RESOURCE GUIDE

GETTING A GRASP ON YOUTH MENTAL HEALTH

Covering Risk Factors, Bullying, Social Media, Eating Disorders, Anxiety, Self-Harm and Much More

Letise Sampson

Getting a Grasp on Youth Mental Health:
A Resource Guide for Teachers, Parents, Young People and the Wider Community

Letise Sampson

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Biography - Letise Sampson

I believe many young people are suffering from some form of mental health disorder.

My first personal experience of poor mental health began when I was a young 18 year-old, a time when I was in college and trying to discover myself. At the time there was a rumour being spread about groups of people going around and stabbing others with hypodermic needles senselessly. It was sort of an urban myth as nobody seemed to know anybody who it had happened to personally; but nonetheless, the rumours spread like wildfire.

I remember one evening I went to the Zenith night club in Park Royal with a group of friends. The club was extremely busy that night and eventually a fight broke out. In the confusion as everybody was pushing to try and get out, I felt the sensation of a thin needle-like object entering my lower back. It was sharp and painful but over very quickly. I didn’t have time to think about it at that time as I was more concerned with getting out of the club.

When I got home, I held up a mirror to my back and saw a tiny red bump in the spot where I had felt the jab. Could the rumours be true? Could I have been jabbed with a needle? I then asked my mum, who was a midwife, what happens if someone pricks your skin with a needle. She said that there can be a small bump and redness at the point of insertion. My worst fear was confirmed, and this was the beginning of many years of post-traumatic stress.

As you can imagine, I went through all the emotions of fear, anger and panic. I began going online looking for information to try and figure out what I should do. I ended up on forums where people were sharing their harrowing stories of needle jabs and being infected with hepatitis and even HIV. I felt isolated and truly afraid. As I read the stories, I felt like demons were invading my mind. I had trouble sleeping and would wake up in a cold sweat. During the day it was all I could think about.

I became so paranoid that I had caught something that I became obsessed with my health. Any cold, runny nose or other symptom threw me into a panic. Instead of seeking help, I instead googled the symptoms online. Instead of alleviating my worries, all this did was feed the anxiety demon.

I convinced myself that I had been stabbed with a needle containing the HIV virus and I was going to die. At that time HIV was known as the monster disease amongst my peers in college. There was a deep and dark stigma attached to it and I felt so ashamed. I didn’t tell anyone what I was going through, not even my mum even though she worked in healthcare.

This went on for years until I eventually got the courage to go to a clinic and get tested. The test came back negative, but the nurse sensed my morbid fear and obsession and asked if I wanted to be referred to a counsellor, which I accepted.

The counsellor actually helped me to rationalise my fears and put my mind at ease. He helped me accept that the tests were negative and that my fears originated from the stories that were going around about groups jabbing people with needles. I was fine for a while.

However, the anxiety and obsession with my health would return a few months later. It seemed like once I had let these disorders into my mind, they didn't want to leave.

Every time I felt unwell or had some sort of symptom, I would automatically fear the worst and head for the internet, which only ever seemed to confirm my fears. It became an obsessive cycle. I realised that I had to put a stop to this and proactively ensure that fear, anxiety and OCD did not take over my life once again.

I continued to undergo counselling. Even though it sounds cliché, it helps to talk about the things that are going on in my head. Fear feeds on isolation. The more you keep things in, the bigger hold fear will have on you. I didn't want that for the rest of my life. When I isolated myself, I thought no one could help me and that there was no hope.

I still find this experience hard to talk about, but I guess I want young people to know that whatever it is you are going through, there is help available and you are not alone.

Introduction

One of the central messages we promote through the 2020 Dreams platform is the importance of early intervention: in tackling gangs, controlling weapon use and, most relevant to this book, in improving mental health. Two statistics supports, in stark terms, the need to get involved with youth mental health while children are still very young:

1) **Three-quarters of all people with mental health problems developed their problems before the age of 18.**

2) **Half had developed them by the age of 15.**

In terms of overall prevalence, the latest reliable evidence puts the number of 5 to 16-year olds with a diagnosable mental health condition at just under 10%. (See Chapter 10: The State of Youth Mental Health for a more detailed breakdown of these numbers.)

Mental health issues are also persistent: a quarter of young people suffering from one (and as many as 43% diagnosed with a behavioural disorder) will still have it three years later.

One of the most damning statistics though is this:

The most likely cause of death for 15 to 34 year olds in the UK is suicide.

In fact, people with a mental health disorder have, on average, a life expectancy which is ten to twenty years lower than the rest of the population.

