What Works with Vulnerable Young Males?
An examination of the research literature in relation to intervening with a range of needs and risk factors that can contribute to vulnerability

Report for the Child Protection Committee
Nina Vaswani, Development Officer, Youth Justice
March 2011
What Works with Vulnerable Young Males?
An examination of the research literature in relation to intervening with a range of needs and risk factors that can contribute to vulnerability

Purpose .................................................................................................................................. 3
Introduction ................................................................................................................................3
Needs and Risks .......................................................................................................................... 3
1. Self-harm and suicide ........................................................................................................ 3
   Prevalence .......................................................................................................................... 3
   Characteristics and Risk Factors .................................................................................... 4
   Intervention ....................................................................................................................... 5
   Conclusions ...................................................................................................................... 7
2. Sexual Exploitation ........................................................................................................... 7
   Prevalence .......................................................................................................................... 7
   Characteristics and Risk Factors .................................................................................... 8
   Intervention ....................................................................................................................... 9
   Conclusions ...................................................................................................................... 11
3. Child Trafficking ............................................................................................................... 12
   Prevalence .......................................................................................................................... 12
   Characteristics and Risk Factors .................................................................................... 13
   Intervention ....................................................................................................................... 13
   Conclusions ...................................................................................................................... 14
4. Absconding .......................................................................................................................... 15
   Prevalence .......................................................................................................................... 15
   Characteristics and Risk Factors .................................................................................... 16
   Intervention ....................................................................................................................... 16
   Conclusions ...................................................................................................................... 17
5. Substance Misuse ............................................................................................................... 17
   Prevalence .......................................................................................................................... 17
   Characteristics and Risk Factors .................................................................................... 18
   Intervention ....................................................................................................................... 18
   Conclusions ...................................................................................................................... 19
6. Persistent Offending and Violence .................................................................................... 20
   Prevalence .......................................................................................................................... 20
   Characteristics and Risk Factors .................................................................................... 20
   Intervention ....................................................................................................................... 22
   Conclusions ...................................................................................................................... 22
7. Learning Disability .......................................................................................................... 23
   Prevalence .......................................................................................................................... 23
   Characteristics and Risk Factors .................................................................................... 23
   Intervention ....................................................................................................................... 24
   Conclusions ...................................................................................................................... 24
8. Homelessness including Unstable or Unsuitable Accommodation ................................ 24
   Prevalence .......................................................................................................................... 24
   Characteristics and Risk Factors .................................................................................... 25
   Intervention ....................................................................................................................... 25
   Conclusions ...................................................................................................................... 29
9. Mental Health .................................................................................................................... 29
   Prevalence .......................................................................................................................... 29
   Characteristics and Risk Factors .................................................................................... 30
   Intervention ....................................................................................................................... 31
   Conclusions ...................................................................................................................... 35
Conclusions and Implications ................................................................................................. 36
References ............................................................................................................................... 37
Purpose

The purpose of this report is to examine the literature in relation to ‘what works?’ in improving outcomes for vulnerable young men. A wide range of vulnerabilities, needs and risks are considered.

Introduction

This review is being undertaken on behalf of the Child Protection Committee and co-exists with parallel pieces of work into profiling the needs and risks of vulnerable young men in Glasgow and a mapping exercise of existing service provision for young men. The overall aim of this work is to review current service provision for vulnerable young men in Glasgow in light of the emerging evidence to ensure that services are fit for purpose.

It should be noted that this report does not purport to be a systematic or exhaustive review of all the literature, but rather is a review of the literature available to the author within the timescales. In addition one of the needs and risks that were requested to be researched (disengagement with education) has not been covered here due to time constraints, and there may be other needs and risks that have not been considered by the working group.

Needs and Risks

1. Self-harm and suicide\(^1\)

Prevalence

A study of 15 and 16 year old students across 41 secondary schools in England revealed that the prevalence of self-harm was around 13% (Hawton et al., 2002). Self-harming behaviour is a strong predictor of future episodes of self-harm and ultimately to the likelihood of a future completed suicide. (Ferguson et al, 2005, cited in O’Connor et al, 2009). And while self-harm is far more common among young women than young men, with 1,109 DSH incidents per 100,000 young women compared to 359 in young males of the same age group (Hawton & Harriss, 2008) some studies suggest that the rates of self-harm are increasing among young men, almost doubling since the 1980s (Mental Health Foundation, 2003, cited in Richardson, 2004).

Furthermore the ratio between deliberate self-harm (DSH) episodes and completed suicide is far lower among young males. The Hawton & Harriss study above looked at more than 4,700 DSH patients who attended an Oxford hospital over a nine year period between 1995 and 2004 found that the overall ratio of DSH to suicide was 88 to 1 for all females, and 19 for males across the age range. This discrepancy was more marked in the adolescent age groups as among females aged between 10 and 14 there were 1,078 DSH incidents for every suicide, and among 15-19 year old females the ratios was 448:1. The comparable figures for males were 103 and 49 respectively.

In Glasgow a profile of vulnerable young men found that self-harm was not the biggest issue facing these young men, falling fifth on a list of documented needs, but nevertheless a significant proportion (at 28%) exhibited episodes of self-harm. Given that this is around double the rate found in the general population and the high suicide completion rate among young men, reducing self-harm among young men is of particular concern to a range of statutory and other agencies. In beginning to understand what might reduce the levels of self-harm among men, it is important to recognise the specific characteristics and risk-factors of their self-harming behaviours.

---

\(^1\) For the purposes of this report the definition of self-harm is any incidence of self-injury or self-poisoning regardless of suicidal intent. Similarly suicide refers to any completed act, irrespective of motivation or suicidal intent.
Characteristics and Risk Factors

Hawton et al (2002) issued self-report questionnaires to 15 and 16 year olds at school in England and found that self-harm was more common in pupils who had been bullied, or had been the victim of physical or sexual abuse. There was a social influence as increased awareness of self-harm (either by a family member or friend) was also associated with self-harming behaviour, as were levels of depression, anxiety, impulsivity and self-esteem. Drug use was also associated with self-harm in males. Similarly Griesbach (2008) found, in a series of interviews with 20 Scottish young people aged between 14 and 25, that the three issues mentioned most frequently, and often in combination, were: being bullied and ostracised at school, being abused or neglected at home and having a serious argument / problems with parents or friends. The young people also mentioned that they felt lonely, isolated, depressed, out of control, frustrated and worthless.

In their study of adolescents requiring hospital treatment after self-harming, Hawton et al. (2003) found that the largest number of self-harming episodes occurred on a Monday, and the least on a Saturday, although this pattern was not present during school holidays, leading the authors to conclude that school issues were a factor in self-harming. Substance misuse (both alcohol and drugs) was significantly more common among male self-harmers than young females (alcohol misuse being twice as frequent, and drug use threefold among males). The same study found that among both males and females, problems in relation to family, work/study, friends and partners were the most frequently occurring issues. Problems with work or studies were significantly more frequent for young men. In addition, housing and financial worries, while less common overall, were significantly more frequently cited by young men than young women.

Over the 10 year period of the study, the authors found that the rate of drug misuse among young males who had self-harmed increased notably, as did levels of violence to others (from 12% of males in 1995 to 39% in 2000). In keeping with previous statistics about the higher rate of suicide in males, around one in three incidents of self-harm featured ‘high’ or ‘very high’ suicidal intent scores as assessed by the Beck Suicidal Intent Scale, compared to only 18% of females.

A Finnish longitudinal study followed up a sample of more than 2,300 Finnish males from age 8 to age 18 (Haavisto et al., 2005). The overall rate of self-harming behaviour (either actual actions, or ideation only) over the preceding six-months was 6.2% at age 18. As per the Hawton study, the researchers found that somatic health problems, problems with family, friends, education or employment, and substance misuse were significantly associated with ideation and acts of deliberate self-harm. Externalising behaviours such as aggression and offending were strongly associated with acts of DSH, whereas internalising symptoms such as withdrawn and anxious symptoms were associated with both ideation and acts.

The authors also conducted analysis to identify any predictive factors from the information gathered at age 8 years. The young boys’ self-report of depression at age 8 predicted both ideation and physical acts of self-harm at age 18, as did the boys’ somatic health problems as reported by the parents. In addition as the level of parents’ education increased the rates of actual self-harm fell, but there was a corresponding increase in ideation. The study also found that very few males who had reported suicidal ideation or self-harm had been in any contact with mental health services.

Vulnerable groups of young males may have increased experience of deliberate self-harm, in particular young males in prison. Rates of self-harm among prison populations are known to be higher than in the general population as a whole (140 per 100,000 as opposed to 11 per 100,000 in the study by Hawton and Harriss, 2008), potentially as violence, aggression and substance use are linked to self-harming in males.

The evidence suggests that suicides in prisons are on the increase (HM Prison Service, 2001, cited in Hales et al, 2003) and a study by Towl and Crighton (cited in Hales et al, 2003) found that very young prisoners (aged between 15 and 17) were over-represented in the prison suicide figures. Hales and colleagues propose that this is due to the ‘social influence’ effect.
described earlier as imprisonment increases the risk of exposure to suicidal behaviour by others. This view was further strengthened by the fact that the length of time spent in prison was significantly associated with self-harming behaviour, presumably as it increases the risk of knowing someone who had engaged in suicidal behaviour, and increased the likelihood of witnessing such an attempt. However Ireland (2000) reports that the risk of suicide is greatest early on within a period of custody (10% within one day of arrival and 45% within one month) and is more common among prisoners on remand.

Young people in care, or have been previously looked after and accommodated have been found to be over-represented in the DSH population, unsurprisingly considering the identified links between family problems, abuse, neglect, substance misuse, violence and offending behaviour and self-harm. Storey et al. (2005) found that around one-in-four young people presenting at A&E department after an episode of self-harm had experiences of being in care.

Worries about sexual orientation were also found to be an issue for young people engaged in self-harm (O'Connor et al, 2009; Hawton et al, 2002).

**Intervention**

So what might encourage young males to seek help for their self-harm? Fortune et al. (2008b) surveyed more than 6,000 15 and 16 year-olds across 41 secondary schools in England, of whom more than half were male, to seek their views on help-seeking behaviour and what might prevent young people from harming themselves. No significant differences were found between males and females in relation to the source of support that they sought, with young people four times more likely to seek help from friends following an episode of self-harm than family. Formal sources of help and support such as helplines, mental health practitioners and teachers were mentioned by few respondents. Boys were less likely to seek help, and referred to their self-harm episode as ‘not that serious’ or ‘my choice’ and that they did not seek help as they could ‘cope on my own’.

This confirms previous studies in relation to gender differences in help-seeking. For example, Gould et al (cited in Fortune et al, 2008b) found that American students at highest risk of suicide had problematic cognitions and problem solving strategies that were help-avoidant i.e. that problems can be tackled alone. Similarly Biddle et al (cited in Fortune et al, 2008b) found that distressed young men aged between 16 and 24 were less likely to seek help of any kind and were significantly more distressed than their female counterparts when they did eventually seek help from their GP. A West of Scotland study of young adult males who had previously self-harmed but were currently desisting found that none of the males consulted attributed their ceasing to self-harm to professional or even more informal help (mental health services, friends, family etc), compared to one-in-five young women (Young et al, 2007).

In relation to preventing self-harm, the most prevalent theme to emerge from the consultation was communication, with 28% referring in some way to talking to people, to listen to people, to give them advice or speak to them about their problems (Fortune et al, 2008a). However this type of response was far more common among girls than boys (32% and 23% respectively). Young males were also twice as likely to mention sports activities, clubs and social experiences than young women (12% versus 6%).

A separate study (Armstrong & Manion, 2006) postulates that this may be due to the role that involvement in sports and extra-curricular activities has in relation to identity and social status among young men. Low social status and identity crises have been identified as risk factors for self-harming behaviour and the authors hypothesise that young males develop their sense of self through participation in organised activities, and also obtain meaningful interaction with peers and thus social support (a known protective factor from suicide). Indeed in their study of young males living in isolated rural areas in Canada it was reported that the less participation or ‘engagement’ in youth activities that a young male had, the higher the risk of suicidal ideation.

Griesbach (2008) also asked the Scottish sample of young people about their experience of services. The most consistently mentioned as being helpful included private sector
counselling services and voluntary sector agencies that provided housing, employability and mental health support. Services designed specifically for young people were often mentioned, as were drop-in services, support groups and one-to-one sessions with a trusted support worker or counsellor.

Unfortunately there has been little research about effective direct interventions for adolescents who engage in deliberate self-harm. Indeed Platt noted in 2000 that “faced with the adverse suicide trend, we find ourselves in the uncomfortable position of being unable to produce an evidence-based blueprint for preventative action” (cited in McAleney et al, 2004).

Hawton and James (2005) highlight several treatment options available including problem-solving, cognitive-behavioural therapy, anger management, treatment of substance misuse, treatment of underlying psychiatric disorder (antidepressants) and family therapy, yet there is little in the way of published evaluations regarding the efficacy of these interventions. Interestingly young people themselves appear to view the prescription of medication as ‘fobbing off’ and, of those who had experienced family therapy, all felt that it had not been particularly helpful although there was a recognition that parents had benefited from it (Storey et al, 2005).

A proportion of young people who self-harm will come into contact with the emergency services at some point, with a presentation at accident and emergency. However a NICE assessment of A&E departments found that more than half of young people are discharged without psychiatric assessment (cited in Richardson, 2004). In addition young people themselves report that often the response from professionals in A&E is perceived as being unsupportive and unhelpful, resulting in already vulnerable individuals feeling more isolated and ‘timewasters’ (YWCA, 2002, cited in Richardson, 2004). A study in New Zealand found that the majority of self-harmers who required emergency treatment were male and nearly one-third of these men rated the help that they received unfavourably (Nada-Raja et al, 2003), although it should be noted that the sample size of those receiving emergency treatment was small. Sinclair & Green (2005), in a series of interviews with 20 self-harm ‘desisters’, noted that young people remembered their admission to hospital as a frightening experience which furthered their perception of lack of control.

