Annexes

Access to mental health support for children and young people involved in or at-risk of serious youth violence across England and Wales: Findings from a multi-strand project

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Annex 1

Effectiveness of psychological and psychosocial interventions for children and young people involved in or at risk of serious youth violence: a rapid umbrella scoping review of the literature

Summary Report: Methodology and Key Findings

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Executive Summary

This umbrella review synthesises global evidence on the effectiveness of psychological and psychosocial interventions delivered to children and young people involved in or at risk of serious youth violence. It forms part of a wider research project exploring access to mental health support for this population across England and Wales.

Young people affected by serious youth violence often face significant challenges to their mental health, many of which stem from trauma, adversity, and systemic exclusion. Addressing these needs through effective support is critical for both reducing harm and improving wellbeing**.**

About this review

We conducted a rapid umbrella review - a synthesis of existing systematic reviews, scoping reviews, and meta-analyses - to map what the international evidence says about the effectiveness of interventions for this population. The review included 66 reviews that assessed the effectiveness of psychological and psychosocial interventions delivered to different sub-groups of children and young people involved in or at risk of serious youth violence. Reviews covered primary studies delivered in a range of countries, with the greatest representation from North America. Studies focused on children and young people with a range of overlapping risk factors, such as justice involvement, behavioural challenges, mental health conditions, trauma, and social disadvantage.

Rather than focusing narrowly on one subgroup, this review takes an inclusive and comprehensive approach, reflecting the reality that many risk factors for violence and poor mental health are shared across different populations. We considered interventions that targeted mental health, behaviour, offending, or related risks, such as substance use or school exclusion.

What we found

Across the included reviews, a range of intervention types were identified. These included, for example:

- **Trauma-focused cognitive behavioural therapies (CBT)** aimed at treating PTSD, depression, and emotional dysregulation;
- **Family-based interventions** working systemically to address behavioural and relational issues;
- **School-based interventions**, often delivered as part of wider multi-level programmes, which targeted emotional regulation, social skills, and violence prevention within educational settings;
- **Creative, arts-based and relational interventions** fostering wellbeing and engagement;
- **Trauma-informed organisational models** that reshape the environments where support is delivered;
- And **other approaches**, such as motivational interviewing, peer mentoring, or **mindfulness-based programmes**.

The strongest and most consistent evidence was found for trauma-focused CBT and some family-based interventions, particularly where these were delivered with fidelity. These

models often led to improvements in mental health, behaviour, and, in some cases, reduced reoffending. Mindfulness and creative programmes showed encouraging results, especially for emotional wellbeing and engagement, but were typically backed by less robust or less consistent evidence.

Importantly, the effectiveness of interventions was shaped by context, including the setting, cultural relevance, delivery quality, and participant characteristics. Voluntary engagement, relational trust, and safe, supportive environments were frequently identified as enablers of impact.

Some intervention types, however, were found to have limited or inconsistent evidence of effectiveness. These included generic behavioural programmes without a clear therapeutic rationale, and interventions lacking cultural or contextual adaptation. Several reviews also highlighted a lack of robust evidence for reducing reoffending, particularly in community settings, with effects often small or short-lived.

Why this matters for access

This umbrella review was designed to identify which types of interventions are effective**,** as a foundation for understanding what children and young people at risk of serious violence *should* be able to access when they need support. The findings clarify what forms of mental health and wellbeing support have the strongest evidence base for improving outcomes in this population.

However, as highlighted in the report's conclusion, effectiveness alone is not enough. Interventions must also be accessible, acceptable, and adapted to young people's identities, lived experiences, and social contexts. Many of the most promising interventions, such as trauma-focused CBT or family-based models, require consistency, cultural sensitivity, and high-quality delivery, which may not always be present in real-world settings.

The review also highlights the value of creative, relational, and mindfulness-based approaches, which were consistently associated with improved emotional wellbeing, peer relationships, confidence, and engagement**.** While these outcomes may be less frequently prioritised in traditional evaluations, they are particularly relevant for young people who may not be ready or willing to engage in formal therapy. These types of interventions may act as crucial entry points into care, helping build the trust, safety, and stability needed for further support or preventing escalation of needs.

Gaps and future research needs

The review revealed significant gaps in the evidence base. These include:

- A lack of high-quality reviews or studies focused on specific groups, such as young people affected by homelessness, sexual exploitation, or community-based violence outside the youth justice system;
- Limited evidence on the effectiveness of interventions for girls, LGBTQ+ youth, and racially minoritised young people, particularly in non-clinical or community settings;
- A predominance of studies from North America, with limited applicability to the UK context, highlighting the need for more locally relevant evaluations.

Future research should focus on:

- Evaluating promising models such as family-based interventions, arts-based, mindfulness, or trauma-informed programmes in UK settings using rigorous designs;
- Including young people's perspectives on what makes interventions meaningful, accessible, and safe;
- Examining the long-term impact of interventions across different domains of wellbeing, not just recidivism;
- Exploring implementation processes**,** including what enables or undermines delivery quality, engagement, and sustainability in real-world settings.

Introduction

As part of a wider project investigating access to mental health support for children and young people involved in, or at risk of serious youth violence across England and Wales, the present umbrella review (a synthesis of existing scoping reviews, systematic reviews and meta-analyses) aims to summarise global evidence on the effectiveness of psychological and psychosocial interventions delivered to children and young people involved in, or at risk of involvement in, serious youth violence. It focuses specifically on what the existing literature says about which types of interventions are effective in improving mental health outcomes, reducing offending behaviours, or addressing known risk factors for violence and offending. This approach allows us to map the types of interventions currently implemented, evaluate their effectiveness, and identify gaps in the evidence base.

By examining interventions that have been shown to reduce offending behaviours, improve mental health outcomes, or address risk factors linked to violence and offending, this umbrella review contributes important contextual understanding about the types of psychological and psychosocial support that are available, and effective, for this population. Whilst this specific report does not assess availability, access routes, or implementation, these findings help set the scene for the wider project, which explores whether children and young people involved in or at risk of serious youth violence actually have access to these kinds of interventions in practice.

Methods

A systematic search of peer-reviewed literature was conducted to identify studies examining psychological and psychosocial interventions for children and young people either involved in or at risk of serious youth violence.

This report was guided by two primary research questions: (1) What psychological and psychosocial interventions are delivered to children and young people involved in or at risk of serious youth violence? and (2) How effective are these interventions? These questions formed part of a broader review strategy developed for the overall project, which also included additional questions on access, specifically, what barriers prevent children and young people from accessing support, and what helps them access the support they need. While all research questions were explored using a shared search strategy, this report focuses solely on intervention effectiveness. Questions relating to access and barriers are addressed in a separate narrative review. Due to the volume of literature retrieved, the effectiveness strand was further divided into two complementary outputs: this umbrella review of global reviews and a separate synthesis of UK-based primary studies (key findings presented in Annex 2).

Whilst the initial focus of this rapid literature review was psychological interventions only, the search was expanded to include psychosocial interventions following discussions with the project advisory board. Psychological interventions are typically structured, clinically oriented therapies delivered by trained professionals and based on a theory of psychological functioning. In contrast, psychosocial interventions take a broader view of wellbeing and include support aimed at addressing social, relational, behavioural, and environmental factors that influence mental health (MacInnes & Masino 2019). While psychological interventions focus directly on the individual's mental health symptoms or processes, psychosocial approaches often aim to improve mental health by changing the conditions in which children and young people live and grow.

The advisory board strongly recommended expanding the scope to include psychosocial interventions, emphasising that many children and young people involved in or at risk of serious youth violence are not immediately ready, able, or willing to engage with formalised psychological therapy. They highlighted the importance of recognising and valuing interventions that build readiness and resilience, foster trust, and support mental wellbeing in less clinical ways. These include relational and environmental supports such as mentoring programmes, family support, and community-based initiatives, that play a vital role in creating the conditions necessary for young people to later engage with psychological therapy, or even reduce the need for it. The board emphasised that for the vulnerable and often marginalised populations in question, mental health cannot be meaningfully understood or supported in isolation from the wider context of their lives.

The search strategy included comprehensive database searches across PubMed, Education Resources Information Center (ERIC), PsycNET, ProQuest and Google Scholar. The Specific databases within the ProQuest platform included the Criminal Justice Database, Education Collection, International Bibliography of the Social Sciences, the Social Science Database and the Sociology Collection.

These databases were selected to ensure broad and multidisciplinary coverage across relevant fields including psychology, mental health, education, youth justice, and social care. As this was a rapid scoping review rather than a full systematic review, the search was necessarily limited by time and resources. The databases chosen were those judged most likely to return relevant studies with minimal duplication and maximum relevance to the research questions, while still allowing for a timely and rigorous synthesis of the evidence. A wider list of potential databases was included in the initial protocol and shared with funders (see Appendix 1). However, the final selection was refined based on access, feasibility, and the volume of literature retrieved. While priority databases such as Medline/PubMed and ERIC were included, others, such as PsycINFO, ASSIA, and Sociological Abstracts, could not be accessed directly due to institutional constraints. Instead, PsycNET and the ProQuest platform was used to access a broad range of relevant social science databases that provided overlapping coverage with many of the proposed sources. Given the substantial volume of literature retrieved, and the umbrella review's focus on synthesising existing systematic reviews and meta-analyses, we supplemented our approach with targeted hand searches of peer reviewed and grey literature rather than expanding to additional platforms with limited unique yield.

Search terms were designed to capture a broad range of studies related to the target population, types of interventions, and desired outcomes. The strategy included two distinct approaches: one focusing on interventions for children and young people identified as already being involved in serious youth violence, and the other targeting those at risk of involvement in serious youth violence.

The search terms were grouped into key categories and combined using Boolean operators. For the population, terms such as “young people,” “adolescent*,” “youth,” “teenager*,” and “minor*” were used. To identify studies relevant to violent behaviour, terms included “violent crime,” “young offender*,” “criminal behaviour,” and “perpetrator*.” For therapeutic interventions, terms such as “psychological therapy,” “mental health service,” “counselling,” “group therapy,” and “forensic psychiatry” were included. Finally, outcome-related terms such as “effectiveness,” “impact,” “evidence base,” and “barrier*” were used to ensure studies addressing intervention outcomes were captured. For studies targeting children and young people at risk of violence, additional terms were included to reflect key risk factors, such as “school exclusion*,” “substance misuse,” “foster care,” “gang,” “weapon,” and “low socioeconomic status,”. The full search strategy has been included in Appendix 1.

The inclusion and exclusion criteria were carefully defined to ensure that only studies addressing the research questions and population of interest were included. Studies were eligible if they focused on young people aged 10–18 years (with at least 50% of the study population or the average age falling between this range), who were either identified as being involved in serious youth violence or at risk due to specific factors, including school exclusion, substance misuse, or involvement in gangs. Interventions needed to be psychological or psychosocial in nature, with measurable outcomes relevant to our research project such as reductions in offending or violent behaviours, improvements in mental health, or reductions in risk factors/risk behaviours such as substance misuse or aggressive/externalising behaviours.

Reviews of the literature and quantitative studies assessing the impact or effectiveness of interventions were prioritised, while theoretical or conceptual studies, case studies, and studies focusing on pharmacological or medical treatments were excluded. Qualitative studies were set to one side to be integrated into the report on barriers and facilitators to accessing interventions (key findings reported in Annex 3). To manage the anticipated volume of results and ensure contextual relevance to the wider study, we applied geographic restrictions at the level of primary studies. Specifically, we included primary studies conducted in the UK, Europe, North America, Australia, and New Zealand - settings deemed to have broadly comparable health, education, and justice systems to the UK. Primary studies from low- and middle-income countries were excluded due to significant contextual differences that may limit applicability. In contrast, we retained a global focus for systematic reviews and meta-analyses, given the difficulty of reliably filtering reviews by country and the potential value of capturing innovative or well-evidenced interventions implemented internationally. Studies addressing universal mental health services or conditions without a direct link to violence-related behaviours were also excluded. Full inclusion and exclusion criteria have been outlined in Appendix Table 1.

The search was restricted to publications in English and limited to studies published within the past ten years to ensure findings were relevant to current practice and policy contexts. Earlier studies were excluded on the basis that significant changes in youth justice policy, mental health provision, and intervention design, particularly in relation to trauma-informed care, contextual safeguarding, and early intervention, mean that older evidence may no longer reflect current systems. In addition, we assumed that interventions with continued relevance or promise would likely be captured in more recent literature, either through re-evaluation, adaptation, or inclusion in systematic reviews.

An initial search of the literature yielded 8,488 records. Given the volume of results and the breadth of the topic, we made the decision to split the effectiveness strand of the review into two complementary parts. The first, presented in this report, is an umbrella review i.e., a review of reviews, that synthesises existing systematic reviews, meta-analyses, and scoping reviews of psychological and psychosocial interventions delivered to children and young

people involved in or at risk of serious youth violence. The second, presented in a separate report, is a synthesis of relevant primary studies focused specifically on the UK and Ireland.

The umbrella review includes only review-level studies. Primary studies are excluded from this report. This decision was taken to enable a high-level synthesis of the global evidence base and to summarise broad trends, patterns of effectiveness, and intervention types across diverse contexts. We chose to retain a global scope for included reviews, as it was often impractical to filter reviews by country, and most reviews included studies from multiple high-income settings, predominantly North America, Europe and Australia (further information presented in the results sections). Global reviews that included primary studies from the UK and Ireland were retained.

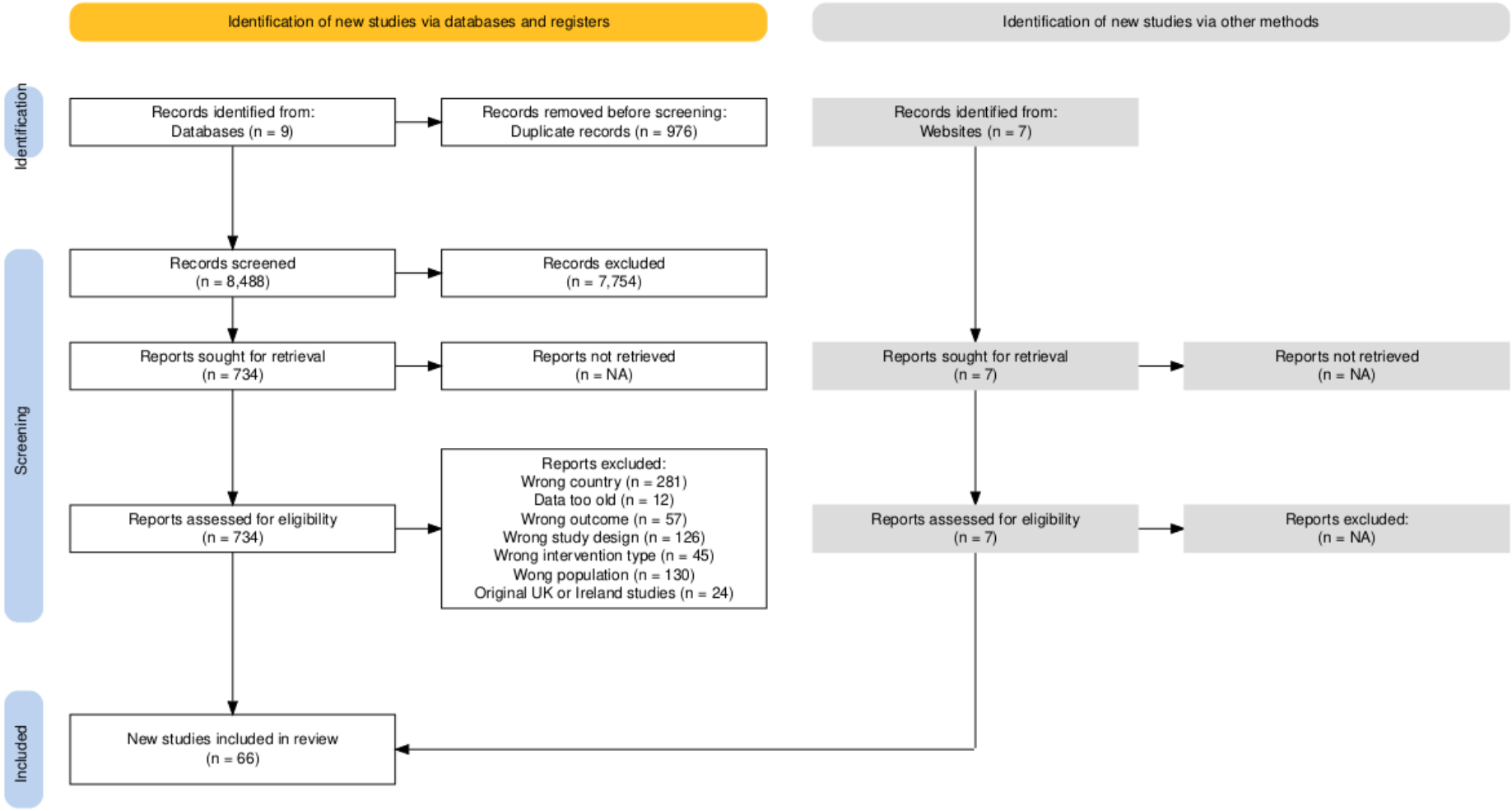
In contrast, the separate review of primary studies focused exclusively on the UK and Ireland. This additional geographic restriction (i.e. excluding primary studies from North America, Europe, Australia and New Zealand) was applied to increase relevance to the local policy and practice context and to ensure the review remained feasible given time and resource constraints. While there may be some limited overlap between the primary studies included in the reviews covered by this umbrella review and those included in the separate UK/Ireland synthesis, we judged this risk to be minimal and unlikely to affect findings materially.

This two-part approach, combining a broad, global synthesis of what works with a focused examination of UK and Ireland-based studies, was designed to balance scope and specificity. It allows the wider project to benefit from insights into international good practice and promising interventions, while also understanding how those findings apply in the specific context of interest.

Following a title and abstract screen and a subsequent full text screen of the relevant reviews, 66 reviews were included in the final analysis (see Figure 1). The included reviews were grouped according to the characteristics of the populations they targeted, including young offenders, perpetrators of violence, victims of violence, looked after children and young people, those exhibiting aggressive or disruptive behaviours, those with mental health challenges, and those with substance misuse challenges. A final category labelled ‘general risk’ was included to capture studies focusing on populations at elevated risk of violence or offending that did not fit clearly into the other predefined groups. This included, for example, reviews focusing on sexual and gender minority youth (where violence victimisation was a key outcome), adolescents experiencing homelessness, and young people with co-occurring intellectual disabilities and mental health conditions. It also included a general adolescent population study that was retained because it reported outcomes specifically related to violence, bullying, and substance misuse - core risk factors within our inclusion criteria. The findings are presented according to these population groups to support comparative insights across different risk profiles.

Given the variation in the types of reviews included, ranging from systematic and scoping reviews to meta-analyses, a narrative overview approach was used to synthesise findings. This allowed for the integration of evidence across diverse methodologies and populations, and enabled the identification of key themes in intervention types, outcomes, and effectiveness without applying a formal meta-analytic technique.

Figure 1: PRISMA flow diagram depicting the inclusion and exclusion of studies



*Created using Haddaway et al (2022)

Key Findings

Of the 66 reviews identified for inclusion in the final review, eight focused on young offenders, ten on perpetrators of violence, three on victims of violence, sixteen on children and young people displaying aggressive, disruptive or problematic behaviours, two on children in foster care, three on children and young people with substance misuse problems, twenty on children and young people with clinical mental health problems and five on children and young people with other general risk factors. One review (Bidonde & Meneses, 2017) was included in both the sections on victims of violence and looked after children seeing as it reviewed interventions for both population groups. Reviews were global in nature, including studies conducted in the UK, Europe, North America, the Middle East, Asia, Africa and Oceania, and were mixture of review-types including meta-analyses, systematic reviews, mixed-methods reviews and narrative or scoping reviews.

The following sections outline the key findings, categorised by the population group or risk factor/risk behaviour of focus of the reviews.

Young offenders[1]

- Trauma-focused CBT interventions (e.g. TF-CBT, CBITS) provided the clearest evidence of benefit, consistently reducing PTSD, depression and emotional dysregulation, especially in custodial settings.
- Mindfulness-based and family-focused approaches (e.g. MST, FFT, MTFC+T) improved stress regulation, relationships and institutional behaviour; MTFC+T and high-fidelity MST show added promise for lowering reoffending.
- Creative / arts programmes enhanced engagement, literacy and peer relationships; quantitative evidence is limited but some projects reported notable drops in delinquency.
- Trauma-informed educational and skill-building models delivered to both young offenders and staff were shown to improve mental health and behavioural outcomes, as well as reducing institutional misconduct, use of physical restraints and violence in residential settings, illustrating the value of organisational-level change.
- Overall, improvements in offending and recidivism outcomes were context-specific and uneven**,** highlighting the need for high-quality, tailored, and trauma-informed systems of care to support sustainable outcomes for justice-involved youth.
- Implementation quality, context and cultural fit heavily influenced results; youth appeared to benefit most when interventions are voluntary, relatable and delivered in supportive environments.

Perpetrators of violence[2]

[1] Heynen et al., 023; Kashuba & Masterson 2022; Malvaso et al., 2024; Mansfield et al., 2024; Murray et al., 2018; Olsson et al., 2021; Simpson et al., 2018; Zettler, 2020.

[2] Badger 2024; Chawla et al. 2024; Farmer et al. 2023; Lester et al. 2017; Melendez-Torres 2016; Melendez-Torres 2023; Piolanti and Foran, 2022a; Piolanti and Foran, 2022b; Russell et al. 2021; Toole-Anstey 2023

- Most evidence focuses on dating and relationship violence**,** with far fewer studies addressing other forms of perpetration such as child-to-parent violence or peer aggression, highlighting a narrow evidence base in this area.

- School-based interventions**,** especially multicomponent and trauma-informed programmes, consistently reduced dating and relationship violence victimisation and perpetration, with the strongest effects for physical and emotional violence.

- Family- and community-based interventions showed some positive effects, particularly in reducing child-to-parent and dating violence, and improving communication, empathy, and accountability. However, results were mixed and often dependent on intensity, structure, and participant context.

- Multi-level interventions (integrating school, home, and community) showed the strongest and most sustained effects**,** particularly for high-risk adolescents.

- Interventions that were longer-term, targeted, and well-integrated were more effective than brief, generic, or standalone programmes, and effectiveness was moderated by gender, risk level, and setting; tailored approaches generally outperformed universal ones.

- Evidence quality was mixed, with many studies rated low to moderate quality. Evidence gaps include limited data on mental health impacts, long-term outcomes, and effectiveness for underrepresented groups including LGBTQ+ youth, children with SEND, and ethnically diverse populations.

Victims of violence[3]

- Trauma-focused CBT (TF-CBT) and CBT emerged as promising interventions, with consistent evidence of small to moderate improvements in PTSD symptoms and emotional regulation across multiple high- or moderate-quality reviews.

- School-based and anti-bullying programmes also showed promise, with consistent positive impacts on mental health, emotional skills, and reductions in bullying victimisation and perpetration.

- Parenting, psychoeducation, advocacy-only interventions, and play therapy showed mixed, limited, or no effects, often due to small sample sizes, methodological issues, or limited relevance.

- Findings highlight the need to support victims of violence early and to generate more targeted evidence for adolescents on the pathway to serious youth violence, especially through age-appropriate, trauma-informed interventions.

- Significant contextual and methodological gaps limited comparability and clarity across studies. There was substantial variation in intervention type, format, and delivery, with most studies lacking standardised outcome measures, detailed subgroup analyses, or consideration of culturally adapted models.

[3] Bidonde and Meneses 2017; Hikmat et al. 2024; Howarth et al. 2016

Children and young people displaying externalising, aggressive, and disruptive behaviours[4]

- Cognitive-behavioural approaches (CBT and ACT) consistently reduced aggression and externalising behaviours, with moderate to large effects reported for anger, emotional dysregulation, and bullying. These interventions were effective across populations and settings, especially when tailored to individual needs.

- Family-focused interventions (e.g. FFT, MST, PCIT) showed promise in reducing recidivism and antisocial behaviour and improving family functioning, particularly when adapted for subgroups like children with callous-unemotional traits. However, effects on school and emotional outcomes were less consistent.

- School-based programmes, including mindfulness and behavioural management interventions, produced moderate effects on aggression and classroom conduct, with stronger outcomes when delivered by trusted staff in familiar environments. Evidence for emotional and academic impacts was limited by methodological issues.

- Community-based and multi-component interventions, such as mentoring and supervision models, demonstrated small but significant effects on aggression, delinquency, and academic engagement, especially when theory-based, longer in duration, and delivered to smaller groups.

- Specialised and adjunctive interventions, including arts, sports, and tech-based programmes, showed some positive effects, particularly on aggression and emotional regulation in children with intellectual or developmental disabilities, but were often based on small, low-quality studies.

- Evidence for impacts on internalising symptoms, school outcomes, and long-term change is limited and inconsistent, highlighting critical gaps in how interventions address the broader and sustained needs of young people with complex behavioural challenges.

Looked after children[5]

- Only two reviews were identified on psychological and psychosocial interventions for looked after children, fewer than for other population sub-groups, highlighting an evidence gap.

- CBT-informed, parenting, and multi-component interventions show short-term promise**:** these approaches were associated with small to moderate improvements in internalising and externalising symptoms, quality of life, and parenting practices across multiple studies, though effects were not sustained over time.

- No significant impacts were found for PTSD, suicidality, or attachment disorders; some domains lacked disaggregated analysis or were assessed using small, low-certainty studies.

[4] Bjørnebekk and Thøgersen 2021; Byrne and Cullen 2024; Castillo-Eito et al. 2020; Hartnett et al. 2017; Hendriks et al. 2018; Jiang et al. 2024; Klingbeil et al. 2017; Kuhn et al. 2015; Littell et al. 202; Nuske et al. 2024; O'Regan et al. 2024; Smeets et al. 2015; Tolan et al. 2014; US Dept of Education, 2016; Weisman and Montgomery 2019; Yang et al. 2023

[5] Bidonde and Meneses, 2017; Trubey et al., 2024

- The evidence base is limited and uncertain. Most findings were based on low or very low certainty evidence, with small sample sizes, inconsistent outcome reporting, and limited disaggregation by intervention type or population subgroup.

Children and young people with substance misuse challenges[6]

- Parent- and family-focused prevention programmes show the strongest and most sustained evidence of effectiveness in reducing adolescent substance use and co-occurring behavioural and mental health difficulties, particularly when delivered universally or to at-risk groups.

- Multidimensional Family Therapy (MDFT) showed short-term reductions in drug use severity and frequency, but effects were not sustained beyond 6 months, and no significant impacts were found on wider behavioural or educational outcomes.

- Therapeutic interventions for youth with co-occurring substance use and mental health problems, especially family-involved and integrated treatment models (such as those combining CBT and family therapy), have shown limited impacts on substance use or mental health outcomes.

- Youth-focused skills training and universal prevention **programmes** (e.g., Life Skills Training, Early Risers) were associated with long-term reductions in substance use and co-occurring behavioural issues in some studies.

- The overall evidence base is weak and uneven, constrained by low-quality primary studies, limited cultural generalisability, and a lack of long-term follow-up, pointing to a critical need for more rigorous, context-sensitive research.

Children and young people with mental health problems[7]

- Trauma-focused CBT and systemic family-based therapies demonstrated the strongest and most consistent effects on PTSD, depression, emotional regulation, and externalising behaviours.

- Guided digital CBT interventions and brief, single-session approaches showed small to moderate improvements in depression and anxiety**,** offering options for scalable, low-cost support, especially for youth on waiting lists or reluctant to engage in traditional services. However, there was limited evidence for sustained impact or effectiveness in complex cases.

