners,[6] while in England young gang members entering the criminal justice system have more suspected mental health problems than their non-gang involved counterparts.[2] The stress of entering secure estate may add to mental health problems, while gang members can face additional psychological challenges such as fear of rival gang members in the same institution and loss of status and social support. Prison services have a critical role in improving mental health and reducing re-offending in young gang members. This includes: identification of mental health problems in those entering secure estate; provision of appropriate interventions based on specific diagnoses and mindful of gang-related issues; early preparation for release that recognises gang-related concerns; and holistic resettlement support including mobilisation of family and community resources, positive peer relationships, housing (including potential re-location), education and employment opportunities.[98,99]

5.6 Looked-after children

Entering care can be a traumatic experience for children. Most looked-after children have suffered adverse childhood experiences such as abuse, neglect or family dysfunction,[100,101] making them vulnerable to a range of emotional, social and behavioural problems. A British study found that looked-after children had significantly higher rates of mental health disorders than their peers in the general population - almost half had a psychiatric disorder, most commonly conduct disorder.[102] Up to a third of children and young people in contact with the criminal justice system are thought to have been looked-after.[103] Factors such as low self-esteem, low resilience, attachment difficulties and possible isolation from friends and family may put these children at risk of gang-affiliation. They can also be particularly vulnerable to sexual exploitation.[37]

National Institute for Health and Care Excellence (NICE) guidance on looked-after children and young people sets out how professionals, carers and organisations should work together to provide high quality care, placement stability and nurturing relationships for young children in care, incorporating services to support emotional wellbeing and mental health.[101] Further guidance on the attachment and therapeutic needs of looked-after children is in development,[104] while statutory guidance on promoting the health and wellbeing of looked-after children is being updated.[103]

6. Preventing the development of poor mental health and gang-affiliation

Addressing the issues raised in this briefing requires a life course approach that supports young people's healthy social and emotional development from the very earliest stages of life.[1] There is growing recognition in both policy and practice of the importance of early life experiences in determining future wellbeing (see box 3). This section summarises information on a range of interventions that can prevent the development of antisocial behaviour and promote mental wellbeing in young people; thereby reducing risk factors for poor mental health and gang-affiliation.

Box 3. The 1001 critical days: the importance of the conception to age two period

This cross-party manifesto[105] highlights the importance of early support and intervention for parents and children to enhance outcomes for children. It recognises the lifelong impacts of inadequate care and adverse childhood experiences (see section 4.1) on health and social wellbeing and sets out a goal for every baby to receive sensitive and responsive care from their main caregivers in the first year of life. The manifesto emphasises the need for a holistic approach to services from pregnancy and through the first few years of life bringing together maternity services, health visitors, social care, mental health services and children's centres and including:

- access to evidence-based services for at-risk families to promote parent-child interaction
- support for all women at risk of or suffering mental health problems, including through specialist midwives and health visitors
- universal access to antenatal classes that address the emotional as well as the physical aspects of parenthood, and infant mental health

6.1 Improving maternal mental health

More than one in ten mothers experience mental illness such as anxiety and depression during pregnancy or the first prenatal year.[106] Left untreated, this can have damaging impacts on children and families, including impaired parent-child bonding and increased risks of children developing poor mental health and behavioural problems.[107,108] Midwives, health visitors and GPs are ideally placed to identify and intervene with mothers experiencing mental health issues. For example, UK research has shown that training health visitors to systematically assess new mothers for postnatal depression and deliver psychologically informed interventions can be effective in reducing postnatal depression.[109] While such services may not produce cost savings in the short term (due to benefits being outweighed by increasing training and staff costs), it is thought they would lead to cost savings in the longer term.[110]

6.2 Home visiting programmes

England has universal midwifery and health visiting programmes that provide a valuable resource in offering parenting support to all new mothers. More intensive home visiting programmes can be effective in supporting vulnerable mothers. The Family Nurse Partnership (FNP) programme runs in many areas in England, offering regular home visits by nurses to new teenage mothers from early in pregnancy until the child is two. Nurses provide prenatal health advice and child development education, and support parental personal development. The programme is based on the Nurse Family Partnership in the US, which has been found to improve health-related behaviours in pregnancy (eg, smoking); reduce child maltreatment, criminal behaviour and welfare use by mothers; reduce serious criminal behaviour by children (particularly girls) in adolescence; and have cost benefits.[111-114]

6.3 Parent training programmes

Parenting programmes aim to strengthen relationships between parents and children and improve parents' skills, knowledge and confidence to support their child's development and manage their behaviour. Programmes can be delivered universally, but are often provided to high risk families and the parents of children at risk of conduct disorders. Behaviour problems in early childhood are a marker of a child's health and wellbeing moving outside healthy ranges (see section 4.3) and effective parenting programmes targeting at risk children can improve parenting practices, reduce parental stress and depression, reduce child emotional and behavioural problems, and be cost effective.[114-116] It has been estimated that parenting programmes for five year olds with conduct disorders could generate savings of £9,288 per child over 25 years – eight times more than programmes cost.[110] Examples of evidence-based parenting programmes include Triple P[117] and Incredible Years.[118] Both are used in England, often delivered through services such as Sure Start Children's Centres.