How to Use this Book

This book is a 2020 Dreams publication. 2020 Dreams tackles those tough issues like youth mental health and knife and gun crime that all of us find difficult to talk about. We raise awareness through education, training, life coaching and mentoring. Please see **www.2020dreams.org.uk** for more details.

This book is designed to be accessible not only to teachers, volunteer groups and community group members but also to parents and students themselves. If you are not a big reader, there are plenty of case studies, discussion points and activities dotted throughout.

This book will provide you with everything you might want to know about youth mental health in the UK. It also looks at how we can (and should) work together as a community to help recognise the signs of suffering, provide support and signpost the way to effective professional help.

For Teachers:

- ✓ Based on established and recent research and latest reports.
- ✓ Broken down into bite-sized chapters to help lesson planning.
- ✓ Can be read cover-to-cover or dipped into.
- ✓ 'Discuss This' panels for class discussion.
- ✓ 'Try This' panels for class activities.

For Parents:

- ✓ Real life case studies.
- ✓ 'Discuss This' panel for discussions at home.
- ✓ 'Try This' panel for family activities.
- ✓ Guidance for improving communication at home.
- ✓ Advice for working with other parents and the community.

For Young People:

- ✓ 'Discuss This' panels gives you things to talk about at school or with your family.
- ✓ 'Try This' panels include fun and useful activities for home and school.
- ✓ Advice to help you improve your own mental health.

For the Wider Community:

- ✓ Based on established and recent research and latest reports.
- ✓ Builds awareness about youth mental health.
- ✓ Practical advice for recognising the symptoms of poor mental health and providing appropriate support.

CHAPTER 2: Defining Mental Health

According to the World Health Organisation (WHO), health is *'a state of (complete) physical, mental and social wellbeing and not merely the absence of disease or infirmity.'*

Mental health is defined as, *'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.'*

The WHO also describes mental health as, *'subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others.'*

Therefore, mental health is seen as a positive quality that benefits both the individual and society.

Activities: What Does Good Mental Health Look Like?

Discuss This!

Before reading the list from the Mental Health Foundation below, divide the class into two to three groups and ask them how they would identify a mentally healthy person. How would they behave? What results would this have?

Discuss with the whole group. Explain how positive behaviours and achievements support each other.

In their 1999 Bright Futures report, the Mental Health Foundation listed a few specific characteristics found in mentally healthy young people. These include:

- ✓ The ability to develop in every way – emotionally, intellectually, psychologically and spiritually.
- ✓ The ability to build, develop and sustain positive relationships.
- ✓ Awareness of and empathy with others.
- ✓ Comfort with keeping their own company.
- ✓ Developing sense of right and wrong.
- ✓ Learning through play.
- ✓ Willingness to face their problems and learn from them.

So, what is a mental health issue? This is a broad term that covers both diagnosable mental health illnesses (e.g. generalised anxiety disorder (GAD), depression, schizophrenia, etc.) and those temporary and permanent mental and emotional problems which may be more difficult to diagnose.

Mental health issues are characterised by disturbances in the way people think, feel and behave (these three elements of psychology are tied in with one another as explained in Chapter 14: The Role of Counselling and Therapy.

These changes can be subtle or obvious, long or short-term. Major disturbances are often categorised and recognised as diagnosed mental illnesses. Other terms

for mental illness include mental disorder, mental ill health, psychiatric illness, nervous breakdown and burn out.

Slang terms used to describe and refer to people living with a mental illness include 'psycho', 'mental', 'nutter,' 'loopy' and 'crazy.' People reading this book should avoid using these terms in any context as they contribute to the stigma around mental health. Stigma is the overall negative impression of people with mental health issues and we look more closely at stigma in Chapter 15: How We Can All Help.

Temporary, non-diagnosable (or yet to be diagnosed) mental health issues should not be underestimated in their impact. They can still have chronic and acute effects. For example, some young people may enter a crisis and have suicidal thoughts despite not being diagnosed with a specific mental illness.

Mental Illness Versus Personality Disorders

Whether or not there is a real difference between a mental illness and a personality disorder is disputed. An article in the British Journal of Psychiatry as far back as 2002 concluded that *'the historical reasons for regarding personality disorders as fundamentally different from mental illnesses are being undermined by both clinical and genetic evidence.'* In terms of classification, personality disorders are divided into three clusters:

1) Cluster A disorders include paranoid personality disorder, schizoid personality disorder and schizotypal personality disorder. People with these disorders may appear to act strangely and find it difficult to relate to others.