- Programmes embedded in schools and communities can be effective, particularly when clinician-led and targeted to at-risk youth in secondary schools. However, universal or teacher-led interventions were less effective.

- Creative, activity-based, and animal-assisted therapies showed promise for engagement, emotional regulation, and self-concept, especially for youth who may not respond to traditional therapies, though evidence for behavioural change was mixed.

[6] Filges et al., 2018; Geijer-Simpson et al. 2023; Ladis et al., 2019
[7] Dellazizzo et al. 2019; Eapen et al. 2024; García-Carrión et al. 2019; Gkintoni et al. 2024; Halldorsson et al. 2021; Haran et al. 2024; Hollis et al. 2017; Jones et al. 2019; Karukivi et al. 2021; McGovern et al. 2024; Opie et al. 2024; Riedinger et al. 2017; Rodwin et al. 2022; Schleider et al. 2020a; Schleider et al. 2020b; Stea et al. 2022; Valentine et al. 2024; Woolard et al. 2024; Zhang et al. 2023; Zhou et al. 2021

- Intervention effectiveness varied significantly by delivery context: clinician-led and culturally adapted programmes outperformed teacher-led and universal approaches, and interventions were less effective for younger children and racially minoritised youth in some cases (and not assessed in others), underscoring the need for targeted, culturally safe, and developmentally appropriate support.

- Evidence quality is mixed**:** Many studies had methodological limitations, such as small sample sizes, short follow-up, and limited diversity. Stronger evidence exists for CBT and trauma-focused models; other areas need further high-quality research.

Additional risk factors[8]

- This section includes reviews that could not be neatly categorised elsewhere but were still deemed relevant. Children and young people experiencing multiple and intersecting forms of adversity, such as homelessness, discrimination, or unmet additional needs, may face heightened risks of violence involvement or victimisation[9], making it important to examine the effectiveness of psychological and psychosocial interventions targeting these diverse populations.

- Family-based and school-based interventions show the most consistent promise, particularly for reducing substance use and depressive symptoms among young people facing additional risks, based on moderate-quality evidence across multiple studies.

- Digital interventions improved emotional regulation, substance use, and cognition but showed small, non-significant effects on depression and PTSD. Similarly, CBT and motivational interviewing often performed no better than usual care.

- Tailoring interventions to specific populations enhanced relevance and engagement, but equity-related impacts (e.g., by gender, ethnicity, or disability) are underexplored, pointing to critical gaps in both evidence and design that must be addressed to ensure effectiveness and fairness.

- Most included reviews and primary studies suffered from methodological limitations such as small sample sizes, short follow-up, and inconsistent quality, limiting confidence in long-term effectiveness.

Conclusions

This umbrella review synthesises global evidence on psychological and psychosocial interventions delivered to children and young people involved in or at heightened risk of serious youth violence. Unlike previous reviews that typically focus on narrow subgroups, such as justice-involved youth or those with specific diagnoses, this review spans a broader set of intersecting populations. By grouping evidence across diverse but overlapping risk profiles, it provides a more inclusive and nuanced account of what kinds of support have been shown to work, for different sub-groups of young people. This matters for the wider project, which seeks to understand and improve access to mental health support for young people who are either already involved in serious youth violence or at risk of becoming so.

In this context, understanding the full range of interventions and outcomes is essential not only for identifying good practice, but also for revealing gaps and misalignments between need and provision. While this review brings together a broad and diverse evidence base, it

[8] Coulter et al. 2019; Gardiner et al. 2017; Lal et al. 2023; Tancred et al. 2019; Wang et al. 2019
[9] Youth Endowment Fund. Outcomes Framework & Measures Database: https://youthendowmentfund.org.uk/outcomes/

was conducted as a *rapid scoping review*, a methodological choice that prioritises breadth and efficiency over exhaustive inclusion. As such, it is possible that some relevant reviews or emerging studies may have been missed. Despite this, the review provides a valuable and timely synthesis of existing evidence across multiple risk groups, highlighting consistent patterns, promising approaches, and areas where further research or service innovation is needed.

What does the evidence show?

The range of interventions identified is wide, spanning structured psychological therapies (e.g. TF-CBT, CBT, MST), relational and family-based approaches (e.g. FFT, MTFC+T), community-embedded programmes (e.g. restorative justice, arts-based interventions), and whole-system organisational models (e.g. TARGET, Sanctuary). The strongest and most consistent evidence of effectiveness across all reviews relates to improvements in *psychological and behavioural outcomes*, especially internalising symptoms (e.g. PTSD, anxiety, depression), emotional dysregulation, aggression, and general behavioural difficulties. Trauma-focused CBT interventions like TF-CBT, CBITS, and Cognitive Processing Therapy, as well as family-focused approaches such as MST and MTFC+T, show moderate to strong effects in improving these outcomes. Whole-system trauma-informed models, like TARGET and the Sanctuary Model, were less frequently evaluated but showed potential in enhancing safety, reducing institutional violence, and shifting organisational culture.

Alongside more established psychological and family-based interventions, the review also identified a range of novel and adjunctive approaches, including arts-based interventions, mindfulness programmes, animal-assisted therapy, and outdoor and physical activity-based models. These interventions often aimed to promote emotional expression, relationship-building, or engagement through non-traditional therapeutic formats. The evidence for their effectiveness was generally more limited or mixed: many studies lacked control groups, used small samples, or did not report on violence or offending outcomes directly. That said, several showed positive impacts on wellbeing, emotional regulation, and engagement**.**

For the wider project, these interventions may have practical implications for access and engagement. While they may not always directly reduce offending, they can serve as important entry points or complementary supports, especially for young people who are disengaged from traditional services, or who are not yet willing or able to participate in formal psychological therapy. Their relational, creative, and often strengths-based design may help to build trust and readiness, reduce barriers to engagement, and offer more culturally and developmentally responsive forms of support. This suggests a need to recognise the role of these approaches within a broader ecosystem of mental health provision, particularly for reaching young people with complex needs or low service engagement.

Cross-cutting comparisons and implications

This review allows for cross-group comparisons of similar intervention types delivered to children and young people with distinct but overlapping risk factors for serious youth violence. Interventions such as trauma-informed and CBT-based therapies, family-based models, and school-based programmes were widely assessed, but their effectiveness varied by population, context, and evidence strength.

Trauma-focused and CBT approaches **(**e.g. TF-CBT, CBITS, SITCAP-ART) consistently improved trauma symptoms, emotional regulation, and internalising symptoms for young offenders, perpetrators of violence, children with mental health difficulties, and those displaying externalising behaviours. General CBT models were ineffective for young

offenders but trauma-focused CBT was more promising. In contrast, for looked after children, general CBT improved internalising and externalising symptoms, however trauma-focused approaches showed limited impact.

Family-based interventions (e.g. MST, FFT, MTFC+T) showed robust evidence of effectiveness for justice-involved youth, violence perpetrators, and those with behavioural challenges, particularly when multicomponent and intensive. Narrower or single-faceted approaches often failed to reduce violence. For young people with substance use issues, parenting-focused interventions reduced substance use, conduct problems, and depression, but systemic models like MDFT showed weaker effects.

School-based programmes were implemented across nearly all risk groups. Targeted interventions helped reduce violence and victimisation for perpetrators and improve outcomes for children with behavioural issues. However, generic anti-bullying programmes were largely ineffective, especially for young people with SEND. Among children with mental health problems, universal non-CBT school programmes showed little benefit, performing worse than targeted or clinician-led models. Similarly, school-based suicide prevention programmes had minimal impact, questioning the effectiveness of universal delivery without specialist input.

Some patterns reflect gaps in evaluation more than ineffectiveness. For example, there was limited research on interventions for neurodiverse children or those facing multiple adversities (e.g. homelessness, discrimination). Other patterns highlight mismatches between intervention design and population needs, such as cognitive-heavy therapies delivered to young people with SEND. For the broader project, these findings emphasise the importance of tailoring interventions not only to individual needs but to structural contexts. Trauma-informed and CBT-based approaches appear broadly effective across different groups of at-risk young people, but their reach is limited by uneven evidence and under-adaptation to marginalised groups. Family and school-based models show promise, but only when meaningfully resourced and delivered with fidelity. The challenge is not just to scale "what works," but to adapt, embed, and diversify interventions to reflect the realities of young people’s lives.

What about offending, recidivism, and violence-related outcomes?

Given the focus of the wider project on *serious youth violence*, a critical question is whether these interventions actually reduce offending, recidivism, or violent behaviours. Here, the evidence is more uneven. Across all included reviews, only a subset of interventions show reliable impacts on offending-related outcomes, and these effects are often conditional on delivery fidelity, intensity, and population fit.

The clearest evidence on reducing offending comes from interventions delivered to young offenders**.** Among these, Multisystemic Therapy (MST) and Multidimensional Treatment Foster Care plus Trauma (MTFC+T) stand out as particularly promising, especially when delivered with high fidelity and tailored to the young person’s context. MST showed small but consistent reductions in recidivism across several reviews, including long-term effects in some cases. MTFC+T was especially effective among adolescent girls in reducing both externalising behaviours and reoffending.

Family-focused and parenting interventions more broadly also showed potential across other groups of young people, with reductions in recidivism and delinquency also seen for perpetrators of violence and young people with substance misuse challenges. A few creative or relational interventions, such as **‘**YouthARTS’ and ‘A Changed World’, reported notable

reductions in delinquency or reoffending, but these findings stem from lower-quality studies, often without control groups.

Overall, while several interventions showed benefits for psychological functioning and behaviour that may reduce long-term risk, direct effects on recidivism or violence perpetration were inconsistently reported and less robustly evidenced**.** This highlights a critical gap in the literature and a major implication for practice: interventions with strong evidence for improving mental health may not automatically reduce violence-related outcomes unless they also address systemic, environmental, and relational drivers of offending.

Implications for the wider project

The wider project aims to understand not just *what works*, but *who is accessing support* and *whether it meets the needs of young people at risk of or involved in serious youth violence*. This review helps answer the first half of that question: what kinds of interventions are available and show promise? But it also begins to show where mismatches may lie.

First, the most effective interventions for reducing offending or violence outcomes such as MST or MTFC+T were not evaluated across all groups of at-risk young people. They are also considered to be intensive and resource-heavy**.** This raises questions for access: do the young people most in need of such interventions actually receive them? Are they available in community settings, or only through justice involvement? Similarly, trauma-focused CBT and other structured interventions show strong effects on mental health, but their accessibility may be limited by long waiting lists, strict eligibility criteria, and a lack of cultural adaptation, findings which emerged from our qualitative research. The implication is that evidence-based care may exist, but many young people may not in a position to access or engage with it**.**

Second, the review highlights the value of interventions delivered to groups not yet involved in serious violence, but who face elevated risks, e.g., those with histories of trauma, substance misuse, or mental health challenges. For these groups, psychosocial interventions, including community-based, arts-led, or mentoring models, may act as earlier supports that build trust, engagement, and emotional regulation before clinical or justice thresholds are reached. While these models are sometimes less rigorously evaluated, their inclusion in this review is important as they represent potentially more accessible entry points into systems of care, often delivered outside of traditional clinical settings. Their role in building readiness for therapy, disrupting harmful trajectories, and enhancing engagement with services should be a focus of further research aiming to inform mental health policy and commissioning.

Third, the uneven distribution of evidence across population groups has implications for both service design and future research. The dominance of reviews focused on male, justice-involved youth leaves substantial gaps in our understanding of what works for girls, neurodiverse young people, Minority Ethnic communities, LGBTQ+ youth, or Looked After young people. For the wider project, which considers access from a systems and equity lens, this gap underscores the need to critically examine who current services are designed for, who gets left out, and how interventions can be better tailored and scaled to meet diverse needs**.**

Gaps and future research needs

Despite the breadth of evidence synthesised in this review, several important gaps remain in the current knowledge base. Much of the existing literature is concentrated on interventions

for young people already in contact with the youth justice or mental health systems, with fewer studies focusing on those who are at risk but not yet engaged with formal services, whose needs may differ and who are often underrepresented in evaluation research.

There is also a notable lack of evidence focusing on marginalised subgroups, including girls and young women, LGBTQ+ youth, and Minority Ethnic young people. Where these groups were included in studies, findings were rarely disaggregated, and the cultural responsiveness or safety of interventions was seldom examined. This limits our understanding of how best to tailor support to different identities and lived experiences, particularly given the unequal risks and barriers to support faced by these groups.

Geographically, the evidence base is skewed toward North American contexts, with only a small proportion of reviews drawing on studies from the UK or similar settings. This limits the applicability of many findings to the policy and service landscape in England and Wales. While this review provides a valuable global overview, there is a clear need for UK-based evaluations of promising models, particularly those delivered in schools, community settings, or voluntary sector organisations.

Future research should prioritise robust evaluations of relational, creative, and trauma-informed interventions**,** especially those being delivered outside clinical settings or to underserved groups. Studies should also aim to incorporate young people's perspectives, using participatory methods to explore what makes interventions feel meaningful, accessible, and safe. In addition, more attention is needed to assess the longer-term outcomes of interventions, including their impact on wellbeing, relationships, and life chances, and to examine the factors that shape implementation and engagement in real-world practice.

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Appendix 1: Rapid scoping review search strategy

The search strategy outlined below was developed for the rapid scoping review component of a broader research project exploring access to mental health support for children and young people involved in, or at risk of, serious youth violence in England and Wales.

As detailed in the project proposal, the review was divided into two complementary strands:

1. A review of the effectiveness of psychological and psychosocial interventions delivered to this population; and

2. A narrative review exploring the barriers and enablers to accessing such interventions.

To ensure efficiency and consistency across both strands, a single foundational search strategy was employed. This initial search was then supplemented by targeted hand-searches and additional scoping to identify literature specific to each strand's research questions. The following sections outline the original proposed search approach, including database selection and search terms.

Research questions

Primary research questions relevant to the effectiveness review

- What therapeutic support is available to children involved in or at risk of violent offending?
- How effective are these interventions/support?
- Who/what approaches are having the best results?

Secondary research questions relevant to the narrative review of barriers to access

- What are the barriers to children accessing this support?
- What helps more children get access to the support they need?

Search 1: Psychological therapies for children/young people who are <u>perpetrators</u> of violence

Group	Search Term	Boolean Operator
Population	"Young people" / "young person"	OR
	child*	
	teenager*	
	adolescent*	
	youth	
	minor*	
Perpetration of violence	Violence	OR
	"Violent crime"	
	"Violent offending"	
	Offend*	
	Re-offend*	
	"Criminal justice system"	
	"Criminal behaviour"	
	"Young offender*"	
	Aggression	
	Perpetrator*	
Psychological therapy	"Psychological support"	OR
	"Psychological therapy"	
	"Mental health service"	
	counselling	
	therapy	
	intervention*	
	service*	
	"Group therapy"	
	"Individual therapy"	

	"Forensic psychiatry"	
Outcomes	Availab*	OR
	Accessib*	
	Reach	
	Effective*	
	Impact	
	Efficacy	
	"Best practice*"	
	"Evidence base"	
	Barrier*	
	Challenge*	
	Obstacle*	
FINAL SEARCH: Population group AND Perpetration of violence group AND Psychological therapy group AND Outcomes group		

Search 2: Psychological therapies for children/young people at-risk of violence

Risk factor groups	**Search Term**	**Boolean Operator**
Education risk-factors	"School exclusion*"	OR
	"School suspension*"	
	"Alternative provision"	
	"Pupil referral unit"	
	"Special educational needs"	
Mental health risk factors	"self-harm"	OR
	"Substance misuse"	
	"Mental health"	
	drugs	
	neurodiverg*	
Social care risk factors	"Children in need"	OR
	"Looked after children"	

	"Social care"	
	"Foster care"	
Crime risk factors	Gang	OR
	Weapon	
	Arrest*	
Deprivation risk factors	"Free school meals"	OR
	"Low socioeconomic status"	
	depriv*	
	"Single parent family"	
All risk factors: Education group OR Mental health group OR Social care group OR Crime group OR Deprivation group OR "risk of violence"		
FINAL SEARCH: Population group AND All risk factors group AND Psychological therapy group AND Outcomes group		

Suggested databases

Database	**Relevance**
Medline/PubMed	Priority
PsycINFO	
Health Management Information Centre - Kings	
National Grey Literature Collection	
Education Resources Information Center (ERIC)	Subsequent searches
Applied Social Sciences Index and Abstracts (ASSIA)	
NSPCC Library catalogue	
Sociological abstracts	
Open Grey	
Social Science Research Network	
Best Practice (BMJ) (Kings)	Targeted hand searches if necessary
UpToDate	
Semantic Scholar	
Google	

Appendix 2: Detailed inclusion and exclusion criteria

	Inclusion	Exclusion
Population	Aged 10-18	More than 50%, or average age >10 or <18
	Defined as young offenders	Universal populations for CYP mental health Sexual abuse perpetrators CSA survivors Mass trauma/conflict Self-harm/suicide Sleep disturbances CYP mental health during COVID CYP with physical health conditions or disabilities without links to challenging behavioural outcomes Eating disorders Survivors of trafficking Military families Perpetrators or victims of cyberbullying General ADHD/ASD/SEN without the identification of aggression or behavioural problems
	Perpetrators of violence, including bullying	
	Have a risk factor for violence, including: Excluded/suspended from school or AP provision DV survivors or trauma in home Alcohol/drug use Involved in gangs/group violence Carried weapons Been a victim of violence Behavioural or clinical mental health problems Aggression Adverse childhood experiences Looked after children SEND alongside aggression/behavioural problems or another risk factor Homelessness + focus on MH/substance use or other relevant outcome	
Type of intervention	Psychological therapies Psychosocial interventions (including educational, sports/arts-based) Effectiveness of general CAMHS services for the UK and ireland Parenting interventions if assesses MH/violence/behavioural outcomes in CYP	Bystander interventions Prevention of exposure to risk factors e.g. prevention of DV or prevention of alcohol/drug use Pharmacologic / drug treatments Electroconvulsive therapy Studies on transition from child to adult MHS Mental health literacy only programmes
Outcomes	Reduction in violence perpetration Reduction in offending / re-offending Reduction in risk factors (e.g. school exclusions, substance use, aggressive behaviours) Improvement in mental health symptoms	Improvements in non-clinical mental health symptoms (wellbeing/quality of life, distress) Improvements in MH literacy Improvements in help-seeking behaviours Improvement in parental symptoms Improvement in bystander actions
Type of study	Reviews Quantitative studies assessing impact/effectiveness of interventions or services	Review protocols Trial protocols Theoretical / conceptual studies Case studies
Location	Reviews: global Primary studies: UK, Europe, North America, Australia, New Zealand	Low- and middle-income countries

Annex 2

Effectiveness of psychological and psychosocial interventions for children and young people involved in or at risk of serious youth violence: a rapid scoping review of evidence from the UK and Ireland

Summary Report: Methodology and Key Findings

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June 2025

Executive Summary

This rapid scoping review synthesises evidence from 46 UK and Ireland-based primary studies evaluating the effectiveness of psychological and psychosocial interventions for children and young people involved in or at risk of serious youth violence. It forms part of a wider project examining barriers to mental health support for this population, and aims to map the current landscape of locally delivered interventions, assess their effectiveness, and identify gaps in the evidence base.

The review found a wide range of interventions delivered across multiple settings, targeting diverse groups including young offenders, victims of violence, looked-after children, and those with mental health, behavioural, or substance misuse challenges. While some interventions were structured psychological therapies (e.g. CBT, DBT, family therapy), many were psychosocial in nature, including mentoring, community-based support, school programmes, and resilience-building initiatives. Interventions often focused on improving mental health and emotional regulation, with outcomes measured through tools like the Strengths and Difficulties Questionnaire (SDQ), self-report measures, and official offending records.

Findings suggest that several interventions, particularly those tailored to the needs and contexts of participants, show promise in improving emotional wellbeing, reducing behavioural problems, and increasing access to mental health support. A smaller subset of interventions, especially focused deterrence and some trauma-informed programmes, were associated with reductions in offence severity and violent behaviour. However, well-established therapeutic models such as Functional Family Therapy and Multisystemic Therapy demonstrated limited impact on reoffending in the UK context.

Evidence across studies was often constrained by small sample sizes, weak or quasi-experimental designs, short follow-up periods, and a lack of diversity in study populations, particularly underrepresentation of girls and marginalised groups. Many studies focused narrowly on single outcomes (e.g. mental health or behaviour), with limited integration of offending-related outcomes or long-term life trajectories. Interventions targeting victims of violence, looked-after children, and young people with substance misuse issues were particularly limited in number and scope, with few robust trials and little understanding of sustained impact.

Overall, while there are promising pockets of practice, the evidence base remains fragmented. There is an urgent need for more rigorous, inclusive, and longitudinal research to identify what works, for which sub-groups of young people, and in what contexts. Interventions that integrate mental health and offending-related outcomes, attend to trauma and social disadvantage, and are co-designed with young people are likely to offer the greatest potential for disrupting cycles of violence and vulnerability.

Introduction

While there is a growing body of global research on interventions for children and young people involved in or at risk of serious youth violence, much of this evidence does not account for the unique socio-political and cultural contexts of the UK and Ireland. As part of a wider project investigating barriers to accessing mental health support for children and young people involved in or at risk of serious youth violence across England and Wales, this review attempts to address some of this gap, by synthesising available primary research on psychological and psychosocial interventions delivered to this population in the UK and Ireland through a rapid scoping review of the literature.

This synthesis builds on a complementary umbrella review of the global evidence base for mental health interventions targeting children and young people involved in or at risk of serious youth violence. While the global review mapped a broad array of intervention types and outcomes, this UK-based review focuses on identifying and analysing interventions that are being delivered locally. By examining their delivery, target populations, and outcomes, the review aims to evaluate what is being implemented, assess the effectiveness of these interventions, and highlight both successes and gaps in the evidence base.

Methods

A rapid scoping review is a method designed to quickly identify and summarise the breadth and depth of available evidence on a specific topic while maintaining methodological rigor. This approach prioritises efficiency by streamlining traditional review processes, allowing researchers to map key concepts, evidence gaps, and the nature of available studies without conducting the exhaustive critical appraisal typically required in systematic reviews (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010; Tricco et al., 2015). Rapid scoping reviews typically involve systematic search strategies, well-defined inclusion and exclusion criteria, and a process of charting and synthesising findings.

For this review a systematic search of peer-reviewed literature was conducted to identify studies examining psychological and psychosocial interventions for children and young people either involved in or at risk of serious youth violence, using the same search process as the one used for the wider umbrella review of the global evidence base. The review was guided by two primary research questions: (1) What psychological and psychosocial interventions are delivered to children and young people involved in or at risk of serious youth violence across the UK and Ireland? and (2) How effective are these interventions? Whilst the initial focus of this rapid literature review was psychological interventions only, the search was expanded to include psychosocial interventions following discussions with the project advisory board.

Psychological interventions are typically structured, clinically oriented therapies delivered by trained professionals and based on a theory of psychological functioning. In contrast, psychosocial interventions take a broader view of wellbeing and include support aimed at addressing social, relational, behavioural, and environmental factors that influence mental health (MacInnes & Masino 2019). While psychological interventions focus directly on the individual's mental health symptoms or processes, psychosocial approaches often aim to improve mental health by changing the conditions in which children and young people live and grow.

The advisory board strongly recommended expanding the scope to include psychosocial interventions, emphasising that many children and young people involved in or at risk of

serious youth violence are not immediately ready, able, or willing to engage with formalised psychological therapy. They highlighted the importance of recognising and valuing interventions that build readiness and resilience, foster trust, and support mental wellbeing in less clinical ways. These include relational and environmental supports such as mentoring programmes, family support, and community-based initiatives, that play a vital role in creating the conditions necessary for young people to later engage with psychological therapy, or even reduce the need for it. The board emphasised that for the vulnerable and often marginalised populations in question, mental health cannot be meaningfully understood or supported in isolation from the wider context of their lives.

The search strategy included comprehensive database searches across PubMed, Education Resources Information Center (ERIC), PsycNET, ProQuest and Google Scholar to ensure a wide coverage of relevant literature. The Specific databases within the ProQuest platform included the Criminal Justice Database, Education Collection, International Bibliography of the Social Sciences, the Social Science Database and the Sociology Collection. Search terms were designed to capture a broad range of studies related to the target population, types of interventions, and desired outcomes. These databases were selected to ensure broad and multidisciplinary coverage across relevant fields including psychology, mental health, education, youth justice, and social care. As this was a rapid scoping review rather than a full systematic review, the search was necessarily limited by time and resources. The databases chosen were those judged most likely to return relevant studies with minimal duplication and maximum relevance to the research questions, while still allowing for a timely and rigorous synthesis of the evidence.

The strategy included two distinct approaches: one focusing on interventions for children and young people identified as already being involved in serious youth violence, and the other targeting those at risk of involvement in serious youth violence.

The search terms were grouped into key categories and combined using Boolean operators. For the population, terms such as “young people,” “adolescent*,” “youth,” “teenager*,” and “minor*” were used. To identify studies relevant to violent behaviour, terms included “violent crime,” “young offender*,” “criminal behaviour,” and “perpetrator*.” For therapeutic interventions, terms such as “psychological therapy,” “mental health service,” “counselling,” “group therapy,” and “forensic psychiatry” were included. Finally, outcome-related terms such as “effectiveness,” “impact,” “evidence base,” and “barrier*” were used to ensure studies addressing intervention outcomes were captured. For studies targeting children and young people at risk of violence, additional terms were included to reflect key risk factors, such as “school exclusion*,” “substance misuse,” “foster care,” “gang,” “weapon,” and “low socioeconomic status,”. The full search strategy has been included in Appendix 1 of Annex 1.

The inclusion and exclusion criteria were carefully defined to ensure that only studies addressing the research questions and population of interest were included. Studies were eligible if they focused on young people aged 10–18 years (more than 50% of the study population) who were either identified as being involved in serious youth violence or at risk due to specific factors, including school exclusion, substance misuse, or involvement in gangs. Interventions needed to be psychological or psychosocial in nature, with measurable outcomes relevant to our research project such as reductions in offending or violent behaviours, improvements in mental health, or reductions in risk factors/risk behaviours such as substance misuse or aggressive, problematic or externalising behaviours.

Reviews of the literature and primary quantitative studies assessing the impact or effectiveness of interventions were prioritised, while theoretical or conceptual studies, case studies, and studies focusing on pharmacological or medical treatments were excluded.