The Centre for Mental Health's *Building a Better Future*[60] report summarises the costs of childhood behavioural problems and the benefits of early intervention. A range of accompanying practical briefings are available for different professionals, including GPs, schools, midwives, health visitors, school nurses, child social workers, Troubled Families teams, substance misuse staff, housing professionals, prison officers and justice professionals. These briefings provide key facts on the extent and impacts of childhood behavioural problems and summarise what professionals can do to support affected families. The report and briefings are available at: www.centreformentalhealth.org.uk/children/parenting.aspx.

6.4 Preschool programmes

Preschool programmes provide social and academic development to children before they start school, often combined with family and health services. In the US, preschool programmes in disadvantaged communities have shown long-term benefits to children, including reduced child maltreatment, better educational outcomes, and reduced violent offending and mental health problems; they have also shown cost benefits.[114,119-123] In England, all three and four year old children are entitled to 15 hours free early education per week, while Sure Start Children's Centres offer services including child education, childcare, health services, outreach and parental support. The Sure Start programme has evolved over time from a focus on the most deprived communities, to universal provision embedded in the welfare system, to a renewed focus on disadvantaged families. Engaging hard to reach, vulnerable families without stigmatising them will be critical in gang-affected areas. Evaluation of Sure Start has faced limitations and reported mixed findings; positive benefits have included better child social development up to (but not beyond) age three, reductions in maternal reports of harsh punishment and increased provision of stimulating home learning environments.[124,125]

6.5 Social and emotional development programmes

Social and emotional development programmes are typically delivered in schools and aim to develop children's self-confidence, self-respect and relationship skills. They cover areas such as empathy, problem solving, personal values, assertiveness and conflict resolution. Effective programmes can increase children's social competence and academic attainment and reduce disruptive behaviours such as aggression and hyperactivity.[126] Examples of evidence-based programmes include Second Step[127] and Promoting Alternative Thinking Strategies (PATHS), which has shown positive impacts in UK schools.[128] Long term evidence is available from the Seattle Social Development Programme in the USA, which has been associated with reduced violence, substance use and risky sexual behaviour in adolescence and improved mental health in adulthood.[129,130] In England, it has been estimated that school-based social and emotional learning programmes to prevent conduct disorder could generate £10,000 in savings per child after ten years.[110]

6.6 Classroom behaviour management programmes

Classroom behaviour management strategies help teachers address disruptive and aggressive child behaviour and develop productive school communities. In the Good Behavior Game (GBG), developed in the US,[131] teachers set out the rules of proper student behaviour to children and divide their classrooms into teams, with a team being rewarded when all of its members behave well. Long term follow-up has associated the programme with reduced rates of drug and alcohol use disorders, antisocial personality disorder, delinquency and incarceration for violent crimes and suicide ideation by the age of 19 to 21 years, with most benefits seen for males only.[131,132] Implementation in the Netherlands has shown similar benefits, with reductions in depressive and anxiety disorders in the teenage years.[133]

6.7 Bullying prevention programmes

Children who are bullied at school can suffer emotional problems and social isolation, both of which can contribute to poor school achievement and attraction to gangs. All schools in England are required to implement measures to prevent bullying. An example of a programme that has shown benefits in reducing bullying is the Olweus Bullying Prevention Programme, which adopts a whole school approach including: clear school rules and management structures for bullying; training for staff; a classroom curriculum for students; parental awareness-raising; and improvements to the school environment.[134] In England, economic analysis has suggested that effective anti-bullying programmes in schools would offer good value for money.[110]

6.8 Dating and relationship programmes

Dating and relationship programmes aim to prevent intimate partner and sexual violence by developing young people's relationship skills and promoting healthy gender norms. Evidence of their effectiveness is limited, yet positive impacts have been reported through the Safe Dates programme in the US. This targets secondary school students and includes a classroom curriculum, play, poster competition and resources for parents. It has shown benefits for both genders in reducing perpetration of sexual, physical and psychological violence against dating partners (with smaller impacts on victimisation),[135] as well as peer violence victimisation and weapon carrying in schools.[136] An adapted Families for Safe Dates programme with additional focus on caregiver-child communication has also reported positive impacts.[137] A UK example of a teen dating abuse programme is the Face Off resource, part of the It's Not OK! suite of educational resources addressing violence and alcohol currently being evaluated across several local authority areas.[138] The Home Office's This is Abuse campaign aims to raise awareness of teenage dating violence and young people to re-think their views of violence, abuse, controlling behaviour and consent within relationships.[139]

6.9 School-based gang prevention programmes

Specific to gang-affiliation, the G.R.E.A.T. (Gang Resistance Education and Training) programme in the US is delivered by police officers and aims to develop children's life skills, reduce gang involvement and encourage positive relationships among parents, schools, the community and law enforcement personnel. A multi-site evaluation reported a 39% reduction in the odds of gang membership, with participants also reporting more positive opinions of police officers and less positive attitudes towards gangs.[140] However, the programme had no effect on rates of violence or delinquency.

