Beyond Adversity:
Addressing the mental health needs of young people who face complexity and adversity in their lives.
1 in 3 adult mental health conditions relate directly to adverse childhood experiences. It is, therefore, vital that we understand the impact that adversity, complexity and trauma can have on the mental health and wellbeing of young people. However, many children, for example, who are neglected, witness domestic violence or face prejudice, still do not have their mental health needs identified.

Sometimes services are too focused on what they see as challenging or risky behaviour. This can stigmatise or criminalise normal responses to childhood adversity and trauma. Responses like these result in the unnecessary escalation of problems and have a profound impact on their social and emotional and development, as well as life outcomes and mental health in adulthood.

Worryingly, we know that experiencing adversity, complexity and trauma in childhood or adolescence increases the risk of mental and physical ill health, and that those young people affected may die earlier than their peers.

Spurred on by additional Government investment, the publication of Future in Mind, and the NHS’ Five Year Forward View on Mental Health, children and young people’s mental health services are going through a period of significant change.

This is a welcome direction of travel - with children’s mental health being prioritised by local areas and transformed through a coordinated local plan. We hope that this will create, on the ground, the positive ambition for meeting children’s mental health needs that was agreed nationally.

However, as the co-chair of the work on Vulnerable Groups and Inequalities for Future in Mind, I remain concerned that progress on transforming care and support for children who are vulnerable and face adversity and complexity is lacking.

We cannot afford for these children to be left behind, creating a two-tier system - one for those whose needs are easier to identify and address, and another for those who seem to be too complex and socially determined.

Furthermore, we must take greater steps to understand the cumulative impact of prejudice on experiences of childhood adversity, and how this is exacerbated by mental health services (for example, through implicit racism) and by the culture in which the child is living (for example, communities where seeking support for mental health is heavily stigmatised). This new report by YoungMinds calls for urgent action by Government, the NHS and local areas to ensure that all of children’s mental health needs and wellbeing are addressed in the local transformation of services.

Sarah Brennan
Chief Executive of YoungMinds

“...It is the experiences we find hardest to talk about in our society which have a lasting impact on the mental health and wellbeing of children and young people. Be it family breakdown, bereavement, domestic violence or sexual abuse, we must ensure that all services are better able to identify childhood adversity and help to resolve the trauma related to it.”

Sarah Brennan
Key messages and recommendations

1. Mental health, childhood adversity and complex lives
   a. Mental health in childhood and adolescence
   b. Childhood adversity and complex lives
   c. Childhood adversity and the increased risk of mental ill health
   d. Commonality of experiences across childhood adversities and complexities

2. Understanding need arising from adversity and complexity
   a. Identifying complexity and adversity in childhood
   b. Identification of adversity and complexity across health
   c. Recognising the impact of adversity and complexity
   d. Experiencing childhood trauma
   e. Acquiring and/or exhibiting social, emotional and cognitive problems
   f. Adoption of risky and challenging behaviours
   g. Increased morbidity and premature mortality
   h. Implications for reform

3. Moving beyond adversity
   a. Principles for the transformation of services
   b. The importance of resilience
   c. Securing momentum for change
   d. Next steps

4. Abbreviations

5. References and Endnotes
This first section sets out the key messages and recommendations that arise from the report. We understand that some of our readers are under significant time pressures, so we wanted to provide a digestible summary of findings. However, we suggest reading the full version for a richer and more detailed examination of the impact of childhood adversity, trauma and complexity on mental health and wellbeing.

All references for this section can be found in the full text of the report.

**i. The majority of lifelong mental health problems commence in childhood or adolescence.**

Around 1 in 10 children and young people have a diagnosable mental health condition, which translates to three students in every class. However, this is just the tip of the iceberg, with many more experiencing emotional distress, having an identified mental health need or another disability, which draws attention away from their additional mental health needs.