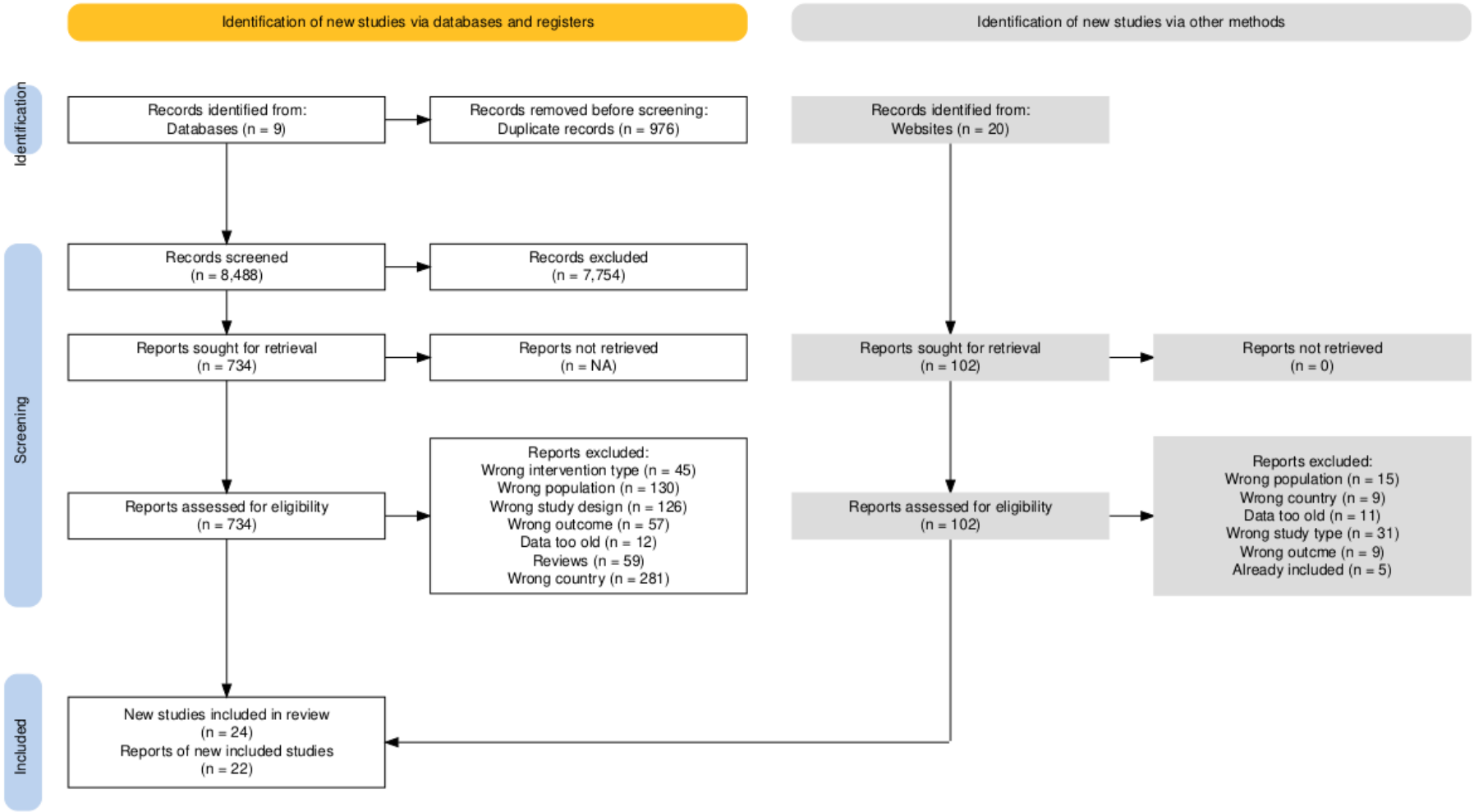
Qualitative studies were set to one side to be integrated into the review on barriers and facilitators to accessing interventions (reported separately). To manage the anticipated volume of results and ensure contextual relevance to the wider study, we applied geographic restrictions at the level of primary studies. Specifically, we included primary studies conducted in the UK, Europe, North America, Australia, and New Zealand - settings deemed to have broadly comparable health, education, and justice systems to the UK. Primary studies from low- and middle-income countries were excluded due to significant contextual differences that may limit applicability. In contrast, we retained a global focus for reviews, given the difficulty of reliably filtering reviews by country and the potential value of capturing innovative or well-evidenced interventions implemented internationally. Studies addressing universal mental health services or conditions without a direct link to violence-related behaviours were also excluded.

The search was restricted to publications in English and limited to studies published within the past ten years to ensure the findings were relevant to current practices. Earlier studies were excluded on the basis that significant changes in youth justice policy, mental health provision, and intervention design, particularly in relation to trauma-informed care, contextual safeguarding, and early intervention, mean that older evidence may no longer reflect current systems. In addition, we assumed that interventions with continued relevance or promise would likely be captured in more recent literature, either through re-evaluation, adaptation, or inclusion in systematic reviews.

An initial search yielded 8,488 articles. Due to the large amount of literature returned, it was decided at this point to further restrict the results only to reviews of the literature and primary studies conducted in the UK and Ireland. These groups of studies were then separated into two complementary reports. This report focuses on the primary UK and Ireland-based studies. Key findings from the umbrella review of the global literature have been presented in Annex 1. Full inclusion and exclusion criteria have been outlined in Appendix Table 2 in Annex 1.

Following a title and abstract screen and a subsequent full text screen of the relevant studies, 24 UK and Ireland-based primary studies were included in the final analysis (see Figure 1). The systematic search of peer-reviewed literature was supplemented with a hand search of key organisational websites to identify additional relevant papers and reports. Key websites included the Children and Young People's Centre for Justice Scotland, the NSPCC, the Early Intervention Foundation, the National Association for Youth Justice, the House of Commons Justice Publications, the UK Home Affairs Committee, the UK Youth Justice Board, the Anna Freud Foundation, the Youth Endowment Fund, Barnados and the UK Department for Education, among others. A further 22 relevant publications were identified from this rapid hand search of grey literature reports. The included research studies were all conducted across the UK and Ireland and published from 2014 to 2024. The final analysis was therefore based on 46 studies.

Figure 1: PRISMA flow diagram depicting the inclusion and exclusion of studies



*Created using Haddaway et al (2022)

In line with the umbrella review of the global literature, the included studies were grouped based on the characteristics of the target population of the study, including young offenders, perpetrators of violence, victims of violence, looked after children, those exhibiting aggressive or disruptive behaviours, those with mental health challenges and those with substance misuse challenges. A final 'general risk' category was included to capture any studies focusing on risk factors that could not be categorised elsewhere. This included, for example, neurodiverse young people and school-based populations that received mental health interventions. The findings have been organised according to these groups.

Key findings

Of the 46 studies identified for inclusion in the final review, nine focused on young offenders, three on victims of violence, eight on children and young people displaying aggressive or disruptive behaviours, four on looked after children, three on children and young people with substance misuse problems, thirteen on children and young people with clinical mental health problems and six on children and young people with other general risk factors. The following sections outline the findings, categorised by the population group or risk factor/risk behaviour of focus of the reviews.

Young offenders[10]

- Some interventions showed reductions in offending or offence severity**.** The *focused deterrence intervention* (Thames Valley, 2024) reduced knife and serious violent crime; *Hubble et al. (2015)* reported reduced offence severity; and *Williams et al. (2014)* found reduced weapons carrying and some decline in violent reoffending.

- Several well-known therapeutic models showed limited impact on reoffending**.** *Functional Family Therapy* (Humayun et al., 2017), *Multisystemic Therapy* (Fonagy et al., 2020), and other community-based approaches showed no significant reduction in criminal convictions or official reoffending rates.

- Improvements were noted in psychological and behavioural outcomes: The *LMV-E* programme (Derbyshire et al., 2018) improved emotion regulation and reduced aggression; *Stubbs & Durcan (2017)* reported better access to mental health support and reduced severity of needs; *Hubble et al. (2015)* also improved emotion recognition.

- Evidence is limited by small samples, male-dominated studies, and weak designs**.** Most studies lacked control groups or had small, male-only samples, reducing confidence in findings and limiting generalisability, especially to girls and to broader wellbeing and social outcomes.

Victims of Violence[11]

- Interventions targeting victims of violence generally focused on emotional and behavioural outcomes, not offending**.** None of the three studies assessed reoffending or criminal outcomes. Instead, the focus was on wellbeing, family relationships, and risk awareness.

[10] Derbyshire et al., 2018; Fonagy et al., 2020; Hubble et al., 2015; Humayun et al., 2017; Stubbs & Durcan, 2017; Thames Valley Violence Prevention Partnership, 2024; Violence reduction network, 2021; Whittaker et al. 2021; Williams et al., 2014
[11] DeMarco et al., 2016; Smith et al., 2020; Walsh et al., 2023

- Two interventions showed promising improvements in emotional and behavioural outcomes**.** The *emergency department-based youth support programme* (DeMarco et al., 2016) and the *DART parent-child intervention* (Smith et al., 2020) both significantly reduced emotional problems, conduct issues, and hyperactivity, with additional improvements in family dynamics and perceived lifestyle risk.
- Evidence is constrained by small samples, weak study designs, and narrow outcome focus**.** No randomised trials were identified, and longer-term mental health or educational outcomes, such as PTSD, depression, anxiety, or school engagement, were largely unmeasured**,** limiting understanding of sustained impact.

Young People Displaying Aggressive, and Disruptive Behaviours[12]

- Some parent- and therapy-based interventions improved behavioural and emotional outcomes**.** Interventions like *Non-Violent Resistance parenting* (Newman et al., 2014), *parent training programmes* (Nitsch et al., 2015), *Functional Family Therapy* (Hartnett et al., 2016), and *counselling through Place2Be* (Toth et al., 2023) showed positive impacts on adolescent behaviour, family functioning, and mental health, including reduced school exclusions.

- Academic and school engagement outcomes also improved in some cases**.** The *Attachment Aware Schools framework* (Rose et al., 2018) led to academic gains and fewer exclusions, and counselling (Toth et al., 2023) significantly reduced fixed-period suspensions.
- Study limitations include small sample sizes, short follow-up, and limited diversity**.** Many studies used pre-post designs without control groups, lacked long-term outcome data, and did not explore how interventions work across different sexes, ethnicities, or socioeconomic groups, limiting confidence and generalisability.

Looked After Children and Young People[13]

- Most therapeutic interventions showed promising improvements in emotional and behavioural outcomes**.** Studies reported improvements in SDQ scores (Deuchar et al., 2021), emotional regulation, anxiety/depression, and reductions in aggression and attention problems (McCullough et al., 2016), suggesting positive impacts on psychological wellbeing for looked after children.

- One preventive intervention showed potential in reducing escalation into statutory care**.** The *SHARE programme* (Calderón et al., 2017) was associated with fewer young people entering care or becoming 'children in need', suggesting early support may help prevent system involvement for at-risk youth.

- Not all interventions showed clear benefits**.** The *Multidimensional Treatment Foster Care for Adolescents (MTFC-A)* (Green et al., 2014) showed no evidence of improved outcomes across mental health, education, or offending metrics, even in a randomised controlled trial.

- Findings are limited by small samples, design variability, and population focus**.** Most studies used pre-post or quasi-experimental designs, and none explored interventions for looked after children in stable placements**,** leaving gaps in understanding of broader applicability or long-term impact.

[12] Edridge et al., 2020; Hartnett et al., 2016; Newman et al., 2014; Nitsch et al., 2015; Obsuth et al., 2017; Rose et al., 2018; Toth et al., 2023; Wynee et al., 2016
[13] Deuchar et al., 2021; Green et al., 2014; McCullogh et al., 2016; Calderón et al., 2017a

Young People with Substance Misuse Challenges[14]

- Most interventions did not significantly reduce substance use**,** with both the psychoeducation and social network-based approaches showing no difference between intervention and control groups in reported consumption or related outcomes.

- One intervention (ReFrame: Coulton et al., 2024) showed some promise**,** with both intervention and control groups reporting increased abstinent days and reduced offending, though no statistical comparisons between groups were made, limiting interpretation.

- All three studies used robust randomised controlled trial designs**,** but two had small sample sizes and lacked gender diversity, with over 75% of participants being male, limiting generalisability and inclusivity.

- Long-term effectiveness and broader outcomes remain underexplored**,** with short follow-up periods and limited focus on mental health, relationships, or education, highlighting the need for more comprehensive, longer-term research.

Children and Young People with Mental Health Challenges[15]

- Many therapeutic interventions showed promising improvements in mental health outcomes**:** CBT, DBT, psychodynamic therapy, and humanistic counselling were associated with significant reductions in depression, anxiety, emotional distress, and self-harm (e.g. Brown et al., 2024; Flynn et al., 2018; Midgley et al., 2021; Pearce et al., 2017), although not all interventions demonstrated consistent effects across all symptom domains.

- Some early intervention and wellbeing-focused services also improved emotional health**.** Interventions like *Jigsaw* (O'Reilly et al., 2022), *Mind and Body* (Roberts et al., 2019), and *peer mentoring* (Stapley et al., 2022) were associated with improved emotional regulation, goal progress, and overall mental health, though effects on specific SDQ subscales and resilience were mixed.

- A few interventions showed limited or no effectiveness**.** The *out-of-hours crisis support service* (Calderón et al., 2017b) and *CBT group intervention for anxiety* (Week et al., 2017) did not significantly improve clinical symptoms, although they may have supported crisis prevention or safety outcomes in other ways.

- Limitations include short-term designs, lack of diversity, and missing long-term or functional outcomes**.** Most studies relied on pre-post designs without control groups, and few addressed intersectionality or explored long-term effects, family dynamics, or wider impacts such as school attendance, relationships, or social functioning

Children and Young People at General Risk[16]

[14] Coulton et al., 2024; Deluca et al., 2020; Watson et al., 2017

[15] Calderón et al., 2017b, Barnados, 2022; Brown et al., 2024; Flynn et al., 2018; Garralda & Slaveska-Hollis, 2016; Humphrey & Panayiotou, 2022; Midgley et al., 2021; O'Reilly et al., 2022; Pearce et al., 2017; Roberts et al., 2019; Stapley et al., 2022; Week et al., 2017; York Consulting, 2022

[16] Anderson and Meints, 2016; Bewley et al., 2016; Bonnell et al., 2018; Cattan et al., 2022; Densley et al., 2017; Meiksin et al., 2020

- Several other studies were identified through a search of peer-reviewed literature and a further grey literature search which were of interest. These were a combination of interventions aimed at youth who may be at a higher risk of committing serious and violent crimes, and interventions aimed at more general populations but with a focus on aggression or violence related outcomes.

- Most school- and family-based interventions showed mixed or limited impact on aggression, violence, or offending outcomes**.** Across *Learning Together* (Bonnell et al., 2018), *GAGV* (Densley et al., 2017), *Project Respect* (Meiksin et al., 2020), and the *Troubled Families* programme (Bewley et al., 2016), no statistically significant effects were found on primary violence-related outcomes, although some showed small effect sizes or indirect benefits like improved wellbeing or reduced substance use.

- The HeadStart programme showed borderline-significant reductions in school exclusions**.** Although *Cattan et al. (2022)* found no effect on absenteeism or attainment, the programme may have prevented around 800 school exclusions**,** suggesting modest behavioural benefits at a system-wide level.

- Animal-assisted therapy showed some promise for children with autism, but evidence is limited**.** *Anderson and Meints (2016)* reported reductions in maladaptive behaviours and improved empathising in children with ASD, but the very small sample size (n=15) and lack of broader adaptive change limits generalisability.

- Overall, studies were diverse and often underpowered, with few targeting high-risk youth directly**.** Most interventions were broad in scope or focused on general school populations; few targeted young people at high risk of violent offending, and none of the school-based RCTs found significant violence-prevention effects**,** indicating a potential need for more targeted and intensive approaches

Conclusion

This document provides a summary of identified studies of interventions targeting children and young people involved in or at risk of serious youth violence, alongside studies focused on broader related risk factors such as aggression, mental health, and substance use. In total, 46 studies from the UK and Ireland (2014–2024) were sourced from peer-reviewed literature and a hand grey literature search.

A substantial amount of research was identified for youth across several areas including interventions for those who have previously offended, young people with mental health issues, and young people with aggressive, problematic, and disruptive behaviours. On the other hand, this summary of intervention studies highlights several areas with sparse research, emphasising significant gaps that need to be addressed. For example, interventions targeting victims of violence are notably underrepresented, despite the high vulnerability of this population. Few studies explored the long-term impacts of victimisation, such as post-traumatic stress, depression, or educational outcomes. Research on Looked After Children or those at risk of entering care is similarly limited, with only a small number of studies focused on their unique needs, and very limited research on those in stable placements. Similarly, interventions targeting substance use in young people lacks depth, with few studies available and an overreliance on small sample sizes. There is also a noticeable lack of research on certain vulnerable groups, such as young people with autism spectrum disorder, who are rarely included in intervention studies despite their distinct challenges and risks. Collectively,

these gaps underscore the need for more comprehensive and diverse research to better support these under-represented populations.

Whilst evaluating the robustness of the studies, some common limitations were noted. Firstly, sample size was limited across many of the studies, limiting the ability to draw meaningful conclusions about the generalisability of effectiveness, and leaving the study vulnerable to the influence of outliers or anomalies. Secondly, many studies used a pre-post design which does not include a control group. For those which did include a control group, many used a quasi-experimental design, meaning that participants were not randomly allocated to an intervention group. Whilst it is understood that it can be difficult to use a randomised controlled trial design due to ethical or logistical complications related to randomisation, limiting randomisation increases the risk of selection bias, and undermines the comparability of intervention and control groups. Together, these limitations not only make it difficult to make comparisons between studies, but restrict the external validity of the studies, making it difficult to apply the findings to broader, more diverse populations.

Across all the studies, the effectiveness of intervention types varies depending on the target population and outcomes measured, but some patterns of success emerge. Therapeutic-based interventions, such as Cognitive Behavioural Therapy (CBT), Functional Family Therapy (FFT), and Dialectical Behaviour Therapy (DBT), consistently demonstrate positive effects. These interventions are particularly effective in addressing mental health symptoms such as anxiety and depression, improving family functioning, and reducing problematic behaviours.

Parent-based interventions are another category with notable effectiveness, especially in managing aggression, reducing behavioural issues, and strengthening family dynamics. Programs like Non-Violent Resistance (NVR) and other positive parenting approaches have proven to be impactful in equipping parents with skills to de-escalate conflicts, enhance emotional regulation, and foster healthier parent-child relationships. These interventions often lead to significant improvements in adolescent behaviour and emotional well-being, underlining the importance of engaging families as part of the solution.

In contrast, certain intervention types have been found to be less successful or demonstrate limited effectiveness, particularly in achieving significant or consistent outcomes. One such category is school-based interventions aimed at promoting positive behaviour or reducing aggression and violence in general youth populations. Programs like Learning Together, Growing Against Gangs and Violence (GAGV), and Project Respect often report mixed or minimal effects on key outcomes such as aggressive behaviour, violence, or gang membership, although they may report slight improvements in other outcomes such as psychological well-being or reduced substance use. This suggests that broad, population-level school interventions may lack the specificity needed to target high-risk individuals effectively.

While many of the interventions reviewed aimed to improve mental health, emotional regulation, and wellbeing, a subset of studies specifically targeted offending-related outcomes. Among these, some interventions showed promise: focused deterrence approaches and tailored support models demonstrated reductions in offence severity, knife-related crime, and weapons carrying. However, several widely used therapeutic models, such as Functional Family Therapy and Multisystemic Therapy, did not significantly reduce reoffending or criminal convictions. Importantly, most offending-related evaluations were concentrated in a small number of studies with methodological limitations, including small sample sizes, limited gender diversity, and weak or quasi-experimental designs. Furthermore, across the wider evidence base, there was a notable lack of focus on offending or reoffending as a measured outcome, particularly within interventions targeting trauma, mental health, or substance misuse. This narrow outcome focus limits our ability to understand whether and how improvements in mental health or wellbeing translate into behavioural change or reduced involvement in serious

youth violence. Robust, longitudinal studies that integrate offending-related outcomes alongside psychological and social indicators are needed to develop a more complete picture of intervention effectiveness.

In summary, whilst the identified studies highlight progress in the development of psychological and psychosocial interventions for children and young people involved in, or at risk of serious youth violence, it also exposes critical gaps in research design and population diversity. Longitudinal, inclusive, and intersectional studies are needed to refine interventions and address the multifaceted needs of vulnerable children and young people involved in, or at risk of serious youth violence.

Relevance to Improving Access to Mental Health Support

These findings are relevant within the broader context of a research study investigating access to mental health support for children and young people involved in or at risk of serious youth violence. The evidence underscores the importance of mental health and psychosocial interventions not only in improving emotional wellbeing, but also, where well-targeted, in potentially reducing offending and violent behaviour**.** However, the lack of consistent focus on offending outcomes in many mental health studies suggests a disconnect between intervention goals and the realities faced by young people at risk of violence. If mental health support is to be meaningfully accessible and impactful for this group, interventions must be designed to respond to both psychological distress and the structural and behavioural risks linked to violence and offending**.** This review highlights the need for integrated, multi-outcome approaches that address emotional wellbeing alongside offending risk, and calls for more rigorous, inclusive research to build evidence for what truly works in supporting vulnerable youth.

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Annex 3

Barriers and Facilitators to Accessing Mental Health Services for Children and Young People Involved in or at Risk of Serious Youth Violence: A Qualitative Synthesis from a Rapid Review of the Literature

Summary Report: Methodology and Key Findings

Dr Abigail Bentley

June 2025

Executive Summary

Overview

This narrative review synthesises evidence on the barriers and facilitators to accessing mental health support for children and young people involved in or at risk of serious youth violence. These young people often face complex, intersecting challenges, including trauma, socio-economic deprivation, and systemic exclusion, which increase both their vulnerability to mental health difficulties and their risk of disengaging from available support.

Drawing on a thematic analysis of 72 included studies, this review integrates findings from global literature reviews and primary research studies conducted predominantly in the UK, Ireland. It provides a qualitative synthesis of how access to mental health support is enabled or obstructed, with a particular focus on implications for minoritised and marginalised youth.

Research Questions

This review was guided by a set of primary and secondary research questions. The primary questions focused on identifying the barriers that prevent, and the facilitators that enable, children and young people involved in or at risk of serious youth violence to access and engage with mental health services and interventions. Secondary questions explored how these barriers and facilitators may vary across different subgroups of young people or according to different risk factors; whether patterns differed between UK-based and international contexts; how access issues were shaped by different service delivery settings; and what specific challenges or enablers existed for minoritised and marginalised groups.

Study Characteristics

The review included a total of 72 studies, encompassing literature reviews, qualitative and mixed-method studies, quantitative analyses, and relevant grey literature. The primary research was largely drawn from the UK and Ireland, ensuring contextual relevance to the wider project, with a small number of North American studies also included due to their focus on justice-involved youth or the innovative nature of the interventions described. The review articles covered a broader geographic scope, incorporating evidence from the UK, Europe, and North America. The studies examined were situated in a variety of settings, including community-based services, clinical environments, educational institutions, and custodial settings, offering a comprehensive view of the environments in which mental health services for at-risk youth are delivered and accessed.

Key Findings

Six overarching thematic categories emerged in relation to barriers and facilitators:

1. **System Design and Structure**
   Rigid thresholds, long wait times, fragmented transitions, and regional funding disparities limit access, especially for marginalised youth. Service fragmentation and abrupt transitions between services often undermine continuity and trust.
2. **Workforce and Capacity Challenges**
   Staff shortages, burnout, and knowledge gaps (e.g., around trauma and neurodivergence) result in reduced service quality, inconsistent relationships, and harmful or exclusionary practices.
3. **Practical Access and Navigation Barriers**
   Economic hardship, geographic isolation, stigma (especially among boys and minority ethnic groups), and unclear information about services impede timely engagement.
4. **Service Responsiveness and Personalisation**
   Services that are culturally competent, flexible in delivery, and embedded in communities are more likely to engage vulnerable youth meaningfully. Community-based, tailored, and trauma-informed approaches are particularly effective.
5. **Coordination and Integration Failures**
   Poor multi-agency collaboration, siloed working, and a lack of shared information lead to duplication or loss of follow-up, weakening intervention impact and engagement.
6. **Harmful or Unsafe Service Experiences**
   Negative prior experiences with services, especially where young people felt judged, criminalised, or unsupported, created deep mistrust and disengagement, sometimes intensifying risk.

Relevance and Implications

This review highlights the need to redesign mental health systems with at-risk children and young people at their centre. Rather than framing disengagement as an individual problem, the findings underscore how many so-called “engagement issues” are rooted in systemic exclusion and inflexible service models that fail to meet the complex needs of this population. Restrictive eligibility thresholds, fragmented service pathways, and short-term funding models often exclude those in greatest need, reinforcing a reactive and inequitable system. In contrast, approaches that prioritise cultural safety, relational continuity, and flexible delivery are shown to support meaningful engagement and should be embedded as core principles across services. Youth-led, community-rooted, and preventative models, particularly those offering integrated, wraparound support, are important for closing the gap between existing mental health provision and the lived experiences of vulnerable young people. Addressing these challenges requires strategic investment in workforce development, multi-agency coordination, and equity-focused service design. Ultimately, this review provides a compelling case for reimagining mental health systems not only to improve access and engagement but also to address the deeper structural inequalities that contribute to both poor mental health and criminalisation among marginalised children and young people.

Introduction

This research report addresses critical questions about barriers and facilitators to accessing and engaging with mental health support for children and young people involved in or at risk of serious youth violence. The report includes a qualitative synthesis of 72 studies that were identified as part of a wider rapid review of the literature. It includes a synthesis of global reviews of the literature to give an overview of patterns and trends in global barriers and facilitators to access for this population, in addition to primary studies from the UK and Ireland to give more relevant contextual insights for the current project.

The report investigates what prevents access or engagement, identifying structural, cultural, and organisational barriers, such as stigma, resource gaps, and inconsistent implementation, while also exploring facilitators to access like peer and family support, culturally competent programs, and flexible service delivery, and whether these factors differ across population and risk groups. Special attention is given to minoritised and marginalised populations who often face intensified disparities due to intersecting social and economic disadvantages (Murthy, 2022).

Methods

As part of a wider rapid scoping review of the literature to understand what psychological and psychosocial interventions are being delivered to children and young people involved in or at risk of serious youth violence and the effectiveness of these interventions in reducing risk factors and/or improving mental health (see Annex 1 and 2), we aimed to also conduct a qualitative review of the barriers and facilitators to accessing such services and interventions.

A systematic search of the literature was conducted as part of the wider review on intervention effectiveness (search strategy included in Appendix 1 of Annex 1). Whilst screening for papers to include in the effectiveness review (methods detailed in full in Annex 1), a simultaneous screen was conducted to identify any papers relevant to answering the question around barriers and facilitators to access. These included any studies that referenced barriers to access as the focus of the study, any process evaluations and any qualitative studies conducted with our population of interest on the subject of mental health services and interventions.

Due to the large amount of literature returned, as with the reviews on intervention effectiveness (Annex 1 and 2), we decided to limit the included papers to reviews of the literature, to give an overview of the global themes and patterns arising around barriers and facilitators to access in this population, or primary studies conducted in the UK and Ireland to add more detail relevant to the context within which this wider project is set. Some original studies from North America were also included where they seemed particularly relevant – either addressing young offender populations or presenting particularly innovative interventions. To supplement the identification of literature from the effectiveness reviews, a hand search of UK-based primary studies and key websites for relevant grey literature was also conducted.

The study used a qualitative thematic synthesis to analyse data from 72 studies, capturing diverse perspectives from various demographic groups, geographic regions, and institutional settings. Thematic synthesis allows for the identification of overarching themes across studies while preserving the contextual richness and depth of individual findings (Barnett-Page & Thomas, 2009). Inclusion criteria guided the selection of studies, ensuring the review focused on those most relevant to the research objectives, whilst remaining open to emerging themes. Studies were included if they focused on mental health support for young offenders or for at-risk children and young people including perpetrators of violence, victims of violence, those displaying aggressive or disruptive behavioural issues, or with significant mental health or substance use needs, and if they addressed some element of access to support.

The included studies were a mixture of literature reviews, qualitative studies, mixed-methods studies, quantitative studies looking at statistics around access and opinion pieces. As previously mentioned, primary studies came from the UK and Ireland with a couple of interesting North American studies. Reviews predominantly included studies conducted in the UK, Europe and North America.

The data were thematically coded using an iterative process to identify patterns and insights across the corpus. Themes were organised to highlight key barriers and facilitators to accessing support. Particular attention was paid to variations by demographics, including age, gender, and socio-economic status, as well as geographic and institutional contexts. This approach allowed the synthesis to capture subtle differences in experiences and outcomes, ensuring relevance across diverse populations and settings (Patton, 2014).

The analysis was guided by key primary and secondary research questions, as follows.