7. Improving mental health in vulnerable and gang-affiliated young people

Young people affiliated with gangs, or at risk of gang involvement, can face significant adversity and have a complex range of mental health needs, alongside multiple physical health and social needs. A range of evidence-based, relevant, accessible and non-stigmatising interventions should be available in gang-affected areas to promote health and emotional wellbeing, support recovery from mental illness and help young people move away from harmful gang-related activities. A holistic approach should ensure that all professionals engaging with young people are sensitive to potential mental health issues and linked in to local care pathways.

Despite a scarcity of research on interventions to improve mental health in gang members, various approaches have been found to be effective at treating mental health conditions in at-risk youth and young offenders. This section summarises these approaches. It does not intend to offer a complete review of psychological treatments for mental health in young people, and the types of treatments used in gang-affected areas should be based on the conditions that are prevalent among gang-affiliated youth (see section 2) and individuals' specific diagnoses. Guidance provided by NICE supports the identification and delivery of effective services across a range of conditions. However, critical gaps in knowledge remain around the effectiveness of interventions with some population groups, particularly young females, and it is important to note that most of the evidence provided in this section relates to males. Engaging gang-affiliated young people in mental health services can be challenging (see box 4) but in some parts of England psychological interventions based on clinical techniques are being delivered to gang members in innovative ways. While these approaches have yet to be rigorously evaluated, examples are provided here.

7.1 Identifying and addressing conduct disorders

Conduct disorders are the most common mental health problems affecting children and young people.[9] They commonly co-exist with other mental health difficulties, are strongly related to offending behaviour, and are particularly harmful to young people's life chances when occurring before secondary school years (see section 4.3).[2] Identifying and addressing conduct disorders in children and young people should be viewed as a critical aspect of preventing gang-affiliation and poor mental health. NICE has produced guidelines on identifying, preventing and treating conduct disorders in children and young people which set out care pathways from initial assessment to intervention.[9] The guidelines emphasise the need for collaboration between health, social care and education professionals to develop appropriate local pathways and ensure information is provided on these pathways to promote access to services. Recommended interventions include:

- group parent training programmes or group foster carer/guardian training programmes (see section 6.3) for parents or foster carers and guardians of 3 to 11-year olds at high risk of, or having, oppositional defiant disorder or conduct disorder, or in contact with the criminal justice system due to antisocial behaviour
- group social and cognitive problem-solving programmes (see section 7.2) for 9 to 14-year olds at high risk of, or having, oppositional defiant disorder or conduct disorder, or in contact with the criminal justice system due to antisocial behaviour
- multimodal interventions (eg, multisystemic therapy, see section 7.3) for 11 to 17-year olds for the treatment of conduct disorder

Box 4. Challenges to engaging gang-affiliated young people in mental health services

A range of barriers can impede young people's access to mental health services, including stigma associated with mental health issues; a preference for self-reliance; a lack of awareness of mental health issues; poor service design; access difficulties (eg, location, timing); poor transitions between child and adult services (see Saunders, 2014[141]); and a lack of developmentally appropriate services.[142] However, additional barriers may be faced by gang-affiliated youth including:

- reluctance to recognise mental health problems in a culture where toughness and resilience is expected
- fear of admitting to a mental health problem, which may be perceived to pose a threat to safety, status and position within the gang
- a general lack of trust in statutory services, with gang members often being conditioned to be distrustful of statutory organisations
- previous negative experiences (either personally, or through family and peers) causing scepticism or mistrust
- reluctance to engage with services through fear of criminal behaviours being exposed or the suspicions of fellow gang members being raised

- restricted geographical access to services due to fears of entering the territories of rival gangs; or even in ‘safe’ areas their proximity to services that might be accessed by other young people affiliated to the same gang (eg, youth offending services)
- a lack of engagement with other services that might signpost young people into support

Novel approaches to promoting mental health in gang-affected communities are overcoming such barriers by engaging with young people in their own environments (eg, through outreach), investing time to build trusting relationships (eg, through the use of key workers or mentors), involving young people in programme development, providing holistic interventions that incorporate mental health promotion among other youth development activities and providing sustained support over several years (see box 7).