2) Cluster B disorders include antisocial personality disorder (ASPD), borderline personality disorder (BPD), Histrionic personality disorder and narcissistic personality disorder. People with these disorders are often unable to control their strong emotions.

3) Cluster C disorders include dependent personality disorder, avoidant personality disorder, obsessive-compulsive personality disorder (note that this is not regarded as the same as obsessive-compulsive disorder). People with Cluster C disorders tend to be fearful of certain situations.

Personality disorders and mental illness can go together. For example, someone with borderline personality disorder may also suffer from depression.

Mental Illness Vs Developmental Disorders

Mental illness is also distinct from developmental disorders such as autistic spectrum disorder (ASD) and attention deficit and hyperactivity disorder (ADHD). However there is a large degree of overlap. For example, there is a link between ADHD and behavioural disorder in young people while ASD, Asperger's Syndrome and ADHD are risk factors for developing mental illnesses such as anxiety and depression.

The Mental Health Continuum

To muddy the waters further, there is no clear dividing line between someone who is mentally healthy, someone who is experiencing mental health issues and someone who is mentally ill. Mental health can be visualised as sitting on a

continuum between mentally healthy and mentally ill with young people moving up and down the scale as they develop. Using this model, even young people with a diagnosed mental illness can recover and become healthy although some mental illnesses are more deep-rooted than others.

If someone is mentally healthy, they usually:

- ✓ Have confidence and self-respect
- ✓ Form relationships with peers
- ✓ Play and set goals
- ✓ Take on challenges
- ✓ Cope with minor problems
- ✓ Seem happy

If someone is experiencing mental health problems, they might:

- ✓ Lack confidence
- ✓ Have problems forming or maintaining relationships
- ✓ Play alone
- ✓ Avoid challenges
- ✓ Have difficulty coping with minor problems
- ✓ Seem down
- ✓ Have trouble sleeping
- ✓ Start eating more or less
- ✓ Take drugs or start drinking alcohol

If someone is mentally ill, they might:

- ✓ Show a number of the symptoms listed above
- ✓ Suffer for a long time with these symptoms
- ✓ Spend time alone doing nothing
- ✓ Suffer panic attacks
- ✓ Be regularly tearful or always down
- ✓ Act strangely or aggressively
- ✓ Hold odd beliefs (delusions)
- ✓ Think everyone hates them (paranoia)
- ✓ Hear voices or see things that aren't there (hallucinations)

See Chapter 15: How We Can All Help and the Appendices for guidance on how to help young people experiencing mental health problems.

Activities: Healthy or Having Problems?

Try This!

It is not always easy to judge whether someone is mentally ill, experiencing mental health issues or just having a bad day. For this activity represent the mental health continuum as a line across a white board or large sheet of paper ranging from mentally ill to mentally healthy.

Read out the scenarios below and ask students to place each child somewhere along the continuum. Afterwards, discuss their choices using the teachers' notes below.

Jimmy came home from school one day looking upset. His mum asked him what was wrong, and he said he was tired after going to bed late and felt sad all day. The next day, Jimmy's mum watched him playing in the park with his friends. He seemed happy and deeply involved in a game. There was one moment when Jimmy and his best friend Tom had a heated argument but ten minutes later they were playing nicely again.

Belinda's dad took her to the doctors two weeks ago because she was refusing to eat, was having trouble making friends and wouldn't go to school without a battle. Part of the advice from the doctor was for her to keep a diary about her feelings and thoughts. Belinda is now eating more and has started going to school without a fuss. However, this morning she threw her cereal on the floor and refused to leave the house. *She eventually calmed herself down and went to school.*

Cameron has always been a quiet boy but he used to laugh a lot more than he does now. A few weeks ago, one of the bigger children pushed him over and threw his school books in the bin. Ever since, Cameron has seemed worried when walking around the school. His grandma saw he had been crying and asked what was wrong, but Cameron got angry and said he was fine.

Lynn has been in and out of school for a long time. She likes to keep herself to herself and is usually unfriendly when her peers approach her. At playtime she sits on the wall away from the other children and often looks sad. Occasionally she has to sit in isolation because she gets angry and throws things at the teacher.

Teachers notes:

Jimmy seems to be mentally healthy. Jimmy's sadness is likely to be because he was over-tired and the fact that he told his mum this shows he can communicate his emotions. He clearly has friends and engages in constructive play. He seems to have coped well with the stress and negativity from the fallout with Tom.

Belinda seems to have been experiencing mental health problems which have affected her eating and her behaviour. Her doctor seems to be taking a 'watch and wait' approach, suggesting her issues aren't severe at this stage. It seems Belinda is returning to mental health but may occasionally have bad days. She does seem to be able to calm herself down which is a good sign and suggests the journal may be helping her work through her problems.