Primary research questions:

1. What are the barriers to accessing or engaging with, mental health services and interventions for children and young people involved in or at risk of serious youth violence?
2. What are the facilitators to accessing or engaging with, mental health services and interventions for children and young people involved in or at risk of serious youth violence?

Secondary research questions:

1. Do findings differ across different populations of children and young people / different risk factors?
2. Do findings differ between UK contexts versus other global contexts?
3. Do findings differ across different settings of intervention/service delivery?
4. What do barriers and facilitators to access look like for marginalised and minoritised groups?

The findings in this report have been structured according to these research questions.

Key Findings

Through the synthesis of various studies, a range of themes and subthemes emerged. The key findings for each have been outlined below.

Barriers and facilitators to accessing mental health services and support for children and young people at risk of serious youth violence.

System Design and Structure

- **Wait Times and Eligibility Criteria[17]:** Long waiting times and restrictive eligibility criteria leave many young people, especially those facing multiple adversities or at risk of violence, without timely or appropriate support, worsening mental health and increasing vulnerability. High thresholds and rigid assessments prioritise only the most severe cases, creating missed opportunities for early intervention, eroding trust in services, and pushing some towards crisis or justice involvement instead of prevention.

- **Mismatch of Services and Abrupt Transitions[18]:** Fragmented services and abrupt transitions, such as between custody and community or child and adult care, undermine continuity, leaving young people confused, unsupported, and at higher risk of disengagement, worsening mental health, or recidivism. More coordinated, planned, and flexible transitions are needed to sustain engagement and meet complex needs.

- **Bureaucracy and Paperwork[19]:** Bureaucratic hurdles including cumbersome paperwork, complicated pathways to care for families to navigate, and dismissive gatekeeping create significant barriers to mental health care, particularly for vulnerable groups such as such as young people exiting prison or those in need of specialised support. These administrative hurdles delay access, may create frustration and helplessness, leave many young people feeling rejected and unsupported and ultimately discourage engagement. More streamlined, integrated, simplified, and youth-friendly processes are needed to improve access and continuity of care.

- **Lack of Follow-up Mechanisms[20]:** The absence of sustained follow-up leaves many young people unsupported after initial interventions, leading to disengagement, relapse, or heightened risks during critical transitions such as moving between services or exiting custody. Without ongoing monitoring, services struggle to maintain continuity of care, adapt to evolving needs or sustain longer-term impact. Embedding planned follow-up e.g through check-ins, case management, or ongoing support plans could ensure continuity, sustained progress and support.

- **Inconsistencies in Service Delivery[21]:** Inconsistencies in service delivery driven by staff turnover, uneven training, variable fidelity to programmes, and unequal distribution of resources can undermine trust, continuity, and engagement. Even well-designed

[17] Appleby et al., 2023, Dunne et al 2016, Gwata et al, 2024, Hunn et al., 2022, Matthews et al., 2024; McCulloch et al., 2024, Midgley et al, 2021; O'Hara et al., 2019, Pinkerton et al., 2022, Radež et al., 2020, Radez et al 2021, Rice et al 2024, Robertson, 2022, Tindle et al, 2023, Public Health England, 2015, Phillips et al, 2023, Williams et al., 2020

[18] Coles et al., 2016, Dunn 2017, Gondek et al., 2017, Livanou et al., 2017, March et al, 2022, McCulloch et al., 2024, O'Reilly et al., 2022, Public Health England, 2015, Robertson 2022, Turley et al, 2021

[19] Corrigan et al., 2014, Dunn 2017, Hawke et al., 2021, Higgins et al., 2020, Klymkiw et al., 2024a, MacNeill 2021, McCulloch et al., 2024, Williams, 2020

[20] Appleby et al., 2023, (Batastini, 2016, Dunne et al., 2017, Klymkiw et al., 2024a, Lester et al., 2020, Livanou et al., 2017, MacNeill 2021, March et al., 2022, Muir et al., 2024, O'Reilly et al., 2022, Rice et al., 2024, Tindle et al., 2023, Watkins et al., 2020

[21] Appleby et al., 2023, Gillon 2020, Jolles & Wells, 2017, Klymkiw et al., 2024a, Lee et al., 2014, MacNeill, 2021, Matthews et al., 2024, March et al, 2022, Muir et al., 2024, Ng et al., 2023, O'Reilly et al., 2022, Phillips et al., 2023, Plaistow et al., 2013, Turley et al, 2021

interventions can fail when delivery is irregular or uneven across regions and providers, leaving young people with fragmented, unreliable, and inequitable access to support.

- **Evidence-Based Approaches[22]:** Evidence-based approaches can improve access by promoting consistency, allowing for continuous improvement, securing funding, and enabling scalable, adaptable models, but they also risk exclusion when interventions are evaluated with narrow populations that do not reflect the realities of diverse or marginalised youth. Their effectiveness depends on balancing scientific validation with inclusivity and relevance, ensuring interventions are both evidence-informed and responsive to young people's lived experiences.

- **Resource and Funding Constraints[23]:** Chronic underfunding, austerity measures, and fragmented resource allocation have left youth mental health services overstretched, unevenly distributed, and overly focused on short-term targets. This scarcity reduces capacity, undermines preventive and community-based provision, and deepens regional and social inequalities, leaving many young people without sustained or equitable support and forcing services into reactive rather than proactive care.

Service Responsiveness and Personalisation

- **Tailored Support Plans and Continuity of Care[24]:** Tailored support and continuity of care are critical for effective youth mental health interventions, ensuring services are relevant to diverse needs and sustained over time. Support that is adapted to an individual's needs and their environment, that accounts for contextual factors, can enhance engagement. While seamless transitions between services, structured post-discharge plans, and consistent provider relationships can build trust and prevent disengagement. When tailored support is combined with continuity of care, the impact of interventions can be amplified.

- **Cultural Competence and Community-Based Approaches[25]:** Culturally competent and community-based approaches enhance access by making services relevant, relatable, and trusted, particularly for marginalised and justice-involved youth. Representation within the provider workforce, culturally resonant practices, and partnerships with local institutions can foster trust, reduce stigma, and improve engagement. Embedding services in familiar community settings can further strengthen relationships and ensure support reflects young people's lived realities, creating more inclusive and effective pathways to care.

- **Flexible Access Options[26]:** Flexible access options, such as outreach, home-based or mobile services, 24/7 availability, telehealth, and adaptable scheduling, can make mental health support more responsive and reduce barriers linked to rigid service structures, young people's discomfort with traditional services, logistical barriers such as transport, or competing demands from multiple services. By allowing young people and families to choose when, how, and where to engage, flexible models can foster autonomy, improve

[22] Adu et al., 2022, Appleby et al., 2023, Forman et al., 2009, Gee et al., 2021, Kagan et al., 2023, Lee et al. 2014, O'Hara et al., 2019, O'Reilly et al., 2022, SAMHSA 2014, Williams et al., 2020
[23] Gee et al., 2020, Gillon 2020, Gwata et al., 2024, March et al, 2022, Matthews et al., 2024, McCulloch et al., 2024, O'Reilly et al., 2022, Tindle et al, 2023, Williams et al, 2020
[24] Adjapong & Levy, 2021, Adu et al, 2022, Dunn 2017, Gee et al, 2020, Gillon, 2020, Kirk et al 2023, Kylmkiw et al, 2024b, Lee et al., 2014, Lester et al., 2020, Livanou et al., 2017, Mishu et al., 2023, SAMHSA 2014
[25] Adjapong & Levy, 2021, Appleby et al, 2023, Gillon et al, 2020, Klymkiw et al., 2024a, Lee et al., 2014, MacNeill 2021, Mishu et al, 2022, O'Reilly et al., 2022, SAMHSA 2014, Williams et al, 2020
[26] Adu et al, 2022, Klymkiw et al., 2024a , Lee et al., 2014, Liverpool et al, 2020, MacNeill 2021, Metzger et al, 2023, Midgley et al 2021, Muir et al, 2024, O'Reilly et al, 2022, Plaistow et al., 2013, Williams et al, 2020

satisfaction, and ensure timely help during crises that are unpredictable in nature, particularly for justice-involved, rural, or underserved populations.

- **Peer, Family and Community Support[27]:** Peer, family, and community support can strengthen engagement by fostering trust, a sense of belonging and inclusion, and continuity of care. Caregiver involvement ensures services address family needs, while peer mentoring and social support particularly through group settings can reduce stigma and normalise experiences. Embedding support in community spaces like youth clubs or mentoring schemes provides accessible, informal pathways that bridge the gap to formal services and reach young people who might otherwise disengage.

Workforce and Capacity Challenges

- **Overburdened Staff & Lack of Capacity[28]:** Staff shortages, high caseloads, and frequent turnover leave professionals overstretched and unable to provide consistent, timely, or preventive care. Limited capacity can undermine continuity, meaningful follow-up and referrals, and contribute to long waiting lists, and a reactive approach where young people often receive support only after their needs have escalated or violence has already occurred.

- **Vicarious Trauma[29]:** Exposure to trauma places frontline staff at high risk of vicarious trauma, burnout, and compassion fatigue, which can erode empathy, create less welcoming and trusting environments, and undermine young people's trust in services. Inadequate supervision and support structures can exacerbate this, leaving practitioners without the resources to sustain their own wellbeing or deliver consistent, high-quality care.

- **Professional Knowledge Gaps[30]:** Gaps in professional knowledge about trauma, neurodiversity, and youth mental health can often lead to misinterpretation of behaviours as 'problematic,' resulting in punitive responses like school exclusion or police confrontation rather than support. Without adequate training, professionals may struggle to provide trauma-informed or developmentally appropriate care, reinforcing cycles of marginalisation and unmet needs. Building awareness and skills across sectors is essential to ensure young people receive appropriate, accessible support.

Practical Access and Navigation Barriers

- **Limited Information and Awareness About Services[31]**: Limited information and poor communication about available services, eligibility, and referral pathways can leave many young people, families, and even practitioners unaware of how to access support. These gaps particularly affect minoritised and justice-involved groups, undermining timely engagement, reducing family involvement, and creating confusion and distrust in fragmented care systems.

[27] Dunn, 2017, Gillon, 2020, Gwata et al, 2024, Fellin et al, 2018, Klymkiw et al., 2024a, Klymkiw et al., 2024b, MacNeill 2021, Muir et al., 2024, Plaistow et al, 2013, Radez et al., 2021
[28] Alliance for Youth Justice, 2024, Damien et al., 2018, Dunn 2017, Gillon, 2020, Johnson-Kwocha et al., 2020, March et al, 2022, MacNeill, 2020, Mendelez et al, 2023, Radez et al., 2021, Robertson 2022, Tindle et al, 2023, Williams et al, 2020
[29] Branson et al., 2017, Lester et al., 2020, Skinner-Osei et al 2019, Sweeney et al., 2016, Williams et al, 2020
[30] Alliance for Youth Justice, 2024, Campbell et al., 2022, Damian et al., 2018, Hart et al., 2022, Inscoe et al., 2022, Pantazakos & Vanaken, 2023, Robertson 2022, Sharpe et al., 2016, Sweeney et al., 2016, Williams et al. 2020
[31] Appleby et al, 2023, Klymkiw et al., 2024a, Lester et al., 2020, March et al, 2022, Plaistow et al., 2013, Seaton, 2021, Tindle et al., 2023, Williams et al., 2020

- **Economic and Logistical Barriers**[32]: Economic and logistical barriers, such as transport difficulties and financial constraints can limit access to mental health services, with rural and low-income communities particularly affected. Missed sessions, geographic isolation, and even safety concerns linked to county lines and gang territories can further restrict access, deepening inequalities and leaving disadvantaged young people more vulnerable to exclusion.

- **Stigma and Cultural Barriers**[33]**:** Stigma and cultural barriers, including fear of judgment, discrimination, or labelling, can prevent many young people, particularly from marginalised groups, from seeking mental health support. Cultural taboos, gendered stigma, mistrust of statutory services, and fears of being criminalised or judged deter engagement, leaving young people reliant on informal networks and reinforcing cycles of avoidance and exclusion.

- **Timely and Accessible Services**[34]**:** Timely and accessible services that are geographically close, affordable and easy to navigate and available through self-referral, youth-friendly settings, and integrated provision are important for early engagement and sustained trust. Services that prioritise immediacy and accessibility can help to prevent escalation, strengthen therapeutic relationships, lay the foundation for long-term engagement and trust and ensure that diverse young people can access care without facing prohibitive logistical or systemic barriers.

Coordination and Integration Failures

- **Lack of Multi-Agency Working**[35]**:** Weak multi-agency collaboration marked by poor communication, siloed working, and inconsistent referral processes can create fragmented care, delays, and gaps in support. Without effective information-sharing and coordination across schools, justice, health, and social services, young people are often passed between agencies without continuity, undermining early intervention and holistic care.

- **Lack of Involvement of People with Lived Experience in Decision-Making**[36]**:** The systemic exclusion of people with lived experience from service design and decision-making can disconnect mental health provision from the realities of young people's lives. Involving youth and those with direct experience of trauma or violence leads to more relevant and responsive interventions, which encourages greater engagement and can lead to improved outcomes, while their absence perpetuates disengagement and leads to services that fail to meet real-world needs.

- **Embedding Support Across Systems and Relationships**[37]**:** Embedding support across families, schools, communities, and services can strengthen access by addressing the relational and systemic factors shaping young people's wellbeing. Multisystemic and family-based approaches can build trust, empower caregivers, and

[32] Metzger et al., 2023, O'Hara et al., 2019, Pinkerton et al., 2023, Public Health England, 2015, Radez et al 2021, Robertson 2022, Seaton, 2021, Tindle et al., 2023.
[33] Alliance for Youth Justice, 2024, Corrigan et al, 2014, Girling et al., 2022; King et al., 2014, Lester et al., 2020; Muir et al., 2024, Mishu et al., 2023, Plaistow et al., 2013, Radez et al, 2021, Williams et al. 2020
[34] Kirk et al, 2023, Klymkiw et al., 2024a, Liverpool et al., 2020, Muir et al., 2024, O'Reilly et al, 2022, Radez et al., 2020, Tindle et al, 2023, Watkins et al., 2020
[35] Adu et al, 2022, Coles et al, 2016, Damian et al, 2018, Dunn 2017, Fellin et al, 2018, Gillon, 2020, Gwata et al 2024, Kagan et al, 2023, Kirk et al, 2023, Klymkiw et al, 2024a, Livanou et al 2017, MacNeill, 2021, Ng et al., 2023, Public Health England 2015, Tindle et al, 2023, Williams et al, 2020
[36] Adu et al., 2022; Gwata et al, 2024, Klymkiw 2024b, McCabe et al., 2022, SAMHSA 2014, Smith et al., 2024, Williams et al, 2020
[37] Appleby et al., 2023, Adu et al 2022, Batastini et al, 2016, Dunne et al, 2016, Jolles & Wells, 2017, Kagan et al, 2023, Klymkiw et al 2024a, Lee et al, 2014, Public Health England 2015, SAMHSA 2014, Weisenmuller & Hilton 2021

bridge siloed services, ensuring coordinated, holistic care that tackles root causes, prevents crises, and creates lasting benefits for both young people and their wider communities.

Harmful or Unsafe Service Experiences

- **Traumatising Services[38]:** When mental health services feel punitive, dismissive, judgmental or culturally disconnected, they can retraumatise young people rather than support them. Long waits, rigid processes, lack of representation, and insensitive practices deepen mistrust and disengagement, highlighting the urgent need for trauma-informed, flexible, and relationship-based approaches that prioritise safety, trust, and cultural understanding.

- **Trauma-Informed Care[39]:** Trauma-informed care reduces barriers by fostering safety, trust, and empowerment, making mental health services more accessible and acceptable for young people with complex trauma histories. When embedded across systems and supported by professional training, this approach helps prevent retraumatisation, strengthens engagement, and improves outcomes for children and young people at risk of serious youth violence.

Are the Barriers to Accessing Mental Health Services the Same Across Different Population/Risk Groups?[40]

- Group-specific barriers shape access to mental health care: young offenders and prison leavers face stigma, mistrust of professionals, and abrupt transitions between justice and community services; gang-involved youth encounter violence, peer pressures, and limited local resources; survivors of violence experience trauma-related barriers and mistrust of authority; young people in foster care deal with fragmented multi-system support and unstable family backing; and those with severe mental health or substance use problems face stigma, unsuitable provision, and inconsistent services.

- Shared barriers such as long waiting lists, fragmented systems, and distrust of professionals affect all groups, but their impact is intensified by contextual factors like peer dynamics, service transitions, or lack of stable family support.

- Many young people live with overlapping risk factors, for example, trauma combined with substance use or severe mental health issues, which compound barriers and demand integrated, multi-issue responses.

- Stigma and mistrust are cross-cutting barriers, particularly acute for young offenders, prison leavers, and survivors of violence, where negative past experiences with authority figures or services deter help-seeking.

[38] Alliance for Youth Justice, 2024, Dunn, 2017, Gillon, 2020, Gondek et al, 2016, Kagan et al, 2023, Livanou et al 2017, MacNeill 2021, Matthews et al., 2024, McCulloch et al., 2024, Metzger et al 2023, Plaistow et al, 2013, Sweeney et al., 2016, Tindle et al 2023, Williams et al, 2020

[39] Branson et al., 2017, Damian et al., 2018), Griffiths et al., 2022, Inscoe et al., 2022, Isobel et al., 2020, Radež et al., 2020, Sweeney et al., 2016

[40] Damian et al., 2018, Dunn, 2017, Gwata et al., 2024, Inscoe et al., 2022, King et al., 2012, Klymkiw et al., 2024, Lidchi & Wiener, 2021, Livanou et al., 2017, Mathews et al., 2024, Mowat, 2015, Ng et al., 2023, Phillips et al., 2023, Pinkerton et al., 2022, Plaistow et al., 2013, Rice et al., 2024, Robertson, 2022, Skinner-Osei et al., 2019

- Fragmentation across systems (justice, child welfare, education, health) particularly affects young offenders, foster youth, and those with severe mental health needs, leaving them “lost in the system” during key transitions.

- To overcome these challenges, services must provide tailored, trauma-informed, and culturally responsive interventions that recognise both distinct group-specific needs and the intersecting risks many young people face.

Are the Barriers to Accessing Mental Health Services for Young People the Same in the UK vs Worldwide?[41]

- Widespread barriers across high-income countries including long waits, fragmented systems, and stigma, affect at-risk youth everywhere, though their impact varies by healthcare structures, funding models, and cultural norms.

- The UK context is marked by workforce shortages, regional disparities, and long waits, alongside poorly managed transitions from CAMHS to adult services that particularly disadvantage marginalised and justice-involved youth.

- Stigma and lack of trauma-informed care are persistent in the UK, especially affecting minority ethnic and LGBTQ+ groups who report feeling unsupported and misunderstood.

- Other high-income countries (e.g. US, Canada, Australia) often benefit from more embedded school-based mental health programs, which reduce stigma and improve engagement, though these models are inconsistently implemented and underfunded in the UK.

- Context-specific adaptation is crucial, since strategies effective in one setting (e.g. culturally relevant mentorship in the US) may not translate directly to different policy, service, and cultural environments like the UK

Are the Barriers to Accessing Mental Health Services for Young People the Same in Different Settings (Educational vs Clinical vs Community)? [42]

- Barriers to mental health access differ across educational, clinical, and community settings, with each environment presenting distinct structural, cultural, and relational challenges that affect young people’s ability to seek and engage with support.

- Educational settings often lack sufficient staff training, integration with mental health services, and resources, while clinical settings face long waiting times, fragmented care, and rigid models that may not meet the needs of marginalised youth.

- Community-based services offer flexibility and family involvement but are hindered by limited awareness, cultural stigma, and inconsistent quality, especially for those navigating complex systems like youth justice or child welfare.

[41] Adjapong & Levy, 2021, Coles et al., 2016, Corrigan et al., 2014, Dunn, 2017, Gee et al., 2020, Gondek et al., 2016, Higgins et al., 2020, Livanou et al., 2017, March et al., 2022, Mathews et al., 2024, McCulloch et al., 2024, Pinkerton et al., 2022, Rice et al., 2024, Sweeney et al., 2016 Weisenmuller & Hilton, 2021, Williams et al, 2020

[42] Adjapong & Levy, 2021, Damian et al., 2018, Dunn, 2017, Gee et al., 2021; Gondek et al., 2017, Johnson-Kwochka et al., 2020, Klymkiw et al., 2024a, Livanou et al., 2017, Mathews et al., 2024, March et al., 2022, Murthy, 2022, Plaistow et al., 2013, Rice et al., 2024, Robertson, 2022, Williams et al., 2020

What Do Barriers and Facilitators to Access to Mental Health Services Look Like for Minoritised Groups?[43]

- Minoritised young people face distinct, intersecting barriers, including systemic discrimination, lack of culturally appropriate care, and services that feel unsafe or exclusionary.

- Stigma and lack of acceptance around identity, especially related to race, ethnicity, gender, or sexuality, can deter help-seeking due to fear of judgment, exposure, or rejection.

- Low awareness, trauma, and mistrust compound these challenges, making engagement less likely without inclusive, representative, and community-embedded support.

- Discrimination within services and systemic inequities, such as long waits and lack of tailored provision, further alienate minoritised youth and compound the effects of stigma and mistrust.

Discussion

This review highlights the pervasive and multi-layered barriers faced by children and young people involved in or at risk of serious youth violence when trying to access mental health support. The findings reveal that these barriers are not only numerous, but deeply systemic, reflecting broader social inequalities, policy failures, and structural inflexibilities within mental health systems. While the barriers may present at the level of the individual, such as reluctance to seek help, lack of awareness, or logistical challenges, these are invariably rooted in wider systemic conditions that shape young people's environments, options, and relationships with services.

The findings reveal a picture of a mental health system that is reactive, fragmented, and frequently out of step with the realities of the young people it seeks to serve. Long waiting lists, rigid eligibility criteria, high thresholds for care, and abrupt transitions between services create a context in which support often arrives too late, if at all. These systemic design features reflect a model that prioritises crisis intervention over prevention, individual pathology over social context, and standardisation over flexibility. As a result, young people whose needs are complex, overlapping, or insufficiently severe to meet access thresholds fall through the cracks, with many only receiving help once they are entrenched in the criminal justice system or experiencing severe mental health crises.

Moreover, this system is not just inaccessible but at times actively harmful. Mental health services were repeatedly described as retraumatising, culturally unsafe, and mistrustful, particularly by young people from minority ethnic backgrounds, LGBTQ+ youth, and those with experiences of care, incarceration, or community violence. A lack of cultural competence, representation, and trauma-informed practice undermines trust and alienates young people, while impersonal bureaucratic processes and gatekeeping mechanisms

[43] Alliance for Youth Justice, 2024, Corrigan et al., 2014, Damian et al., 2018, Gwata et al., 2024, Higgins et al., 2020; Inscoe et al., 2022, Kagan et al., 2023; Klymkiw et al., 2024a, Mathews et al., 2024, Murthy, 2022, Radež et al., 2020

convey messages of exclusion and rejection. For young people already marginalised by society, these experiences confirm existing perceptions that services are not for them.

Importantly, the review also surfaces critical facilitators that point to what better could look like. Across diverse studies and contexts, young people and professionals consistently highlighted the importance of relational, flexible, and culturally relevant models of care. Services that build trust through continuity, co-design, and community embedding are more likely to engage young people early, meaningfully, and sustainably. Flexible delivery modes, including drop-in options, mobile and digital support, and out-of-hours provision, reduce logistical barriers and meet young people where they are. Culturally responsive and trauma-informed approaches were shown not only to improve engagement but to actively mitigate the harms caused by prior service experiences.

A recurring theme is the need to re-centre relationships in mental health support. Services that prioritise connection, between young people and practitioners, between systems and communities, and across life transitions, were seen to be more trusted and more effective in engaging young people. This relational model requires a shift not only in practice, but in how services are designed, funded, and evaluated. Short-term funding cycles, narrow outcome metrics, and siloed service structures all undermine the possibility of consistent, holistic, and preventive care.

Workforce issues are also central to this story. Overburdened staff, high turnover, and gaps in training, particularly around trauma, neurodivergence, and adolescent development, contribute to inconsistent care and missed opportunities for support. Professionals themselves often lack the resources and support to respond meaningfully to young people's needs, particularly when facing their own experiences of vicarious trauma and burnout. Without a well-supported, well-trained, and culturally competent workforce, even the most well-intentioned interventions are likely to fall short.

Critically, this review demonstrates that barriers are not experienced equally. Young people in the care system, those with justice involvement, gang-involved youth, young survivors of violence, and those with intersecting risk factors such as neurodivergence or substance use face compounded challenges to access. These are often magnified for minoritised young people, whose experiences of racism, discrimination, and cultural stigma create additional layers of exclusion. This intersectionality demands responses that are equally nuanced and multi-dimensional, recognising that no single model will work for all, and that equitable access requires active redress of structural disadvantage.

Relevance and implications

First, the findings of this review underscore the need for a paradigm shift, from a reactive, medicalised, and fragmented system to one that is preventative, relational, inclusive, and embedded within the communities it serves. Mental health services must move beyond simply being available to becoming accessible, acceptable, and appropriate, particularly for the most marginalised.

Second, the evidence points clearly to the importance of systemic change. This includes redesigning referral pathways, reducing bureaucratic complexity, addressing workforce

shortages, and embedding trauma-informed and culturally safe practices at every level. Importantly, it also means rethinking funding structures to prioritise long-term, relational work over short-term outcomes, and to ensure equitable provision across regions and groups.

Third, there is a need to centre young people, not just as service users, but as co-creators of the systems intended to support them. Lived experience must be embedded in service design, governance, and evaluation. Without this, services will continue to misalign with the realities and preferences of those they seek to serve.

Finally, we must recognise that improving access to mental health services for children and young people at risk of serious youth violence is a social justice issue as well as a clinical necessity. Mental health need does not occur in a vacuum. It is shaped by poverty, racism, exclusion, and trauma. The way we respond to that need reflects broader societal values. Ensuring that these young people can access safe, timely, and meaningful support is not just about improving mental health outcomes. It is about breaking cycles of harm, and building systems rooted in dignity, equity, and hope.

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Annex 4

Assessing regional rates of serious youth violence, risk factors related to serious youth violence, and access to children and young people's mental health services: A secondary analysis of publicly available data from England and Wales

Summary Report: Methodology and Key Findings

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June 2025

Executive summary

Introduction

Understanding serious youth violence (SYV) and its links to the mental health of children and young people (CYP) is a critical national concern in England and Wales[44]. Many of these young individuals have experienced trauma and Adverse Childhood Experiences (ACEs), highlighting the urgent need for accessible mental health support.[45,46] This project sought to understand the regional landscape of SYV, its associated risk factors, and the availability of mental health services for CYP.

Aims

The purpose of this research project was to locate, summarise, and compare publicly available regional data for England and Wales across three key themes:

- Serious youth violence
- Risk factors related to serious youth violence
- Access to children and young people's mental health services (CYPMHS)

This work also sought to identify data gaps and recommend improvements for data providers, laying the groundwork for future in-depth research and informing policy and intervention development.

Methodology

A search of publicly available data was conducted to discover which data were available related to these key themes for the nine IT1 regions of England (North East, North West, Yorkshire and The Humber, East Midlands, West Midlands, East, London, South East, and South West) and Wales, as used by the Office for National Statistics.[47] Datasets included those maintained by the Youth Justice Board for England and Wales, Ministry of Justice, HMRC, Department for Work and Pensions, and Department for Education, alongside data from the Office for National Statistics (ONS) and the National Health Service (NHS).