For those young people who receive community follow-up after an episode of self-harm, adherence and engagement is reported to be low. In order to address this Ougrin et al. (2008) developed a method of therapeutic assessment, based on cognitive-analytic therapy. Seven clinicians received ten hours of training in the brief manualised model and young people were compared with adolescents receiving standard psychosocial assessment on two measures: attendance at the first appointment and engagement. The four aims of the therapeutic assessment were: to develop a joint understanding of the young person’s difficulties, to enhance motivation for change, to instil hope and to explore possible alternatives to self-harm. Assessment as usual followed a standard psychosocial history and risk assessment as set out in NICE guidelines. Results found significantly higher levels of attendance at the first appointment and subsequent engagement with services in the experimental group. However the authors note that as the model developed a range of features emerged in response to young people’s needs, and they advocate the use of a variety of therapeutic tools in order to achieve the best results.

Slee and colleagues (2008) carried out a randomised–control trial of a cognitive-behavioural intervention among patients aged 15 to 35 who had recently engaged in self-harm. The model took the form of a brief 12-session intervention to supplement ‘treatment as usual’ with the assumption that vulnerability to self-harm can be changed by modifying suicidal and negative thinking and problem-solving deficits. The focus centred on assessing and investigating the emotional, behavioural and cognitive factors involved in self-harm, with specific maintenance factors such as emotional regulation difficulties and poor problem-solving being addressed. A total of 90 participants were randomly assigned to the experimental group or the control group of only ‘treatment as usual’. The results showed that patients who received the supplementary CBT displayed significantly lower levels of self-harm, suicidal cognitions and symptoms of depression and anxiety along with increased self-esteem and problem-solving skills at follow-up.
In Glasgow, the Deliberate Self-Harm team offers a home-based intervention model and has seen an increase in treatment compliance and after three years of operation (back in 2002) had not experienced any of its clients committing suicide. Young people who received a service also scored significantly lower on the Beck Hopelessness scale following treatment. Other studies have found Multisystemic Therapy to be particularly effective at reducing self-harming ideation and/or behaviours in young people (Wood et al, cited in Ougrin et al, 2008), and at the time of writing an MST service is currently being piloted in the North and West areas of Glasgow.

In addition, as part of the Choose Life Strategy, training in SAFETALK and ASIST has been rolled out across Youth Justice practitioners and other Children’s Services in 2009 with the aim of ensure that all practitioners are ‘suicide aware’ and have appropriate referral pathways for young people at risk. Anecdotal evidence to date suggests that this approach is proving effective.

**Conclusions**

There is little in the way of constructive evidence about what works to reduce self-harming behaviour in young males. The high prevalence of self-harm among teenagers, and the potential role that school issues and anxieties may have to play in the incidence of self-harm suggest that school-based resources and drop-in support may have some benefit for all young people.

Similarly young people often report the emergency response to self-harm incidents as frightening and unhelpful. Some consideration should be given as to how this can be improved, and to ensure that opportunities to intervene appropriately with these young people are not wasted.

With the evidence quite clear that people who self-harm often have poor problem-solving abilities, and the knowledge that vulnerable young people (for example young offenders) also display similar difficulties, it may be prudent to ensure the delivery of cognitive-behavioural programmes to increase problem-solving skills (for example ROSS2 or similar), either in mainstream provision such as school, or in more specialist and targeted provision.

The evidence suggests that interventions to promote help-seeking behaviour in young males, and to ensure that young men have access to social support networks and prosocial activities may serve to prevent self-harming behaviour. In addition with clear links between substance misuse and male self-harm, tackling the misuse of alcohol and drugs may in turn reduce levels of self-harm among young men.

2. Sexual Exploitation

**Prevalence**

The sexual exploitation of young men can take many forms, and is often seen as a point on a continuum of the sexual abuse of children. However for the purposes of this report the sexual exploitation of children is defined as:

> Any involvement of a child of young person below 18 in sexual activity for which remuneration of cash or in kind is given to the young person or a third person or persons. The perpetrator will have power over the child by virtue of one or more of the following – age, emotional maturity, gender, physical strength, intellect and economic and other resources e.g. access to drugs.
> (Creegan et al, 2005)

Even with an agreed definition of sexual exploitation much of the research stresses that it is very difficult to assess the prevalence of sexual exploitation in Britain today, and building up an accurate picture of young men in particular is especially difficult given the often ‘hidden’ nature of male sexual exploitation. While, as Lillywhite & Skidmore (2006) note, much of the
contemporary literature is focused on young women it has done little to help assess the actual numbers of young women involved, and the situation is even more complex for males (Palmer, 2001).

Barnitz (2001) notes that conservative estimates indicate that more than two million children and young people around the world are affected by sexual exploitation, however she also notes the potential for wide regional variations. In the United Kingdom referrals of under 18s to specialist Barnardo’s services over a two-year period numbered 387, with young women comprising 86% of those referred and males only totalling 54, or 14% (Scott & Skidmore, 2006). Research by Scott and Harper (2006) estimated the prevalence of young people at risk across London to be around 1,000, but noted that services questioned rarely identified young men at risk. The profile of vulnerable young men in Glasgow identifies that 17% of young men were deemed to be at risk of sexual exploitation, although this definition also rather loosely included risky sexual behaviour.

More recently the focus has been on the sexual exploitation of children and young people through new technologies, with research indicating that approximately one-in seven online young people aged between 10 and 17 had received a sexual solicitation or approach over the internet, with 4% receiving an aggressive sexual solicitation. More than one-in three had had unwarranted exposure to sexual material (Wolak, 2006, cited in Burgess et al, 2008). The same study also reports that the main sexual exploitation offences referred to US attorneys shifted from sex abuse (73%) in 1994 to child pornography (69%) in 2006.

Characteristics and Risk Factors

The literature suggests that both sexually exploited males and females share similar background histories and risk factors, despite the nature of the sexual exploitation often differing. In a case study analysis of 42 young people (only seven of whom were young men), Scott and Skidmore (2006) found the following common characteristics: disrupted family life; history of abuse and disadvantage; problematic parenting; disengagement from education; going missing; exploitative relationships; substance misuse and poor-health and well-being. An additional issue that only occurred for young males was that of sexual identity, with four identifying as gay or bisexual but almost all finding it very difficult to discuss their sexuality. For the young men there was considerable denial of sexual exploitation in their relationships with adult men. The study identified absconding as the most immediate risk factor, and positive engagement with education as the strongest protective factor.

Creegan et al (2005) also found the same types of risk factors in a sample of young people in secure care in Scotland. In their analysis these were grouped into underlying vulnerability factors (i.e. previous abuse, domestic violence, family breakdown etc) and immediate vulnerability factors (i.e. absconding, substance misuse, association with ‘risky’ adults). Connell & Hart (2003) found similar backgrounds among male sex workers, aged between 17 and 48, in Edinburgh and Glasgow. These background factors also mean that young men have often experienced a significant care history, which in itself has also been identified as a risk factor, with some residential units targeted by potential abusers (for example, Creegan et al, 2005).

Palmer (2001) identifies two main ‘categories’ of young males at risk of sexual exploitation: firstly those who are ‘escaping’ from situations where they are vulnerable to abuse and who engage in transactional sex for survival on the street and secondly, those whose early sexual abuse ‘conditions’ their own abusive behaviour towards peers, leading them to a ‘prostitution life’.

Scott and Skidmore (2006) found that there were differences (non-significant) in the levels of sexual exploitation between age-matched young men and women, with 30% of young women referred to services identified at the initial assessment to be experiencing ‘definite and current’ sexual exploitation compared to only 17% of young men. However it is not clear whether this is again due to under-reporting and difficulties in disclosure by males, or an actual difference in the level of sexual exploitation, although roughly equal numbers were assessed as being ‘at high-risk’ of sexual exploitation.
Studies have also found key differences between males and females (Palmer, 2001; Creegan et al, 2005; Scott & Skidmore, 2006), with sexually exploited males slightly younger on average than females and they tend to become exploited at a younger age but also tend to leave the ‘prostitutional scene’ in their twenties; boys are less likely to be controlled by a pimp / abusing adult and boys are much less visible than girls in selling sex (due to societal stigma about same gender sex).

In addition there is a general view that boys and young men have particular difficulty in negotiating safe sex as they are less likely than females to receive sex education within the family and are less likely to seek out information or advice on sex education and face additional challenges due to the complex nature of their sexual identity, with young males frequently confused about their sexual orientation, often in denial about being homosexual, or erroneously believing that they are because of the activities they have engaged in with men (either through previous sexual abuse, or sexual exploitation).

Sexually exploited young men have also been found to have inadequate social support networks (Davies & Feldman, cited in Lillywhite & Skidmore, 2006; Palmer 2001), and the ‘support and friendships’ received through sex work was often seen as a barrier to leaving (Connell & Hart, 2003).

The risks that sexually exploited young males face are wide-ranging and vary with the nature of the exploitation, but include serious emotional and physical risks such as violence, sexually transmitted diseases, rape, substance misuse (either used to ‘entrap’ young men, or used to self-medicate) and legal issues. In light of these risks, coupled with the fact that many young men would deny or do not realise they are being exploited and the finding by Connell & Hart that most adult males in the sex trade regretted having started (usually starting in their teenage years through a range of routes) and most had tried, unsuccessfully, to leave sex work at least once suggests that targeted interventions at young males would be of benefit.

**Intervention**

Despite this, Lillywhite and Skidmore found that practitioners acknowledge that they rarely focus their concerns on young men, mostly to do with a lack of knowledge and understanding of male sexual exploitation, and the difficulties in even identifying young men who are being exploited or who are at risk of being so. Identifying and reaching these young males by necessity has to be the starting point for intervention, but studies consistently show that males are reluctant to seek help, are unwilling to (or cannot) discuss issues in relation to being exploited and their sexual identity - often due to a fear of being labelled as ‘gay’. Problems with responding appropriately can be compounded by the fact that societal values mean that at times the issue is ignored or under-reported, especially as young males have a tendency to externalise issues (i.e. act out) when in emotional distress and are often seen as ‘trouble-makers’ rather than vulnerable (Palmer, 2001; Creegan et al, 2005). Creegan et al. also found that staff in secure care felt uncomfortable discussing sexual issues and that there was a tendency to treat young people as children, rather than acknowledge the accelerated ‘adulthood’ that had resulted from their experiences.

Male sex workers themselves attributed a lack of formal support and service provision for males to negative professional and social attitudes relating to gender, sex and sexuality (Connell & Hart, 2003). Where professional support had been received this was highly valued (men in Edinburgh and Glasgow mentioned services such as GUM, Steve Retson Project, SOLAS and addictions services). Information and advice was particularly valued but support varied across the men, with those selling sex on the street often only likely to come into contact with outreach workers, rather than other professionals.

When asked how services could be improved these males requested support and service provision to leave sex work, via education and employment advice, support to end drug addiction and long-term support to be able to build alternative social networks. Other recommendations included the development of outreach work, particularly in Glasgow, including a more responsive service that was available at the appropriate times and days of the week and the need for emotional and psychological support was highlighted (many men
reported feelings of stress, anxiety and low self-worth as a result of being involved in the sex trade.) Men felt that these services could be delivered through a specialist internet service, along with a multi-purpose drop-in centre which provides information, counselling and advice by specially trained staff, particularly a service located in neighbourhoods where ‘renting’ is high.

Connell & Hart also noted that differing policing approaches and attitudes could also impact on how likely males were to report incidents of violence or other offences against them, and men with experience of working in both Glasgow and Edinburgh found their experiences of policing in Glasgow to be more negative.

The National Youth Campaign on Sexual Exploitation works with young people aged under 25 who have had some involvement with prostitution / sexual exploitation and, although based in London, has a national remit. The campaign arose from a number of reports that revealed that young people feel disempowered due to their sexual exploitation, and the campaign aims to represent the views of these young people when influencing governments, policy, service development and strategy (Brown, 2006). However again young men are under-represented in the youth campaign, only comprising 12% of the young people who had taken part in the campaign.

As part of the campaign, two young women with experience of sexual exploitation ran a workshop at a one-day conference on sexual exploitation. The young women discussed their experiences of the care system, with both describing multiple and extensive placement histories and how they felt that the use of secure care was not appropriate for them. Themes such as being involved in decision-making and having a ‘choice’ were felt to be important rather than simply being ‘told what to do’. In relation to young men the young women were clear that services were inadequate as sexually exploited young men were often provided with services for gay men, despite the fact that many of the young men did not identify with being gay and noted that ‘the shame and guilt is ten-fold for the boys’.

The views of these young women are also reflective of the views of academics in the research literature. A survey of secure units by Barnardo’s (2005) found that between 40% and 90% of young women in secure accommodation were there at least in part for concerns about possible sexual exploitation. Young males were less readily identified but it was considered a factor in individual cases. However many authors raise the moral and ethical issues of locking up young people who have not necessarily committed an offence (Barnardo’s, 2005), an ethical dilemma compounded by the fact that secure units rarely provide therapeutic interventions to meet the needs of sexually exploited young people. Within Scottish secure units there was a small amount of therapeutic work undertaken with young women at some secure units, but across the country very little evidence of such interventions in relation to young men (Creegan et al, 2005). Practical problems also arose when vulnerable young people were placed with young people who had committed violent or sexual offences.