The majority of enduring mental health problems manifest in teenage and young adulthood, and it is estimated that half of all mental health problems manifest before the age of 14 years, with 3 in 4 enduring mental health conditions being present by the age of 24 years. Providing support in childhood has the positive impact of both improving adult mental health outcomes, and reducing the financial cost of mental health crisis in adulthood.

**ii. Experiencing adversity, trauma or additional complexity in childhood has a significant impact on the mental health and wellbeing of children and young adults.**

Around 1 in 3 adult mental health conditions relate directly to adverse childhood experiences. These experiences are created by a wide variety of social factors, and for many it results in significant psychological trauma and emotional distress. These factors and impacts include:

**Maltreatment:** including experiences of childhood abuse, neglect and exposure to substance misuse. For example, it has been suggested that around 2 in 5 victims of Child Sexual Exploitation experience mental health problems (including Post Traumatic Stress) and are 17 times more likely to experience a psychotic episode than their peers.

**Violence:** including exposure to, and involvement in, gangs, sexual and domestic violence, or being a child victim of torture. For example, the primary reason for half of all children identified as being ‘in need’ is due to ‘abuse or neglect’ (and in nearly half of all cases the primary factor creating this need was domestic violence).

**Bullying and victimisation:** including childhood experiences of enduring discrimination, harassment, hate crime, isolation, and prejudice resulting from homophobia, sexism, racism, or disablism. For example, over half of LGBT youth report deliberately harming themselves, and 44% have considered suicide.

**Loss and bereavement:** including death of parent or sibling, involvement in an accident, acquiring an illness or injury, and surviving a natural disaster. For example, bereaved children are 1.5 times more likely than their peers to be diagnosed with a mental health condition and have a higher risk of depression.

**Dis- or re-location:** including complex family breakdown, being looked after, adopted or leaving care, being detained in a secure children’s service (including young offenders), experience of being homeless in childhood, migration, or seeking and gaining refuge or asylum. For example, 2 in 5 looked after children have a diagnosed behavioural condition and 3 in 5 more have some form of emotional and mental health problem.

**Adult responsibilities:** including caring for adults or siblings in the family, and engaging in child labour. For example, 2 in 5 young carers have a mental health problem, and almost half of young carers report additional stress relating to the care they provide or lack of support they receive.
iii. Despite the wide variety of needs that these children have, there are important commonalities of experience that should be used to inform service reform and transformation.

From the studies we draw upon in the report, we have identified commonalities across these groups of children and young people. These include:

- Social factors which create additional adversity and complexity in these children’s lives.
- All have significant social, emotional and health needs arising from social factors in their lives.
- For some, these factors interact in a complex way and mean that they will face multiple adversities in their childhood and/or adolescence.
- Many children and young people, have existing interactions with state services and public authorities, but their full level of need may not have been identified nor responded to.
- Some young people face additional complexity because they find it difficult to access or engage with public services and therefore receive additional support.
- These adverse childhood experiences and additional complexities increase the risk of mental ill health and emotional distress.
- For some children, this also increases the risk of poor physical and sexual health, and for others it can significantly increase the risk of exhibiting challenging and anti-social behaviour, which in turn could be criminalised by authorities.

iv. Government now has a welcome focus on meeting the mental health and emotional needs of these children, however this is not translating into change and practice on the ground.

Government and local agencies do not share a common understanding of adversity, complexity, vulnerability and trauma in childhood. This means that there is significant variance between local areas and service responses to identifying and meeting their needs. For example, a recent review of Local Transformation Plans suggests that 1 in 5 local areas are not sufficiently covering the needs of children and young people who face adversity and complexity in their lives.

v. This is particularly worrying because experiencing childhood adversity, trauma and/or complexity increases the likelihood that a child will go on to have poor social and health life outcomes.

Psychological trauma is the emotional response children and young people can have to experiencing distressing, adverse experiences. Importantly, trauma does not always result from a single, identifiable traumatic event or life adversity. The cumulative impact of adverse environments, events and relationships can have a traumatic impact on the development of a child or young person.