Cameron also seems to be experiencing mental health problems, possibly triggered by an episode of bullying. Cameron's reaction to his grandma suggests he is embarrassed about showing emotions. This is something that can be a particular problem with boys who may think it's wrong to cry. Cameron may benefit from talking to a doctor about his feelings.

Lynn is showing signs of mental illness. She struggles to build relationships and often seems down. Perhaps she is depressed.

The fact that she is in and out of school could suggest either an unstable home life, bouts of severe mental illness or both. Aggressive behaviour is also associated with poor mental health and could indicate behavioural disorder.

Finally, it is worth reminding children that it is difficult to realise someone is experiencing mental problems from one or two examples of behaviour. The important thing is that children look out for one another and support their friends.

CHAPTER 3: Why Mental Health Is Important

This chapter looks at the importance of good mental health and how mental health issues can affect young people.

The Benefits of Good Mental Health

Why is mental health so important for the health and wellbeing of children and young adults? Simply, it impacts on every aspect of their lives, including their:

- Ability to focus and learn and make the most of their education.
- Happiness and productivity in the workplace (and hence their employability).
- Ability to form mutually beneficial peer relationships and to resist peer pressure.
- Success in forming healthy intimate relationships.
- Ability to make positive health-related choices (e.g. choosing protected sex; avoiding drugs and excessive drinking; being sensible with money; etc.)
- Resistance to violence, gang involvement and crime.

The Effects of Poor Mental Health

So what happens when mental health goes wrong?

Here are some of the documented effects of poor mental health:

- **Reduced concentration and motivation** - This causes a delay in cognitive (thinking) development which affects a young person's self-worth, education and ultimately work prospects. It is difficult (though not impossible) to make up for this delay, both in practical terms and in the recovery of self-esteem. This is why early mental health intervention is a must!

- **Social withdrawal** - Avoiding other people impairs social and psychological development which negatively impacts relationships. As positive connections with teachers, peers and, later, work colleagues are vital for success at school and work, these two issues reinforce each other.

- **Increased likelihood of alcohol and drug use** - Drinking alcohol while young, especially in excess, can interfere with brain development and lead to cognitive impairments (problems thinking). This can become a vicious circle.

- **Physical illnesses -** Some mental illnesses have been linked to an increased risk of contracting physical diseases. For example, people suffering from depression are four times more likely to suffer from coronary heart disease than the general population (taking out other risks such as living in poverty). Other cardiovascular conditions and immune system disorders have also been linked to mental ill health.

- **Severe weight loss** - Children who develop eating disorders can damage their long-term fertility with dramatic weight loss interfering with the reproductive cycle. Severe weight loss is a symptom of anorexia nervosa, a serious psychiatric illness with a high mortality rate (see Appendix B)

Also see the appendices for other specific mental health issues, from commonly diagnosed illnesses like anxiety and depression to less prolific disorders (e.g. schizophrenia and bipolar disorder).

CHAPTER 4: Risk Factors for Poor Mental Health

Experts recognise that there are many different reasons why some children develop long-term mental health problems, some experience short-term problems and recover and others are relatively unaffected.

These reasons are termed risk factors and include being around parental stress in the home, exposure to violence, substance abuse and genetics.

The picture is complicated by separate but related issues such as developmental disorders, personality disorders and behavioural problems.

Let's look more closely at these risk factors. They can be broadly divided into three categories although these will overlap.

1) Individual risk factors

Individual risk factors are a youth's personality traits, impairments and behaviours. They may be inherent (i.e. genetic) or, more often than not, brought about by the early childhood environment of the youth.

Examples of individual risk factors include:

- Genetic predisposition
- Low birth weight

- Birth injury
- Learning disabilities/low IQ
- Physical disabilities
- Attachment issues
- Delayed development
- Long term childhood illness
- Childhood behavioural disorder
- Low self-esteem
- Poor social skills
- Poor academic achievement
- Substance abuse
- Hormonal changes (e.g. puberty)

Learning disabilities and physical disabilities:

In England, almost a million people are estimated to be living with a learning disability although only a fifth are thought to be known to disability services. 36% of children and youths with learning disabilities have a diagnosable psychiatric disorder; this is compared to 8% of the general population (25-40% are estimated to have a non-specific mental health issue).

In addition, children with learning disabilities are 33% more likely to be on the autistic spectrum and more likely to have a behavioural or emotional disorder. The challenges from having to live with a physical disability can also have a negative impact on mental health.