Barnardo’s are clear that although secure units provide ‘containment’, it was relational security that was considered essential to helping sexually exploited young people build positive relationships with workers and achieve positive outcomes. Barnardo’s state that there is no evidence that secure accommodation achieves the intended outcomes for this group of young people, and may in fact make it even less likely that a young person will access the long-term support that they need afterwards. The briefing for parliament by Barnardo’s outlines key principles for service delivery that the organisation believe will respond best to young people’s needs. These include:

- Early intervention is vital when indications of risk are first identified. In particular work with young people who are starting to abscond can prevent their exposure to risk escalating.
- Safe accommodation is required that can provide the maximum relational security at the lowest possible physical security, preferably in the young person’s current home or placement.
- Continuity of care should be aimed for, rather than multiple placements and interventions, and intervention should be intensive.
• Services should be tailored to young people individually and may involve workers adopting assertive outreach methods such as daily phone-calls, text messages and ‘door-stepping’

• Multi-agency co-ordination and intervention is required.

Some specific examples include the Camden-based project Children Abused Through Sexual Exploitation (CATSE) which was established in 1999 to identify at-risk-young people, divert young people, identify levels and nature of actual abuse and formally intervene as appropriate (Lebloch & King, 2006). The project recognised three categories of young people as: category 1 who are at risk of being groomed for sexual exploitation; category 2 where young people are targeted for opportunistic abuse through the exchange of sex for drugs, accommodation and goods, and category 3 which covers those young people whose exploitation is habitual, often self-defined and where coercion / control is implicit.

The project has then developed a model of intervention for each category of risk. Category 1 intervention involves diversion planning and addressing vulnerabilities, with sexual health, possible drug use and offending all required considerations in the plan. The Child Protection Officer, Team Leader and Social Worker are responsible for compiling the plan. At levels of risk 2 and 3 a multi-agency planning (MAP) meeting is convened to formulate a co-ordinated and structured intervention. Each young person receives specialist intervention from Barnardo’s. Unfortunately the details of the interventions were not available to the author within the timescale for this report (but are apparently available), and the author is not aware of formal evaluation of outcomes.

A two-year evaluation of Barnardo’s sexual exploitation services (Scott & Skidmore, 2006) found a highly significant reduction in the level of sexual exploitation between the initial assessment and the final review. The evaluation also found significant reductions in the risk factors related associated with sexual exploitation such as going missing (a reduction from 63% to 31%) and a reduction in the number of young people who had no or little awareness of their rights or no ability to assert these rights. There was a very small reduction in the numbers of under 18s who had accommodation needs, and by the time of the final review there was a notable increase in the number of young people who had a ‘reasonable’ relationship with their current carers. However there was a (non-significant) increase in the number of young people who were not in education, employment or training at the final interview, something that the authors attributed to the increasing age of the young people. Considering that the same study identified education as the strongest protective factor against sexual exploitation this is of some concern. In addition the outcomes study was focused on a sample of 226 young people who accessed one of ten Barnardo’s services nationwide, but only a small proportion of these were young men, and gender differences were not included in the analysis.

The Barnardo’s model is centred around the four A’s of Access, Attention, Assertive outreach and Advocacy. Put simply this means that the service is accessible to young people by virtue of referral routes and environment etc; that young people receive consistent and persistent attention from a named worker; that establishing and maintaining contact is achieved through a range of methods including texting, calls, home visits, and meeting where the young person feels comfortable; and finally ensuring that staff advocate for whatever services the young person might need.

Conclusions

Frustratingly it has been difficult to assess the scale and nature of the sexual exploitation of young men, and there is little in the way about research into effective interventions for young people in general, but even less for young males specifically. What is clear is that meeting young men’s wider needs should enable protective factors to reduce sexual exploitation. In particular reducing absconding at an early stage should help to prevent sexual exploitation (for example through use of the vulnerable missing young person’s protocol, and through some of the interventions outlined elsewhere in this report). The Barnardo’s model of intervention appears to be particularly effective for young people in general, although as mentioned this was not analysed for gender differences in outcomes.
It also seems to be important to encourage help-seeking and widen young males social support networks in order to provide resilience against sexual exploitation and enable young males to access the support that they need. The high levels of abuse in the backgrounds of sexually exploited young men and young men that abscond (see later sections), the fact that the literature stresses that young men feel that they have no-one to talk to about abuse, and that when they do disclose they do so at a much later stage than young women (meaning that the abuse is often not dealt with) stresses this point further (Edinburgh et al., 2006). In addition services around gender, sex and sexuality should be made readily available for young men as confusion and concern about this was a specific risk factor for young men.

3. Child Trafficking

Prevalence

The Palermo Protocol (2000) defines trafficking as:

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs.

The Palermo protocol regards child victims of trafficking as special cases and children and young people (aged under 18) are regarded as victims of trafficking regardless of whether 'consent' has been given (UNICEF 2003, cited in Dowling et al, 2007), the assumption being that children cannot give their informed consent.

The covert and coercive nature of child trafficking means that assessing the prevalence of the issue in the UK is fraught with difficulties. CEOP (2009) estimate that there were 325 children identified as being a potential victim of trafficking or exploitation covering the one-year period between March 2007 and February 2008. Around two-thirds (68%) of those young people identified were female, with 29% male, and 3% unknown.

Beddoe’s 2007 study across Birmingham, Manchester and Newcastle identified 80 children and young people as potential victims of trafficking over a period of between one and two years. Of these young people 19 (24%) were male. The Anti-Trafficking Monitoring Group (2010) found that there were 143 children referred to the National Referral Mechanism (NRM) during 2009, of whom 58 were boys. In Glasgow, Rigby (2009), following a case-file analysis of unaccompanied asylum-seeking children, estimated that up to 28 UASC were probable trafficking victims, with 21 causing 'high concern', four of whom were male (19%).

However it is widely acknowledged that all attempts to quantify the issue result in conservative estimates. This is particularly the case for young males. As children they are less likely than adults to seek help or know what their rights or where to seek help, and this is particularly true for boys (Dowling et al., 2007). In addition male victims are more likely than females to have entered the UK through clandestine methods (such as through hiding in lorries etc) and thus are less likely to come to the attention of the authorities (CEOP, 2009). Beddoe also stressed that with responsibility for trafficking often falling on asylum teams in the past, the likelihood of detecting young people travelling accompanied, or with European Economic Area documents for example is low, further compounding the underestimates of trafficking.
**Characteristics and Risk Factors**

With a lower number of young males identified than females, there is even less knowledge about the specific nature of their exploitation, and much of the research literature focuses on the trafficking of women and girls for the purposes of sexual exploitation. Some studies have begun to suggest that while the risk factors for trafficking may be similar between the genders, the nature of that exploitation may differ. Beddoe (2007) found that while both boys and girls were victims of sexual exploitation and restaurant and catering labour, only girls were thought to be exploited in domestic servitude and forced marriage.

CEOP (2009) found that 96% of sexual exploitation victims and 80% of domestic servitude victims were female, but that male victims were more likely to be forced into labour (78%) or work in cannabis farms (91%). The study also noted that some boys trafficked for labour may not feel exploited, as they would often be expected to work back home in the same way, meaning that they are less likely to seek help. The report also postulates that some cultural backgrounds might mean that males do not wish to be perceived as ‘weak’ when it comes to seeking help.

The recent report by the Anti-Trafficking Monitoring Group found that referrals to the NRM in 2009 showed that boys made up 72% of those young people trafficked for forced labour, 37% of those forced into domestic servitude and 4% of those sexually exploited. Rigby’s study of UASC in Glasgow identified various and multiple exploitative situations that young people found themselves in, but presumably due to the very low number of males in the sample did not include an analysis by gender. However in relation to age and country of origin there do not appear to be any discerning trends in relation to gender (Dowling et al., 2007).

The experience of being trafficked will affect children and young people in many varying ways, dependent on the perception of the child of their own situation, the nature and extent of the abuse and exploitation suffered, and the individual characteristics and inner resilience of the young person. However Beddoe (2007) reports on findings of the impact of trafficking on children’s mental health including a high level of depression, hostility, stress, anxiety and fear. Outward manifestation of these issues may present as panic attacks, challenging and antisocial behaviour and suicidal ideation. One key aspect identified was the impact of trauma, and in particular the difficulty of recalling and reconstructing traumatic experiences. Other risks include physical and sexual abuse, neglect and all of the associated risks with living life on the streets or in unsafe locations.

One startling finding has been the sheer number of young people identified as potential victims of trafficking who go missing from local authority care. Out of the 80 young people identified in Beddoe’s study, 48 (60%) have gone missing and never been found. CEOP found the figure to be lower, but still concerning, at 20% (but did not include those who had gone missing but had been subsequently located). Beddoe outlines two different scenarios for going missing, with the first being that the trafficker maintains contact with the child and removes the young person from the area as soon as possible. The other is that the child runs away from care out of fear of being found by the traffickers, but thereby leaving themselves open to further abuse and exploitation as an ‘abscondees’. It was found that the vast majority of children who go missing do so within the first week of being taken into care. In Glasgow the ratio was far lower, with only 6% of UASC disappearing from care, although it was not known whether these young people were in fact potential child trafficking victims (Rigby, 2009).

**Intervention**

The research reports have made a number of recommendations over the years, that have been taken on board as policy and practice in this area has developed. Beddoe’s study for ECPAT ended with a number of recommendations including giving young people whose age is in dispute the benefit of the doubt until an independent assessment has been made to ensure that child victims are not treated as adult asylum seeker. The report recommended that young people who are victims should be taken out of the immigration system while a decision is made, in response to the frustration displayed by a number of practitioners that
immigration control took precedence over child protection. Other recommendations included the provision of free, specialist legal representation. Similar recommendations were made by Dowling et al (2007).

Encouragingly many of these recommendations have been adopted by the subsequent Council of Europe Convention on Action against Trafficking in Human Beings which came into force in the UK in April 2009 including the establishment of the identification procedure, the National Referral Mechanism (NRM). However a recent report by the Anti-Trafficking Monitoring Group into the implementation of the Convention concludes that, although there are pockets of good practice (notably in the Bristol Coalition on Trafficking and in Wales), the necessary safeguards for child victims have been overlooked. The report argues that the child protection system exists to protect and safeguard all children but that statutory agencies with responsibility for child protection are now required to refer the case for decision to the NRM, which was viewed by a number of respondents as having insufficient expertise in relation to children.

Beddoe in 2007, on behalf of ECPAT and Dowling et al. (2007) also made a number of recommendations to ensure that young people are kept safe, including the need for a system of guardianship, where children are allocated a guardian to advocate and ensure that young people receive the service that they need. In order to provide safe accommodation ECPAT recommends a two-tiered approach, with (1) highly specialised foster carers and (2) an accommodation model that has a fully integrated approach to ‘safety’ including the provision of services as and when needed.

The same report concludes that the impact on trauma, and difficulties in recalling traumatic events can impact on the credibility of the child when giving evidence or information, and recommends that expert and specialist advice should be sought.

While Rigby (2009) notes that in Glasgow children were provided by social work services with levels of support and care to meet the minimum basic needs of children and many young people embraced the educational aspect of that support, continuing education beyond the school leaving age. As a rule cultural and language barriers were found to be dealt with sensitively and appropriately. Young people were referred to psychological services for counselling when trauma was suspected or evident, although often appeared reluctant to access these supports. Rigby also notes some examples of positive work by individual professionals but concludes that agencies struggled to deal with the additional complexities and needs of trafficking victims, and advocated for a specialist child trafficking service in the city, with specific interventions available to address the consequences and experiences for children.

Conclusions

Significant progress has been made over recent years to better identify victims of child trafficking and to intervening appropriately, following the implementation of the Council of Europe Convention on Action Against Trafficking in Human Beings, the National Referral Mechanism and Scottish-specific guidance from the Scottish Government in relation to safeguarding children who may have been trafficked (2009a). However still not enough is known about children and young people who have been trafficked, especially young male victims who may enter the country via unconventional routes and are less likely to seek help, or even identify themselves as victims. Positively, over the last year or so in Glasgow child protection case conferences have begun to be used where there are suspicions about child trafficking, and recent awareness-raising has begun for practitioners through communications and conferences.

What is clear is that finding ways to encourage victims of child trafficking to be aware of their rights and to seek help to escape from their exploitation without fear of deportation is, obviously, crucial, but equally more work is required to establish how to keep these young people safe once they have sought help. There is also limited knowledge about what constitutes effective service provision for young victims of trafficking.
4. Absconding

Prevalence

The research literature clearly documents the risk factors that young people who have run away may face in order to 'survive' including becoming involved in crime, being sexually exploited, being exposed to violence, increased use of substances as well as struggling to meet basic health and care needs. That Wade (2001, cited in Malloch, 2006) estimated that approximately 9,000 children and young people run away from home in Scotland each year means that reducing the risk of absconding, and in particular repeat absconding, is a priority for services.

In relation to young males, the research literature consistently cites young females as significantly more likely to run away than males, for example a study in Canada found that of all children in care only 6% of males absconded in a six-month period compared to 29% of females (English & English, 1999). However as a profile of the needs of vulnerable young males in Glasgow (Vaswani, 2007) found that 39% of young males were made vulnerable at least in part by their running away, and that young people looked after or looked after and accommodated (and therefore the responsibility of the Local Authority) are over-represented in the absconding population, the need to focus attention on young males is not reduced.