7.2 Cognitive behavioural approaches

Cognitive behaviour therapy (CBT) is one of the most widely used and studied approaches to addressing harmful behaviours and improving mental health in vulnerable young people. CBT helps individuals manage their problems by changing the way they think and behave. It is a brief, problem-oriented talking therapy in which therapists help people to identify and address negative thought patterns that contribute to problem behaviours. CBT can be delivered in one-to-one or group sessions in a range of settings and is an effective treatment for many common mental health conditions.[143] It is recommended by NICE for the treatment of depression,[144] conduct disorder,[9] ADHD,[10] PTSD[145] and alcohol dependence[146] in children and young people.

CBT-based programmes can be beneficial in reducing mild to moderate mental health conditions (such as anxiety and depression) in young offenders.[147] The focus of most studies of CBT with young offenders has been on reducing conduct problems and recidivism rates.[148] Programmes can address multiple risk factors and typically cover aspects such as social and cognitive skills training, moral reasoning and anger management.[149] High quality programme implementation is important, while anger control and interpersonal problem solving have been identified as key programme components.[148] CBT-based programmes for young offenders are typically delivered in group sessions and therefore require careful management where young people may be affiliated to rival gangs, including risk assessment of individuals participating in the group.

CBT techniques have been incorporated and adapted into a variety of different therapeutic approaches for young people with severe behavioural problems (eg, see box 5). For example, aggression replacement training is a cognitive behavioural intervention that targets adolescents with persistent aggressive and violent behaviour. It

focuses on interpersonal skills, moral reasoning and anger control and has been shown to improve social skills, reduce serious offending and be cost effective.[114,150]

Trauma-focused interventions

Many young people affiliated to gangs will have been exposed to traumatic events. Trauma-focused interventions focus on the management of anxiety and the modification of maladaptive thoughts related to the traumatic experience. Trauma-focused cognitive behavioral therapy (TF-CBT), for example, is a structured programme that includes both skills-based and trauma-specific components for children and their caregivers. Clients are taught relaxation skills, coping strategies and how to manage their emotions before trauma-specific components are addressed.[151] Initially developed to address the psychological trauma associated with child sexual abuse, TF-CBT has been adapted for a wide range of traumatic experiences and has demonstrated positive effects in reducing symptoms of PTSD.[152] There is also moderate evidence of its effectiveness in improving behaviour problems and depression in children and adolescents.[153] Other approaches include Eye Movement Desensitisation and Processing; a psychotherapy that uses dual attention exercises to disrupt stored memories of trauma.[154,155]

Box 5. The Star Project

The Star Project is a pilot scheme developed and implemented by South London and Maudsley and West London Mental Health Trusts (CAMHS) in partnership with local schools and youth offending services to support the mental health needs of young people at risk of involvement in serious violence and gangs. Project participants receive the Reasoning and Rehabilitation 2 (R&R2) as a core intervention,[156] which uses a revised cognitive behavioural approach to teach emotional and behavioural skills and build prosocial competence. R&R2 has previously shown benefits in improving violent attitudes, anger cognitions and problem solving among adult male offenders with mental illness in the UK.[157,158] This intervention is delivered within the broader context of a mentalising approach, which encourages young people to consider their own and others' states of mind and intentions as a means of addressing problem behaviours. A preliminary evaluation of the Star Project suggested that some participants successfully gained skills and strategies for prosocial behaviour.[159] Based on these initial outcomes, the project is evolving to provide a bolt-on intervention for young people experiencing trauma, and to include a programme for young offender institutions. This will build on the mentalising approach with both young people and staff, with the aim of reducing the antisocial and violent behaviour of high risk gang-involved youths both in the short term and following release from prison.

7.3 Family therapies

Family therapies aim to improve youth behaviour by working with families and the systems surrounding young people (eg, peer groups, schools) to generate and mobilise

strengths and contain damaging behaviours. These programmes are largely targeted at young people with severe and persistent behaviour problems at risk of, or already engaged in, the criminal justice system. Many of these young people are likely to meet the criteria for conduct disorder. Examples of programmes include:

Functional family therapy (FFT)

FFT works with the families of young people with severe and persistent behavioural problems to bring about positive behaviour change. It is used in several parts of England, with young people often referred to the programme through the youth justice system, although referral pathways can vary. Delivered either within the family's home or in a community or clinical setting, FFT aims to reframe family relationships so that all family members are motivated towards change, providing the family with effective problem solving skills to improve family functioning and assisting them to generalise these skills beyond the family context. FFT allows a therapist to match evidence-based strategies to the specific needs of the family. While FFT is being evaluated in England,[160] most evidence comes from the US where the programme has been shown to be effective in reducing offending behaviour and to have cost benefits.[114,161]

Multisystemic therapy (MST)