Indicators that conveyed relevant information about crime statistics for serious youth violence, risk factors for serious youth violence and access to statutory mental health services in England and Wales were identified and extracted for use. Each indicator was formatted to display a regional proportion and these were then combined to create a composite measure, or index, that summarised each key theme. National level data for Wales was not available for

[44] The Youth Endowment Fund (2024). Beyond The Headlines 2024 Summary: Trends in violence affecting children in England and Wales. Available at: https://youthendowmentfund.org.uk/reports/beyond-the-headlines-2024/summary/

[45] NIHR (2022). Adverse childhood experiences: what support do young people need? Available at: https://evidence.nihr.ac.uk/collection/adverse-childhood-experiences-what-support-do-young-people-need/

[46] Soneson E, White SR, Howarth E, Ford T, Fazel M, Jones PB. Access to and perceived unmet need for mental health services and support in a community sample of UK adolescents with and without experience of childhood adversity. Epidemiol Psychiatr Sci. 2024 Jan 24;33:e1. doi: 10.1017/S2045796024000027

[47] https://www.ons.gov.uk/methodology/geography/ukgeographies/eurostat#international-territorial-levels-itls-

most of the indicators, therefore the Welsh data was only included in the serious youth violence composite index.

Given the vast array of risk factors related to serious youth violence, this key theme was broken down into the following subgroups:

- School-related risk factors for serious youth violence
- Parent-related risk factors for serious youth violence
- Victim of violence-related risk factors for serious youth violence
- Previous contact with police-related risk factors for serious youth violence
- Deprivation-related risk factors for serious youth violence

A composite index was created to summarise each subgroup of risk factors related to SYV, as well as an overall risk factor composite index summarising all subgroups of risk factors .

Analyses were conducted to understand regional differences across indicators and composite indices. Firstly, the regional rate of each indicator was calculated and compared. Secondly, the regional scores for each composite index, including the risk factor subgroup composite indices, were plotted onto heatmaps and ranked to show how each theme varied by region. Finally, correlations were calculated between composite indices, between composite indices and indicators, and directly between indicators to comprehensively understand the relationships within the data.

Results

Composite index scores

For the serious youth violence composite index, London had the highest score, making it the worst region for serious youth violence, and Wales had the lowest. Scores were generally lower in the South of England and Wales, whereas scores were higher in London, the Midlands and North of England. Similarly, for the serious youth violence risk factors composite index, London had the highest score, making it the worst region for risk factors associated with serious youth violence, whereas the South West had the lowest score. Overall, scores were higher in London and the North of England and lower in the South and Midlands. The access to CYPMHS services composite index was highest for the South East, making it the worst region for accessibility to children and young people's mental health services. Conversely, the lowest score, and best accessibility to CYPMHS, was observed for London. Overall, in contrast to the other composite indices, higher scores were generally observed for the South and Midlands, and lower scores were observed for London, the East and North of England.

Despite London generally showing higher levels of SYV and risk factors related to SYV, and better access to CYPMHS, it's important to consider that this does not necessarily mean that children and young people involved in or at risk of serious youth violence are the ones gaining access to these mental health services. Overall availability might not translate to effective engagement for these most vulnerable groups.
For the risk factor subgroup composite indices, the school-related risk factors composite index was highest for the North East of England making it the worst region for school-related risk factors, whereas the South East had the lowest score. Scores were generally higher in the

North, West Midlands and South West, and lower in the South East, London and East. The parental risk factors composite index was highest for London, making it the worst region for parent-related risk factors, and lowest for the South East. Overall, the highest scores were for London and the North of England, whereas scores were lower in the Midlands and South. The North East had the highest score for the victim of violence-related risk factors composite index, making it the worst region for victim of violence-related risk factors. In contrast, the lowest score was reported for the East region. Generally, scores were higher for the Northern regions and lower for the Midlands and South. The previous contact with police-related risk factors index was highest for London, making it the worst region for previous contact with police-related risk factors, and lowest in the South West. Overall, the highest scores were observed for London and the North, whereas scores were lower for the Midlands and South of England.

Correlations between composite indices

A positive correlation was found between the serious youth violence index and the risk factors for serious youth violence index (r=0.71, p=0.0314), and a negative correlation was found between the risk factors for serious youth violence index and the access to CYPMHS index (r=-0.69, p=0.0414). When looking at indices for subgroups of risk factors, a positive correlation was found between the serious youth violence index and the parent-related risk factors index (r=0.72, p=0.0296), previous contact with police-related risk factors index (r=0.74, p=0.0221), and deprivation-related risk factors index (r=0.68, p=0.0431). A negative correlation was found between the access to CYPMHS index, and both the parent-related risk factors index (r=-0.76, p=0.0166) and the previous contact with police-related risk factors index (r=-0.74, p=0.0220). Positive correlations were also observed between the school-related risk factors index and the victim of violence-related risk factors index (r=0.73, p=0.0257), the school-related risk factors index and the deprivation-related risk factors index (r=0.73, p=0.0257), the parent-related risk factors index and the previous contact with police-related risk factors index (r=0.92, p=0.0004), the parent-related risk factors index and the deprivation-related risk factors index (r=0.80, p=0.0096), the victim of violence-related risk factors index and the deprivation-related risk factors index (r=0.76, p=0.0187), and the previous contact with police-related risk factors index and the deprivation-related risk factors index (r=0.68, p=0.0445).

Correlations between indicators

Numerous significant positive correlations were identified between indicators. Within school-related risk factors, strong correlations were observed between suspensions, exclusions, unauthorized absences, and alternative provision placements. In parental factors, the modelled prevalence of children in households with parental substance abuse strongly correlated with the modelled prevalence of children in households with parental severe mental health problems and parental domestic abuse.

Across indicators related to different indices, strong correlations were found between deprivation, family structure, and previous contact with police. For example, lone-parent families were closely linked to free school meal eligibility, the modelled prevalence of parental severe mental health problems, and the modelled prevalence of parental domestic abuse.

Additionally, police interactions, such as stop-and-search and arrests, correlated positively with several indicators related to physical abuse and parental instability.

Recommendations for improving data collection and reporting

Greater consistency across trusted public data sources in the following key areas:

- Improvement in the granularity of available data, ideally at a level more granular than regions, so that regions with significant demographic diversity, such as London, are accurately and effectively represented.
- Improved availability of demographic data such as age, sex and ethnicity across data sources.
- Consistency in the time-period covered by different data sources, particularly for datasets released annually, either according to only the calendar year or only the financial year.

Additional recommendations:

- Increased availability of regional level public data related to children and young people's mental health including mental health outcomes for young people who offend, number of NHS staff trained in children and young people's mental health, availability and numbers accessing or waiting for non-NHS based mental health services (e.g. school or community-based services), and the type and effectiveness of treatments.
- Exploration of robust ways to link datasets across different sources whilst protecting anonymity of individuals.
- Governments across England and Wales working together to either release combined datasets for both nations or individual datasets that contain the same variables for the same demographic populations across the different countries.
- Larger surveys carried out to collect data on sensitive issues such as child alcohol misuse, being involved in gangs or parental substance misuse, with sample carefully designed to be representative of regional populations. Other methodologies for collecting these sensitive data should also be explored.

Introduction

This research project aimed to provide a comprehensive overview of publicly available regional data across three key themes: serious youth violence, risk factors associated with serious youth violence, and access to mental health services for children and young people. By gathering and synthesising data across these areas, the project sought to identify both the current state of affairs and any data gaps that could hinder a more in-depth understanding.

The primary objectives were to locate, summarise, and compare the publicly available regional data for England and Wales across the specified themes. This included documenting areas with limited data availability and noting the challenges encountered in accessing this data. The research team also aimed to integrate data from diverse sources to create composite indices representing each key theme. Through these indices, regional variation was assessed, offering valuable insights into the disparities across different areas. Furthermore, recommendations were generated for authoritative data providers, aimed at improving the quality and availability of data to expand the scope of future research.

This secondary data analysis serves as a foundational step in a wider research project focused on understanding the factors influencing youth violence and mental health support for CYP. The findings presented here not only offer an initial overview of the regional landscape in terms of SYV involvement and mental health access but also help highlight potential areas for further investigation within the broader research. By identifying regional disparities and gaps in data, the project provides essential context for future work aimed at addressing these critical issues and guiding policy and intervention development.

Methodology

Summary of methodology

The first step was to establish our key themes for this research project, which were:

- Serious youth violence
- Risk factors related to serious youth violence
- Access to children and young people's mental health services

Given the vast array of risk factors related to serious youth violence, this key theme was broken down into the following subgroups:

- School-related risk factors for serious youth violence
- Parent-related risk factors for serious youth violence
- Victim of violence-related risk factors for serious youth violence
- Previous contact with police-related risk factors for serious youth violence
- Deprivation-related risk factors for serious youth violence

A search of publicly available data was conducted to discover which data were available related to these key themes and subgroups. Data were only included if they were recently collected and available at a regional level (or lower) across England and/or national level (or lower) for Wales. From these datasets, useful indicators were identified and extracted.

Our aim was to be able to make comparisons across regions for each of these indicators. Therefore, we first had to clean and format the indicator data, where necessary, to create regional variables from lower geographical level data and reduce the data to our age range of interest (10 to 18 years), or where this was not possible, the age-range which most closely aligned with our age range of interest. Next, we formatted the data for each indicator so that rather than displaying a regional total number of children for a given indicator, we instead showed a proportional indicator. This proportional indicator takes the total number of children in a region and tells us what proportion of them are included in the indicator (e.g. the proportion of children in London who have been cautioned or sentenced for possession of a weapon or knife).

Finally, after the indicators had been cleaned and formatted, we combined the individual proportional indicators to create composite measures, or indices. This was done for the indicators for each subgroup, in the case of the risk factors for serious youth violence, and for the indicators for each key theme for serious youth violence and access to children and young people's mental health services. A further overall composite index for risk factors for serious youth violence was also created which combined the subgroup composite indices. However, it was determined that the school-related risk factors composite index was not associated with serious youth violence and that the deprivation-related risk factors composite index was strongly related to the other risk factor subgroup composite indices. Therefore, these were not included in the overall risk factor composite index. Unfortunately, corresponding Welsh national level data was not available for the majority of the indicators. Therefore, the Welsh data was only included for the serious youth violence composite index and was not included in the risk factor subgroup composite indices, the overall risk factors for serious youth violence composite index, or the access to children and young people's mental health services composite index. The final composite indices included in the analyses for each key theme were:

For serious youth violence:

- Serious youth violence composite index (data from nine regions of England, and Wales included)

For risk factors for serious youth violence:

- School-related risk factors composite index (data from nine regions of England included)
- Parent-related risk factors composite index (data from nine regions of England included)
- Victim of violence-related risk factors composite index (data from nine regions of England included)
- Previous contact with police-related risk factors composite index (data from nine regions of England included)
- Deprivation-related risk factors composite index (data from nine regions of England included)
- Overall risk factors for serious youth violence composite index - combined data from parent-related risk factors composite index, victim or violence-related risk factors composite index, and previous contact with police-related risk factors composite index (data from nine regions of England included)

For access to children and young people's mental health services:

- Access to children and young people's mental health services composite index (data from nine regions of England included)

A summary of the methodology outlined above can be seen in Figures 1-3. A further detailed description of each aspect of the methodology can be found in the following sections.

Figure 1: Methodology outline for the calculation of the serious youth violence composite index using data from the 9 regions of England, and Wales

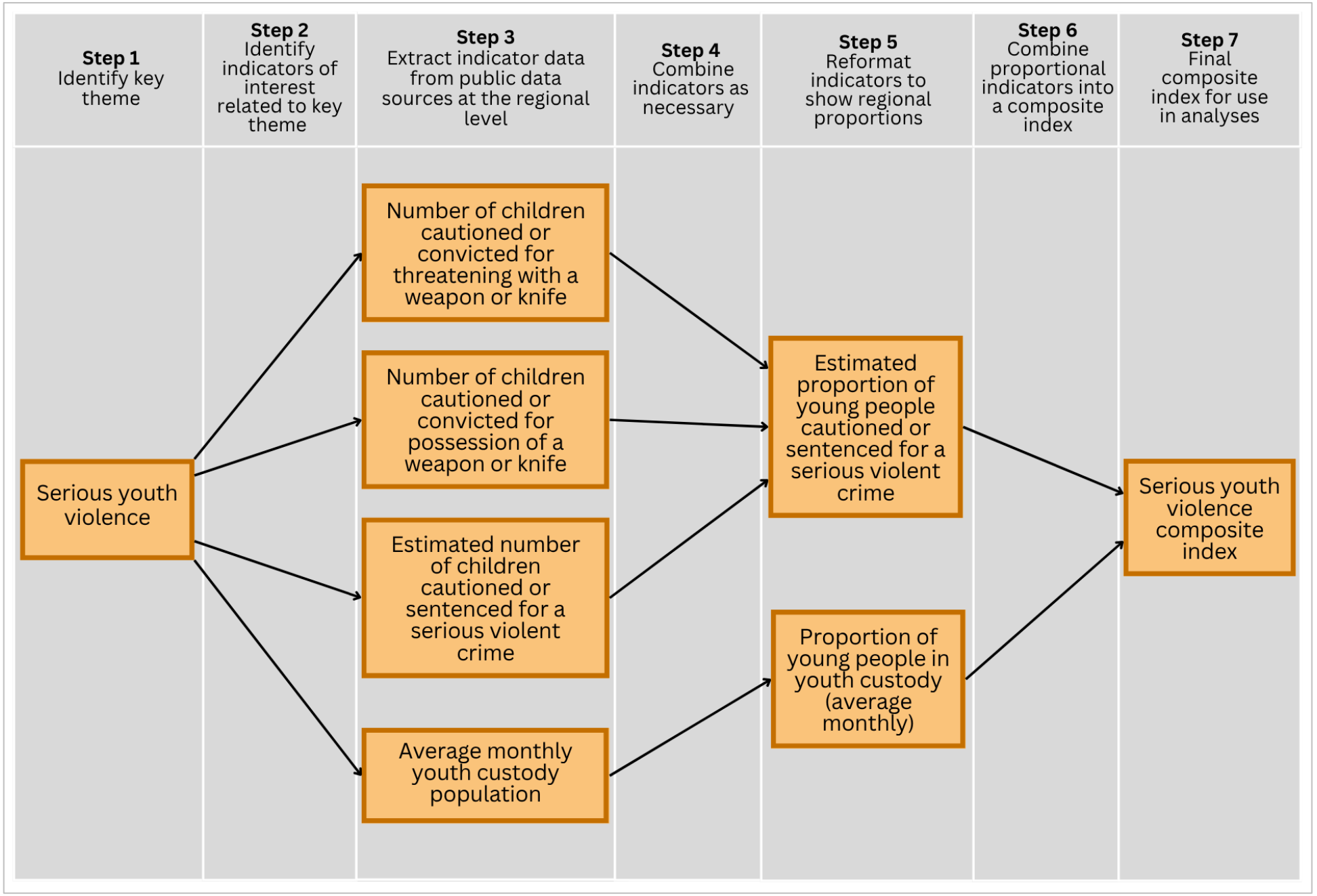
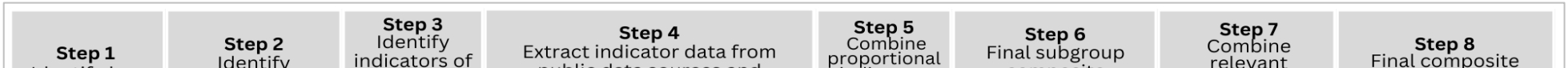
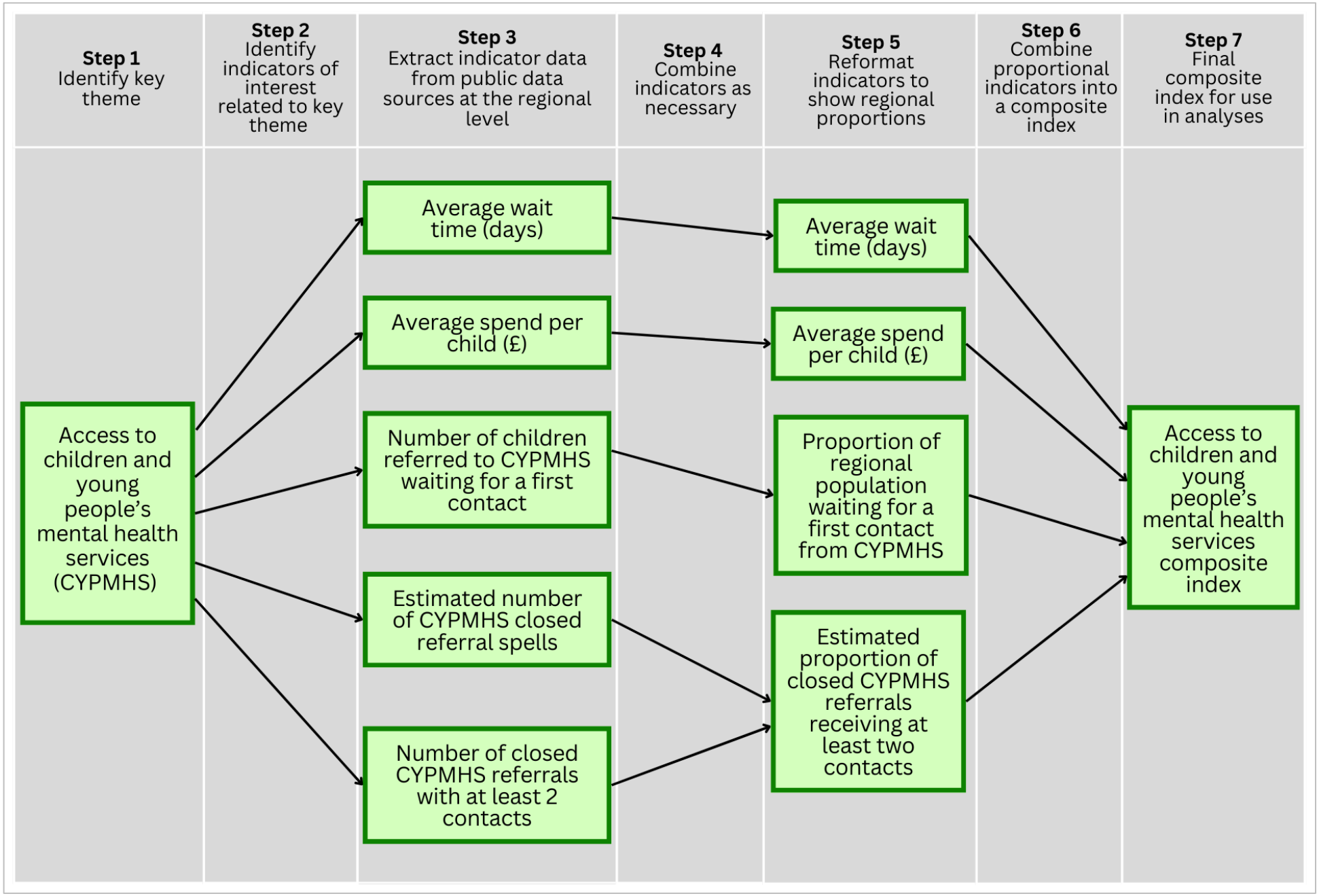


Figure 2: Methodology outline for the calculation of the risk factors for serious youth violence composite index and related subgroup risk factor indices using data from the 9 regions of England



It was determined that the school-related risk factors composite index was not associated with serious youth violence and that the deprivation-related risk factors composite index was strongly related to the other four risk factor subgroup composite. Therefore, these were not included in the overall risk factor composite index

Figure 3: Methodology outline for the calculation of the access to children and young people's mental health services (CYPMHS) composite index using data from the 9 regions of England


Step 1
Identify key theme
Step 2
Identify indicators of interest related to key theme
Step 3
Extract indicator data from public data sources at the regional level
Step 4
Combine indicators as necessary
Step 5
Reformat indicators to show regional proportions
Step 6
Combine proportional indicators into a composite index
Step 7
Final composite index for use in analyses
Access to children and young people's mental health services (CYPMHS)
Average wait time (days)
Average spend per child (£)
Number of children referred to CYPMHS waiting for a first contact
Estimated number of CYPMHS closed referral spells
Number of closed CYPMHS referrals with at least 2 contacts
Average wait time (days)
Average spend per child (£)
Proportion of regional population waiting for a first contact from CYPMHS
Estimated proportion of closed CYPMHS referrals receiving at least two contacts
Access to children and young people's mental health services composite index

Definitions of regions

Regions were defined using the International Territorial Levels (ITL) for referencing the subdivisions of the United Kingdom, as used by the Office for National Statistics (ONS).[48] ITL1 regions were used, which include nine regions within England: North East, North West, Yorkshire and The Humber, East Midlands, West Midlands, East, London, South East, and South West; in addition to Wales. Note that Scotland and Northern Ireland were not included within the scope of this research project. It was not possible to disaggregate further due to the unavailability of data at a more granular geographic level.

Choosing risk factor indicators

Indicators for risk factors related to serious youth violence were based on previous research, with a particular focus on risk factors identified in the Youth Endowment Fund's (YEF) second annual Children, Violence and Vulnerability report, 2023, and intelligence from our advisory board.[49] The report includes survey responses from over 7,500 teenage children aged 13-17 in England and Wales about their experiences in the past 12-months. From this report and other previous research, the following areas of interest were identified:

- Previous police contact
- Carrying a weapon
- Being in a gang
- Using drugs
- Misusing alcohol
- Receiving support from a social worker
- Regularly missing education
- Attending alternative provision school
- Receiving free school meals
- Parental mental health concerns
- Parental substance misuse
- Being exposed to domestic violence
- Being in a lone-parent family
- Living in a deprived area.

Data sources

We used a range of data sources to explain and calculate the indicators included in our composite indices. Where possible population level data were used from authoritative data sources. These included data published by the UK Government and produced by the Youth Justice Board for England and Wales, Ministry of Justice, HMRC, Department for Work and Pensions, and Department for Education, alongside data from the Office for National Statistics (ONS), National Health Service (NHS) and Mental Health Services (MHS). Additionally, school level data was included from the Department for Education. Where population data was not available, modelled population level estimates were used. These were sourced from the

[48] https://www.ons.gov.uk/methodology/geography/ukgeographies/eurostat#international-territorial-levels-itls-

[49] https://youthendowmentfund.org.uk/reports/children-violence-and-vulnerability-2023/

Children's Commissioner and Labour Force Survey. Further details about all data included in the indicators can be found in Tables 1-7.

Data for Wales

Where possible, data has been obtained from sources which cover both England and Wales. However, for the majority of the indicators, data were only found which covered the nine regions of England and not Wales. In these cases, separate data were sourced to cover Wales, and efforts were made to try and align these as closely as possible to the data covering England. Differences in age-ranges covered, time-periods covered, and data collected made it difficult to combine data that came from one source for Wales and another for England. Specific details for indicator data for Wales only that could not be combined with data for England can be found in Table A1.

All the data which cover Wales only were published by the Welsh Government and came from the children receiving care and support census, pupil level annual school census (PLASC), management information provided by schools, and pupils educated other than at school information. Further details about these data sources can also be found in Table A1.

Definition of serious violent crime

One key indicator which was identified in relation to serious youth violence was the number of children cautioned or sentenced for a serious violent crime. To extract data for this indicator, we first had to define serious youth violent crime. Our definition of serious violent crime came from the Department for Education "Education, children's social care and offending: multi-level modelling" technical report, 2023.[50] Their definition was based on Home Office offence codes and was broadly based on the following categories of offence groups and offence types: violence against the person offences (indicatable only), robbery offences (indicatable only), and possession of weapons offences (triable either way or indictable only). We have chosen to exclude sexual offences for the purposes of this project (see "Sexual offences" section for further details).

The publicly available datasets on youth crime which were used in these analyses, which include data from the Youth Justice Statistics (YJS) from the Youth Justice Board for England and Wales and weapon offence data from the Ministry of Justice (MoJ), do not present Home Office offence codes. Further, for the YJS data, offence groups were already defined and information for offence group was not available by caution or sentence type. Therefore, for our definition of serious violent crime, we used available data for the following groups, which aligned closest with the offence groups and offence types defined by the Department for Education:

- Violence against the person offences
- Robbery offences
- Possession offences of having an article with a blade or point in a public place or on school premises

[50] https://www.gov.uk/government/publications/education-childrens-social-care-and-offending

- Possession of offensive weapon without lawful authority or reasonable excuse in a public place or on school premises
- Offences involving threatening with a knife or offensive weapon in a public place or on school premises

Estimating the total number of children cautioned or sentenced for a serious violent crime

The number of children cautioned or sentenced for a serious violent crime was estimated using data from the Ministry of Justice (MoJ) and Youth Justice Statistics (YJS). Data related to weapons offences were extracted from the MoJ data and included the number of offenders convicted and cautioned for threatening with a knife or offensive weapon offence, and the number of offenders convicted and cautioned for knife and offensive weapon possession offences. Additionally, two variables were extracted from the YJS. These were the number of children cautioned and sentenced, and the number of proven offences committed by children, where a child receives a youth caution or sentence, by the type of proven offence. Given that a child may have multiple custodial orders simultaneously, the number of proven offences is not a count of children, and these data cannot be directly linked to the number of children cautioned or sentenced. Therefore, it was necessary to develop a methodology to estimate the number of children cautioned or sentenced for a serious violent crime in the YJS data. The following methodology was used to achieve this.

Firstly, the proportion of proven youth offences for a serious violent crime offence type (robbery or violence against the person) was calculated regionally, by dividing the number of proven youth offences for a serious violent crime offence type by the total number of proven youth offences. For example, if a region had 1,000 total proven youth offences, and 50 of these were serious violent crimes, then the proportion would be 5%. Next, we inferred that the proportion of proven offences for a serious violent crime would be the same as the proportion of children cautioned or sentenced for a serious violent crime. In other words, if serious violent offences constituted 5% of all proven offences in a region, we would then assume that approximately 5% of the children cautioned or sentenced in that region had committed a serious violent crime. We used the proportion of proven youth offences for a serious violent crime to calculate the estimated number of children cautioned or sentenced for a serious violent crime in the YJS. This was achieved by dividing the regional total number of children cautioned or sentenced by 100, and then multiplying this number by the regional proportion of proven youth offences for a serious violent crime. Note that the same methodology was used to estimate the number of children cautioned or sentenced for a non-violent crime, which included all offence types except robbery and violence against the person. The estimated number of children cautioned or sentenced for a non-violent crime was an indicator included in the previous contact with police-related risk factors composite index. For both violent and non-violent youth crime, sexual offences were removed from the data.

To estimate the total number of children cautioned or sentenced for a serious violent crime, the sum of the estimated number of children cautioned or sentenced for a serious violent crime in the YJS, the number of offenders convicted and cautioned for threatening with a knife or offensive weapon offence from the MoJ, and the number of offenders convicted and cautioned for knife and offensive weapon possession offence from the MoJ was taken.

Estimating the precise number of children cautioned or sentenced for a serious violent crime involves integrating data from different sources and making necessary inferences. Therefore, while our methodology is robust, a number of factors influence the confidence of our estimates, and a degree of caution is warranted in their interpretation. A key step in our methodology involves inferring that the proportion of proven offences for a serious violent crime is equivalent to the proportion of children cautioned or sentenced for a serious violent crime. However, the accuracy of this inference depends on how closely the distribution of offences aligns with the distribution of children involved. If a small number of children were responsible for a disproportionately large share of serious violent offences compared to non-violent ones, our estimate may over-represent the true number of unique children. Conversely, if serious violent offences were more evenly distributed among a larger group of children, the inference would be stronger. Due to the aggregated nature of the available data, precisely quantifying this potential discrepancy is not feasible.