Characteristics and Risk Factors

Young males and females who run away often share similar background characteristics; including higher than average rates of physical and sexual abuse, neglect, parental rejection, placement instability, substance misuse and a history of absconding (see for example Tyler et al, 2001, cited in Kempf-Leonard & Johansson, 2007 or Whitbeck et al, 1997, cited in Tyler et al, 2004). Some studies have found gender differences, with girls more likely to abscond, but boys tending to do so at an earlier age (Wade, cited in Mallon 2006). However a report about the Aberlour ROC project in Glasgow, a refuge for young people who have run away, found that while only 34% of their admissions were boys there did not appear to be any notable difference in age at admission between the two genders (Mallon, 2006). Other studies have found little difference between risk factors for males and females (Tyler et al. 2004).

A Texan study analysed gender differences between all 6,473 young people charged with the status offence of ‘runaway’ between 1997 and 2003 (35% of whom were male). Young males who had runaway were significantly more likely to be involved with offending than young women who had runaway, and early onset offending was positively correlated with absconding for young males, but not for young women. Other positive correlates specific to young men were: living away from parents and gang involvement.

A similar large-scale study of children running away from out-of-home placements in Illinois found that the majority of young people who ran away were girls, were aged over 14, had a history of placement instability, a mental health diagnosis or substance abuse problem, a history of absconding and placements in residential facilities (Clark et al, 2008). Being male was itself a protective factor, as was living with a relative or being placed with a sibling or in a family-type placement such as foster care. The English & English study in 1999 also found that young people who ran away from care in one area of Newfoundland were more likely to be female, most ran from some form of emergency placement, were more likely to have had a history of placement breakdown, have a higher rate of involvement with juvenile justice systems and have more issues from school than those young people who did not run away.

A study by the Children’s Rights Director for England (Morgan, 2006) attempted to explain why looked after and accommodated children absconded in children’s own words, after carrying out a series of discussion groups across the country. Reasons given included: frustration at ‘boarding-out procedures’; bullying; being separated from siblings or boyfriends/girlfriends; frustration at rules that were ‘unfair’; wanting to live somewhere else; boredom and the same ‘24-7’ routine in children’s homes and, on occasion, simply to ‘go and have fun’. Most young people stated that once a young person had run away once, they were more likely to run away again, in keeping with the research evidence.
Young people stated that it was generally their intention to return from absconding and that they returned because they knew that people were worried about them, because they wanted to resolve their issues or because they wanted some basic comforts. Young people generally felt that running away did not resolve their issues, and that there were real dangers involved in absconding, including: drink; drugs; sex; prostitution and victimisation by ‘dangerous’ adults.

**Intervention**

Identifying young people who are more likely to run away may mean that any interventions can be targeted accurately. Nesmith (2006) studied all young people aged 11 to 18 years who were placed in foster care via a private fostering agency over a four-year period. Nesmith found that around one-in-four young people ran away at least once, and found that the odds of running away increased with age and history of previous absconding, in accordance with the findings of many other studies. Young people with formal plans for reunification with their families were significantly less likely to run away than those with ‘other’ plans. Amending the child’s placement plan was found to significantly reduce the likelihood of absconding. It was also found that the Child Behaviour Checklist externalising score was positively correlated with the risk of running away, with a one point increase on the 50 point scale increasing the odds of running away by 6%. In addition the social worker’s ratings of the foster carers also gave an indication of who might run away, with young people least likely to abscond from the higher-rated foster carers.

These findings suggest possible processes for reducing the likelihood of absconding from foster care and potentially other forms of residential care. These include identifying young people at risk of absconding (potentially using the CBCL) and ensuring that the young person has a clearly communicated plan about their placement and realistic expectations about returning home. That amending the plan during placement, regardless of what the change was, reduced the risk of absconding suggests that if young people feel that plans are up-to-date, relevant to their current needs and risks, and are responsive to their views then there is less of a need to abscond. In addition ensuring that foster carers are fully skilled and equipped, and that young people assessed at risk of absconding are placed with the highest skilled carers could reduce the level of absconding.

However there appeared to be little available research on effective interventions for children who run away from home or placements. In the study by Morgan (2006) young people themselves stated that local centres with counsellors should be provided, in order to provide a safe place that children can ‘run away to’, and felt that staff in residential placements need to develop a better understanding of being in care, to be better at dealing with bullying within units and to understand that locking young people up because of their running away does not resolve any issues.

The Running other Choices refuge run by Aberlour in Glasgow indeed provides such a centre, offering young people who have run away a place to stay for up to 14 days and providing support to identify the reasons for running away, support to rebuild family relationships (where appropriate), individual support and access to other services. An evaluation of the service in 2006 (Mallon, 2006) found that the young people viewed the refuge very positively and most felt that the refuge had improved things for them, at least in the short-term, but sometimes in the long-term. However it should be noted that the evaluation was reliant on consultation with only 10 young people and a small number of referrers, and did not attempt to measure objective outcomes to assess effectiveness.

A study of young people admitted to a shelter in the United States over a two-year period also provides some food for thought when considering the timing of interventions. The study by Baker et al (2003) measured the recidivism of young people over the 12-month period following their admission and found that young people who returned to the shelter had stayed significantly longer the first time than those who did not return to the shelter, around 11 days longer on average. The authors did not postulate on the reasons behind this, but it may be due to the possibility that the longer that a young person has been away from home the more likely they are to make a ‘break’ from the home environment. Thus intervening as early as
possible, and facilitating a speedy return home where appropriate may reduce the likelihood of any further absconding. However it may also be that those young people who stayed longer the first time had more complex or challenging circumstances to begin with.

The only available study that looked at specific interventions in depth was one by Clark et al. (2008) that looked at a functional approach to reducing the incidence of running away and stabilising placements for young people in foster care. The functional approach in this instance related to a ‘functional assessment’ of the conditions that maintain a specific behaviour (i.e. running away) and then the use of this information to formalise an intervention plan to meet the circumstances and the needs of the young person. Two of the primary outcomes of the functional assessment were to identify what ‘function’ running away has for the young person i.e. what purpose it serves and to identify the antecedent conditions (i.e. events, situations) that help predict when the behaviour is more likely to occur.

The approach was delivered by the Behavior Analysis Services Program (BASP) in Florida and the study in question compared the impact of the intervention for 13 young people to a matched comparison group who had not received the intervention. The authors found a significant decrease in the percentage of days in the following 12 months on ‘runaway’ status in the BASP group (18% compared to 38% in the matched comparison group) and a significant reduction in the number of ‘runaway episodes’ in the following year. There was also a significant reduction in placement change and instability. A detailed case study of a young woman referred to BASP highlighted some of the small changes (including very simple steps such as changes to her lunch box from the standard group-home packed lunch) made to the young person’s careplan following the functional assessment that resulted in the elimination of her absconding behaviour. However a limitation with this study for the purposes of this report is that 11 out of the 13 young people were females and whether the findings apply to young males specifically is not entirely clear.

Conclusions

It has been difficult to draw definitive conclusions about what constitutes an effective approach to reducing the risk of young males absconding from home or care. Much of the literature does not explore interventions in any detail, and those that do, such as the Clark study above, have been heavily focussed on young women who far outstrip young males in terms of their absconding.

What does appear to be effective are small simple steps such as: trying to identify those at risk of absconding early on, ensuring that young people in care receive adequate communication about their placements; ensuring that young people are placed with siblings as far as possible, and ensuring that young people’s views are taken into consideration. While this is fairly common sense and should already constitute standard practice in Glasgow it may be worth considering using a formal framework (such as using the CBCL as a predictor, or using the functional approach) to provide additional structure to existing practice.

5. Substance Misuse

Prevalence

Research across the UK suggests that British schoolchildren are among the heaviest drinkers for their age group in Europe, with 72% of 15 and 16 year olds having been intoxicated at least once, with more than half (55%) falling into the category of ‘binge’ drinking i.e. drinking at least five drinks on one occasion (Cox et al. 2006). Currie and colleagues (cited in Newbury-Birch et al, 2009) reported that 23% of young males in England reported that they had first been drunk at age 13 or younger. Certainly in the profile of Glasgow’s vulnerable young men (Vaswani, 2007) alcohol misuse was the second most commonly occurring risk and need (59%), with drugs fourth (35%). Thus the misuse of substances clearly contributes to the vulnerability of young males in the city.
Characteristics and Risk Factors

The high-rates of alcohol use by adolescents in the UK suggests that young people’s substance misuse may reflect a wider cultural approach towards substances. However the importance of tackling adolescent substance misuse is highlighted by the strong associations between substance misuse and self-harm or suicide in young males (Hawton et al. 2003) and with offending (Kinlock et al, 2004), violence and sexually transmitted diseases (Sells & Blum, 1996, cited in Bauman 1999). In addition Kulis et al (2002, cited in Usher et al. 2005) found that males are more likely to be regular drug users than females and Griffin et al (2002, cited in Usher et al, 2005) suggested that males are more likely to adopt later cannabis use if they have started using at an early age. Lastly Ezzati et al. (2004, cited in Toumbourou et al, 2007) estimate that hazardous alcohol use causes 31.5% of all deaths among 15 to 29-year-old men in the developed world.

A systematic review of the literature by Newbury-Birch et al (2009) found that risk factors for the problematic use of alcohol include physical and sexual abuse in childhood, a family history of alcohol problems, stress and anxiety and early behavioural problems. The impact of excessively drinking alcohol on young people was found to include health concerns such as eczema, sleep disturbance, compromised brain development, vomiting, liver disease and coma, injuries and accidents, depression and mental health problems as well as increasing the likelihood of the risks outlined above.

Cox et al. (2006) found that young people who drank for negative reasons (i.e. to ‘drown sorrows’ or to mask other negative feelings) were more likely to experience drinking-related problems than those young people who drank for ‘positive’ or social reasons (i.e. to have fun or to gain peer approval). Other studies found a strong correlation between anxiety levels and alcohol use, but no similar link between anxiety and cannabis use, (Low et al, 2008) and this was found to be particularly true for young males (Schmidt et al. 2007, cited in Low et al. 2008).

Intervention

Studies that have focused on early screening of adolescent substance misuse problems and brief interventions to encourage behaviour change using motivational interviewing principles highlight a promising approach particularly at the lower range of the spectrum(Leech, 2008). One example of this is the Brief Alcohol Screening in College Students (BASICS) programme which has been proven to be effective in reducing binge-drinking and excessive drinking in college students over the long-term follow-up period (Dirneff et al, 1999, cited in Toumbourou et al., 2007). BASICS has been selected as a model programme in the USA.

However some young people will require more than a brief intervention. A seven-year study of young adults (18 to 25 years old) who met criteria for problem drinking suggested that the average consumption of alcohol fell significantly between the ages of 18 and 25, but that the reduction in frequency of binge drinking was not statistically significant (Delucchi et al, 2007). This suggests that the maturation process is not sufficient for these young people to reduce their problematic drinking, and that early intervention strategies (if in place) have not worked.

Thus intervention or ‘treatment’ is necessary for some young people in order to reduce their problematic substance misuse, particularly in light of the associated risks and needs. However systematic reviews show inconsistent outcomes after intervention for substance-use disorders in adolescence (Toumbourou et al., 2007) and that even with intervention it is difficult to effect long-lasting behavioural change (Bauman & Phongsavan, 1999). Indeed this is concordant with the profile of vulnerable young males in Glasgow (Vaswani, 2007) in which the most commonly recorded risk and need for young males six-months post the vulnerability discussion was alcohol, which had overtaken offending for the top spot despite the addictions service being the most frequently recorded service input. Similar difficulties in making a notable impact on substance misuse have been found in the evaluation of MST (Vaswani, 2010, as yet unpublished) and with the reviews of Intensive Services (Vaswani, 2008)
One approach to substance-use reduction that has been developed over the last few decades is that of peer programmes / social skills programmes that attempt to influence peers and social pressures to misuse substances, and enhance the social skills needed to resist offers to misuse substances. Again evaluation of interventions has produced mixed results, although it should be noted that many of these programmes were focussed on reducing tobacco-smoking among adolescents. For example the Alcohol Misuse Prevention Study (AMPS) used a social resistance skills approach focusing specifically on reducing alcohol misuse among high-risk students in the 6th grade (Shope et al., 1994, cited in Bauman, 1999). At the two-year follow-up, there was significant increased knowledge about alcohol among the intervention group but no evident changes in alcohol misuse. A similar project designed to reduce substance misuse noted some short-term effects on smoking rates but non-significant effects on alcohol or illicit drug use (Clayton et al, cited in Bauman, 1999). Other studies have reduced substance misuse in the short-term and also found some positive effects on attitudes that last for up to six years, although the same study appeared to produce negative effects for high-risk young people.

The authors conclude, from reviewing a number of small and large-scale programmes, that school-based programmes may delay the onset of, but not necessarily prevent or reduce, substance use, especially among high-risk young people who are additionally influenced by social and environmental factors such as family and neighbourhood. The authors postulate that given the multiple roots of substance use, enhancing social resistance and changing social norms may be necessary in order to reduce substance misuse but are not sufficient to do so alone.

Indeed a multi-intervention approach in Minnesota run over a five-year period found a significant reduction in smoking rates among young people who had received a school-based programmes complemented by community activities, exposure to mass media messages and smoking cessation clinics. At the six-year follow-up 14.6% of students in the intervention group were weekly smokers compared to 24.1% in the reference community (Perry et al, 1992, cited in Bauman, 1999).

Other evidence-based approaches to intervention include cognitive-behavioural therapy, contingency management, family-based therapy and 12-step programmes. However again Toumbourou et al (2007) conclude that while generally some form of intervention is better than no intervention, more research is required to assess which approaches are effective, and for whom under what circumstances.

Conclusions

Glasgow is in the process of training all children’s services staff in early substance misuse screening tools and alcohol brief interventions, so it is heartening to observe that these approaches are viewed as efficacious by the research literature. An evaluation of the approach in Glasgow will be undertaken over the coming year.