MST is an intensive family therapy for 11 to 17-year olds at high risk of placement in custody or care due to persistent offending or severe behaviour problems. Therapists use strength-based and cognitive behavioural therapeutic approaches with young people and their families. They work to strengthen parenting skills and family cohesion, increase young people's engagement with education and training, and tackle families' underlying health and social problems. In the US, research has followed recipients of MST over more than 20 years and found them to have lower arrest and recidivism rates than a comparison group that received individual therapy.[162] The programme has been shown to have cost benefits.[114] MST is used in several areas in England[163] and research has found it to have greater benefits than standard youth offending team services in reducing youth-reported delinquency, parental reports of youth aggression and non-violent (but not violent) offending.[164] A wider UK study examining the impacts of MST is underway.[165]

Box 6. Engaging parents in family-focused interventions for gang members

Involving parents in family-focused interventions for gang-affiliated young people can be challenging, due to factors including denial of the existence of problems, past negative experiences with statutory services, fear of stigma and blame, and intimidation (with gang-related violence often affecting whole families, including through child to parent violence). Research[166] has suggested that preparatory work with families may be needed to address these issues, including:

- reassuring parents that interventions are there to support them and that they are not being judged or blamed for poor parenting practices
- presenting the intervention to parents alongside the recognition that the family is one of several influences on their child's behaviour, including social disadvantage and neighbourhood factors
- directly addressing parents' fears of children being taken into care
- packaging interventions in a way that does not lead to parents being stigmatised within their local community
- minimising the number of staff that parents need to engage with during the intervention, possibly through the use of a key worker, and ensuring intervention staff are well trained and seen as being 'on their side'
- addressing risks of child-to-parent violence[167]

In 2012, the government launched the Troubled Families Programme to help turn around the lives of families affected by youth crime and antisocial behaviour, truancy, and parental unemployment by working with the whole family to identify underlying problems. An evaluation of the programme is currently underway.[168]

Multidimensional treatment foster care (MTFC)

MTFC is an intensive intervention that provides treatment and substitutive care for young people with chronic behaviour problems. Through placements with specialist foster carers (typically lasting 9 to 12 months), young people are provided with support in all areas of life, from developing better relationships to solving problems and coping with adversity. As well as promoting the young person's strengths and addressing their difficulties, foster carers provide close supervision and set clear limits on behaviour, reinforcing prosocial behaviours and monitoring negative peer relationships. MTFC can also support the young person's birth family through interventions such as counselling, family therapy and parenting training. In many cases the intervention aims to enable young people to return home or enter a stable long-term placement. In the US, MTFC has been associated with reductions in antisocial behaviour and crime for both boys and girls; although concerns have been raised as to the generalisability of findings.[169] Positive effects on behaviour have also been reported in Sweden.[170] Such positive effects are yet to be replicated in the UK.[171]

7.4 Community approaches

Interventions targeting gang-affiliated young people, or those at risk of gang-affiliation, can incorporate a variety of psychosocial approaches in broader programmes to support young people. These types of programmes are often delivered by charities, which link in to statutory services. For example, Music and Change (MAC) UK in Camden uses an approach informed by attachment theory, lifespan development theory and community psychology theory to engage vulnerable youth and provide intensive support to improve

mental health and promote personal development (see box 7). Community approaches to supporting mental health and addressing the behavioural problems and multiple needs of vulnerable youth often involve the use of a key worker to act as a single point of contact for young people and, where appropriate, their families.[149] Key workers often have backgrounds in youth or social work and aim to build trusting therapeutic relationships that allow them to deliver psychosocial interventions and support to young people. Where possible and appropriate, key workers work collaboratively with young people to identify exit strategies and support gang desistance. With many gang-affiliated youth having a deep mistrust of statutory agencies, a dedicated key worker can limit the number of services that young people and their families have to deal with and help them access appropriate services. Key workers can encourage and facilitate development opportunities such as employment or training and provide links with other services when needed.

Box 7. Integrate: street therapy for gang-affiliated youth in Camden

MAC (Music and Change) UK was established to make mental health accessible to excluded young people involved in gangs and anti-social behaviour in Camden. Working with young people, they have developed the Integrate Model, which takes psychologists, social workers and youth workers out of traditional service settings and into the community to engage with young people on their own grounds. Therapists work to build up young people's trust and deliver 'street therapy' in places where young people feel comfortable, such as in streets, cafes or even on public transport. Street therapy uses recognised psychological theories such as attachment theory and lifespan development theory in a highly adaptable way.

Integrate works with up to 50 young people a year, focusing on those with high levels of offending and social exclusion. It aims to engage young people for two to four years by providing them with the opportunity to create and develop their own project. Projects have included activities such as music, sport, theatre and entrepreneurialism with participants receiving ongoing support to achieve their goal. As well as support with areas such as training, employment and access to health and social services, young people receive therapeutic interventions and brief motivational interviewing focusing on empowerment and mental health promotion. An initial ethnographic evaluation found that the programme engaged hard to reach vulnerable young people and had psychological benefits.[172] An independent evaluation of the programme is underway.