Hormonal changes:

The hormonal changes that come with puberty can affect cognition and mood to such a degree that they trigger mental health issues.

2) Relationship risk factors:

Relationship risk factors are those which arise from the connection between a young person and others in their close circle. This can include the first mother-child relationship, the immediate family unit, the wider family and even peers. Some of the risk factors listed can be classed as adverse childhood experiences (ACEs). These are explored in more depth later in the chapter.

Examples of relationship risk factors include:

- Postnatal depression
- Having a single parent
- Having a young carer
- Low parental IQ
- Lack of affection
- Lack of stimulation
- Childhood abuse/maltreatment
- Childhood neglect/rejection
- Domestic violence
- Poor parental supervision
- Lack of adaptation to a child's age-appropriate needs (e.g. treating young adults as infants or expecting young children to be completely independent)

- Unhealthy parent practices (crime, drug-taking, alcoholism, etc.)
- Large, rapidly expanding family
- Family instability or conflict
- Family breakdown
- Parental/family mental illness or personality disorder
- Weak family structure
- Unacknowledged bereavement
- Delinquent peers
- Bullying (including cyberbullying) / peer rejection
- Peer pressure (overt and internal)
- Relationship breakup

Childhood abuse and neglect:

Childhood abuse and neglect increases the risk of lifetime depression by 1.8 to 2.7 times for women and 1.6 to 2.6 times for men. A UK study on rates of severe maltreatment (Ferguson et al, 2005) revealed the following:

- Of more than 2,200 11 to 17 year olds, 18.6% experienced severe maltreatment. 6.9% had been severely physically abused; 4.8% had experienced contact sexual abuse; 9.8% had been severely neglected and 13.4% had been severely maltreated by a parent or guardian.

- Of more than 1,700 18 to 24 year olds, 25.3% experienced severe maltreatment. 11.5% had been severely physically abused; 11.3% had experienced contact sexual abuse; 9.0% had been severely neglected and 14.5% had been severely maltreated by a parent or guardian.

Family instability and conflict:

The negative effects of growing up in a dysfunctional family are not surprisingly linked to higher incidences of mental health issues. However, children from relatively stable and supportive homes are not immune from developing problems.

For example, some parents deliberately or unknowingly put a lot of pressure on their children to achieve. This can lead to problems with anxiety and, if not controlled, these can develop into chronic anxiety disorders.

Unacknowledged bereavement:

Following a family breakup, young people of any age can suffer from symptoms similar to bereavement (over the loss of the other parent and, where they have moved from an area, the loss of childhood friends).

Bullying:

Bullying is one of the most common reasons young people contact Childline, making up around 9% of all counselling sessions (Savage, 2014). In fact, it is the second most common reason for boys and third most for girls.

Depending on the source, cyberbullying affects at least 8% and perhaps as many as 34% of young people in the UK (Ogilvie et al, 2014). See Chapter 9: Social Media, Gaming, Cyberbullying & Mental Health for more details.

Peer pressure:

Peer pressure is a risk factor whether children are being actively pressurised or creating their own pressure. For example, children are bombarded with messages about their appearance and this becomes a central part of their identity as they develop. Insecurities in this area can lead to a wide range of mental health issues including anxiety, depression, eating disorders and over-exercising.

Many youngsters face pressures to act contrary to what feels right. If they give in to the pressure they can end up feeling ashamed or anxious but if they refuse to do what's asked, they are likely to feel anxious about not fitting in with their peers. Are we doing enough, as a society, to equip young people with the skills they need to handle these pressures (which can now come at them 24/7 due to the evolution of technology and social media!)?

Relationship break-up:

Adolescents are also trying to handle the strong emotions that come from break-ups and other relationship issues. Inexperience and a lack of skill in this area can lead to frustration. This can sometimes develop into mental health problems such as self-harm, substance abuse and eating disorders.

Risk factors are not mutually exclusive. For example, family breakdown can be linked to crime or alcohol abuse which can lead to unclear/inconsistent discipline and neglect or abuse.

To get an idea of the scale of the problem, in an average class of children, ten will have experienced their parents separating; eight will have experienced severe neglect, physical violence or sexual abuse; seven will have been bullied and one will have been affected by the death of a parent.

3) Community and society-based risk factors

Just as individual risk factors are sometimes difficult to tease apart from relationship risk factors, relationship and community and society-based risk factors often blend into one another.