However in relation to intervention it is equally disheartening that substance misuse appears to be a difficult behaviour to change, not least because of the societal and cultural norms within which these young people live. That interventions may not be effective for high-risk young people, and that evaluation of our own services suggests that alcohol misuse often responds the least well to intervention means that further work should be undertaken to review our own services and to further identify best practice from the literature.

In addition the evidence suggests that around 60% of adolescents with substance use disorders also have one or more co-occurring disorders. Young people with comorbid disorders generally report greater severity of symptoms and respond less well to intervention than those without the presence of comorbid disorders (Rowe et al, 2007, cited in Toumbourou, 2007). Vulnerable young males are likely to fall into this category, compounding the problem further and this needs to be considered when developing interventions.
Lastly the research suggests that an early intervention and public health approach is necessary to reduce substance misuse, which is outwith the scope of the working group.

6. Persistent Offending and Violence

Prevalence

Young males are far more likely to become involved in offending than young females. Data taken from the Strathclyde Police Corporate Database for the year 2009/2010 shows that in Glasgow young males commit almost four times as many offences as young women. The differences are also particularly striking when looking at the ‘per head of the population’ figures for young people who were involved in offending last year. In relation to serious violence, young males were charged with 89% of all violent offences committed by under 18s in the year. The table below highlights this in more detail:

<table>
<thead>
<tr>
<th>Differences between male and female offending in Glasgow, 2009/2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>males</strong></td>
</tr>
<tr>
<td>no. of young people committing an offence</td>
</tr>
<tr>
<td>no. of offences committed</td>
</tr>
<tr>
<td>average no. of offences per young offender</td>
</tr>
<tr>
<td>no. of young people offending per head of the population²</td>
</tr>
<tr>
<td><strong>persistence</strong></td>
</tr>
<tr>
<td>no. of yp committing more than 10 offences in the year</td>
</tr>
<tr>
<td>% of males / females committing more than 10 offences in the yr</td>
</tr>
<tr>
<td>no. of yp committing more than 20 offences in the year</td>
</tr>
<tr>
<td>% of males / females committing more than 20 offences in the yr</td>
</tr>
<tr>
<td><strong>violence</strong></td>
</tr>
<tr>
<td>no. of serious violent offences committed³</td>
</tr>
<tr>
<td>% of all serious violent offences across males and females</td>
</tr>
<tr>
<td>serious violence as a % of all offences by males / females</td>
</tr>
</tbody>
</table>

The table above clearly shows that offending is an issue for more young men than young women in Glasgow, and that serious violent offending is almost entirely specific to males in this age group. In addition the profile of vulnerable young men in Glasgow (Vaswani, 2007) found that by far the most frequently occurring need and risk was offending (70% of all vulnerable young men).

Characteristics and Risk Factors

A number of factors have been identified as pre-disposing a young person to become involved in offending behaviour, although this does not necessarily indicate a causal relationship. These factors, known as criminogenic needs, can be broadly categorised as follows: relationships, individual factors, vocational and community factors. Some of these needs are listed below, but this does not represent an exhaustive list.

Relationship factors
- negative or anti-social peer associations (McGuire et al., date unknown; Audit Scotland, 2001; Hawkins et al., 2000)
- poor parental supervision (McGuire et al., date unknown; Woolham, 2003)
- family breakdown (Audit Scotland, 2001)

² Per 1,000 of the male or female population of Glasgow, aged between 8 and 17 inclusive
³ As defined by Strathclyde Police (does not include, for example, petty assault, or weapon carrying without use)
• parental substance misuse (Audit Scotland, 2001)
• hostile parenting style (Woolham, 2003)

Individual factors
• displaying anti-social tendencies (McGuire et al., date unknown)
• other behavioural issues (Audit Scotland, 2001)
• cognitive distortions (Woolham, 2003; Bennett & Gibbons, 2000)
• low levels of self-control and/or impulsiveness (McGuire et al., date unknown)
• substance misuse (Audit Scotland, 2001)
• pro-criminal or anti-social attitudes (Hawkins et al., 2000)

Vocational
• low educational achievement (Audit Scotland, 2001)
• other school and/or employment problems (McGuire et al., date unknown)

Community
• social exclusion (Woolham, 2003)
• high crime levels in community (Hawkins et al., 2000)
• availability of drugs and weapons (Hawkins et al., 2000)
• low income, both individual and familial (Audit Scotland, 2001)

In relation to violent offending specifically a report by Vaswani (2009a) profiled young people from Glasgow who had been charged with one of three serious violent offences (murder, attempted murder or serious assault) over a nine-month period. The analysis found that 129 young people had been charged with at least one of the above offences, the vast majority were male (87%), and that the young person was aged 16 on average at the time of the offence. Unexpectedly, the profile found a small, but important, number of young people (around 20%) who had never been known to social work prior to their violent offence, and around half of those that were known were not a current client, with only one-in-three ever having been subject to a supervision order. This contrasts with previous profiles undertaken locally about young offenders more generally, particularly ‘persistent’ young offenders.

Analysis of risk factors and potential ‘triggers’ found that three-quarters of violent offenders were assessed as ‘low’ or ‘moderate’ risk using the YLS structured risk assessment tool⁴. Common needs and risks identified in the 12 months prior to the offence were assessed and included school; peers; alcohol; anger management and previous violence. However it should be noted that for a substantial number of young people there were not extensive (or at times, any) casenotes, due to their limited or non-existent involvement with social work prior to the offence, thus these risks may only apply to those young people with a history of social work involvement.

The analysis also looked at the proportion of young people who had ever experienced or witnessed domestic violence, or had displayed previous violent behaviours (either frequent or serious), as it was hypothesised that these might be risk factors for future violent behaviour. However it should be noted as many young people had sparse case records it was at times difficult to ascertain significant events in their lives. The table below highlights the proportion of young people with these background experiences:

<table>
<thead>
<tr>
<th>Number of young people ever experiencing domestic violence / displaying previous violence (n=129)</th>
<th>Yes</th>
<th>No</th>
<th>Not known</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence</td>
<td>42</td>
<td>37</td>
<td>50</td>
</tr>
<tr>
<td>Previous violent behaviour (serious or frequent)</td>
<td>37</td>
<td>65</td>
<td>27</td>
</tr>
</tbody>
</table>

⁴ It should be noted that the YLS measures risk of rule-breaking (including offending) rather than risk of harm per se. Therefore someone could potentially be at low-risk of future offending, but at a high risk of harm to others if they did offend.
Thus it can be seen that more than half of those young people whose backgrounds are known had experienced or witnessed domestic violence, and almost one-in-four had exhibited previous violent behaviour. In addition the report also uncovered some evidence of bullying acting as a potential trigger for violent behaviour. However the author notes that this report was only a first attempt to identify triggers, and further research is required into violent behaviour.

**Intervention**

There is a substantial evidence-base, spanning several decades, about ‘what works?’ to reduce offending by young people (see for example, Vaswani 2004, for a summary of the national and international literature). What this report will focus on is the evaluation of local evidence to assess the effectiveness of services for young males in Glasgow.

At the Stage 3 and 4 levels of service delivery (targeted, intensive and specialist service provision) there are a number of services designed to tackle serious and persistent offending. These include Youth Justice teams, Intensive Support and Monitoring Service (ISMS), Programmes, Local Youth Justice Forums and Multisystemic Therapy (MST). Most of these services or approaches have been monitored, reviewed or evaluated and have been proven to be effective. The latest available annual report for youth justice (2008/2009) highlights a fall in offence referrals to the Reporter of 30% over two years and a drop in overall crime of 9% on the previous year (with violent crime down 11%). This suggests that the plan put in place to tackle youth offending by the Youth Justice Strategy Group is effective across the wide spectrum of youth offending. Early indications for 2009/2010 are that this downward trend is continuing.

The evaluation of ISMS (an intensive intervention designed to provide an alternative to secure care for high-risk and prolific offenders) has revealed a notable drop in offending of around 50%, sustained for up to two years after leaving the service (Vaswani, 2009b). The recently established ISMS: alternative to remand team, which offers the court an alternative to custody for young people, has also been found to reduce offending in the region of 46% (Vaswani, 2010b). The programmes team, who deliver cognitive behavioural programmes to young offenders, has been found to reduce offending by up to 36% (Merone, 2007). An evaluation of Local Youth Justice Forums, multi-agency groups that meet locally to discuss and plan for the most frequent or concerning young offenders in the area, found that offending was reduced by 30% in the six-months post discussion (Henry et al, 2009). An interim evaluation of MST, an intensive community-based intervention with a strong evidence-base, has found the overall reduction in offending to be almost 39% (Vaswani, 2010). Many of the services also demonstrated a reduction in the seriousness of offending and are cost-effective compared to alternatives.

**Conclusions**

The evidence is clear that the investment in Youth Justice Services over the past few years, and the focus on evidence-based interventions, has paid off. This is not to say that there is not room for improvement across services for young offenders, and the fact that offending is still a common risk factor for vulnerable young men six-months post VYP discussion means that more can be done in ensuring that young men access the services they need. However most evidence-based offence interventions have been designed specifically for, and have been validated on, young (or adult) males. These include developing interventions that best meet male learning styles such as structured programmes, reward-based behavioural techniques and team-building through activities. Thus it appears that the development of specific services for young men in relation to offending may not be the first priority for development.
7. Learning Disability

Prevalence

The terms ‘learning disability’ and ‘learning difficulty’ tend to be used interchangeably within health, education and social care legislation with no consensual definition. The Same as You report in 2000 defined people with learning disabilities as:

A significant, lifelong condition that started before adulthood, that affected their development (physically and/or mentally) and which means they need help to:
understand information, learning skills and cope independently

In the above definition intelligence is usually impaired (i.e. an IQ of below 70). Learning ‘difficulty’ often refers to specific learning difficulties that affects a person’s ability to learn, follow rules or socialise with others, but does not impair intelligence. As such the term covers a range of difficulties that can include conditions such as dyslexia, dysgraphia, people with speech and language difficulties, attention deficit and hyperactivity disorder and Asperger’s syndrome and autism. The degree and extent of learning difficulties varies between people and its presence is not always obviously apparent or visible, with individuals themselves sometimes unaware that they have difficulties. Mindroom (a Scottish charity dedicated to raising awareness about learning difficulties) views the distinction between learning difficulties and disabilities as two points on the same spectrum. This report will not distinguish between ‘difficulties’ and ‘disabilities’ unless clearly indicated.

Prevalence figures suggest that about 2% to 3% of the general population (120,000 people in Scotland) have some degree of learning disability, with around 20 in every 1,000 having a mild to moderate learning disability, and approximately four in every 1,000 have a profound learning disability (DOH, 1995). Learning disability disproportionately affects males with specific learning and communication difficulties often found to be three times as common among boys than girls (Robinson 1987, cited in Cross, 2007). The Audit Commission estimates that almost two-thirds (64%) of children identified in primary and secondary schools as having special educational needs (SEN) are male (Dockrell et al, 2002).

Statistics also suggest that vulnerable populations, such as children with other difficulties, are more likely to experience learning difficulties, although these are interlinked with some complexity. For example Loucks (2006) estimates that between 20 and 30% of all offenders have some form of learning difficulty that impacts on their ability to cope with the criminal justice system and everyday life. A survey at Polmont YOI in 2003 found 26% of young men had clinically significant communication problems and 70% of young offenders had literacy and numeracy problems (BBC News, 2007).

Characteristics and Risk Factors

It is outwith the scope of this report to cover the nature of learning difficulties and disabilities in detail, being worthy of a full literature review in itself. Indeed a literature review of the impact of learning difficulties on young people and the links to their offending and effective interventions is currently underway on behalf of the Youth Justice Strategy Group in Glasgow and will report before the end of 2010.

It is clear however that young men are hugely over-represented in the learning disability population, and that young people with learning difficulties are more likely to display challenging, aggressive and antisocial behaviours, particularly those with associated ADHD (see for example, Hall, 2000). Young people with learning difficulties have often been found to have higher rates of psychiatric disorders (including conduct disorders, anxiety disorders and substance misuse issues (see, for example, Allington-Smith, 2006; Emerson, 2003). Hall (2000) states that a mild learning disability may easily be missed when there is a co-morbid behavioural disturbance.

Young people with special educational needs, particularly those with undetected difficulties are far more likely to suffer school problems than the general population, often being excluded from mainstream activities leading to an imbalanced curriculum or are up to six
times more likely to be permanently excluded (Dockrell et al., 2002). Exclusions can often lead to further difficulties such as underachievement and social exclusion, for an already excluded group of young people.

People with learning difficulties are also particularly vulnerable to abuse (Brown and Craft 1992, cited in Cooke & Sinason, 1998); bullying (Mishna, 2003), social skills deficits and peer rejection (Kistner & Gatlin, 1989) and physical health difficulties (Disability Rights Commission, 2006).

**Intervention**

The literature is clear that early and better identification of children with learning difficulties is crucial in targeting interventions and preventing the escalation of behavioural problems and under achievement (see for example, Reid Lyon 1996).

Social skills training in the form of cooperative learning in the classroom has been advocated within the literature as a particularly effective way to improve social functioning and promote the inclusion of young people with behavioural problems and/or special educational needs. (Stevens & Slavin, 1995; Gilles 2004) Cooperative learning is viewed as a gender-inclusive approach to learning, recognising that males and females have different learning styles and offering a more inclusive environment by incorporating the skills and abilities of all students while addressing the weaknesses in both boys' and girls' learning. The cooperative learning approach is currently being explored as a potential approach in some of Glasgow's alternative to mainstream education units, although not focused especially on children with learning difficulties nor males.