In addition to acquiring and/or exhibiting social, emotional and cognitive problems, a young person may adopt risky or challenging behaviours, which are frequently misinterpreted or criminalised by those who do not identify their full need.

Furthermore, it can result in young people living with more years of ill mental and physical health, and ultimately lead to an earlier death than would otherwise have been expected. For example, it has been estimated that people with schizophrenia die up to 20 years earlier than their peers, and adults who have experienced childhood adversity have higher rates of the most common early adult deaths, such as heart disease, respiratory disease and cancer.

Additionally, these experiences in childhood are associated with a significantly higher risk of suicide in adolescence, adulthood and later life.
vi. The reform of public policy and services for children’s mental health and wellbeing must be fully informed by the impact of adversity, trauma and complexity on children and young people’s lives.

Identifying and intervening early in child adversity and trauma is crucial to avoid an unnecessary escalation of need and reduce the likelihood of poorer mental and physical health, and avoidable early death, in adulthood. To do this we need to take a life-course approach to understanding the impact of adversity, complexity and trauma on children’s mental health and wellbeing.

The evidence we have reviewed in the report suggests reform of public policy and services must include:

• Consolidation of the diverse ways that the State and local services attempt identify adversity and complexity in childhood.

• Diversifying access to services to ensure that wider presentations of adversity and trauma, rather than clinical diagnosis, are the entry point.

• Understanding the meaning of presenting behaviours, as these are not always what they seem. Being either withdrawn or exhibiting challenging or risky behaviours may be a way in which a child communicates emotional distress and attempts to make sense of the adversity and complexity they have experienced, especially if they do not yet have the verbal skills to name emotions.

vii. Future in Mind (specifically the Vulnerable Groups and Inequalities Task and Finish Group sub-report) provides an important template for the transformation of services for children who have experienced adversity, trauma and complexity. These must now be embedded into refreshed Local Transformation Plans.

The sub-report sets out reform and operating principles for future services and interventions to support the mental health and wellbeing of children who have faced adversity and complexity in their childhoods – we have summarised these below.

As a result of the Future in Mind transformation, commissioners, services and interventions should be:

• Increasing access for children who have faced adversity and complexity in their lives, which may not otherwise have been identified.

• Increasing access for children who have faced adversity and complexity in their lives, but who may not usually meet the thresholds set for child, adolescent or young adult mental health services.

• Improving referral and access where these are known to exclude children who have faced adversity and complexity in their lives.

• Ensuring that children who have faced adversity and complexity in their lives receive integrated support from a range of qualified and well-trained professionals across health, education, social care, youth justice, the police and the voluntary sector, to ensure that their needs are met in a co-ordinated way.

• Early intervention to prevent an escalation of need or avoid preventable exposure to additional adversity, complexity or trauma in children’s lives.
• Co-commissioned, possibly with a lead agency, to ensure that there is consistency of pathways across and within services and the interventions that children who have faced adversity and complexity in their lives will receive.

• Ensuring all services and interventions are ‘trauma focused’ or ‘trauma informed’, meaning there is a good understanding of trauma relating to Adverse Childhood Experiences and additional complexity, and the treatment and care young people receive is informed by this.

• Meaningfully engaging and involving children who have faced adversity and complexity in their lives in decisions about their treatment, care and future.

viii. Government, the NHS and local authorities must take urgent action to ensure that the needs of children who face adversity, complexity or trauma are sufficiently met in the reform of policy and transformation of services.

Our work on trauma and Adverse Childhood Experiences will continue, and YoungMinds will be convening a national policy summit and national clinical summit in 2016 to bring together decision makers (policy makers, commissioners and service providers) and people with experience of adversity and complexity to co-develop recommendations that support the continued transformation of support for children’s mental health.

In the interim, we recommend that:

• The Department of Health and Department of Education urgently establish a national expert group exploring common areas across all childhood adversities and build a consensus on models of care and practice - building on the existing commitments around looked after children and care leavers.