The community at large – as well as the school community – can be a source of risk factors for poor mental health. Examples of community and society-based risk factors include:

- Increased autonomy for older children
- Easy availability of drugs and/or alcohol
- Gang presence
- High crime levels
- High unemployment
- Loss of community or weak structure
- Socioeconomic disadvantage (i.e. low income with weak social connections)
- Low social mobility (i.e. few people improving their situation)
- Poor quality homes
- Social inequality
- Poor quality schools/education
- Exclusion from school

- Limited healthcare provision
- Lack of outdoor spaces
- Prejudice and discrimination
- Social exclusion/isolation
- Perceived lack of personal protection

Increased autonomy:

Why is increases autonomy counted as a risk factor? When they are away from parental control, adolescents find it easier to take risks such as experimenting with alcohol and drugs. Together with their specific impact on brain chemistry, these substances can lead to adverse life events.

For example, if a young person kills or injures someone when they are drink driving or are involved in an assault there could be feelings of loss, guilt and shame. These can lead to depression.

Even increased autonomy on its own can lead to anxiety, particularly where a young person has previously had much of their decision making done for them. While most young people come through this period as a necessary stage of growth, others succumb to the pressure and suffer from mental illness.

Low social mobility:

Low social mobility and a lack of social capital (i.e. connections) leads to a general feeling of hopelessness about the future. Seeing no value in long-term goals, young people are likely to focus on short-term gains and may indulge in

risky and antisocial behaviour, including violence. Evidence suggests that males are particularly vulnerable to this outcome.

The problems are often compounded due to limited facilities, unhelpful social norms and a lack of community organisation and social control.

Limited access to services:

Some areas, particularly rural areas, suffer from a lack of specialist services with people suffering from mental health issues having to spend extra time, effort and money on accessing services. This has a negative impact on crisis interventions with the availability of outreach services and response time (including advice and counselling services) limited. There are often insufficient age appropriate services due to the declining youth population in rural areas.

Restricted services are compounded by fewer opportunities for independence and social mobility. For example, there are often fewer opportunities for education, training, employment, recreation and housing.

This situation is contrary to the aims set out in the Department of Health's National Service Framework (NSF) for Children, Young People and Maternity Services.

For example, the NSF aimed to:

- Improve access to services for all children according to their needs, and

- Tackle health inequalities, addressing the particular needs of communities and children and their families who are likely to achieve poor outcomes

Prejudice, discrimination and social exclusion:

Discrimination, stigma and social exclusion can have a big impact on mental health due to the importance adolescents place on their peer relationships. If they are not being included in cultural, sports and social activities, including online communities, they are at risk of becoming lonely and developing mental health issues such as anxiety, depression and low self-esteem. This will lead to further social withdrawal and more severe problems which can persist into later life.

Social exclusion has also been linked with aggressive behaviour. Affected youths may show disregard for society's norms and rules, leading them to break laws, carry out violence and join gangs to access the social support they crave.

Social exclusion can disproportionately affect minority groups. For example, black and ethnic minority (BAME) groups with mental health issues are more likely to experience racism, discrimination, poverty, unemployment and homelessness than the wider population. BAME adults are less likely to seek help for their mental health issues than the wider population, often due to a perceived lack of cultural sensitivity and sometimes due to language differences.

Delaying treatment can mean that a young person's mental health condition deteriorates for a long time before they finally get a diagnosis and treatment. For mentally ill parents, this in turn influences their children and may contribute to their over-representation in the care system and children's services.

Even when accessing the healthcare system, BAME youths can experience institutionalised racism or simply unequal care. It is important to recognise that every young person is an individual and that individual differences are just as important to recognise as are cultural differences.

Other minority groups which may struggle with getting help are asylum seekers and refugees. Access to services can be difficult for them due to the language barrier and a lack of information. Children of asylum seekers often have complex backgrounds and may have experienced loss, political oppression and even torture. They may have been temporarily detained in prison or isolated from other members of their culture by being dispersed throughout the country.

A failure of mental health service providers to understand these complications can lead to a low uptake rate, disengagement and ineffective interventions. Sometimes, asylum seekers and refugees are incorrectly thought of as just temporary residents which may affect their long-term care.

Gypsy and Traveller communities struggle to receive specific mental health support with only 3% of the population able to access services. In a survey, 18.4% of Travellers said they had a mental health issue and 24% were on anti-depressants. There may also be a higher need for bereavement-linked mental health support since 17% of Traveller and Gypsy mothers were found to have experienced the death of a child compared to 1% of the wider population.

In addition to an increase in individual mental health risk factors, young people with learning disabilities also experience community and social-based risk

factors. For example, surveys of this demographic have revealed that a third have no contact with their friends and one in twenty have no friends at all.