In relation to young offenders with learning disabilities, the research suggests that as traditional cognitive behavioural interventions are language-based many young people are less able to access, or are unlikely to benefit from such interventions, due to difficulties with understanding the material and struggles with enhanced thinking skills (Davies et al., 2004). Brier (1994) states that “intervention projects with the greatest effect on recidivism have been found to be those that emphasise skills and address skills deficits and are matched to the learning styles of the individual”. This was supported by the findings from a 24-month study that compared the recidivism rates of 73 offending adolescents in receipt of targeted treatment for their particular assessed learning difficulty needs with a comparison sample of 85 young people not in receipt of learning difficulty treatment. Young offenders who were in receipt of the programme were found in the 20-month follow up period to have a significantly lower recidivism rate (12%) compared to a re-arrest rate of 40% for the comparison group.

**Conclusions**

The area of learning disability / difficulty has been somewhat under-researched for this report and would benefit from further exploration before definitive conclusions are drawn. However better and earlier identification of learning difficulties, and more inclusive and responsive models of intervention appear at this stage to be of benefit.

8. Homelessness including Unstable or Unsuitable Accommodation

**Prevalence**

Homelessness does not necessarily mean ‘rooflessness’ and included here in this section of the report are young people living in temporary, unstable or unsuitable accommodation. Gaetz (2004: p9) defines such accommodation as that which is “characterized by a lack of security, by their temporary nature, and by the limitations that such conditions place on people’s ability to stay safe and healthy, gain employment, continue their education or otherwise move on with their lives”.

A report by Quilgars et al (2008) for the Joseph Rowntree Foundation estimates that at least 75,000 young people experienced homelessness in the UK during 2006/2007. However the
same study indicated that the rate of homelessness in Scotland is three times higher than it is
in England, at 15.1 young people per 1,000 of the young people in the population, compared
to 4.9 in England. This rises to around 20 per 1,000 of 16 to 24 year olds (Shelter, 2009).
Thus Shelter estimate that in 2008/2009 that there were 22,000 children living in households
accepted as homeless in Scotland.

Homelessness seems to disproportionately affect young people, with single people aged 16
to 24 comprising almost one-quarter of all homeless households (23%), despite only 3% of
households in Scotland being headed by a single young person aged under 25 (Shelter,
2009). Shelter note that 60 young people become homeless in Scotland every day. Indeed a
survey by Action for Children and Young Scot (2008) revealed that homelessness is young
people’s second highest concern after poverty.

Homelessness is a particular issue for Glasgow’s children and young people. A Scottish
Government Statistical Bulletin (2009b) found that there were 3,825 households with children
in temporary accommodation as at 31st March 2009, 1,004 of whom were living in Glasgow
(26%). While across Scotland the rate of families with children living in temporary
accommodation was 0.65% as at 31st March 2009, this was more than double in Glasgow at
1.44%

Very little data exists on gender differences relating to the prevalence of homelessness.
Quilgars et al (2008) found that young women are more likely to be statutorily homeless than
young men, but young males over the age of 18 are more likely to be classified as ‘non-
statutorily’ homeless. Research by Fitzpatrick et al (2000) found that the vast majority of
single homeless people are men, but that the reason for this is that a high proportion of
homeless women are accompanied by children, and almost all homeless lone parents are
women.

However, certain vulnerable groups are more likely to become homeless, including care
leavers, and people leaving prison. A study of homeless people in Canada (cited in
Echenberg et al., 2009) found that 47% of ‘street youth’ had been in some form of residential
group home. Centrepoint (2006) report that up to 32% of rough sleepers have been in care at
some point. Nacro Cymru (2006) report on a study of forty-three 15 to 17 year olds across
three Young Offenders Institutions and found that 60% had unstable living arrangements, and
that the situation rarely improved after a period of incarceration. Given that young men are
significantly more likely to experience a period of time in custody, it follows that more males
will be affected by homelessness in this circumstance than young women. The Howard
League found that 14% of young men in custody reported being homeless prior to entry into
prison, and noted that on release half reported that the address they had expected to live at
on release had changed, and in all but one instance had changed for the worse.

**Characteristics and Risk Factors**

This section is to some extent related to the section on absconding, as young people who are
homeless, or who live in temporary accommodation, face many of the same risks and needs
as young people who have absconded from home or care. However this section should be
distinguished from the absconding section in that it was assumed for young people who
abscond that a conscious decision had been made to run away, regardless of the ‘push’ or
‘pull’ factors that precipitated the decision. In this section, young people may be homeless or
living in unsuitable conditions for a range of reasons; through family, placement or
relationship breakdown; they may be living in this situation with their families due to adverse
or disadvantaged circumstances; or, for example, young people may have been evicted or
asked to leave their home due to a failure to pay rent or through antisocial behaviour.

In a study of 160 homeless young people Wincup et al (2003) found that on average the
young people first became homeless at 17. Clear risk factors for being homeless or living in
unsuitable accommodation have been identified in the literature and include: socio-economic
disadvantage (Fitzpatrick et al, 2000; JRF, 2008); substance abuse and mental illness
(Fitzpatrick et al, 2000; Wincup et al, 2003; Echenberg & Jensen, 2009;); previously
institutionalised i.e. leaving custody, care or the armed forces (Fitzpatrick et al, 2000; Howard
League, 2005; Youth Justice Board, date unknown; Nacro, 2006; Shelter, 2009); family conflict or relationship breakdown; (Fitzpatrick et al, 2000; JRF, 2008; Echenberg & Jensen, 2009) and a lack of social support (Fitzpatrick et al, 2000; JRF, 2008). As noted by the Joseph Rowntree Foundation (2008), homelessness is often caused by complex needs, but at the same time can compound a number of the problems already faced by young people, in particular substance misuse and mental health problems.

For example, there is a complex and cyclical link between homelessness and crime. The Misspent Youth report (Audit Commission, 1999) found that young people living in unstable conditions were more likely to offend and Devitt et al. (2009) report that one in three prisoners do not have stable accommodation prior to imprisonment. A lack of suitable accommodation can increase the risk of crime, either through the need for simple survival, through poor neighbourhood relations and high levels of antisocial and criminal behaviour in the community, or through the existence of other risk factors that can contribute to offending as well as homelessness.

Lack of appropriate accommodation can in turn also increase the risk of custody. Nacro (2005) report that young people are less likely to be bailed by the police or courts if they do not have a suitable address to go to. In addition suitable accommodation is required for some bail conditions and disposals such as curfews, or electronic tagging. The Audit Commission estimates that in England and Wales, 1,000 young people per year are remanded because they do not have a viable Bail address, and that over 800 young people per year receive custodial sentences because they are not in stable accommodation.

However a custodial experience (whether remand or sentence) can increase the likelihood of housing problems, such as losing a tenancy or family breakdown leading to homelessness. Yet the Howard League (2005) note that housing is a crucial component to the successful resettlement of ex-prisoners. One pertinent issue for people in custody is that housing benefit is only available for up to 13 weeks for sentenced prisoners, making it difficult to sustain accommodation. A Social Exclusion Unit report (cited in YJB, date unknown) stated that stable, suitable and sustainable accommodation could mean a reduction of more than 20% in reoffending rates for the most serious offenders and the Home Office (cited in Nacro, 2005) reported that those people released from prison as homeless were twice as likely to offend as those released to stable accommodation.

Factors specific to young people include the fact young people under 25 are entitled to less Job Seekers Allowance, less housing benefit and many receive a lower level of minimum wage. A study by Centrepoint (2005) found that while B&Bs have been deemed unsuitable for families, and thus 16 and 17 year-olds who are homeless with their families are fast-tracked out of B&B accommodation, the same does not necessarily apply to 16 and 17 year-olds who are alone. Young people themselves report the issues with B&B accommodation to be: unsafe and intimidating; isolated; no support; poor conditions; no access to health care; a disrupted education; feeling too young to cope or residing in a B&B being part of a downward spiral (Centrepoint, 2005). In Scotland the Unsuitable Accommodation Order (2004) Act bans the use of B&Bs for families with children and, as at 31st March 2009, there was only one family placed in such accommodation in Glasgow.

Fitzpatrick et al (2000) found in a study of young homeless people in Glasgow that the friendship and social support networks of young people who were sleeping rough or staying in the city centre became very much centred around other young homeless people, making it very difficult for them to move forward from their situation. In comparison, young people who remained in their local area tended to retain long-standing friendships and contacts from childhood, a feature that helped them along their homeless pathway. Fitzpatrick however reports that these young people found their situation, and reliance on these supports, ‘acutely embarrassing’.

The Standing Committee on Community Services and Social Equity (2002) also found that a major impact of homelessness on young people was disrupted education and friendship networks. Home Office research (cited in Nacro, 2006) found that successful resettlement of ex-prisoners was more likely for those prisoners who had maintained positive contact with
friends and family while in custody. The JRF (2008) also note that young people in the
general population are experiencing extended transitions to adulthood, whereas transitions to
independence among care leavers occur at a relatively young age, and in the absence of
social support networks are even more likely to be characterised by crises and
homelessness.

The research literature appears to have little to say about gender, or at least about males
specifically, but Heath (2008) notes that in the general population young men are more likely
than young women to remain in the parental home, and to not leave until a much later stage.
Heath also notes that the transition to independent living for care leavers can happen at a
particularly young age (aged 16, compared to 22 in the wider population, Devitt et al., 2009),
thus suggesting that this may be more difficult for young male care leavers who are forced to
move to independent living long before they are ready to take on the responsibility. Stein
(2005) noted that young people who are able to ‘move on’ from care, that is having stability
and continuity and coping well with the challenges of independence, were more likely to be
young women. Stein identified that not only were young female care leavers better qualified
educationally than young men, but that they were also able to manage better. Young women
were twice as likely to have good practical skills, especially controlling their finances and
managing their accommodation by maintaining reasonable relations with landlords,
neighbours and friends.

**Intervention**

A search of the research literature revealed little in the way of useful evidence about
interventions for young people in unstable accommodation. The comprehensive JRF review
by Quilgars et al (2008) concluded that “there were significant gaps in the evidence-base of
‘what worked well’ for young homeless people. The success of provision was widely agreed
to depend to a significant degree upon the quality of individual project staff and their
relationship with young people…” A number of studies reported promising or potential
approaches, but very few included formal evaluations or published outcomes in relation to the
services.

However there is some evidence that support can help young people move on. Despite the
increased vulnerability of care leavers, a study by Simon (cited in JRF, 2008) found that they
often fared better than non-care leavers with comparable levels of disadvantage. He found
that the incidence of crisis moves and youth homelessness was twice as high among the non-
care leavers, and postulated that statutory duties meant that young care leavers were offered
more consistent housing support and advice, and had easier access to supported lodgings
than other young people in difficulty. Wade and Dixon, in the same report, however, reiterate
that care leavers remain a vulnerable group and require targeted support.

Many studies cited a need for better temporary accommodation for young people, and better
‘moving-on options’ plus a change to the benefit system that penalises young people in terms
of housing benefit (see for example, Fitzpatrick et al, 2000; Quarriers, 2007 etc). Quarriers
also recommend that interventions focus on addressing any underlying issues as well as
presenting issues, thus they advocate for more therapeutic counselling and support to be
integrated with existing support services to build resilience and self-confidence in young
people.

Fitzpatrick et al. (2000) recommend that services provide homeless people with access to
mainstream accommodation; improve the quality of temporary accommodation; combine
housing and support with support provided through day centres, street outreach and
resettlement services. The report also argues for the early deployment of prevention services
to people displaying a range of known risk factors for homelessness. The authors argue that
preventative approaches can be particularly effective if targeted at people at known trigger
points (such as leaving care or prison). They highlight potential preventative interventions as
including: befriending and mentoring services; family mediation; education in schools about
homelessness and leaving home; tenancy support for young people; outreach work with
young people and resettlement programmes for people leaving prison. However it should be
noted that their recommendations do not always focus on young people per se.
Other articles stress that the longer a young person is homeless and spending time in unsafe and inappropriate environments the more hardened and entrenched attitudes and behaviours can become, making a move forwards more difficult (see for example, Centrepoint, 2005; Nacro, 2006). This again highlights the importance of good preventative work, and early intervention in a housing crisis.

Given that many young people end up homeless after long-standing family conflict and fragile relationships culminate in their eviction from the family home a number of studies report family mediation as a potential intervention (Centrepoint, 2005; Nacro, 2006). However studies have also expressed concern about situations where young people have been encouraged to return to abusive or harmful families and care needs to be sought when assessing the appropriateness of family mediation (see, for example, Centrepoint, 2005; Nacro, 2006).

A study of 30 young homeless people in Dublin (Drugnet Ireland, 2009) found two different pathways out of homeless (independent i.e. moving home or obtaining a tenancy; and dependent i.e. moving to transitional or supported housing). The authors found that out of the young people following independent exits, those with continued contact with and support from their families throughout the homeless experience made a smoother transition home and were more likely to view the move in a positive light. Those following a more ‘dependent’ pathway still benefited from support by family members.

As well as strengthening family relationships a number of studies suggest strengthening wider social support networks, given that the evidence suggests that weak or negative support networks can increase the risk of homelessness (Quarriers, 2007; JRF, 2008 etc). Drugnet (2009) report that successful transitions often involved the breaking of ties with former peer networks and the establishment of positive and enabling social relationships. Fitzpatrick et al. (2000) state that the issue of homeless people's friendship networks is decidedly under-researched. The authors stress that this area needs to be better understood in order to facilitate more constructive social contacts through 'befriending' and other similar approaches to homelessness that emphasise ‘informal’ rather than professional support as far as possible.