Box 8. Young Women's Advocacy Project (Women and Girls Network)

Provided by the Women and Girls Network and funded by the Home Office, the Young Women's Advocacy Project is a specialist service offering one-to-one and group support to young women (11 to 18 years) who are victims of or at risk of sexual violence and/or gang-related violence, many of whom are referred by domestic or sexual violence services. Based on a holistic model that focuses on immediate crisis intervention, safety planning and risk management, advocates also address the legacy of violence, supporting the young women's mental and physical health, social functioning and

longer-term wellbeing. Advocates can offer practical support with safeguarding, criminal justice processes, housing and employment, and link young women in with other relevant services as required (eg, specialist counselling). As well as one-to-one support in person, via telephone, email and text message, the project provides group workshops covering topics such as women's rights, what it means to be a woman, relationships and communication, consent and decision making. To engage with young women, lunch time drop-in surgeries are offered in schools, where school assemblies are also used as opportunities to raise awareness of sexual violence and gang involvement. The project offers an on-going fortnightly "open space" to any young woman who has previously accessed support or attended a workshop. This allows the young women to continue to explore issues or concerns with their peers under the guidance of an advocate. As well as delivering seminars to statutory agencies and community organisations involved with girls and gangs, advocates work with partners such as the police to help to identify girls who are most at risk.

Mentoring programmes

Mentoring programmes provide trained mentors to work with young people either at home, at school, or in the community. Typically targeting disadvantaged youths, mentors provide non-familial adult role models that are able to share knowledge and skills with young people and offer psychosocial support. For example, the Big Brothers, Big Sisters (BBBS) mentoring programme has been adopted worldwide and aims to improve the self confidence, academic success, interpersonal relationships and behaviour of at-risk youths. Supported by case workers, volunteer mentors develop bespoke schedules for their mentees and are encouraged to enjoy activities together. Evidence from the US suggests that BBBS can reduce the chance of a young person initiating drug or alcohol use, improve academic attitudes and performance among female mentees, and have a positive impact on family relationships.[173] No impacts have been demonstrated on participants' self-worth or self-confidence.

Mentoring is a key component of several programmes working with vulnerable and gang-affiliated youth in the UK with programmes delivered through criminal justice (see box 5), community, school (see section 7.5) and health services (eg, King's Youth Violence Project[174]). In many such cases, mentors will have lived experiences of gang involvement. It will be important that mentors have an awareness of mental health issues as well as sexual violence and gang-related violence. Through the Ending Gang and Youth Violence Programme, the Home Office is working with the Early Intervention Foundation to help local areas identify and use early intervention programmes to address gang involvement. Guidance for commissioning mentoring programme has been produced as part of this work.[c]

[c] Available at www.eif.org.uk/preventing-gang-and-youth-violence

Box 9. The SOS Project

Working across many of London's most deprived boroughs, the SOS Project provides one-to-one intensive support to former prisoners and those involved with gangs. Practical assistance (eg, with housing, finances), advocacy and social and emotional support is provided by a mentor who has had first hand-experience of the criminal justice system. Ex-offenders are carefully selected as mentors and supported in attaining relevant qualifications (eg, in youth work). While mentors' experiences provide them with a certain credibility that allows them to build rapport with clients, they must also share the ideals of the charity – providing support to offenders but recognising they are accountable for their own actions and their needs do not supersede those of their victims or communities. Where mentors identify issues of substance use or other mental health problems, clients are referred to relevant local services, where many will then receive treatments such as MST. Mentors also visit schools to engage with young people and demystify the reality of gangs, while the project provides training to professionals within health, education and youth services to raise awareness of key issues facing those involved with gangs. The intervention has not yet been evaluated.[175]

'Pulling levers' policing

'Pulling levers' policing refers to a model of problem-oriented policing that identifies a problem (eg, gang violence) and convenes a multi-agency partnership to address it through research and targeted enforcement, deterrence and support. It was initiated in Boston, US, through Operation Ceasefire**,** which aimed to address increasing youth homicides. This brought together criminal justice agencies, social services, community-based practitioners and other partners and used research and firearms tracing data to identify violent gang members. Police adopted a zero tolerance approach to violence and firearms offences, which was communicated to gang members through meetings and outreach work along with the offer of social support (eg, job referrals, access to social services) to help them desist from gang violence. Evaluation of the programme reported reductions in youth homicides, firearms assaults and police call-outs for gunshots.[176] Similar strategies have since been implemented and evaluated in other cities across the US, with a meta-analysis of studies finding the approach to have a significant, medium-sized crime reduction effect.[177]

This model has been adopted in several UK cities including in Glasgow through the Community Initiative to Reduce Violence (CIRV). Bringing together partners from justice, government, community safety services, housing, careers, education, social work, health and the community, the initiative targets resources towards high-risk street gang members who do not traditionally engage effectively with services. In its first two years, CIRV referred 176 gang-involved young people to employment-based personal development programmes. The most challenging clients were offered an intensive mentoring programme that focused on building resilience around emotional wellbeing

and supporting engagement with education, training and employment. According to data reported by police, CIRV clients demonstrated, on average, a 46% reduction in violent offending and an 85% reduction in weapons carrying offences, with greater reductions seen among those engaging with intensive, long term mentoring and support.[178]