People with learning disabilities are often disempowered. For example, over half have their money controlled by a third party while only 17% of those of working age have a job. Discrimination is also an issue with one third revealing that someone, normally a stranger, had been rude to them within the previous year and a third admitting to feeling unsafe on public transport.

Information on the mental health of young LGBT people is limited, partly due to the fact that there is no requirement for separate monitoring. Nevertheless, some statutory mental health bodies, community groups and voluntary organisations have carried out research. This has revealed that levels of anxiety, depression, drug and alcohol misuse and self-harm are all higher than in the general population. This broadly corresponds with a review of international literature which has shown that drug and alcohol dependence, levels of self-harm, suicidal feelings and general mental health issues are all over-represented in the LGBT community, particularly by those identifying as bisexual.

Research has also found that lesbian and bisexual women are particularly at risk of developing suicidal feelings and becoming dependent on drugs and alcohol. Men identifying as gay or bisexual are four times more likely to attempt suicide than heterosexual men. The reasons for this are complex but a range of familial and social factors are likely to be involved. These include bullying and lack of support from within the family; less favourable treatment by health professionals and feelings of isolation from and rejection by peers. However, poor mental

health within the LGBT community has also been specifically linked to homophobic discrimination and prejudice.

A 2007 survey of schools by LGBT charity Stonewall found that 65% of young LGBT people experienced homophobic bullying with that number rising to 75% in faith schools. Although a follow-up survey ten years later found that the incidence had dropped to 45%, perhaps indicating a growing tolerance in society, levels of poor mental health are still very high. In 2017, 61% of lesbian, gay and bisexual young people reported they had self-harmed while 22% had attempted suicide. This compares to 56% and 23% five years previously.

Young people within the care system are another demographic strongly affected by community and social-based risk factors with mental health issues affecting 60% of 'looked-after' youths and 72% of young people in residential care (NICE, 2010).

Statistics have shown that children in care are two to three times more likely to develop a mental illness. In addition, those with emotional and/or behavioural disorders were more likely to drink, take drugs and have underage sex. The consequences of these behaviours can negatively impact mental health in this group.

Of course, early familial relationship will contribute to poor mental health in this group and the majority of those in care and in the criminal justice system had started to offend before being taken into care.

Regardless of the causes, the effects are dire with a large proportion of such youths experiencing poor health and educational and social outcomes post-care and into adulthood. Risk of attempted suicide (when adults) is over four times higher than with those young people outside of the care system.

A third of all young people within the criminal justice system are those who are 'looked-after.' They are a staggeringly 18 times more likely to commit suicide than the general population.

For specific information about minority groups connected with, or at risk of joining, gangs see Chapter 6: Gangs, Violence & Mental Health.

A more profound form of rejection arises when the treatment of mental health is experienced as being different to the treatment of physical health within health institutions. The reasons for this are complex and may include factors such as the lack of proper facilities and even discrimination from individual professionals.

The World Health Organisation reminds us that:

'All people with mental disorders have the right to receive high-quality treatment and care delivered through responsive healthcare services. They should be protected against any form of inhuman treatment and discrimination,' (WHO, 2003).

Many community-based risk factors exist in combination, placing young people at increased risk of poor mental health outcomes.

Disadvantaged neighbourhoods, for example, are often plagued by drugs, crime, gangs, unemployment, loss of community, social inequality, prejudice and discrimination.

Adverse childhood experiences (ACEs):

ACEs span both the individual and relationship categories and have a cumulative effect. That's to say, the more risk factors that are present, the more the individual child is likely to experience negative outcomes.

Children with more ACEs are at higher risk of future violence (as perpetrator or victim), prison, substance dependency and teen pregnancy. They are also more likely to suffer from anxiety, depression, eating disorders and post-traumatic stress disorder (PTSD).

An American study has linked ACEs to higher rates of bullying, dating violence, delinquency, fighting, self-harm, suicidal attempts, suicidal thoughts and weapon-carrying. Examples of ACEs include abuse, neglect and problems in the home environment (e.g. domestic violence, maternal mental health issues and substance misuse). ACEs are common in the UK with half of adults exposed to at least one ACE while growing up and 9% affected by four or more.

The first UK-wide study of child abuse and neglect was carried out by the NSPCC in 2000 and followed up a decade later with a larger sample. The 'Child Abuse and Neglect in the UK Today' report (Radford et al, 2011) studied over 6,000 people, including over 1,700 18 to 24 year olds. Over 2,200 11 to 17 year olds and over 2,100 parents of under 11s.