There were very little specific or detailed examples of best practice within the research literature in relation to any of these approaches. Centrepoint (2005) note some particular examples about reducing the use of B&B and other inappropriate accommodation for 16 and 17 year olds. For example they briefly illustrate an example from Sunderland City Council, where a new team was set up to focus on 16 and 17 year-olds. The team offers a personalised service to support young people in their tenancies where each young person has a full needs assessment and is given an intensive support package that covers benefits, health and family contact. The team have found that while in the past 50% of tenancies broke down, this was reduced to 3% after the scheme was introduced. However the report does not explore the details of the scheme, or exactly how this was evaluated.

Another study in the North East of England (Harding, 1997) explored best practice in relation to housing and leaving home education, and noted that there was very little delivery of such education within schools in the region (Harding, 1997). Harding notes that although there was strong support for ‘housing and leaving home’ education from both the statutory and voluntary sector there were a number of factors that made this difficult to deliver effectively. One reason was that “young people did not realise that the information presented to them might, at some point in the future, be relevant to them” (p4). Harding places his findings within education theory, in particular Kolb’s experiential learning theory that emphasises a cycle of learning that incorporates concrete experience, reflective observation on that experience, abstract conceptualisation (concluding / learning from the experience) and active experimentation (applying what has been learned). Kolb states that this cycle may be entered by the learner at any stage, but must follow through the cycle in sequential order. Harding questions whether the difficulty in providing home and housing education is because of the inherent challenges of introducing a ‘concrete experience’ prior to the young person leaving home.
In order to test this theory Harding examined the Yorkshire Metropolitan Housing Foundation’s *Where Will I Live?* resource pack which was available for purchase in the region. The pack consisted of information sheets and twenty-five exercises designed to encourage active learning. Harding classified each of the exercises according to which part of the learning cycle they fitted into and found that none of the exercises fell into the concrete experience part of the cycle, with the majority falling into abstract conceptualisation. Harding found that delivery of the pack was viewed by professionals as better received and more effective when some element of ‘concrete experience’ could be delivered. In this instance this simply incorporated the worker describing the experiences of young people that she had worked with in a housing capacity which, although third-hand, appeared to add to the education experience and cause reflective observation to take place. However it should be noted that this study was based on a small sample of young women only, and did not use any objective outcomes to measure success, rather professional opinion alone.

The only study that looked at services for males specifically was an Australian inquiry that looked at the needs of homeless men and their children (Standing Committee on Community Services and Social Equity, 2002). As part of this inquiry it was found that crisis accommodation services designed for men were few and far between, with only one such service identified in Canberra, and the inquiry also identified a need for specific programmes for boys who have experienced or have perpetrated domestic violence. It was the view of the inquiry that the support needs of children and young people were not being met in crisis accommodation, and that the cycle of domestic violence was not being broken. However there was little detail about what these programmes might need to look like, given the confines of temporary crisis accommodation etc.

**Conclusions**

More research is required into effective interventions for young people whose accommodation situation makes them vulnerable. However what literature is available suggests that preventative approaches for all young people, along with targeted supports at vulnerable young people and at crisis points, along with a focus on family mediation and the creation of social support networks may reduce homelessness, and may help to move young people into more stable and sustainable living arrangements.

9. **Mental Health**

**Prevalence**

The Mental Health Foundation (2005: p8) provide a broad definition of mental health that reaches further than simply the absence of mental illness: “...the emotional and spiritual resilience which allows us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others’ dignity and worth”. Adolescence and young adulthood is the time when many young people begin to experience or display the first signs of mental health problems, with most major disorders manifesting themselves by this time (Kessler et al, 2005, cited in Wright et al, 2006).

A study by the Office for National Statistics (cited in Mental Health Foundation, 2005) reported that 10% of children age 5 to 15 experience clinically defined mental health problems (i.e. a psychiatric disorder) and that the prevalence of problems has been increasing over the past 50 years. For example, the rates of depression and anxiety have increased by 70% over 25 years. A further ONS study (cited in Williams & Pow, 2007) estimate that 13% of boys aged 11-15 and 10% of girls meet the criteria for a mental health problem. Among Scottish teenagers aged 15 or 16, the self-reported rate was 22%, with no significant difference between the genders (Williams & Pow, 2007).

In relation to specific mental health problems Lewinsohn et al. (1998) estimate from their study of more than 1,700 high school students that by age 19, 28% of young people have experienced at least one episode of major depression (35% of young women and 19% of
young men), and find major depressive disorder (MDD) is by far the most prevalent form of affective disorder among adolescents.

Studies have also found that comorbidity rates (the presence of two or more disorders or health issues) are high among adolescents. Lewinsohn et al (1998) report that 43% of adolescents with a major depressive disorder also have a lifetime occurrence of another mental disorder. Comorbidity rates for other disorders are even higher, ranging from 70% (anxiety), 78% in conduct disorder and 83% for drug abuse or dependence. In relation to depression Lewinsohn and colleagues found comorbidity involving depression and substance misuse to be the most harmful with increased rates of suicidal behaviour, increased problems at school and greater impairment across other functioning.

The Office for National Statistics report (cited in Mental Health Foundation, 2005) highlights that children with a mental health problem are more likely to be boys. Meltzer & Gatwood (2000, in Williams & Pow, 2007) also report that mental health problems are more common among adolescent boys than girls. However gender differences may vary across disorders. Lewinsohn et al. (1998) report that among adults there is a gender difference in rates of depression by 2:1, and that among children under the age of 12 there is no gender difference or potentially a slightly elevated rate among boys compared to girls. Their study revealed significant gender differences in the rates of depression by age 14, and concluded that such differences therefore emerge in the very small window between the ages of 12 and 14. However Cotton et al. (2009) report a higher prevalence of psychotic disorder among males but note that the research is at times contradictory as to whether gender differences exist in the prevalence of psychotic disorders.

Characteristics and Risk Factors

Risk factors and symptomology clearly vary widely across specific disorders, however some commonalities exist. The ONS Survey (cited in Mental Health Foundation) highlighted that children suffering from mental health problems are more likely to come from families where there is social or economic disadvantage (i.e. low income, lone parent, social sector housing etc). Chanen et al (2008) cite the same issues as risk factors for personality disorders among adolescents, along with a history of abuse or neglect and disruptive behaviour.

In relation to major depressive illness the risk factors have been identified as: internalising problems; sub-threshold depressive symptoms; a past history of depressive episodes; suicide attempts and the presence of a non-affective disorder (Lewinsohn et al, 1998). It is often reported that adolescents that are depressed experience more adverse life events than non-depressed young people. However Bramesfeld et al. (2006) suggest that it is not a single event per se, but rather chronic adverse living conditions, such as long-standing family conflict that ultimately results in the development of depression. Children of depressed parents are at elevated risk of developing depression themselves, but only when exposed to additional environmental stress (Hammen et al, 2004 cited in Bramesfeld et al, 2006). This has clear implications for young people subject to vulnerability procedures in Glasgow, who are more likely to have experienced past trauma and live in adverse circumstances than other young people.

Common symptoms of major depressive disorder are reported to be: depressed mood; thinking difficulties; and sleep and appetite/weight disturbance (Lewinsohn et al, 1998). The analysis highlighted significant gender differences in types of symptom presentation, with depressed girls more often reporting weight or appetite disturbance and feelings of worthlessness or guilt. Males were more likely to complain of reduced ‘effectiveness’ in their lives, and reduced coping skills. Thus the authors suggest that there may require to be distinct treatment focuses for girls and boys.

Risk factors for a psychotic episode include subthreshold psychotic symptoms; poor functioning; depression and disorganisation, which have been found to predict the onset of a psychotic episode in 40% of ‘at-risk’ cases (Berger et al, 2006). Yet the authors state that young people presenting with such symptoms often have their issues ignored or trivialised.
Berger et al also suggest that the presence of a close relative with a psychotic illness increases the chance of schizophrenia or bipolar affective disorder by around 10%.

Psychotic disorders more frequently manifest themselves in males as non-affective disorders (i.e. schizophrenia) whereas females more typically present with affective psychotic disorders (bipolar disorder, depression with psychotic features etc) (Cotton et al, 2009). Research also suggests that in young people experiencing a psychotic episode, the severity of the first episode is often much greater in males (Cotton et al, 2009). In addition negative symptoms and comorbid substance misuse are more common in males and the evidence suggests that males with first-episode psychosis have more problems adapting to school life, developing relationships and social networks, and maintaining external interests than females, thus the impact on overall functioning tends to be much more pronounced (Preston et al 2002, cited in Cotton et al, 2009).

The existence of a childhood mental health problem can have long-lasting negative effects that continue into adulthood. The Mental Health Foundation highlights that three-quarters of 26-year old patients with psychiatric disorders received their initial diagnosis between the ages of 11 and 18. The same report found that there is a higher risk of poverty at age 30 and lower chance of participation in paid employment for children who had mental health and / or behavioural development difficulties. Given the potentially poor outcomes for this group of young people, successful intervention is therefore crucial for positive outcomes throughout the life course.

**Intervention**

The literature is clear that adolescents are often reluctant to seek help for mental health problems and emotional distress, with only 23% of moderately or severely depressed adolescents seeking help for their problems and only 17% seeking professional help (Möller-Leimkühler, 2002). The rates of help-seeking for mental health issues are reportedly even lower among males (Andrews et al 1999, cited in Rickwood et al, 2007; Stead et al, 2010). The reasons given for this include poor mental health literacy among males, the potential stigma associated with mental illness (see, for example, Timlin-Scalera et al, 2003; Howerton et al, 2007), a lack of awareness of where to seek help (Timlin-Scalera et al, 2003; Rickwood et al, 2005;) and the tendency for young men to feel that they should cope with problems on their own (Mansfield et al, 2005). To complicate this there is also a paucity of appropriate treatment options available for children and adolescents, with some pharmacological options ineffective or controversial, and psychotherapeutic options not always tested in 'real world' situations, even when young people do seek help (Lewinsohn et al, 1998; Bramesfeld et al, 2006).

Research has highlighted striking differences in mental health literacy between young males and females (aged 12 to 25), with females significantly more likely to be able to correctly identify depression and have better awareness of sources of help (Cotton et al, 2006). However the same study found that both genders had poor literacy in relation to psychosis, although males were significantly less likely to endorse seeing a doctor or other professional for treatment, and more likely to advocate inappropriate coping strategies such as alcohol or antibiotics than females. The authors conclude that this is particularly concerning as males in that age group have potentially a higher risk of developing psychosis. Thus it appears that interventions to improve mental health literacy will have benefit to both genders, but especially so for young men.

Williams & Pow (2007) studied the knowledge and attitudes of almost 500 Scottish schoolchildren towards mental health and people with mental health problems. The study confirmed that boys have lower levels of knowledge and understanding about mental health problems, have more negative attitudes towards people with mental health problems and are less likely to see the need for further information about mental health issues. This led the authors to conclude that strategies to reduce these gender differences should be considered in health promotion approaches, and furthermore suggest that any public health campaigns may be more effective if they are gender specific.
One study of a mental health literacy community awareness campaign, the ‘Compass Strategy’ targeted young people aged 12 to 25 in Australia. The programme used messages in the national and local media, developed a website, created a mental health information line and created resources for use in the classroom. Analysis of the programme after 14 months found significant increases in knowledge and understanding in relation to perceived suicide risks of people with mental health problems, reduced barriers to help-seeking, correct estimates of prevalence rates and increased self-identified depression compared to regions that did not participate in the campaign. Although help-seeking rates significantly improved overall this change was not significant for those people with an identified mental health problem.

Some studies argue for a non-medicalised approach to intervening on an individual basis with mental health problems such as depression, as distress can be caused by physical, social and economic problems (Mead et al, 2010). In their meta-analysis the authors found that, overall, befriending had a modest but significant effect on depressive symptoms in both the short and long term. It was hypothesised that befriending led to an increase in the perceived levels of social support which in turn bolstered coping skills. However the study examined a wide range of befriending modalities, from a wide range of professional and lay people, and in relation to a wide range of target groups which may mask where the intervention does and does not work so well. For instance, befriending was found to be less effective than Cognitive-Behavioural Therapy (CBT) in treating adolescents with depression, but as effective as systemic family therapy with the same client group. This suggests that further investigation may be required into the impact of befriending across a range of disorders before considering its use in Glasgow, however befriending may also offer a low-stigma and straightforward approach to supporting young people with mental health problems.

Cognitive behavioural or cognitive analytical approaches are commonly used to treat affective and other disorders and the literature is consistent that these are appropriate ways to intervene with individuals. However some people question whether these approaches remain as effective outside of the controlled-trial environment (Bramesfeld et al, 1996). Lewinsohn et al (1998) describe their Adolescent Coping with Depression Course (CWD-A) which is a cognitive behavioural group treatment for depression consisting of 16 two-hour sessions delivered over an 8 week period. Participants are taught skills (mood monitoring, social skills, relaxation, constructive thinking etc) to control their depressed mood via structured learning tasks, short quizzes and homework assignments. Two randomised controlled trials found significant pre-and post-change on all treatment measures, although the addition of a nine-session parent intervention did not result in any significant outcomes. At the 24-month follow-up very few young people met the criteria for depression.

Hides et al (2010) studied the impact of cognitive behavioural therapy for young people suffering from comorbid depression and substance use disorders, as the co-occurrence of these two factors results in poorer outcomes and greater harm. 52 young people aged 15 to 25 received 10 sessions of individual CBT intervention delivered with case management over a 20-week period, and none received any pharmacological intervention during that period. The intervention was the Self-Help for Alcohol/other Drug use and Depression (SHADEY) programme and incorporates motivational interviewing, cognitive behavioural and mindfulness skills delivered within a harm minimisation framework. At the 20-week follow up CBT resulted in significant reductions in the presence and number of substance use disorders (particularly drug use), and the severity of dependence on substances and 83% had a full or partial remission of MDD, with reductions in negative cognitions, anxiety levels and increases in functioning and coping skills. Treatment gains were maintained at 44 weeks post-treatment. The outcome measures were particularly robust, including urine samples, but the study was limited by the lack of a control group for comparison, and there were only a few identified changes in alcohol use.