• NHS England undertakes or commissions a more detailed review of the refreshed (following the NHS Five Year Forward View on Mental Health) existing Local Transformation Plans (LTPs) and wider Sustainability & Transformation Plans (STPs) to assess the sufficiency of transformation to meet the common needs of children who face adversity in their lives. If collectively there is insufficient coverage of all childhood adversities, NHS England should provide additional advice and support to local areas to increase their understanding and actions in this area.

• Local areas (through Clinical Commissioning Groups) ensure that their refreshed Local Transformation Plans meet the reform and operating principles for future services and interventions that arise from Future in Mind (see above).

• HM Government commits to a national focus in 2018/19 on tackling childhood adversity to create momentum at a local level and share good practice interventions.
a. Mental health in childhood and adolescence

Around 1 in 10 children and young people have a diagnosable mental health condition. Many young people do not have a clinical diagnosis, but experience a period of mental ill health or emotional distress during their childhood or adolescence. The Government’s own measures of children’s wellbeing found that almost 1 in 4 showed some evidence of mental ill health (including anxiety and depression).

During the last decade there has been a suggested increase in the number of children who are presenting with mental ill health, and whose needs are being identified by professionals. Because of the inadequacies of existing data, it is hard to say for certain whether this is an increase in the number of children experiencing mental ill health or an increase in identification and diagnosis.

For this reason, the former Government Minister responsible for children’s mental health suggested that the Government, and Child and Adolescent Mental Health Services (CAMHs), are ‘operating in a complete fog’ in relation to data. To help clarify the current situation, the Government is investing (at the time of writing) in the collection of robust data on prevalence and needs of children experiencing mental ill health.

Similarly, there are just over 169,000 students in England with an identified Special Educational Need or Disability (SEND) relating primarily to their social, emotional or mental health. This represents 1 in 6 of students known to have a SEND, and equates to 2% of the total student population of primary and secondary schools, including alternative provision (i.e. special schools and Pupil Referral Units).

Not all children who experience mental ill health, or social or emotional difficulties, will be identified as having a Special Educational Need, as they do not meet the definition and threshold for additional support. Furthermore, some children who experience social, emotional or mental health problems will not have this classified as their ‘primary’ SEND need, and, as such, more children in need are hidden within other ‘primary need’ classifications, for example children with ‘speech, language and communication needs’.

There is, however, a wider population of students who require support. It has been estimated that around three children in every classroom in the country have a diagnosable mental health condition, with many teachers suggesting that at least a quarter of their students are experiencing mental health problems. These children face disruptions and difficulties in their learning because of the impact that adverse experiences have on their development.
The highest rate for permanent school exclusions is for students with an identified SEND, but who are ineligible for support (58.8%). This is compared to those with support (6.7%) and those with no known SEND (34.5%)\(^\text{14}\). Worryingly, students with identified Behavioural, Emotional & Social Difficulties (BESD) are significantly more likely to be excluded from school than other SEND groups. 1 in 5 students with identified BESD are excluded for at least one fixed period of time, with 1 in 100 being permanently excluded\(^\text{15}\).

b. Childhood adversity and complex lives

Within the mental health, SEND, BESD and wider student population there are groups of children who face adversity and complexity in their lives. This adversity or complexity might arise from (for example) caring for a family member, being taken into care themselves or witnessing domestic violence. These young people are at additional risk of acquiring a mental health condition or developing mental ill health as a result of the adverse experiences and additional complexity they have experienced.

It is important we also understand the mental health needs of this group of children as research suggests that almost \textbf{1 in 3 diagnosed mental health conditions in adulthood relate directly to adverse childhood experiences} that have subsequently impacted on their psychological development and wellbeing\(^\text{16}\).