The proportion of children who reoffend by region is provided by YJS, although this is not available by offence type. With the exception of the West Midlands region, there is minimal difference in the proportion of children who reoffend across regions (minimum=31.0% for South East and maximum=33.4% for London, range 3.3%). Given the similar proportions of reoffenders across these regions, we would expect any inaccuracy in our estimates of the number of children cautioned or sentenced for a serious violent crime, which would be driven by any individual children who commit multiple offences, to be similar across regions. This consistency provides a degree of confidence that any relative differences in our estimates between these regions are more likely to reflect genuine variations rather than methodological artifacts related to reoffending patterns. The proportion of reoffenders is slightly lower for the West Midlands region, with a value of 26.5%, however, we would expect our estimate of the number of children cautioned or sentenced for a serious violent crime to be more accurate as the reoffending rate reduces. This difference in reoffending rates means that direct comparisons of absolute numbers between the West Midlands and other regions should be made with greater caution. In addition, we also note that the latest data for the proportion of reoffenders comes from the period between April 2021 to March 2022, whereas the latest data for the number of children cautioned and sentenced, and for the number of proven offences committed by children, comes from the period between April 2022 and March 2023. Therefore, it is possible that reoffending rates may have changed across regions between these two time periods, which could impact the precision and comparability of regional estimates.

Finally, it's important to acknowledge that the underlying data from both the MoJ and YJS are derived from administrative records. While these datasets are robust and systematically collected, all administrative data can be subject to limitations such as reporting inconsistencies, changes in recording practices, or inherent complexities in classifying offences. These factors contribute to the overall context affecting the precision of any statistics derived from such sources.

Sexual offences

The definition of serious violent crime used for this research project, from the Department for Education, does not include sexual offences. Given the possibility that risk factors for committing sexual offences, and the subsequent interventions needed to address this are likely to be specific to this type of offence, we opted to exclude sexual offences from our YJS

datasets prior to estimating the total number of children cautioned or sentenced for a serious violent crime, where possible.

To achieve this the same methodology was used as outlined in the "estimating the total number of children cautioned or sentenced for a serious violent crime" section for the YJS data, to estimate the number of children cautioned or sentenced for a sexual offence per region. The estimated number of children cautioned or sentenced for a sexual offence was then subtracted from the total number of children cautioned or sentenced per region.

Indicator methodology

After identifying and obtaining all required public datasets, each dataset was processed to extract the necessary data. First, each dataset was reduced to only include the most recently publicised data, ideally across a 12-month period. Where possible, the dataset was then further reduced to our age-range of interest (10-18 years). Where this was not possible, the dataset was reduced to the age-range which most closely aligned with our age-range of interest (see Tables 1-7 for further details). Where necessary, a variable containing the ITL1 regions was then constructed using the geographical information available to that dataset. Finally, the dataset was reduced to only include the indictor/s of interest and region variable.

To allow for regional comparisons across indicators, a proportional indicator variable was constructed using the following formula:

$$Proportional\ indicator = \left(\frac{observed\ indicator\ value}{regional\ population\ of\ young\ people\ aged\ 10-18}\right) \times 100$$

Where data for 10 to 18 year olds was not available, or the unit being measured was not the number of young people, a different appropriate denominator was selected.

For the access to children and young people's mental health services indicators, the proportional indicators were constructed and then the additive inverse was taken for several of the indicators (see Table 7 for details). For example, if a region had a proportion of 23% for a given indicator, that value would be changed to -23%. This was to ensure that all the proportional indicators were in a consistent direction, i.e. a higher value for each indicator equated to worse access to mental health services and a lower value equated to better access to mental health services.

Composite indices methodology

Composite indices were constructed to summarise indicators using the methodology for constructing the United Nations Human Development Index (HDI), as outlined in the Human Development Report 2023/2024 technical notes.[51] In summary, all indicators were first standardised to take values between zero and one using the following formula:

$$Standardised\ indicator\ (I) = \frac{actual\ value - minimum\ value}{maximum\ value - minimum\ value}$$

[51] https://hdr.undp.org/sites/default/files/2023-24_HDR/hdr2023-24_technical_notes.pdf

Maximum and minimum values were defined using aspirational targets or available historical data. Where historical data were used, all available data from previous years (10 years maximum) was summarised regionally and the maximum and/or minimum regional value was extracted. As the maximum possible value is likely to be higher than the maximum observed value, an additional ten percent of the value was added to the maximum observed value. Similarly, an additional ten percent of the value was subtracted from the minimum observed value.

To construct our composite indices, the geometric mean of the corresponding standardised indicators was taken, using the following formula:

$$Composite\ index = \sqrt[n]{I_1 \times I_2 \times \cdots I_n}$$

Where *I* is the standardised indicator and *n* is the total number of indicators for a given composite index.

Note that data for Wales was only complete and perfectly aligned to the regional data for England for serious youth violence. Therefore, Welsh data was not included for the serious youth violence risk factors indices or the access to children and young people's mental health services index.

Risk factor composite indices

Given the large number of risk factor indicators, it was decided to create subgroup composite indices to summarise these indicators and simplify interpretation. To decide how the indicators should be combined we used the same criteria as defined in the GOV UK "State of the Nation 2023: people and places" technical annex, from the Social Mobility Commission.[52] Firstly, an exploratory factor analysis was completed, and the factor loadings were examined to see how different indicators associated with different factors. We note that the sample size for these analyses is only nine, therefore factor loadings may be unreliable. Secondly, we reviewed whether our selection of indicators made conceptual sense based on previous research findings. In total five composite indices were created to summarise the risk factor indicators. The subgroup composite indices for risk factors related to serious youth violence were: the parent-related risk factors composite index, the victim of violence-related risk factors composite index, the previous contact with police-related risk factors composite index, the school-related risk factors composite index, and the deprivation-related risk factors composite index. The indicators included within each subgroup composite index are specified in Tables 2 to 6.

An overall risk factors for serious youth violence composite index was also created to summarise the data from the subgroup risk factor composite indices. However, the correlation between the school-related risk factors index and the serious youth violence index was approximately equal to zero. This indicates that the school-related risk factors had no measurable linear relationship with serious youth violence. Given that we want our overall risk factors composite index, to only include risk factors shown to be associated with serious youth

[52] https://www.gov.uk/government/publications/state-of-the-nation-2023-people-and-places

violence, it was decided that the school-related risk factors index would not meaningfully contribute to the overall risk factors index, and it was therefore not included. In addition, the deprivation-related risk factors composite index was found to be strongly correlated to the other risk factor subgroup composite indices. Therefore, it was determined that the deprivation-related risk factors index would add redundant information rather than providing unique insight, and it was also excluded from the overall risk factors index. The final overall risk factors for serious youth violence composite index was comprised of the parent-related risk factors composite index, the victim of violence-related risk factors composite index, and the previous contact with police-related risk factors composite index. A supplementary composite risk factor was created which additionally included the deprivation index.

To create the overall risk factor composite index, the weighted geometric mean of the selected subgroup risk factor indices was calculated, using the following formula:

$$Overall\ risk\ factor\ index = \left(\prod_{i=1}^{n} {X_i}^{W_i}\right)^{\frac{1}{\sum_{i=1}^{n} W_i}}$$

Where X_i are each of the individual risk factor indices (parental factors, victims of violence factors, and previous contact with police factors), W_i are the weights allocated to each risk factor index, and n is the number of risk factor indices. The weights used correspond to the correlation between each subgroup risk factor composite index and the serious youth violence composite index.

Please note that for the school-related risk factors composite index, two separate indicators were included to represent the proportion of children in alternative provision placements (see Table 3 for details). To avoid these two indicators disproportionately influencing the geometric mean, a weighted geometric mean was instead calculated, where each of the alternative provision indicators were assigned a weight of 0.1, and the remaining four indicators were each assigned a weight of 0.2.

Analyses

To analyse how indicators vary across regions, indicator rates per 100,000 children for the indicators included in the serious youth violence composite index, and per 10,000 children for all other indicators, were calculated per region.

To understand regional differences across composite indices, index scores were plotted on a series of heat-maps and the regions were ranked from lowest to highest.

As the values of the different composite index scores could not be directly compared across regions, Pearson's correlation coefficients were calculated to make comparisons. Correlation coefficients were calculated between all composite indices, as well as between individual indicators. A correlation was deemed significant if the associated *p*-value was less than 0.05. Correlation matrices were created to present results.

A sensitivity analysis was also performed to assess the reliability of results, using different indicator variables for the parent-related risk factors composite index which were identified from an alternative data source. The alternative parent-related risk factors index was calculated using the same methodology as the other composite indices. The correlation between the alternative parent-related risk factors index and the serious youth violence index was found to be approximately equal to zero, indicating no measurable linear relationship. Therefore, it was concluded that the alternative parent-related risk factors index would not meaningfully contribute to the risk factors index, and as such no alternative risk factors index was created. The sensitivity analyses completed were the same as the main analyses. Indicators rates were compared across regions, and the alternative parent-related risk factors index scores were plotted on a heat map and regions were ranked from lowest scoring to highest scoring. Correlations were also calculated between the alternative parent-related risk factor index and all other composite indices used in the main analyses, as well as the indicators included in the alternative parent-related risk factors index with all other indicators included in the main analyses.

Table 1: Data sources and information for indicators included in the serious youth violence composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Number of offenders convicted and cautioned for threatening with a knife or offensive weapon offence	GOV UK, Ministry of Justice	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	These three indicators are summed to give the estimated total number of young people cautioned or sentenced for a serious violent crime
Number of offenders convicted and cautioned for knife and offensive weapon possession offence	GOV UK, Ministry of Justice	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	
Estimated number of children cautioned and sentenced for serious violent crimes	GOV UK, Youth Justice Statistics	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	
Average monthly youth custody population	GOV UK, Youth Justice Statistics	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	This data includes 14 youths in custody for sexual offences (monthly average)

Table 2: Data sources and information for indicators included in the parent-related risk factors composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Modelled prevalence of children in households where parent suffering alcohol/drug dependency	Children's Commissioner	Created in 2019, data 2014 Adult Psychiatric Morbidity survey	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	
Modelled prevalence of children in households where parent suffering severe mental health problem	Children's Commissioner	Created in 2019, data 2014 Adult Psychiatric Morbidity survey	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	
Modelled prevalence of children in households where parent suffering domestic abuse	Children's Commissioner	Created in 2019, data from 2014 Adult Psychiatric Morbidity survey	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	

Table 3: Data sources and information for indicators included in the school-related risk factors composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Number of pupil enrolments with a permanent school exclusion	GOV UK, Department for Education	School year from September 2021 to July 2022	10 to 18 years	Total pupil headcount from data source	Nine regions of England	Includes state-funded primary and secondary, and special schools
Number of pupil enrolments with one or more suspensions	GOV UK, Department for Education	School year from September 2021 to July 2022	10 to 18 years	Total pupil headcount from data source	Nine regions of England	Includes state-funded primary and secondary, and special schools
Number of school sessions of unauthorised absence	GOV UK, Department for Education	School year from September 2022 to July 2023	School year 6 to 12+	Total number of sessions possible from data source	Nine regions of England	
Number of placements in local authority funded alternative provision	GOV UK, Department for Education	School year from September 2022 to July 2023	10 to 18 years	ONS Census population data (2021) for 10 to 18 year olds	Nine regions of England	To avoid these two indicators disproportionately influencing the geometric mean, a weighted geometric mean was calculated, where each of the alternative provision indicators were assigned a weight of 0.1, and the remaining four indicators were each assigned a weight of 0.2
Number of placements in state funded alternative provision	GOV UK, Department for Education	School year from September 2022 to July 2023	10 to 18 years	ONS Census population data (2021) for 10 to 18 year olds	Nine regions of England	
Number of children cautioned or sentenced for any offence with special educational needs (SEN)	GOV UK, Department for Education & Ministry of Justice	March 2019 to April 2020	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England	

Table 4: Data sources and information for indicators included in the victim of violence-related risk factors composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Number of young people with an episode of need at any point during the year	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	
Number of young people with an episode of need at any point during the year where “emotional abuse” is a factor identified at the end of assessment	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	Used as a proxy for the total number of young people suffering emotional abuse
Number of young people with an episode of need at any point during the year where “neglect” is a factor identified at the end of assessment	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	Used as a proxy for the total number of young people suffering neglect
Number of young people with an episode of need at any point during the year where “physical abuse child on child” is a factor identified at the end of assessment	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	Used as a proxy for the total number of young people suffering physical abuse, child on child
Number of young people with an episode of need at any point in the year where “physical abuse adult on child” is a factor identified at the end of assessment	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	Used as a proxy for the total number of young people suffering physical abuse, adult on child
Number of young people with an episode of need at any point in the year where “domestic abuse” is a factor identified at the end of assessment	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	Used as a proxy for the total number of young people suffering domestic abuse

Table 5: Data sources and information for indicators included in the previous contact with police-related risk factors composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Number of young people stopped and searched by police	GOV UK, Youth Justice Statistics (YJS)	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	
Number of young people arrested by police	GOV UK, Youth Justice Statistics (YJS)	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	
Estimated number of children cautioned or sentenced for a non-violent offence	GOV UK, Youth Justice Statistics (YJS)	April 2022 to March 2023	10 to 17 years	ONS Census population data (2021) for 10 to 17 year olds	Nine regions of England, and Wales	
Number of young people with an episode of need at any point during the year where “gangs” is a factor identified at the end of assessment	GOV UK, Department for Education	April 2022 to March 2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Nine regions of England	Used as a proxy for the total number of young people in gangs

Table 6: Data sources and information for indicators included in the deprivation-related composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Number of children in households where income is less than 60% of contemporary median household income	GOV UK, HMRC and Department for Work and Pensions (DWP)	April 2022 to March 2023	0 to 15 years	ONS Census population data (2021) for 0 to 15 year olds	Nine regions of England, and Wales	
Estimated proportion of families with a lone parent	ONS, Labour Force Survey (LFS)	April 2022 to March 2023	NA	Total number of families from data source	Nine regions of England, and Wales	
Number of children eligible for free school meals	GOV UK, Department for Education	School year from September 2023 to July 2024	School year 6 to 13	Total headcount data from data source	Nine regions of England	Includes state-funded primary, secondary and special schools, non-maintained special schools and pupil referral units

Table 7: Data sources and information for indicators included in the access to children and young people's mental health composite index

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Additional notes
Average wait time in days for children who are accepted into mental health treatment services	Children's Commissioner (from NHS sources)	March 2021 to April 2022	0 to 17 years	NA	Nine regions of England	
Average spend (£) on children's mental health per child	Children's Commissioner (from NHS sources)	March 2021 to April 2022	0 to 17 years	NA	Nine regions of England	The proportional indicator was calculated and then the additive inverse was taken
Number of open children and young people's mental health services (CYPMHS) referral-spells waiting for a 1st contact at the end of the monthly reporting period	NHS Mental Health Services Data Set (MHSDS) Monthly Reports	December 2024	0 to 18 years	ONS Census population data (2021) for 0 to 18 year olds	Nine regions of England	
Estimated number of CYPMHS referral-spells that closed in the reporting period (monthly)	NHS MHSDS Monthly Reports	December 2024	0 to 17 years	NA	Nine regions of England	Numbers given quarterly and pro-rated to give a monthly estimate
Number of closed CPYMHS referrals with at least 2 contacts (monthly)	NHS MHSDS Monthly Reports	December 2024	0 to 17 years	Estimated number of CYPMHS referral-spells that closed in the reporting period (monthly)	Nine regions of England	

Key Findings

- London was the worst region for serious youth violence and risk factors related to serious youth violence, and the South East was the worst region for access to children and young people's mental health services
- A clear divide was seen between the North and South of England for both serious youth violence and risk factors related to serious youth violence, with both being worse in the North than the South. However, for access to CYPMHS higher scores and worse access were generally observed for the South and Midlands, and lower scores and better access were observed for London, the East and North of England.
- A significant positive correlation was found between the serious youth violence index and risk factors for serious youth violence index. A significant negative correlation was reported between the access to CYPMHS index and the risk factors for serious youth violence index
- A significant positive correlation was found between the serious youth violence index and several of the subgroup risk factors indices, including the parent-related risk factors index, previous contact with police-related risk factors index and the deprivation-related risk factors index. A significant negative correlation was found between the access to CYPMHS index, and both the parent-related risk factors index and the previous contact with police-related risk factors index
- Within indicators for school-related risk factors, strong correlations were observed between suspensions, exclusions, unauthorized absences, and state-funded alternative provision placements. In the indicators for parent-related risk factors, children in households with parental alcohol/drug dependency strongly correlated with parental severe mental health problems and parental domestic abuse. Across indicators for different indices, strong correlations were found between deprivation, family structure, and previous contact with police

Table 8: Rates per 100,000 children for indicators included in the serious youth violence index

	North East	North West	Yorkshire & The Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Estimated total number of children cautioned and sentenced for serious violent crimes per 100,000 children	115	138	149	169	155	133	230	125	108	92	151
Average monthly youth custody population per 100,000 children	8	11	8	8	10	6	12	5	4	4	8

Range for each row: = highest value and = lowest value

Table 9: Rates per 10,000 for indicators included in the school-related risk factors index

	North East	North West	Yorkshire & the Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Number of pupil enrolments with permanent school exclusion per 10,000 children	26	21	14	13	19	12	8	7	15	—	14
Number of pupil enrolments with ≥1 suspension per 10,000 children	682	589	670	545	571	476	465	447	560	—	538
Number of school sessions of unauthorised absence per 10,000 sessions	403	344	407	290	320	265	272	271	289	—	309
Number of placements in local authority funded alternative provision per 10,000 children	62	66	49	63	70	63	68	87	85	—	69
Number of placements in state funded alternative provision per 10,000 children	45	39	27	22	23	18	25	13	24	—	25
Number of children cautioned or sentenced for any offence with SEN per 10,000 children	330	252	283	277	243	253	312	252	252	—	269

Range for each row: = highest value and = lowest value

Table 10: Rates per 10,000 children for indicators included in the parent-related risk factors index

	North East	North West	Yorkshire & The Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Modelled prevalence of children in households with parent alcohol/drug dependency per 10,000 children	423	412	437	401	421	392	421	384	395	—	408
Modelled prevalence of children in households with parent severe mental health problem per 10,000 children	1474	1493	1392	1228	1255	1240	1583	1157	1220	—	1339
Modelled prevalence of children in households with a parent suffering domestic abuse per 10,000 children	702	693	673	610	609	612	784	602	631	—	660

Range for each row: = highest value and = lowest value

Table 11: Rates per 10,000 children for indicators included in the previous contact with police-related risk factors index

	North East	North West	Yorkshire & The Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Number of young people stopped & searched by police per 10,000 children	134	309	146	83	114	136	405	125	84	149	188
Number of young people arrested by police per 10,000 children	147	113	125	92	81	111	118	103	69	98	105
Estimated number of children cautioned or sentenced for a non-violent offence per 10,000 children	17	15	18	15	11	14	14	14	12	16	14
Number of young people with an episode of need where “gangs” is a factor identified per 10,000 children	13	10	9	10	10	8	14	6	7	—	9

Range for each row: = highest value and = lowest value

Table 12: Rates per 10,000 children for indicators included in the victim of violence-related risk factors index

	North East	North West	Yorkshire & The Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Number of young people with an episode of need per 10,000 children	803	665	655	518	606	400	648	641	563	—	605
Number of young people with an episode of need where “emotional abuse” is a factor per 10,000 children	105	99	98	87	106	61	79	73	73	—	85
Number of young people with an episode of need where “neglect” is a factor per 10,000 children	112	74	75	75	72	58	57	72	66	—	70
Number of young people with an episode of need where “physical abuse child on child” is a factor per 10,000 children	17	14	15	12	12	15	17	11	9	—	14
Number of young people with an episode of need where “physical abuse adult on child” is a factor per 10,000 children	59	50	70	42	42	23	48	52	39	—	47
Number of young people with an episode of need where “domestic abuse” is a factor per 10,000 children	58	57	60	55	46	30	46	51	44	—	49

Range for each row: = highest value and = lowest value

Table 13: Rates per 10,000 children for indicators included in the deprivation-related risk factors

	North East	North West	Yorkshire & The Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Number of children in households where income is <60% of median household income per 10,000 children	2114	2698	2325	2489	2870	1400	1581	1327	1739	2153	1996
Estimated proportion of families with a lone parent per 10,000 families	1897	1907	1818	1509	1559	1408	2130	1280	1331	1667	1640
Number of children eligible for free school meals per 10,000 children	3285	2896	2821	2448	2985	2047	2884	1971	2127	—	2557

Range for each row: = highest value and = lowest value

Table 14: Rates for indicators included in the access to children and young people's mental health services index

	North East	North West	Yorkshire and the Humber	East Midlands	West Midlands	East	London	South East	South West	Wales	England
Average wait time (days) for children who are accepted into mental health treatment services	48	37	32	33	48	33	38	52	47	—	41
Average spend (£) on children's mental health per child[1]	101	84	66	64	86	69	87	67	74	—	78
Number of children waiting for a first contact from CYPMHS per 10,000 children	213	156	214	217	344	175	85	317	216	—	213
Estimated number of closed CYPMHS referrals receiving at least two contacts per 10,000 closed referred[1]	5894	5529	6607	4944	4345	6117	5413	3209	6352	—	5108

Range for each row: = best performing region and = worst region performing region[1]

[1] For these indicators, the observed rates are displayed, however, for the composite index the additive inverse was calculated. As such for these indicators the best performing region will have the lowest observed value, and the worst performing region will have the highest observed value.

Table 15: Composite index scores and rankings across regions of England, and Wales

	Composite index													
	Serious youth violence (SYV)		Risk factors										Access to children and young people's mental health services (CYPMHS)	
			Overall risk factors[3]		Previous contact with police (PCWP)-related risk factors		School-related risk factors		Parent-related factors		Victim of violence-related risk factors			
Region	Score	Rank[1]	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank
North East	0.2106	5	0.4560	8	0.2409	7	0.8186	9	0.9051	8	0.4243	9	0.5029	5
North West	0.2669	9	0.4538	7	0.2545	8	0.6897	8	0.8975	7	0.3571	7	0.4545	2
Yorkshire and the Humber	0.2348	6	0.4275	6	0.2192	6	0.6340	7	0.8848	6	0.3853	8	0.4841	4
East Midlands	0.2540	7	0.3582	3	0.1723	4	0.5536	4	0.7982	3	0.3153	3	0.5447	7
West Midlands	0.2663	8	0.3590	5	0.1682	2	0.6204	6	0.8171	5	0.3220	5	0.6736	8
East	0.1901	4	0.3589	4	0.1922	5	0.5005	2	0.7956	2	0.2334	1	0.4631	3
London	0.3634	10	0.4918	9	0.2961	9	0.5115	3	0.9605	9	0.3247	6	0.3127	1
South East	0.1671	3	0.3514	2	0.171	3	0.4219	1	0.7684	1	0.3162	4	0.7387	9
South West	0.1416	2	0.3202	1	0.1382	1	0.5958	5	0.8017	4	0.2785	2	0.5343	6
Wales[2]	0.1249	1	—	—	—	—	—	—	—	—	—	—	—	—
Definition	*High score=high rates of SYV* *Low score=low rates of SYV*		*High score=high rates for risk factors for SYVC* *Low score=low rates for risk factors for SYVC*		*High score=high rates for PCWP-related risk factors* *Low score=low rates for PCWP-related risk factors*		*High score=high rates for school-related risk factors* *Low score=low rates for school-related risk factors*		*High score=high rates for parent-related risk factors* *Low score=low rates for parent-related risk factors*		*High score=high rates for victim of violence-related risk factors* *Low score=low rates for victim of violence-related risk factors*		*High score=worst access to CYPMHS* *Low score=best access to CYPMHS*	

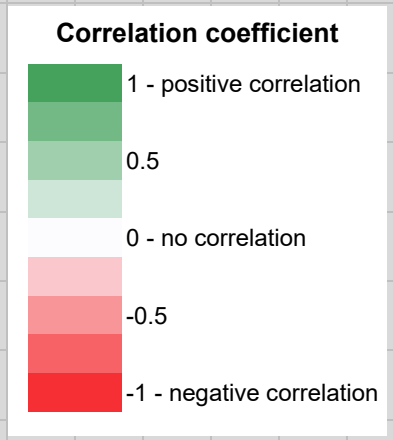
[1] A rank of 1 is given to the lowest index score and a rank of 10 is given to the highest index score, unless Wales is not included in the index, then a rank of 9 is given to the highest index score

[2] Wales data was only complete and perfectly aligned to the regional data for England for serious youth violence. Therefore, Welsh data was *not* included for the serious youth violence risk factors indices (overall risk factors or subgroup indices: school-related risk factors, parent-related risk factors, victim of violence-related risk, previous contact with police-related risk factors) or the access to children and young people's mental health services index

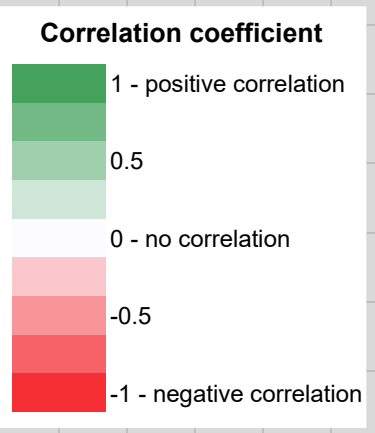
[3] The overall risk factors composite index combines data from the previous contact with police-related risk factors composite index, the parent-related risk factors composite index, and the victim of violence-related risk factors composite index.