7.5 The role of schools in promoting mental health

Schools have a key role to play in supporting the mental health needs of vulnerable children and young people, including those at risk of, or affiliated to gangs. Mental health directly impacts on learning and development and children who are facing mental health difficulties may struggle in school. Failure to support the mental health needs of pupils may contribute to absenteeism and risk of school failure,[179] which have been associated with longer-term problems such as unemployment, involvement with the criminal justice system and gang membership.[180,181] In addition to the delivery of programmes to develop children's social and emotional skills and prevent bullying (see section 6), there is growing evidence for school-based programmes that aim specifically to promote mental wellbeing and address poor mental health.

Whole school programmes targeting mental health aim to promote mental wellbeing across all children. In Birmingham, for example, the SchoolSpace programme (which is currently being evaluated)[182] aims to reduce stigma related to mental illness and improve mental health literacy among secondary school students. Other programmes focus on skills-based development, such as the Mindfulness in Schools Programme (MiSP) which teaches pupils mindfulness as a way of dealing with the stressors of everyday life. A study exploring the impacts of MiSP in six English secondary schools suggested it had benefits in reducing symptoms of depression and stress.[183]

Therapeutic interventions can offer more individualised support. For example, Place2Be is a charity that offers individual and group counselling support to children in primary and secondary schools in England and Scotland. The approach focuses on children's interpersonal relationships, self-awareness and the value of play therapy, along with support for parents and training for school staff. Children engaged with Place2Be have shown reductions in social and emotional difficulties and increases in positive behaviours.[184] Tailored one-to-one support can also be provided through mentoring programmes (see section 7.4). For example, Chance UK provides mentors to work closely with primary school children with behavioural difficulties who are at risk of developing antisocial or criminal behaviour. Using a solution-focused approach, mentors draw on the strengths of the child to raise their self-esteem. An evaluation of Chance UK's work found that mentees showed improvements in emotional symptoms, conduct problems and problems with peers.[185]

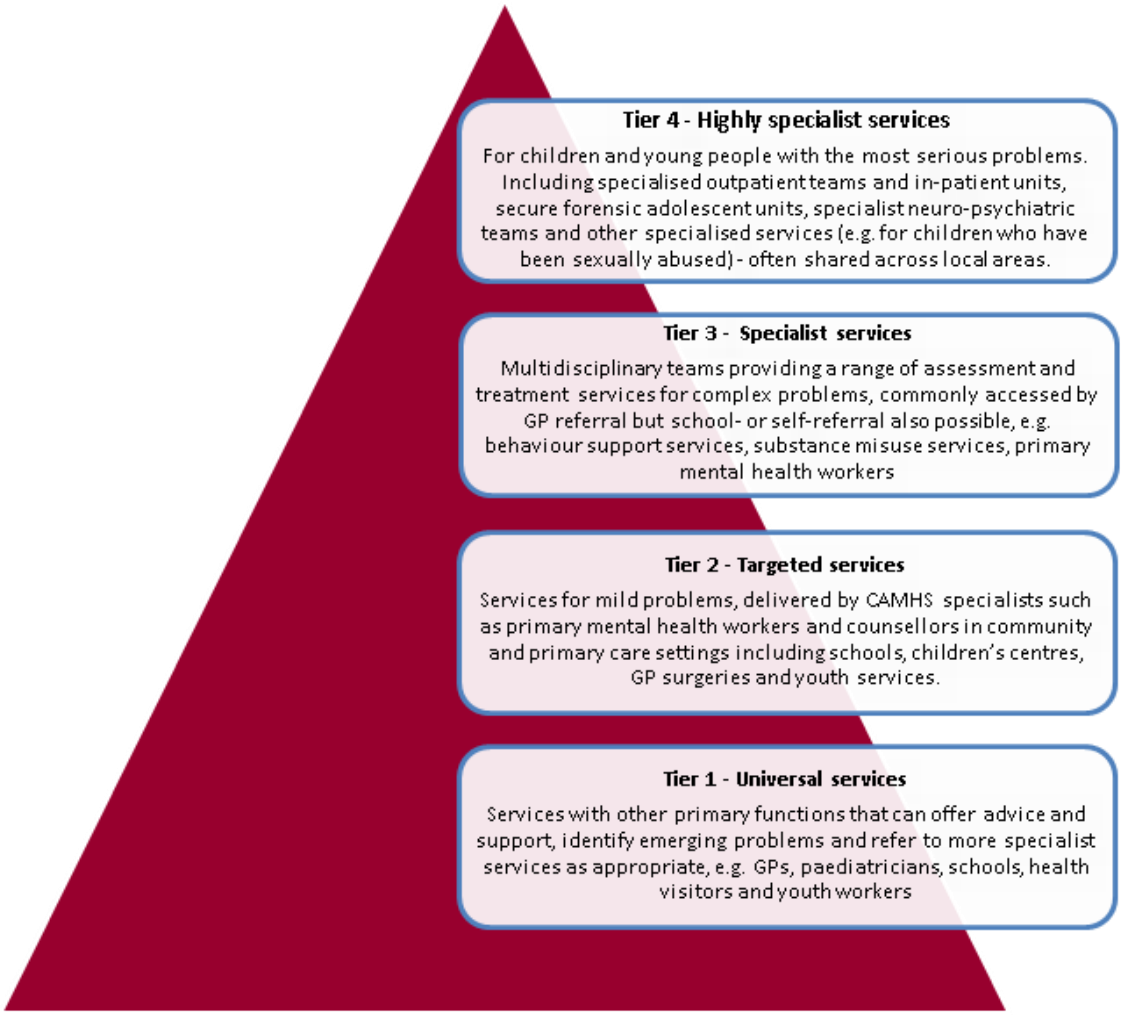
The Department for Education has published advice for primary and secondary school staff on supporting pupils with mental health needs.[186] Children and young people with a