Cognitive Analytic Therapy has also been used to effectively treat young people with emerging signs and risk factors for Borderline Personality Disorder (BPD) and has demonstrated significant improvements in outcomes over the two-year follow-up period (Chanen et al, 2008). However the intervention did not display statistically significant
outcomes to manualised good clinical care. This latter approach was a standardised
approach to deliver high-quality clinical care, using problem-solving and additional modules
according to the young person’s individual needs. Some elements of this approach
incorporated cognitive behavioural methods. There was, however, some evidence to suggest
that patients in the cognitive analytical group showed more rapid improvement gains, and in
addition it is not clear how reflective standardised ‘good clinical care’ is of care delivered in
the real-life clinical setting.

Cognitive therapy has also been proven to work when used as a preventative approach to
reducing depression among whole populations or ‘at risk’ groups. A study was carried out
with 172 ‘at risk’ high school students, namely those young people with elevated depression
scores that did not reach clinical levels, and who had never previously had a diagnosis of
a study by Clarke et al (1995, cited in Lewinsohn, 1998) participants were randomly allocated
to the intervention or ‘usual care’ groups. The intervention comprised a 15-session
programme (with each session lasting 45 minutes) in which cognitive therapy techniques
were taught to help students identify and challenge negative or irrational thoughts. There
were significantly fewer cases of MDD or dysthymia (a chronic condition, but with milder
symptoms than MDD) in the experimental group at the 12-month follow-up (14.5% compared
to 25.7% in the control group).

On a practical level Bramesfeld et al (2006) note that to implement such an approach on a
population-wide basis would be challenging, inefficient and would require mass screening.
However given the effectiveness of the approach in reducing symptoms, they recommend
that such preventative interventions are not discarded, and are instead targeted at ‘at-risk’
groups such as the children of depressed parents, or those that are seeking help for
subthreshold symptoms. The implementation of the former would require that the child’s
health and well-being becomes an integral part of the parent’s intervention plan. This may be
an approach worth considering for already vulnerable child populations in Glasgow.

One approach that attempted to deliver an intervention for adolescent depression in a primary
care setting was that of collaborative care (Richardson et al, 2009). This brought together a
multisystem strategy designed to reorganise treatment for depression. Young people aged
12 to 18 attending three primary care clinics for the treatment of depression received an
integrated programme composed of: the allocation of a depression care manager; enhanced
patient education about depression; encouragement of self-management strategies and the
provision of enhanced medication care or a Problem-Solving Treatment (based on the
patient’s own choice). All cases were supervised and overseen by child mental health
specialists. The study found that there were significant improvements in depression scores
and functioning from baseline to six-month follow-up, and both parents and young people
reported high levels of satisfaction with the service. However the limitations included the lack
of a control group for comparison, and only 10% of patients were male.

Multi-Systemic Therapy (MST) has emerged in recent years as one of the most effective
interventions for addressing behavioural and offending issues in young people. The
intervention adopts a strengths-focused and family-preservation approach that addresses the
multiple ‘systems’ that interplay in the development or maintenance of offending and
behavioural problems. In 2009 an MST scheme was established in Glasgow and early
findings suggest that it has been effective in producing improved outcomes for these
particular issues (Vaswani, 2010).

However the programme is not yet licensed for young people whose main presenting
behaviours are severe psychiatric problems, such as psychosis or suicidal behaviours etc
(although it can be used when the main presenting issue is behavioural with comorbid
emotional problems that are mild to moderate). To address this MST has also undergone
evaluation to assess its suitability for intervening with a range of emotional disturbances.
Henggeler et al (2003) randomly assigned 156 children and adolescents who were being
hospitalised on an emergency psychiatric basis to home-based MST or inpatient
hospitalisation followed by usual services. The standard MST approach was adapted to
include: the integration of additional clinical staff (i.e. psychiatrist) to assist with the
development of safety plans; addition of pharmacological interventions to complement the usual evidence-based MST interventions (mainly for ADHD) and the planned use of short-term out-of-home placements such as hospital or foster care if it would promote safety or the attainment of treatment goals. The hospitalisation and usual services approach included a structured inpatient behaviourally-based programme and points system that was followed by psychiatric evaluation and aftercare planning by physicians and nursing and social work staff. This plan attempted to link young people with the appropriate mental health service providers in the community following discharge.

Both groups displayed statistically and clinically significant reductions in symptoms over time, but the MST condition appeared to bring on a more rapid onset of recovery, particularly within the first few weeks and was more effective at maintaining young people at home and in regular school placements. However by 12-months post admission both treatment options produced similar results, unlike studies of MST for other needs where the effects of MST were found to be enduring. Henggeler et al propose that due to the complexity of problems suffered by the young people and families in the study, the short-term nature of MST (between 3 and 5 months) may not be sufficient. In addition almost half of young people in the MST group were hospitalised at some point between admission to the study and the completion of the MST intervention. Henggeler et al suggest that home-based MST alone may not be sufficient for severe disorders and more intensive intervention may be required. However the potential for MST to intervene in severe emotional disturbance is still the subject of continued exploration.

The treatment of psychosis has also been the subject of a number of studies. Linszen et al (2001) advise that patients with first-episode schizophrenia respond well to treatment in the first year, but that psychosis which remains untreated for more than a year is associated with more severe forms of schizophrenic illness. Berger et al (2006) suggest that this may be in part due to structural, functional and metabolic brain changes that occur around the onset of psychotic illness. Both studies therefore conclude that early intervention during the onset of a psychotic illness is crucial.

Linszen et al (2001) report on the findings of a study that provided a three-month highly structured inpatient programme and psychosocial education for family, followed by a 12-month outpatient programme that comprised two forms of psychosocial intervention (including anti-psychotic medication). One half of the participants were randomly allocated to a behavioural family intervention also. At the end of treatment only 16% of patients had suffered a psychotic relapse, although the behavioural family intervention offered no additional benefits to outcomes. However at 5-year follow-up three-quarters of patients had relapsed, with no significant difference between the two conditions. A similar rate of relapse was found in a Scottish study, where 78% of first admissions had relapsed within five years. Linszen and colleagues conclude that it is possible to intervene early in schizophrenia, however over the long-term schizophrenia is associated with poor symptomatic and functional outcomes. However in relation to the short-term benefits and long-term outcomes there was no comparison with a ‘treatment as usual’ group, with the only difference being the addition of family therapy, therefore it is difficult to say if the main body of the intervention was indeed having the assumed effect.

Cotton et al (2009) examined the impact of the Early Psychosis Prevention and Intervention Programme among 661 young people aged 15-29 experiencing first-episode psychosis (FEP). Most of the clients were male (66%) who were more likely to be suffering from non-affective psychosis, to have no insight into their condition, with cannabis use common at entry. On entry to the programme males had lower levels of functioning, less education and less likely to be living independently than females. The treatment programme spanned 18 months on average.

The authors found that males were more likely to have inpatient admissions during treatment and to be non-compliant with treatment. At discharge males were more likely to have no insight into their condition and to have lower levels of social and vocational functioning, suggesting that intervention is less successful in males. The authors conclude that lower compliance and greater symptom severity may be linked to the greater prevalence of
comorbid substance use in males. In addition they postulate that better functioning and social adjustment among females may act as a buffer against psychotic symptoms and disruption of social roles. Thus Cotton et al conclude that males with FEP are more likely to require therapeutic intervention around developing social skills and networks, vocation / education and substance use.

Berger et al (1996) believe that the most important goal in assessment of young people with psychotic symptoms is the engagement of the patient in therapeutic alliance. They state that the quality of the first contact is crucial as unnecessary trauma (i.e. involuntary hospital admission; restraint etc) may jeopardise the ongoing therapeutic alliance with the patient and their family and their ongoing engagement with services.

Similarly Rogers et al (2008) report that the greatest variance associated with client change is related to factors associated with the therapeutic relationship, including the therapeutic alliance. Given the association of the therapeutic alliance with improvements in client mental health the authors were keen to identify whether there was an impact of symptom severity and/or diagnosis on the development of a therapeutic alliance. Previous studies (Coyne et al, 1976; Siegel & Alloy, 1990; both cited in Rogers et al, 2008) had identified that depressive symptoms can adversely impact the therapeutic relationship, theorising that individuals with depression have poorer social skills and experience interpersonal difficulties such as rejection, potentially by inducing a negative mood state in others.

To ascertain what the impact of symptomology was on the therapeutic alliance, Rogers et al (2008) studied a sample of 100 adolescents (of whom 53 were male) who were attending drug treatment services in Australia. In relation to mental health, 69% had a lifetime history of a mental disorder. It was found that having any lifetime mental health diagnosis, but not substance use severity, was associated with lower client ratings of the therapeutic alliance at baseline. The researchers also found that a more positive client perception of the therapeutic alliance was associated with a reduction of depressive symptoms at four-month follow-up, but had no impact on substance use severity. In addition, those who were more depressed at the outset experienced a greater deterioration in the case manager’s view of the therapeutic alliance. While other research claims that the therapeutic alliance may contribute more to improved outcomes than some specific factors such as therapist background, or treatment type, the authors are more cautious noting that there is not sufficient data relating to adolescents to draw such conclusions at this point, although the emerging data is promising.

Conclusions

There is a large body of literature to suggest that cognitive-based interventions are particularly effective with a range of mental health problems, although not necessarily each and every one. However in relation to this report, the data was somewhat limited into interventions with young males specifically. Studies either involved small samples of young males or did not discuss gender in their findings. Those that did concern themselves with gender suggested that often males had lower levels of help-seeking, greater symptom severity and poorer outcomes from treatment, potentially due to increased levels of comorbidity (particularly substance use).

Indeed Cotton et al (2009) state that being female is one of the most powerful predictors of good outcomes for psychosis at 6 year follow-up. Despite these negative findings there is also some evidence that addressing comorbid illnesses may impact upon other mental health issues. For example reduced substance use can produce promote better outcomes in relation to psychosis (Cotton et al, 2009) and reducing conduct disorder in childhood can reduce levels of depression at a later stage (Bramesfeld et al, 2006).

The research also indicates that interventions may need to focus on reducing barriers to help-seeking, and increasing mental health literacy, social skills and social support. However the research would suggest that even population-wide public health campaigns may need to be gender-specific.
Conclusions and Implications

It is important to state at this stage that young men are rarely affected by one ‘discrete’ need, but often have multiple needs and risks that have complex and interconnected relationships with each other. This review of the literature has begun to highlight the tangled web of these needs and risks. For example, substance misuse is associated with higher rates of self-harm in males and with offending and violence. Confusion regarding sexual identify is a feature in young people who have been sexually exploited and for those young people who self-harm. Absconding is linked to increased risk of sexual exploitation and substance misuse. Abuse appears to feature in the backgrounds of young people who abscond, self-harm, misuse substances and are exploited. Outcomes are poorer for young people with comorbid mental health and substance use disorders. This is not to say that one risk or experience causes another, but that there are associations and links between them.

This makes identifying specific interventions for specific needs rather complicated, but encouragingly it is clear that addressing one need might reduce or eliminate another (reducing absconding for example will significantly reduce the risk of exploitation). However it should also be noted that co-morbidity can impact on a young person’s ability to engage or benefit from an intervention i.e. a learning difficulty may impact on the understanding of offence-based interventions; substance-misuse issues may need to be resolved before more structured work about previous abuse can be undertaken etc.

A feature that commonly occurred among the literature for young men in particular, and across the range of needs and risks, was that of a reluctance, or ‘inability’, to seek help. Even when young males do seek help this has often found to be at a much later stage (often crisis point) than young women and opens them up to prolonged suffering (Childline, 2003). To highlight just one example, the prevalence of abuse in the backgrounds of many vulnerable young men suggests that such a life experience plays at least some part in increasing the vulnerability of young men. However the evidence suggests that, as young males are less likely to disclose abuse, the support and interventions required to address the impact of the abuse are often delayed, or never delivered at all. This, coupled with the fact that young males are more likely to externalise (i.e. act-out) when in emotional distress, increases their vulnerability further, as many are dismissed as ‘trouble’ and the overt behaviour can mask the underlying vulnerability.

A linked issue appears to be that of the insufficient social support networks available to young men, particularly those that are already vulnerable, isolated and excluded, or separated from usual support networks (i.e. through being accommodated, or having run away). Having a positive social support network can provide resilience and may encourage help-seeking behaviour.

Thus although this literature review has highlighted some specific interventions, services and approaches that should be considered when reviewing services to vulnerable young men in the city, it also appears that encouraging help-seeking behaviour and encouraging young men to build their own social support networks will also be of great benefit in ensuring that these young men access the services that they need at the time that they need them. It goes without saying that services should be accessible, welcoming and designed to meet the specific needs of young people. How to encourage help-seeking and the creation of social-support networks further is not necessarily clearly set-out at this stage, particularly within a culture where even adult and ‘non-vulnerable’ men are also documented as less likely to seek help. This may be worthy of further research, as without encouraging access, use and sustained engagement by young men at the time that it is most needed, then even the most effective service will still struggle to improve outcomes for vulnerable young men.
References


Gilles, R. M. (2004). The effects of cooperative learning on junior high school students during small group learning. Learning and Instruction, 14: 197-213


Mindroom. *www.mindroom.org*


Standing Committee on Community Services and Social Equity. (2002). Accommodation and support services for homeless men and their children. *Report Number 2, Legislative Assembly for the Australian Capital Territory.*