Figure 9: Correlation matrix between indicators including data from the nine regions of England

	Estimated total violent crime	Youth custody population	School exclusions	School suspensions	Unauthorised absence	Local authority alternative provision	State alternative provision	SEN[1]	Estimated parental alcohol/drug dependency	Estimated parental mental health	Estimated parental domestic abuse	Police stop & search	Police arrests	Estimated non-violent crimes	Gangs[2]	Children in need	Emotional abuse[2]	Nelgect[2]	Physical abuse child on child[2]	Physical abuse adult on child[2]	Domestic abuse[2]	Income <60% of median household income	Lone parent families	Free school meals	CYPMHS wait time	CYPMHS spend[4]	Still waiting for CYPMHS first contact	Closed CYPMHS referrals receiving two contacts[4]
Estimated total violent crime																												
Youth custody population	**0.72**																											
School exclusions	-0.44	0.22																										
School suspensions	-0.35	0.14	**0.80**																									
Unauthorised absence	-0.27	0.22	**0.71**	**0.95**																								
Local authority alternative provision	-0.27	-0.46	-0.32	-0.56	-0.61																							
State alternative provision	-0.13	0.48	**0.85**	**0.76**	**0.75**	-0.43																						
SEN[1]	0.34	0.38	0.21	0.36	0.43	-0.42	0.55																					
Estimated parental alcohol/drug dependency	0.36	0.66	0.44	**0.69**	**0.76**	**-0.70**	0.60	0.52																				
Estimated parental mental health	0.49	**0.79**	0.31	0.33	0.43	-0.47	**0.72**	**0.67**	**0.69**																			
Estimated parental domestic abuse	0.57	**0.69**	0.10	0.16	0.27	-0.31	0.57	**0.72**	0.59	**0.96**																		
Police stop & search	**0.67**	**0.76**	-0.14	-0.22	-0.08	-0.14	0.29	0.32	0.33	**0.82**	**0.85**																	
Police arrests	0.09	0.35	0.30	0.38	0.58	-0.59	0.58	**0.74**	0.47	0.66	0.58	0.37																
Estimated non-violent crimes	0.00	0.16	0.16	0.48	0.65	-0.67	0.44	0.60	0.42	0.44	0.36	0.14	**0.85**															
Gangs[2]	0.64	**0.82**	0.30	0.24	0.29	-0.47	0.61	**0.79**	0.65	**0.86**	**0.83**	0.64	0.56	0.29														



	Estimated total violent crime	Youth custody population	School exclusions	School suspensions	Unauthorised absence	Local authority alternative provision	State alternative provision	SEN[1]	Estimated parental alcohol/drug dependency	Estimated parental mental health	Estimated parental domestic abuse	Police stop & search	Police arrests	Estimated non-violent crimes	Gangs[2]	Children in need	Emotional abuse[2]	Nelgect[2]	Physical abuse child on child[2]	Physical abuse adult on child[2]	Domestic abuse[2]	Income <60% of median household income	Lone parent families	Free school meals	CYPMHS wait time	CYPMHS spend[4]	Still waiting for CYPMHS first contact	Closed CYPMHS referrals receiving two contacts[4]
Children in need	-0.05	0.36	0.49	0.56	**0.68**	-0.07	**0.69**	0.58	0.56	0.58	0.54	0.27	0.55	0.44	0.46													
Emotional abuse[2]	0.00	0.55	**0.74**	**0.78**	**0.79**	-0.43	**0.69**	0.28	**0.76**	0.42	0.23	0.03	0.29	0.28	0.44	**0.69**												
Neglect[2]	-0.42	0.03	**0.74**	**0.73**	**0.74**	-0.23	**0.70**	0.54	0.34	0.21	0.09	-0.28	0.55	0.50	0.29	**0.72**	0.66											
Physical abuse child on child[2]	0.44	0.59	0.19	0.22	0.37	**-0.69**	0.51	**0.72**	0.59	**0.81**	**0.75**	0.60	**0.85**	0.59	**0.78**	0.30	0.19	0.20										
Physical abuse adult on child[2]	0.01	0.24	0.23	0.62	**0.77**	-0.33	0.45	0.48	0.65	0.43	0.40	0.13	0.53	**0.69**	0.24	**0.82**	0.63	0.55	0.24									
Domestic abuse[2]	-0.04	0.29	0.37	0.65	**0.73**	-0.31	0.54	0.39	0.51	0.35	0.26	0.05	0.40	0.63	0.23	**0.75**	**0.72**	0.64	0.07	**0.89**								
Income <60% of median household income	0.04	0.51	0.63	0.62	0.53	-0.43	0.47	-0.10	0.56	0.18	-0.04	-0.06	-0.08	0.02	0.23	0.25	**0.85**	0.33	-0.06	0.28	0.51							
Lone parent families	0.57	**0.86**	0.30	0.37	0.48	-0.56	**0.69**	**0.69**	**0.78**	**0.98**	**0.92**	**0.78**	0.66	0.48	**0.89**	0.58	0.51	0.23	**0.81**	0.50	0.42	0.29						
Free school meals	0.28	**0.77**	**0.68**	**0.67**	**0.71**	-0.54	**0.81**	0.59	**0.87**	**0.76**	0.61	0.38	0.53	0.34	**0.79**	**0.71**	**0.87**	0.57	0.58	0.55	0.55	0.63	**0.82**					
CYPMHS wait time	-0.41	-0.30	0.17	-0.05	-0.04	**0.74**	-0.01	-0.10	-0.23	-0.27	-0.20	-0.26	-0.22	-0.41	-0.22	0.45	0.14	0.35	-0.45	0.09	0.05	-0.12	-0.31	-0.01				
CYPMHS spend[4]	-0.06	-0.52	-0.66	-0.36	-0.38	0.03	**-0.75**	-0.52	-0.46	-0.64	-0.58	-0.38	-0.41	0.00	**-0.70**	**-0.68**	-0.55	-0.55	-0.46	-0.19	-0.17	-0.23	-0.60	**-0.77**	-0.41			
Still waiting for CYPMHS first contact	-0.47	-0.43	0.09	0.07	0.05	0.36	-0.34	-0.48	-0.19	**-0.71**	**-0.76**	**-0.71**	-0.40	-0.31	-0.58	0.03	0.23	0.22	-0.65	0.06	0.08	0.23	-0.64	-0.17	0.62	0.15		
Closed CYPMHS referrals receiving two contacts[4]	0.10	-0.01	-0.34	-0.52	-0.42	0.55	-0.45	-0.31	-0.40	-0.39	-0.35	-0.07	-0.26	-0.30	-0.24	0.06	-0.02	-0.05	-0.43	-0.05	0.03	-0.04	-0.33	-0.21	0.53	0.07	0.59	



[1] SEN is restricted to children cautioned or sentenced for any offence with SEN

[2] These indicators are restricted to young people with an episode of need where the label for this indicator is a factor identified at the end of assessment

[3] CYMPHS – children and young people's mental health services

[4] The additive inverse of these indicators are included

[5] Correlation coefficients are shown in bold type where p≤0.05

[6] See Table A6 for 95% confidence intervals and p-values

Summarised Discussion and Conclusion

This report compared regional data on serious youth violence (SYV), related risk factors, and access to children and young people's mental health services (CYPMHS).

- **Regional patterns:** London showed the highest levels of SYV and related risk factors but comparatively better access to CYPMHS. The South and Midlands generally had poorer access, while SYV and risk factors were more pronounced in London and the North than in the South. However, availability of CYPMHS does not necessarily mean that those most affected by SYV are accessing them.

- **Correlations:** SYV was positively associated with several risk factors, including parental issues, deprivation, and previous police contact, but not with school- or victim-related factors. Access to CYPMHS was negatively correlated with parental and police-related risk factors.

- **Data limitations:** Analyses were constrained by inconsistent granularity, demographic breakdowns, and time periods across data sources. Limited availability of linked datasets and reliance on proxy or outdated prevalence estimates further restricted insights, especially for sensitive issues like parental substance misuse or child gang involvement. Weak associations between proxies and prevalence estimates highlighted validity concerns.

- **England/Wales gap:** Differences in how England and Wales collect and report data limited cross-nation comparison.

- **Recommendations:**

    - Greater data consistency and granularity, including demographic detail (age, sex, ethnicity) and alignment across England and Wales.

    - Improved availability of regional data on CYPMHS staff capacity, non-NHS services (e.g. school- or community-based), and treatment effectiveness.

    - Development of safe data-linkage methods across sources.

    - Larger, representative surveys for sensitive issues such as substance misuse, parental violence, or gang involvement.

Overall, findings confirm strong regional disparities and links between SYV and multiple risk factors but highlight significant data gaps. These results should be interpreted cautiously and used as a basis for more robust future analyses.

Appendix

Table A1: Indicators for Wales only and reason that data could not be included

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Reason for Wales data not being included
Number of pupils with a permanent exclusion	Welsh Government, pupil level annual school census (PLASC)	School year from September 2021 to August 2022	All school aged children	Number of pupils for all maintained schools from this data source	Wales only	Not able to limit data to young people aged 10 to 18 years
Number of pupils with a fixed-term exclusion (suspension)	Welsh Government, pupil level annual school census (PLASC)	School year from September 2021 to August 2022	All school aged children	Number of pupils for all maintained schools from this data source	Wales only	Not able to limit data to young people aged 10 to 18 years
Number of school sessions of unauthorised absence	Welsh Government, management information provided by schools	School year from September 2023 to August 2024	School years 6 to 11	Total number of sessions from this data source	Wales only	Not able to overlap with the same school years (6-12+) and data collected in different years
Number of pupils educated other than at/in school	Welsh Government, pupils educated other than at school	School year from September 2021 to August 2022	All school aged children (<2 to 19+ years)	PLASC data (2021/22) for number of pupils from all maintained schools	Wales only	Not able to limit data to young people aged 10 to 18 years and data collected in different years
Number of pupils eligible for free school meals	Welsh Government, pupil level annual school census (PLASC)	School year from September 2023 to August 2024	All school aged children (<2 to 19+ years)	PLASC data (2021/22) for number of pupils from all maintained schools	Wales only	Not able to limit to the same school years as the England data (6-13)
Number of children receiving care and support but not looked after and not on the child protection register	Welsh Government, children receiving care and support census	2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Wales only	Not equivalent to the number of young people with an episode of need at any point during the year

Definition	Data source	Time-period covered	Age range included	Denominator for proportional variable	Regions covered	Reason for Wales data not being included
Number of children receiving care and support where domestic abuse is listed as a parental factor	Welsh Government, children receiving care and support census	2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Wales only	Not equivalent to the number of young people with an episode of need at any point during the year
Number of children receiving care and support where parental substance or alcohol misuse is listed as a factor	Welsh Government, children receiving care and support census	2023	0 to 17 years	ONS Census population data (2021) for 0 to 17 year olds	Wales only	Not equivalent to the number of young people with an episode of need at any point during the year
Number of children attending counselling	Welsh Government, Local Authority School Counselling Services collection	March 2022 to April 2023	School years 6 to 13	ONS Census population data (2021) for 0 to 17 year olds	Wales only	Not equivalent to the number of children referred to CAMHS receiving at least two contacts and data collected in different years
Number of children attending more than one counselling episode	Welsh Government, Local Authority School Counselling Services collection	March 2022 to April 2023	School years 6 to 13	Number of children who received counselling from data source	Wales only	No equivalent data for England identified
Average spend on children's mental health per child	NHS Wales	March 2022 to April 2023	0 to 18 years	NA	Wales only	Not able to limit data to young people aged 0 to 17 years and data collected in different calendar years
Number of patients who waited over 28 days from a referral to a Local Primary Mental Health Support Service (LPMHSS) assessment	Welsh Government, Mental Health Measure data collection	July 2023 to June 2024	0 to 18 years	Total number of referrals from data source	Wales only	Categories presented rather than average wait times and data collected in different years
Number of patients who waited over 28 days from a LPMHSS assessment to the start of a therapeutic intervention	Welsh Government, Mental Health Measure data collection	July 2023 to June 2024	0 to 18 years	Total number of assessments from data source	Wales only	Categories presented rather than average wait times and data collected in different years

Annex 5

Barriers to Accessing Mental Health Services and Support for Children and Young People Involved in or at-risk of Serious Youth Violence: A Qualitative Study Across England and Wales

Summary Report: Methodology and Key Findings

Dr Abigail Bentley

Dr Adam Ferner

June 2025

Executive Summary

This report presents findings from a qualitative study exploring the barriers children and young people (CYP) involved in or at risk of serious youth violence face in accessing mental health support across England and Wales. Based on interviews and focus groups with 100 professionals, parents, and young people, it offers a grounded account of the systemic, structural, and interpersonal factors shaping access to care.

While many challenges such as underfunding, long waits and high thresholds, are well-known, this study highlights how these issues are experienced by CYP and those around them, and how they intersect with deeper dynamics of trust, culture, and power. The findings reveal a system often ill-equipped to respond to the complexity, adversity, and mistrust that CYP carry.

At the heart of the findings is a mismatch: clinical, standardised services are poorly aligned with what young people need which is support that is relational, flexible, culturally safe, and grounded in their realities. Rigid thresholds, inflexible structures, and risk-averse cultures exclude those most in need and prioritise protocol over relationship.

Trusted relationships with youth workers, mentors, teachers, and support staff were repeatedly described as key to engagement. These “pre-therapy” relationships are rarely recognised or funded, yet are often the gateway to healing. Professionals stressed that where relational trust could be built, services were more likely to connect meaningfully.

Yet the findings highlight that the system often undermines these relationships. Fragmented commissioning, short-term funding, and poor coordination create unstable support ecosystems. Community and third-sector services, best placed to offer culturally competent, early, and responsive care, are overstretched and underfunded, despite being increasingly relied on to fill statutory gaps.

Structural inequities including racism, classism, and cultural exclusion run throughout. Young people from minority ethnic or under-resourced backgrounds are more likely to be misread, pathologised, or punished rather than supported. A lack of representation and narrow definitions of mental health that don’t account for trauma, neurodiversity and behavioural presentations of poor mental health feed disengagement and barriers to access.

Despite these challenges, examples of promising practice exist. Services that are local, embedded, trauma-informed, and person-centred were seen as more effective in reaching and supporting CYP. These models share a commitment to meeting young people where they are, emotionally, culturally, and contextually, and are sustained by adequate time, funding, and leadership. The findings point to the need for systemic change: investing in community-rooted services, embedding multidisciplinary teams, improving representation, and shifting from rigid, protocol-driven models to flexible, relationship-led care. Above all, this means recognising that CYP at risk of serious youth violence are not hard to reach, they are navigating systems that are hard to access, hard to trust, and hard to stay in. Meaningful change requires not just reforming services, but reimagining care on young people’s terms.

Introduction

This report presents findings from a qualitative study investigating the barriers that children and young people involved in or at risk of serious youth violence face in accessing mental health services and support across England and Wales. The study forms part of a wider project aiming to improve understanding of mental health needs and service accessibility for this group, with the qualitative component representing the most substantial element of the research.

The research sought to build a detailed and grounded picture of the challenges young people face by engaging directly with those most closely affected: practitioners and service providers working on the front line, parents and caregivers, and young people with lived experience. While existing data can provide a high-level overview of service uptake or referral patterns, it is only through qualitative insights that we can begin to understand the real-world obstacles - structural, relational, and emotional - that shape young people's experiences of seeking or receiving mental health support.

Methods

This qualitative study sought to explore the barriers to accessing mental health services and support for children and young people involved in, or at risk of, serious youth violence across England and Wales. A total of 100 participants took part in the study, comprising a mix of service providers and professionals, parents and caregivers, and young people with lived experience. Data collection was carried out through 66 in-depth individual interviews and four focus groups, with efforts made to ensure diversity in professional roles and geographical coverage.

The four focus groups included one with Youth Justice CAMHS practitioners based in London, one with a Youth Justice Team in the North West, two with a group of young people supported by separate NGOs in London. All interviews and focus groups with young people were conducted in close collaboration with trusted NGO partners, to ensure that young participants were supported by adults familiar to them and to help create a safe, comfortable environment for sharing their experiences.

Participants were recruited through a combination of purposive and snowball sampling, with the research team contacting individuals via email and phone. While the majority of interviews were conducted online, focus groups with professionals and all data collection involving young people took place in person. All participants received a voucher as a token of thanks for their time and contributions. A favourable ethics opinion for the qualitative research was granted by the Social Research Association in November 2024[53]. All interviews were conducted only after explicit informed consent was granted. Interviews were confidential, with transcripts anonymised and data stored securely in line with GDPR requirements.

[53] https://the-sra.org.uk/

Professional participants represented a wide range of sectors and roles, including clinical psychologists, consultant psychiatrists, forensic psychologists, counsellors, youth workers, social workers, directors and staff within NGOs, service leads and staff within youth justice services and youth justice boards, magistrates in the youth court, safeguarding leads in education and local authorities, A&E navigators, liaison and diversion teams, trauma-informed practitioners, support workers, youth justice nurses, speech and language therapists, occupational therapists, and headteachers within both pupil referral units (PRUs) and further education colleges. Participants with a range of professional levels were included, allowing for both frontline and strategic perspectives. The table below gives a breakdown of the number of professionals, parents / caregivers and young people included in the research:

Group	**Number of Participants**
Professionals	66 (66%)
Parents / Caregivers	10 (10%)
Young People	24 (24%)
Total	100 (100%)

Participants were recruited from across England and Wales, with representation from urban, suburban, and rural areas. The highest number of participants were based in London and the West Midlands, with the East of England being the least represented region. The table below shows the representation from each region:

Region	**Number of Participants**
London	41 (41%)
South East	3 (3%)
South West	6 (6%)
East of England	2 (2%)
East Midlands	10 (10%)
West Midlands	13 (13%)
Yorkshire & The Humber	5 (5%)
North West	8 (8%)
North East	8 (8%)
Wales	4 (4%)
TOTAL	100 (100%)

All interviews and focus groups were recorded (with consent), transcribed, and analysed using thematic analysis[54], allowing for an in-depth exploration of patterns and experiences across diverse participant groups. This approach enabled the identification of cross-cutting themes as well as group-specific insights, contributing to a rich understanding of the multiple and intersecting barriers that shape access to mental health support for this population.

Key Findings

While pursuing this research, we were constantly struck by the complexity and often vicious circularity of the phenomena at issue. In order to present our findings, it has been necessary to impose a somewhat artificial structure. In what follows, the research output has been grouped into three main sections; the first relates to the factors that lead children and young people (hereafter "CYP") towards involvement in serious youth violence; the second concerns the barriers these CYP face in engaging and accessing support services; the third speaks to the socio-political / systemic factors underpinning many of the barriers to access and obstacles to improving these services. However as was highlighted by our findings, the causal links between these phenomena and structures are far from linear, and often marked by overlapping experiences of exclusion, vulnerability, trauma and unmet needs.

CYP Involvement in Serious Youth Violence and the Youth Justice Service

1. Understanding Serious Youth Violence

This section does not attempt to document the full range of risk factors that need to be considered when discussing serious youth violence, but instead attempts to capture the most significant themes raised by professionals in order to provide context for subsequent sections, and to validate what is already known in this sector.

1.1 Risk factors

- Participants linked serious youth violence to poverty, racial disproportionality, care experience, neurodiversity, trauma histories, and emotional suppression.
- They highlighted multiple, overlapping needs.
- Many risk factors have systemic and structural foundations.

> ***"If you're going to pick one thing that would indicate where the children come into contact with the justice system, it's social deprivation."***
>
> *-Professional, Youth Justice Board, London*

> ***"There's a disproportionate amount of young people who are from the Black and minority ethnic communities within that cohort, disproportionate to our local census data…"I think about 1% of the population is looked after... I think probably nearly 40% of our cohort is looked after. So it gives you some idea of what we're dealing with."***

[54] Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

- *Professional, Youth Justice Service, Yorkshire & The Humber*

1.2. Changes in Trends

- Greater complexity: Participants described a smaller youth justice cohort with more serious needs, including younger children involved in violence and exploitation.
- More girls: Practitioners noted a rise in girls entering the system, often linked to serious offending, exploitation, and mental health issues.
- Pandemic impacts: Participants highlighted ongoing effects of COVID-19, including disengagement and anxiety, but also increased awareness of mental health and neurodiversity.

> ***"When we started work 10 years ago, annually, there were over 150 young people from the area sentenced to custody. We now are under 40 per annum... But in doing that, what we've done is we've now got the real complex young people who've had life challenges."***
>
> - *Professional, Youth Justice Service, Yorkshire & The Humber*

> ***"They're coming into contact for more serious things younger... Now there are 10, 11, 12 year olds coming in for much more serious offences than they would have done in the past."***
>
> *-Professional, Youth Justice Board, London*

1.3. Perceived Influences on Changing Trends

- Targeted grooming of younger children: Participants suggested that exploitation is targeting younger children, driven by perceptions that they are less likely to be detected by authorities.
- Social media as a risk environment: Professionals, parents, and CYP highlighted how social media platforms can escalate violence, enable grooming, and contribute to hidden mental health harms.
- Generational disconnect: Participants described a growing gap between adults and CYP in navigating online spaces, with young people demonstrating sophisticated digital literacy that can hinder adult oversight.

> ***"There's a kind of ladder of adults exploiting young people who are exploiting younger children... Most of the crime is a result of exploitation on some level."***
>
> - *Professional, Youth Justice Board, London*

> **"*Sometimes people use slang words to get past the system. So, for example, if you type 'I want to kill myself', it shows up with a helpline. If you type 'I want to off myself', it'll show up with the actual searches.*"**
>
> - *Young person*

2. Drivers of Missed Opportunities

A strong thread in the data was the idea that young people at risk of serious youth violence often have complex needs that go unidentified or unsupported for many years. Given that

delayed intervention can increase the risk that young people's situations will escalate, these drivers of missed opportunities have been included here as additional factors leading to CYP involvement in youth violence and the youth justice system. However, missed intervention and missed opportunities should also be viewed as a feature of systemic barriers to service access, as discussed in later sections.

2.1. Professional Knowledge Gaps

- Participants highlighted that neurodiverse children and young people are frequently mislabelled, particularly those with autism, ADHD, or communication needs, leading to exclusion, isolation, and missed or inappropriate support.
- Practitioners expressed concern about systemic gaps in training, tools, and early assessment, which can result in misdiagnosis, ineffective interventions, and long-term disadvantage for vulnerable children.

> ***"I feel like some external providers may label children as being naughty or having behavioral this, that, or the other, when actually it's not. There's been an underlying neuro developmental condition that's not been picked up till now".***
>
> *-Professional, Youth Justice CAMHS, North West*

> ***"Neurodiversity and trauma often present in a very similar way… It's often assumed that it's the trauma presentation that we're seeing, rather than something else."***
>
> *-Professional, NHS Vanguard, West Midlands*

2.2. System Drivers of Missed Opportunities in Health and Social care

- Participants described widespread delays in support, with young people often only receiving help after harm has occurred or thresholds are met, by which point trust may be eroded and opportunities for prevention lost.
- Practitioners highlighted how institutional biases and narrow diagnostic frameworks contribute to the mislabelling and marginalisation of neurodiverse and minority ethnic children and young people, particularly when distress is expressed through behaviour.
- The youth justice system was often described as a backdoor to care, with some young people only receiving assessments or interventions after entering the system - seen by participants as a failure of preventative support.

> ***"What CAMHS end up doing is saying: we do mood and anxiety, we do PTSD, we do suicidal ideation. We don't do anger….if you express your distress through behaviour rather than low mood or suicidal ideation…your difficulties are seen as behavioural problems, not a mental health issue."***
>
> - *Professional, Youth Justice CAMHS, London*

> ***"Black children are less likely to be diagnosed as having a mental health need, it is more likely to be understood as a behavioral problem…there's a suggestion that…more often with black children, they're more likely to get periods of exclusion or expulsion, or referred into the PRU than their white counterparts, who might be seen as being having a mental health need and being in more need of support than the discipline approach"***

- *Professional, Care prevention team, West Midlands*

"It's a source of frustration for pretty much everyone involved in youth justice that it takes something bad happening for them to come into contact with the system to get that kind of accelerated service… If that had happened earlier, they may never have committed an offence."

-Professional, Youth Justice Board, London

2.3. Drivers of Missed Opportunities in Schools

- Participants described schools as both a key opportunity and a point of risk, often failing to recognise or respond to the needs of neurodiverse and vulnerable CYP, leading to exclusion and missed support.
- Professionals highlighted the impact of rigid policies, punitive responses, and lack of trauma-informed practice, particularly for CYP whose distress is expressed through behavioural presentations.
- Systemic pressures on schools (limited resources, accountability demands, and staff burnout) were seen to reduce capacity for early intervention, reinforcing a reactive rather than preventative system.

"schools don't seem to be trained in this kind of thing, to recognise that what they see as being naughty…if they just recognised it could be [that the kid is] overstimulated, because the room is really quiet, or it's really noisy, or maybe they're a bit too hot or cold."

- Parent, East of England

Barriers to Support Services

3. Barriers to Engagement

A variety of barriers may lead children and young people to be reluctant to engage with mental health services, even when the services are "accessible". Importantly, the barriers to engagement intersect and emerge from the complex interplay of individual, relational and systemic issues, therefore the three sub-sections that follow describe phenomena that cannot be taken in isolation from each other.

3.1. Personal Barriers

- Participants identified internalised stigma, particularly around masculinity and emotional vulnerability, as a major barrier to mental health support, especially for adolescent boys.
- Professionals and CYP linked help-seeking reluctance to survival strategies, shaped by dangerous environments, distrust of services, and the need to maintain a "hard" exterior.
- Engagement was seen to depend on emotional readiness and trust; participants emphasised the need for trauma-informed, relational approaches that meet young people where they are.

> ***"Boys want to be seen as masculine, as tough, this and that, so most likely they wouldn't want to speak about mental health. From their point of view, they might think 'If I speak about mental health, I'm going to look weak and not masculine.' It's the same when people say 'boys can't cry' because of this and that."***
>
> - *Young person*

> ***"When people are in it, living a very dangerous life, it's difficult to stop and think about what you need... if you've been hypervigilant, letting your guard down can be threatening."***
>
> *-Professional, NHS Speech & Language Therapy, London*

3.2. Family and Community Barriers

- Participants emphasised that CYP engagement with mental health support is shaped by family dynamics, cultural beliefs, and structural inequalities, not individual choice alone.
- Stigma, mistrust, and intergenerational trauma were seen as major barriers, with families often reluctant to engage due to fears of judgement, labelling, or consequences from professionals.
- Professionals highlighted the systemic burden placed on parents and carers, who are expected to advocate and navigate complex systems, often without the capacity, resources, or trust to do so.

> ***"You've got those cultural nuances. A lot of people grow up in environments where what goes on in the house stays in the house, then you've got stigma…it's very hard. There's very few places you can go and say, I've got a problem, and people really hold that space to work through what it is that you're going through. So a lot of times people bottle things up, you know, because you're supposed to appear to be tough, strong. And then, as a result of that, they find escapism through drugs and alcohol."***
>
> *-Professional, NGO, London*

> ***"We talk about young people disengaging, but sometimes it's the parents. They're overwhelmed. They've got three other children, they're working three jobs, and they don't know how to fill out the CAMHS form…If the parent doesn't push, the referral doesn't go anywhere. But not all parents can push."***
>
> -Professional, NHS Vanguard, West Midlands

3.3. Social Context and Perceptions of Services

- Participants described widespread mistrust of mental health services, particularly among minority ethnic communities, rooted in experiences of exclusion, lack of cultural competence, and stigma from professionals.
- Young people and practitioners highlighted the importance of representation and lived experience, noting that trust and engagement often depend on whether services feel relatable, relevant, and understanding of young people's realities.

- Resistance to services was seen as a rational response to systems experienced as unwelcoming, irrelevant, or harmful, underscoring the need for culturally responsive, community-rooted, and relational approaches.

> ***"I don't think I'd want to talk to someone who doesn't understand me. Like, if they ain't been through what I've been through, how they gonna get it?"***
>
> - *Young person*

> ***"Mainstream have caused their own problems. The way they're treated, discredited, discriminated... a lot of people would not go to mainstream services even if they needed support…"Why would I go to somewhere where the person doesn't understand me, doesn't want to understand me, doesn't care whether I'm healthy or unhealthy?"***
>
> *-Professional, NGO, London*

4. Barriers to Access

In the previous section, the notion of "barriers to engagement" was problematised; the issue was not that CYP simply did not *want* to engage with the relevant services, but that there were understandable reasons for them to avoid engagement. In this section, we explore the logistical and conceptual obstacles to accessing services.

4.1. Practical Barriers to Access

- Participants described widespread logistical barriers, including transport, cost, time, and digital exclusion, that make accessing mental health services difficult or unsustainable for many families.
- Service invisibility and complex referral systems were seen as major obstacles, with professionals and parents highlighting a lack of clear information about what support exists and how to access it.
- Safety concerns, poor communication with schools, and inaccessible service locations were reported to further isolate young people, especially those already facing multiple disadvantages.

> ***"I would certainly say that poverty also plays a part. People not having funds to get on the bus to get to an appointment, maybe running out of credit on the phone to talk to staff."***
>
> *-Professional, Youth Justice Service, North West*

> ***"Occasionally you'll hear, if it's anything to do with behaviour and exploitation, there might be areas of the borough we can't go to because it's not safe for them. There'll be other groups or gangs that have a problem with them, and that might create some risk. So sometimes that might prevent the child from being able to go to a certain area."***
>
> *-Professional, Youth Justice Board, London*

> ***"I would like to know what kind of mental health services exist…I didn't know that GPs are in mental health services. I thought they were just for other types of illness"***

-Parent, London

4.2. Barriers to Communication

- Participants described widespread communication barriers, including language, terminology, and systemic jargon, that make it harder for children, families, and even professionals to understand or navigate mental health services.
- The language of the system was seen to privilege certain forms of expression, with access often dependent on whether young people or referrers could "speak the right language" - a major barrier for those with communication needs, trauma, or neurodivergence.
- Breakdowns in communication between services and lack of joined-up infrastructure were reported to result in missed referrals, confusion, and underuse of trusted community-based support.