The report found that:

- 24.1% of the children had experienced contact or non-contact sexual abuse by an adult or peer.
- 18.6% of 11 to 17 year olds had suffered severe maltreatment (13.4% said this was instigated by a parent or guardian).
- 15 to 17 year old girls reported the highest rate of past years' abuse.
- 65.9% of the contact sexual abuse reported by children 17 years old and younger was by other children under 18.
- 61.4% of 11 to 17 year olds had been exposed to some level of community violence.
- 22.9% of those 11 to 17 year olds physically hurt by a parent or guardian told no-one.
- 34% of 11 to 17 year olds who had experienced contact sexual abuse by an adult (and 82.7% of those assaulted by a peer) told no-one.
- Only one in eight sexually abused children come to the attention of the authorities.

More recently, in 2017, the NSPCC released another report: 'How safe are our children?' (Bentley et al, 2018). This report looked at recorded sexual offences against children in the year 2015/16. It found:

- Recorded sex offences across UK were double those of 2005/6.
- 2015/16 saw the highest number of recorded sexual offences against children in the past decade.
- In England, 37,778 offences against under 16s were recorded (over 36 per 10,000 children). This was up 23% on the previous year.

It should be noted that the scale of this increase is likely to be partly due to improvements in recording practices and an increased willingness of children to come forward.

Pregnancy and motherhood:

Around one in ten mothers experience mental health problems during pregnancy or over the first year of motherhood. This might include anxiety and post-natal depression. If this isn't recognised and treated early there is likely to be impaired bonding between mother and child which increases the risk that the child will develop poor mental health and behavioural problems.

It has been pointed out that health professionals are usually best placed to spot the warning signs and intervene. This is covered fully in Chapter 18: Early Intervention: School & Family Strategies.

As the next section explains, the developing brain is very sensitive. Evidence suggests that ACEs damage the brain and disrupts social and emotional development.

The Adolescent Brain and Development

Why do ACEs cause such harm in young children?

This is likely to do with the way in which the human brain develops between birth and the age of two. This is a period of incredible growth with the brain increasing in size from around a quarter of that of an adult's brain to about 80%.

We are talking here about billions of brain cells and trillions of synapses (the connections between brain cells that are involved in thinking and emotions).

The reason so many connections are formed is because only a relatively small number will be kept until adulthood. The rest will be discarded. This is a natural evolutionary process with those connections that are used most often surviving and the others dying off.

Many of these early connections are involved in creating a bond with the primary caregiver and learning about the world. This leads to either secure or insecure attachment.

Children who grow up in a safe and nurturing environment, with caregivers who are sensitive and available, form secure attachments. This helps them to feel supported as they explore the world around them with more curiosity and reduced fear. As they get older, this foundation leads to greater trust, self-worth and self-control. They tend to go on to form healthy relationships based on a continuation of the positive emotional connection they had with others from a young age.

In contrast, children who are neglected, abused or exposed to trauma while growing up may never develop that secure attachment. As a result, they approach life with less trust and more fear. This leads to short-term survival thinking, avoidance, resistance, heightened stress and dulled emotions. When facing stress, the fight or flight mechanism is easily triggered making it difficult for these young people to express themselves rationally, control their emotions or concentrate.

The internal picture they have grown up with is one where the world doesn't meet their needs, where relationships are painful and where they fail to have an impact.

This hampers everything from their self-confidence, overall communication abilities, forming of social bonds and their performance at school. This, in turn, contributes to isolation, a risk factor for poor mental health outcomes such as behavioural problems, as well as making gang affiliation potentially attractive as a way to belong.

This is why early intervention is so important. It is much easier to guide young people on to the right path while their brains are still flexible and forming new connections than it is later in life when their brains have become relatively 'hard-wired.'

That doesn't mean we should give up adolescents and older youths as a lost cause! The brain's amazing plasticity means it is possible to change established mental habits – it's just that much harder!

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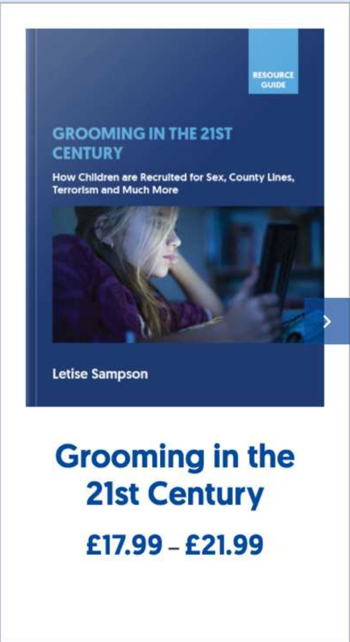

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