range of complex social, emotional and mental health difficulties may require special educational provision, either within the school setting or involving specialist staff or support services (see figure 3).

7.6 Comprehensive child and adolescent mental health services (CAMHS)

While mental health services are delivered by a range of agencies, the comprehensive CAMHS system provides a framework for collaborative work to support mental health in children and young people. Comprehensive CAMHS are delivered by a whole system four-tiered approach starting with the universal promotion of emotional wellbeing through to the treatment of complex cases with evidence-based specialist services (see figure 3). CAMHS are important partners in work to support the emotional and mental health needs of gang-affiliated young people (eg, see box 5). Services operating in gang-affected areas should be aware of the specific challenges faced by gang-affiliated youth and linked in to broader community and school-based programmes to ensure that young people receive appropriate support, particularly in the transition through to adult services. Older adolescents and younger adults have often faced a gap in service provision, as neither child nor adult options have been developmentally appropriate or culturally attractive for this population. There is a growing awareness of the need for services to bridge this gap and provide flexible services that cater for young people as they transition between child and adult services.[141] There is also increasing recognition of the need for investment in integrated services that can address a young person's mental health needs alongside other personal, health and social issues. Guidance provided by Youth Access and the Young People's Health Partnership highlights the importance of young-person focused services for those aged 11 to 25 delivered in independent, informal settings and providing coordinated support for inter-related issues (eg, mental health, sexual health, substance use, employment).[187] Such holistic support is likely to be particularly important for young people involved in gangs who often face multiple health and social problems.

Figure 3. The four tiers of comprehensive CAMHS[188]



8. Summary

Poor mental health and exposure to violence have profound impacts on young people's life chances and affect priorities across all public services, including criminal justice, health, education, social services and employment. Promoting mental health and preventing violence, including gang-related violence, is consequently in everyone's interest. In gang-affected communities, effective prevention strategies can protect children from the risk factors that contribute to problematic behaviours, gang-affiliation and poor mental health. For those young people already affected by these issues, improving mental health can be fundamental in supporting their movement away from harmful gang-related activities.

This briefing has outlined the extent of mental health problems in gang-affiliated young people, the relationships that tie poor mental health and gang-affiliation together and the shared risk factors that contribute to both. It has also outlined the types of interventions that can contribute to a lifecourse approach to preventing gang-related violence. A comprehensive approach should provide support to children and their families from the very earliest stages of life, preventing risk factors, building strong emotional wellbeing, and responding promptly to early signs of poor mental health and crisis. Young people already affiliated to gangs often face significant adversity and can have a complex range of mental health needs. Recognising these needs and ensuring relevant and accessible services are available in gang-affected communities to promote mental wellbeing and support recovery from mental health conditions is a fundamental step in addressing gang-related violence.

Many of the interventions highlighted in this briefing are already being used at varying levels in England and emerging evaluations will help us understand their benefits and aspects of successful implementation. Effectively addressing the relationships between gang-affiliation and poor mental health requires a strong, collaborative approach that co-ordinates services across a wide range of organisations. Work to measure the cost benefits of mental health interventions across different sectors has already been undertaken by the Department of Health.[110] Strengthening and disseminating this evidence will support collaborative responses.[d]

[d]The Washington State Institute for Public Policy in the USA identifies evidence-based strategies to inform State policy. It systematically assesses high quality studies across key policy areas (including child welfare, child and adult mental health, juvenile and adult justice, education, substance misuse and public health) and produces benefit-cost analyses for a wide range of programmes. While findings relate specifically to Washington State, they provide a useful resource for identifying effective and cost effective programmes.

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