> ***"When we see children where English isn't their first language… if we look at talking therapies…access to support in their native language isn't readily available at all… we don't do enough."***
>
> *-Professional, CYP Health and Justice, West Midlands*

> ***"The communication difficulties within our cohort is huge. Children just having the words to explain what it is that they're thinking and feeling is a real barrier as well…we can do lots to that lower level emotional literacy, education, understanding communication difficulties. How do we ensure that children can understand the situation that they're in and what's happening? But it's that next tier, it's tier three services, that where's the real gap, because we still have to refer in to them"***
>
> *-Professional, CYP Health and Justice, West Midlands*

> ***"If you can't speak that language, and you don't have that relationship to how to express in the right way, you don't get through the door. When you express your distress and your trauma…through externalising behaviour in your actions, rather than traditional internalising symptoms…then effectively you're speaking the wrong language."***
>
> - *Professional, Youth Justice CAMHS, London*

4.3. Structural Barriers

4.3.1 Thresholds and Waiting Lists

- Rigid thresholds and fragmented commissioning structures were described by participants as systematically excluding a "missing middle": young people whose needs are too complex for low-tier support but not severe enough for CAMHS, leaving them without appropriate mental health care.
- Long waiting lists, especially for CAMHS and neurodevelopmental assessments, were viewed as a major structural failure, often resulting in children being left unsupported for months or even years, during which needs escalate, risks increase, or opportunities for early intervention are lost.
- Participants emphasised that the system's reactive nature, i.e. waiting for crisis before responding leaves young people, families, and professionals without timely or adequate

support, with some young people only receiving help after contact with youth justice services.

> ***"There's also a mental health gap for children and young people. Most community-based services have got criteria. We've got criteria for our counseling, which was created by the commissioning body, and that supports mild to moderate needs for children and young people. CAMHS support severe. So between moderate and severe, there's a gap, and there's no provider who's providing support in that gap"***
>
> *-Professional, NGO, South East*

> ***"It's not always easy to get a counsellor or a therapist. I was waiting for my therapist for a year…"***
>
> - *Young Person*

> ***"CAMHS has a three-year waiting list. So whilst they're waiting for that, sometimes things escalate…I think we're quite limited in terms of what support is available [in the meantime]"***
>
> *-Professional, Care prevention team, West Midlands*

4.3.2 Inability to Deal with Complexity

- Participants consistently highlighted how mental health services struggle, or are structurally unable, to hold complexity, particularly for young people with intersecting needs such as trauma, neurodiversity, exploitation, or substance use. This results in children being excluded not because of lack of need, but because they don't fit a neat diagnostic category.
- To access support, young people's experiences often had to be reduced or 'flattened' into narrow diagnostic terms that services would recognise. Professionals described this as a barrier that distorts the reality of young people's lives and excludes those who do not or cannot communicate distress in system-legible ways.
- Even when eligibility thresholds are met, services often lack the capacity, flexibility, or relational foundations to engage meaningfully, leading to cycles of assessment, referral, and disengagement that ultimately reflect a system designed around simplicity, not complexity.

> ***"One of our biggest barriers is substance misuse, because often complex trauma that leads to mental health issues gets hidden behind substance misuse issues and a lot of our services aren't set up for a dual diagnostic approach…if you come to CAMHS under the influence you get thrown out of CAMHS, not only do you get your meeting disengaged but you get your intervention disengaged"***
>
> *-Professional, CAMHS, East Midlands*

> ***"Even if he got to the top of the waiting list, his first appointment would have been his last. Because there's no capacity to build a relationship….half of these services aren't able to really understand the need, but also constantly revolve the door around them. Close, open. Close, open. So yeah, they get lost, lost."***
>
> - *Professional, Youth Justice CAMHS, London*

4.3.3. Inability to Hold Risk

- Participants described widespread institutional reluctance to “hold risk”, with services across statutory, community, and school settings often avoiding or excluding young people whose needs are seen as too complex, risky, or associated with offending.
- Risk was often framed in narrow, clinical terms, focused on diagnosable mental illness or self-harm, excluding those whose distress is expressed through violence, substance use, or behavioural difficulties, and leading professionals to modify referrals or risk assessments just to fit system requirements.
- This systemic aversion to complexity and risk was described as creating significant barriers to access across the mental health landscape, resulting in young people being bounced between services, excluded from both early and intensive support, and left without care at moments of acute vulnerability.

> ***“The outline of the services is basically based around the model where your risk is driven by harm to self or mental health risk. An example is that we do a lot of work with complex cases and do a lot of risk assessments but we would rarely [assess someone] as high risk because our risk protocols indicate that if it's high risk, I need to be saying that risk is due to a mental health disorder, and it's very difficult to define it that way.”***
>
> - *Professional, Youth Justice CAMHS, London*

> ***“CAMHS have such a strict referral criteria that if the young person is presenting with anxiety and low moods, they may not reach the threshold… so then there’ll say there’s a lower level…like a charity organisation that can offer support…but then they’ll say, because of the risks, they're not prepared to work with the young person.”***
>
> *-Professional, Forensic CAMHS, East Midlands*

> ***“We do divert quite a lot through for talking therapies… The difficulty when we consider violent offending is that they [the service] are often very reluctant because of the risk… those are the children that actually, in my mind, need some wraparound support. But the willingness of mainstream services to work with those children… they see situations such as carrying knives as a policing issue rather than a mental health issue.”***
>
> *-Professional, CYP Health and Justice, West Midlands*

4.3.4 Inflexible Services

- Participants described inflexible service models, like clinic-based care and “three strikes” discharge policies, as fundamentally misaligned with the lives of young people facing trauma, instability, or neurodiversity, often penalising non-engagement rather than adapting to support it.
- Rigid, clinical environments and standardised protocols were seen as barriers to trust and engagement, especially when they fail to offer safe, welcoming, or emotionally accessible spaces.
- Professionals called for trauma-informed, flexible, and relational approaches, arguing that services must shift from protocol-driven models to ones capable of holding complexity and building sustained, trust-based support.

> ***“CAMHS do clinic appointments, and if you don’t show up twice, then it’s a discharge…that kind of process doesn’t help our young people to engage.”***
>
> *-Professional, CYP Health and Justice, West Midlands*

"A clinic-based model for children, quite often, is a massive barrier, because the case gets shut down quite quickly if children don't engage. Where you've got very complex children, the likelihood of children engaging at the front end is very small. You have to work that engagement."

-Professional, Youth Justice Service, Wales

5. Barriers to Retention

Even when young people make it through the door of a mental health service, there is no guarantee that their needs will be met, or that they will remain engaged. While accessing mental health support represents a critical step for children and young people involved in or at risk of serious youth violence, many of the challenges do not end at the point of entry. This section draws out some of the main themes that emerged in relation to barriers to retention.

5.1 The Importance of Trusting Relationships

- Trusting, consistent relationships were described as essential for engagement, especially for young people with histories of trauma, exclusion, or mistrust of services; without this foundation, formal mental health support was often ineffective or avoided altogether.
- Relational approaches, including informal, flexible, and non-clinical interactions, were seen as a vital "pre-therapy" step, helping young people feel safe enough to open up and eventually access support.
- Participants emphasised that trust is not a bonus but a prerequisite, and highlighted the need for trauma-informed, person-centred care models that prioritise connection, persistence, and authentic engagement over rigid protocols.

"Someone who has a trusted adult relationship, that young person is more likely to be able to open up and to discuss what's going on for them than someone who's not got those strong attachments. I think that's consistent across the board for all of the young people we work with."

-Professional, Youth Justice Service, North West

"I feel it's okay to talk about my problems, but it has to be with someone who I trust."

- *Young person*

"I've met a couple of young people out for a coffee somewhere and just kind of had a chat, and it's a lot less formal. The idea is that you are trying to engage with them on a level that is their level, rather than going in with…a formal kind of meeting. It's very intimidating for a young person, so we don't touch that so much

-Professional, Liaison & Diversion Team, South West.

"We have to build very, very good relationships with young people…those relationships… is how we pass young people along to other professionals, with them trusting who's passing them on."

-Professional, NGO, London

5.2. Ongoing Communication Barriers

- Professionals described ongoing communication breakdowns as a major barrier to sustained engagement, including unclear explanations of what therapy involves, inconsistent messaging, and a lack of transparency around processes, decisions, and expectations.
- Young people's disengagement was often linked to mistrust, emotional fatigue, and poor communication, with repeated retellings, limited feedback loops, and unmet expectations reinforcing a sense that services are not safe, responsive, or for them.
- Participants called for services to take more responsibility for engagement, reframing disengagement not as young people being 'hard to reach,' but as a sign that services need to communicate better, adapt more flexibly, and build relationships that foster understanding and trust.

"They don't know what's going to happen. No one tells them. Then they get into a room with a stranger and are expected to open up. Of course they're going to shut down."

-Professional, CAMHS, East Midlands

"Some young people have never had the opportunity to tell their stories, and others repeat, repeat and repeat."

-Professional, Professional Body, London

"They've been referred to every man and his dog, and they feel that nobody's actually done anything to help them... So what's the point? Because they don't want to help me…we see kids that are just so despondent and think that they can't be helped... that has a huge impact on children's perception of self, but also their willingness to then engage as they move forward…let's collaborate and share [information], rather than expecting them to keep repeating their story... it's about giving people the option of what they do, what they say, what they share, rather than forcing people through services."

-Professional, CYP Health and Justice, West Midlands

5.3. The Influence of Parents, Families and The Environment on Sustained Engagement

- Chaotic home environments, unmet basic needs, and systemic instability were cited as major barriers to sustained engagement, with services often assuming stability that many young people lack.
- Parental involvement and family dynamics were described as shaping engagement outcomes, yet parents often felt unsupported, scrutinised, or excluded, highlighting the need for holistic, non-judgemental, and family-inclusive approaches.
- Practitioners called for services to acknowledge and adapt to the wider context of young people's lives, recognising that without trust, flexibility, and support for the whole family, therapeutic interventions may be inappropriate or unsustainable.

"How do you provide that [therapeutic] need when the very, very basic needs are not being met? …When you're trying to provide it and they go back home to something that's very, very chaotic, they're not getting fed, they're not getting looked after. They may be suffering neglect and abuse."

-Professional, Youth Justice Board, Wales

"Instead of it being used to prevent these as an early preventative measure for children, it's being used to scrutinise adults and say that because they haven't had a good childhood, they can't possibly give a good childhood to their children."

- *Parent, West Midlands*

"We had to get the right adult, not just for the child, but also for Dad... he lacked trust in professionals."

-Professional, Care prevention team, West Midlands

5.4. The Need for Individualised, Person-Centred Care

- Professionals consistently emphasised the need for flexible, individualised, and person-centred support that meets young people where they are, rather than relying on rigid models or standardised approaches.
- Therapeutic choice, agency, and relational trust were seen as essential for engagement, especially for young people with complex needs, neurodivergence, or histories of trauma and exclusion.
- Tailored support delivered with creativity, patience, and adaptability was viewed as best practice, enabling young people to feel heard, respected, and in control of their own therapeutic journey.

"It's really difficult to pin it down to a model. Yes, I think it has to be very much individualised. What I found in practice is that… almost that label of 'we're going to use this kind of therapy' doesn't work. It needs to feel very informal, and it very much needs to be led by the young person."

-Professional, CYP Health and Justice, West Midlands

"Therapeutic choice is what it's really about… and the right counsellor for that child or young person."

-Professional, Professional Body, London

"If you speak to 10 or 20 therapists, they're all going to lean towards different modalities… but for me, best practice is to meet people where they are. You use the modality that is most sufficient… depending on what is presented to you."

-Professional, NGO, London

Systemic Underpinnings

While this report has so far discussed different points along the mental health access pathway, professionals repeatedly emphasised that these barriers are not isolated and not linear. Instead, they form a complex web of intersecting issues, rooted in structural decisions, cultural norms, and institutional design. In this section, we draw those threads together to highlight how the system as a whole produces, and reproduces, barriers to service access.

6. Lack of Funding and Resources

- Chronic underfunding and years of austerity were seen as the root cause of many structural barriers, driving high thresholds, long waits, fragmented services, and an inability to provide sustained, flexible support.
- Professionals described a system where overstretched teams, short-term projects, and workforce burnout are the norm, limiting relationship-based work and forcing services to prioritise more serious cases at the expense of early intervention.
- Cuts to broader community and youth provision were described as having hollowed out the ecosystem of support, leaving many young people without the foundational services that could have prevented or mitigated escalating mental health needs.

> ***"CAMHS provision in terms of youth justice, because we work with more complex children, is still extremely limited. We've got a CAMHS officer one day a week. That CAMHS officer is really squeezed. But you know, CAMHS services are squeezed across the board, and I think it is about how we create enough resource to be able to advise those other practitioners where children are underneath that threshold, but then for that practitioner to assist those children that are not able perhaps to get to a clinic."***
>
> -Professional, Youth Justice Service, Wales

> ***"The main barriers are the lack of resources and funding within our system. I think the system of austerity, of government cuts for the last 15 years, has meant that those hardest hit areas of the country are not being reached for mental health services, or for any services. All the crisis intervention services are reacting to higher levels of need and higher thresholds, and actually those young people that are needing the early intervention, prevention and diversion, they are getting missed because there isn't any investment"***
>
> - *Professional, NGO / Youth Court, South West*

> ***"We've been through a period of much reduced public funding, some would classify as austerity, where it's really squeezed, not only mental health service, but all manner of other services, which are the safety net and the fabric of a functioning society and safe society. Because a lot of those have been thinned…I think it's where we've had isolated children, children who haven't had their full gamut of services…sometimes therapy is not just about the therapeutic process, and those additional services just haven't been there or been at the same scale to look after the children at the same level, and to keep those needs in check, prevent the needs from arising in the first place".***
>
> *-Professional, Youth Justice Service, East Midlands*

7. Commissioning Structures

7.1 Commissioning Priorities, Cycles and Criteria

- Professionals expressed frustration that funding decisions are often made without input from those delivering services, leading to fragmented provision and priorities that are misaligned with young people's actual needs and frontline realities.
- Short-term, ring-fenced, and criteria-driven funding structures were seen to drive instability and fragmentation, with services frequently decommissioned just as they gain traction, and eligibility rules excluding young people most in need.

- Commissioning processes were seen to often favour large, generalist providers and fail to sustain specialist or community-rooted services, leaving smaller organisations to fill gaps without adequate resources, creating inequity in support and limiting their ability to scale, sustain, or be recognised.
- Commissioning cycles were seen as outdated and restrictive, forcing services to adapt to what is fundable rather than what is effective, leaving young people to navigate a patchy and disjointed system shaped more by funding logic than lived need.

> ***"We were given funding for early intervention, so when kids were coming in for a first event, they were given part of a pot of money that would offer extra money to do activities and things. However, the exclusion criteria was if any child had had any form of intervention or support from social care or Children's Services previously, they didn't qualify for that help. So that child just had to come in with a first offense of whatever. A child could come in with the first offense of possession of cannabis, but they otherwise have a stable home life…who might get the funding. You've got another child picked up for the same thing, on the same day, but because they've had previous intervention support, they don't get that money. The logic behind these things, to me, is lacking. It doesn't seem to make any sense"***
>
> *-Professional, Forensic CAMHS, East Midlands*

> ***"I think the main barrier is funding, and also appropriate funding that matches what the actual need is. Sometimes there's been bits of money that we haven't gone for because we would have to manipulate our service to such a degree that actually we're not comfortable with. We can say we're very successful at doing X, Y and Z. And funders go, that's great, come and apply for money because we're giving it for A, B and C. Well, that's not what we do. So I think the amount of money, and actually the longevity of the funding as well, because you sometimes get funding for one or two years. And when you're looking at working with young people, if you're working with them for even eight to 12 months, if they're not in at the beginning of that funding, [they're not going to get supported]."***
>
> *-Professional, NGO, North East*

> ***"Other services don't deliver so the public sector will sort of help the local authority. We get so many referrals from the local authority, but we're not getting the funding at the minute. The funding is not there yet it's social care who aren't fulfilling the requirements of young people on their caseload, who are referring them to us with an expectation that we will be able to provide this service and respond to referrals really quickly, yet the funding isn't there"***
>
> *-Professional, NGO, North East*

7.2 National vs Devolved Models and Postcode Lotteries

- Professionals valued locally commissioned models for their ability to tailor services to area-specific needs, particularly in youth justice, but highlighted that this often results in a "postcode lottery" of provision, with significant disparities in what young people can access based on where they live.
- Centralised funding and national programmes were seen as potentially useful for establishing consistent baseline provision, but practitioners warned that when spread too thin, they risk replicating the very gaps they aim to fill.
- There was broad agreement that a hybrid model is needed - one that combines national consistency and equitable funding with local flexibility to design services rooted in community needs.

"We've got a holistic, one-stop shop, with mental health practitioners embedded in our team. In the next borough, they've got a nurse in YJS three days a week. There's a massive disparity."

- *Professional, Youth Justice CAMHS, London*

"One borough gets over a million. Another borough gets half as much—but that borough has got more children, more need….but no one wants to take money away from areas that vote for them and give it to areas that don't. It gets political."

-Professional, Youth Justice Board, London

"Maybe it's about having enough funding so that each area can have that embedded model. You have to start local… and then you can add the centralised element."

- *Professional, Youth Justice CAMHS, London*

8. Structural Challenges in Service Design and Delivery

While individual-level barriers are often foregrounded, this section explores how the broader architecture of services, how they are designed, coordinated, and governed, can create or compound access challenges.

8.1. Lack of Multi-Agency and Multidisciplinary Working

- Professionals widely criticised the lack of multi-agency and embedded multidisciplinary working, describing a fragmented system where siloed services, poor data-sharing, and misaligned thresholds result in disjointed care and young people falling through gaps.
- Where multidisciplinary teams and joint working were in place, especially within youth justice services, practitioners reported better outcomes and more responsive care, but these models were the exception and varied significantly by location, often dependent on local leadership or funding.
- Collaboration was often sustained by individual relationships and practitioner initiative, rather than being built into systems or structures, highlighting both the importance and fragility of relational workarounds in the absence of systemic integration.

"The NHS have a system. Education have a different system. Police have a different system… So trying to get all the information together at the right time, for the right person is impossible."

Professional, NHS Vanguard, West Midlands

"What some services do is quite nice… they have a panel—clinical psychs, forensic psychs, ed psychs. A practitioner can bring a case and ask, 'What do you think?' It's not just about direct work, but reflective practice too."

Professional, Youth Justice Board, London

"Not many youth justice services have an in-house CAMHS practitioner on their team. So I think we're really fortunate. I know I've experienced it working in youth justice and other authorities, where a barrier would be, you've identified these concerns, but then we've got to go to mainstream CAMHS, put them on the waiting list, and then they might get closed due to

difficulties with engagement. Whereas we've got that offer in-house where we're able to keep them open for longer and build relationships"

Professional, Youth Justice Service, North West

"We have, thankfully, very good relationships with our colleagues in tier three and our CAMHS colleagues…We have a very supportive team, a very supportive consultant. I'm supervising a psychologist in tier three to work with a child I was going to see in youth justice. Tier three didn't want to see him… but because we were connected, we made it work...Being able to work with CAMHS as well as YJS means now we can bridge gaps"

- *Professional, Youth Justice CAMHS, London*

8.2. Pressure on Non-Statutory Services

- Non-statutory services are increasingly relied upon to fill critical gaps left by overstretched statutory provision, particularly in mental health, yet they are often expected to support high-risk young people without the resources, funding, or formal recognition to do so safely or sustainably.
- Practitioners described holding significant emotional and professional risk, supporting young people in distress who fall between service thresholds, while facing limited access to statutory safeguarding or specialist support and navigating fragmented systems with little systemic backing.
- Schools and community organisations are under mounting pressure, with teachers and youth workers frequently absorbing mental health responsibilities without adequate training or supervision, and with external services often judged by narrow academic outcomes rather than meaningful wellbeing impact.

"More young people than ever are accessing our services since COVID, and they're having to wait weeks and months for mental health support…It's too long... what they were doing [in the meantime] was hanging on to their youth workers, or whoever was around them."

Professional, NGO, London

"We've had lots of interaction with our so-called peers in statutory services where we're really worried about a young person and not got the backup... and actually been left thinking, 'Oh my God, this person is literally at risk for their life,' and I, as a professional, cannot access useful support."

Professional, NGO, South West

8.3. Therapeutic Modalities and The Evidence Base

- Practitioners questioned the dominance of CBT and other standardised therapies, arguing that their prominence may reflect what is easiest to measure through traditional evidence standards rather than what is most effective for young people affected by trauma, violence, and systemic adversity.
- There was strong support for more relational, flexible, and youth-centred approaches to evaluating impact, with calls to move beyond narrow metrics and adopt models that better capture meaningful change and therapeutic progress from the young person's perspective.

"CBT becomes so evidence-based, and knocks everything else off. But it actually, for me, is all very well if you want to work on behaviours, thoughts and feelings… But it isn't trauma-informed. It doesn't take into account ACEs…unless you use CBT as part of a more integrative approach… You're missing the trauma, you're missing the story."

Professional, Professional Body, London

8.4. Whose Voices are Heard in Service Design and Delivery?

- Professionals described a system where frontline insight and lived experience are undervalued, with decision-making concentrated at senior levels and limited involvement of those who work directly with young people or have experienced the system themselves.
- Participants highlighted the absence of meaningful opportunities for young people and families to be heard, describing services as overly professionalised and process-driven, often failing to listen even when young people actively ask for help.

"If you're a service lead or a clinical lead you're probably going to get people to listen to you. I don't like to say it, but that's true."

- *Professional, Youth Justice CAMHS, London*

"Sometimes the family and children's voices aren't put across enough, because it's all professional views."

Professional, Care prevention team, West Midlands

8.5. Lack of a Trauma-Informed System

- While trauma-informed practice is widely referenced, professionals described a gap between rhetoric and reality, with many services lacking a shared understanding or meaningful implementation of trauma-responsive approaches across sectors.
- Systemic barriers, such as rigid commissioning, short-term funding, high caseloads, and fragmented care, undermine the relationship-based, flexible support that trauma-informed care requires, leading to re-traumatisation and reinforcing young people's mistrust in services.

"We've heard that word trauma-informed, trauma-identified practice, quite often over the past years, and agencies say 'yes, we're trauma-informed, we're this, we're that'. Sometimes defining what that actually means is an interesting conversation…so you're trauma informed, what does that actually mean? And they'll say, 'we've been on a course, we understand adverse childhood experiences, we understand that and we're empathetic to that and therefore we're trauma-informed'. But the next stage is all about well, how responsive are you? What do you do specifically around trauma? How far do you go down that line?"

Professional, Pupil Referral Unit, Wales

"I do think there's a huge gap in understanding about that kind of awareness of trauma, about thinking about how we might identify these young people in the first place, how we might identify them as somebody who might need mental health support, rather than labelling them as a challenging young person"

Professional, NHS Vanguard, West Midlands

9. Inequitable Systems

- Black and Minority Ethnic young people are disproportionately misdiagnosed, excluded, or penalised within services shaped by Western clinical norms. A lack of cultural representation, understanding, and flexibility contributes to mistrust, misinterpretation of distress, and systemic alienation from mental health care.
- Children from less resourced or working-class backgrounds face systemic barriers to accessing support, including complex referral systems, reliance on clinical language, and expectations of advocacy that favour more privileged families. The system assumes institutional fluency and penalises those without it, functioning as a gatekeeper rather than a safety net.
- Neurodiverse children are structurally excluded across education, health, and justice systems, often misread as disruptive, punished instead of supported, and placed into systems not designed to meet their needs. This reflects a broader failure to adapt services to neurodiverse experiences, resulting in cycles of exclusion and compounded harm.
- Cycles of violence, trauma, and mistrust are often intergenerational, rooted not in individual failure but in systemic neglect. Parents and caregivers described how historic lack of support and structural disadvantage have compounded across generations, creating deep mistrust and undermining family capacity to engage with services, even when support is urgently needed.

"I think we don't do enough to understand the impact of culture… around their understanding of mental health care or accessing support. Even things like the role that violence plays within families… I don't think we understand properly the nuances that kind of those cultural differences bring."

Professional, CYP Health and Justice, West Midlands

"You need to speak our language to get these referrals, to get support. Unless your child is sitting in front of us saying, I have A, B and C—depression, low mood, and help me please—then it doesn't really work… it's an institutionally discriminatory system that is classist as a result."

- *Professional, Youth Justice CAMHS, London*

"When I was a child, things that I wouldn't have recognised back then as being mental health issues and caused by my environment... I can see that, yeah, I was suffering with those issues, and they did lead to some more severe issues in later life. And the help wasn't there because it wasn't recognised. That I was just a naughty child….My mom did try and get me support, but all that they could offer me was anger management. It wasn't that I was angry, I was afraid, I was terrified... That did lead to some quite dark times in my life."

- *Parent, West Midlands*

10. What Young People, Parents and Professionals Want

Despite the many barriers outlined in this report, participants also spoke with clarity and hope about what *could* work, and, in some cases, what *is* working in pockets of good practice. At the heart of these insights was a call for services that are flexible, relational, culturally safe, and genuinely responsive to young people's lived realities:

- Local, Trusted, and Embedded Support
- Earlier Intervention and Wraparound Support
- Cultural Safety and Representation
- Flexible, Trauma-Informed, and Relationship-Based Models
- Holding the Whole Person
- Multiagency Working and Embedded Models of Care

Limitations

To some extent, the preceding sections suggest relatively neat causal chains: e.g. schools are underfunded, therefore unable to proactively pursue preventative strategies; young people have internalised stigma, therefore are reluctant to engage in stigmatised mental health services (etc.). It is important to note, however, that there is a linearity to the way the information is presented that fails to fully represent the vicious circularity inherent to the systems under discussion. The sections above were organised, in part, to create a narrative thread, but (perhaps necessarily) fail to represent the contorted and sometimes recursive causal logic described by the participants. Similarly, the representation of the data is limited insofar as it organises the issues (e.g. drivers of violence, barriers to access) into neat categories. In so doing, it falls foul of the reductive, simplifying strategies it aims to critique.

In addition to these structural constraints in analysis and presentation, there are also limitations in whose voices are represented within this study. The majority of participants were based in major urban hubs, particularly London and the West Midlands, which may limit the generalisability of some findings to rural or less densely populated areas, where service provision, community dynamics, and risks may differ considerably. Despite attempts to secure a broad geographical spread, participation from some regions was low.

A further limitation relates to the inclusion of children and young people themselves. While the research team made extensive efforts to collaborate with NGOs and community organisations to engage CYP with lived experience, this proved extremely challenging in practice. The final sample includes fewer young people than originally hoped, and those who did take part were supported by trusted adults and organisations, suggesting a level of stability, support, and access not shared by all CYP affected by serious youth violence. The perspectives of those most deeply disengaged, mistrustful, or marginalised may therefore be underrepresented.

More broadly, participation across all groups depended on time, interest, and capacity. This means the research reflects the voices of those who had the motivation and availability to contribute. It is possible, and likely, that those most disillusioned with or alienated from the

system, or most burdened by frontline work, were unable or unwilling to take part. As a result, some perspectives and experiences may be missing.

Finally, while every effort was made to ensure ethical, reflexive, and inclusive research practice, the interpretation of data is shaped by the researchers' own positionalities and analytical decisions. Although the report strives to amplify the insights of participants, it is ultimately a curated representation of their accounts, filtered through processes of theme development, narrative construction, and writing. These limitations should be kept in mind when interpreting the findings and considering their application.