Specifically, young adults who have experienced childhood adversity and trauma have an increased risk of both poor mental (including psychosis\(^\text{17}\)) and physical health\(^\text{18}\). This is reflected in studies conducted by neurologists and geneticists, which found that \textit{“childhood maltreatment is likely to influence fundamental biological processes and engrave long-lasting epigenetic marks, leading to adverse health outcomes in adulthood”}\(^\text{19}\). In other words, experiencing adversity and complexity in childhood can trigger genetic predispositions towards mental ill health\(^\text{20}\).
Adversity and complexity in children’s lives can be created by a wide variety of social factors and for many it results in significant psychological trauma and emotional distress. We have listed in the box to the right a number of these social factors, by way of illustration.

Some researchers include living in material deprivation and child poverty, and existing involvement of statutory services (such as children’s social services). Organisations and services might describe these social factors as ‘external factors’ which increase the ‘vulnerability’ of the child. The list of factors should be seen as interrelated, with many children having experienced multiple adversities in their lives.

c. Childhood adversity and the increased risk of mental ill health

It is vital that we identify adversities that children and young people face as early as possible to ensure we can mitigate the impact of this additional complexity and prevent further escalation of emotional distress and mental ill health. The majority of enduring mental health problems manifest in teenage years and young adulthood. It is estimated that half of all mental health problems manifest before the age of 14 years, with 3 in 4 enduring mental health conditions being present by the age of 24.

Below we give some examples of the groups of children (described to the right) who are at additional risk of poor mental health as a consequence of adverse, complex or traumatic experiences they may have faced in childhood. We have done this to better illustrate both the specific and common mental health needs that arise across these groups.

Maltreatment: Victims of Child Sexual Exploitation

At least 2,400 children are victims of sexual exploitation, the majority girls and young women. The actual number may be much higher as sexual abuse of all forms is underreported and some data sets do not distinguish between child sexual abuse and child sexual exploitation specifically. There have been concerns that the gendered debate around Child Sexual Exploitation (CSE) (which has necessarily focused on girls and young women) may have neglected the experiences of boys and young men who face this adversity. To illustrate the scale of CSE amongst boys, a recent study highlighted that a third of all children accessing CSE services are boys or young men.

Factors relating to adversity and complexity in childhood

- **Maltreatment**: including experiences of childhood abuse, neglect and exposure to substance misuse.
- **Loss and bereavement**: including death of parent or sibling, involvement in accident, acquiring an illness or injury, and surviving a natural disaster.
- **Dis- or re-location**: including complex family breakdown, being looked after, adopted or leaving care, being detained in a secure children’s service (including young offenders), migration, seeking and gaining refuge or asylum.
- **Adult responsibilities**: including caring for adults or siblings in the family, and engaging in child labour.
- **Bullying and victimisation**: including childhood experiences of enduring discrimination, harassment, hate crime, isolation, and prejudice resulting from homophobia, sexism, racism, or disablism.
- **Violence**: including exposure to, and involvement in, gangs, sexual and domestic violence, or being a child victim of torture.
Some children experience CSE as a result of being trafficked or through their involvement in gangs and/or adult groups. Statistics from the National Crime Agency suggest that 22% of potential victims of human trafficking were children, and the main reason for trafficking remains to be sexual exploitation\textsuperscript{31}.

Additionally, a review of calls to ChildLine suggests that around 3 in 5 cases of sexual abuse relate to online grooming\textsuperscript{32}, which is also a channel used by perpetrators of CSE to identify, and communicate, with their victims.

Experiencing CSE has a significant impact on the mental, physical and sexual health of the child and their everyday functioning\textsuperscript{33}. It has been suggested that around 2 in 5 victims of CSE experience mental health problems (including Post Traumatic Stress) and are 17 times more likely to experience a psychotic episode than their peers\textsuperscript{34}. An inquiry held by the Children’s Commissioner for England found that around 1 in 4 children were exhibiting mental health problems, with almost a third having self-harmed as a result of their experience, rising to over three quarters of those interviewed directly\textsuperscript{35}.

Victims of CSE also exhibit increased risk-taking behaviour and criminality as a way of making sense of the adversity they have faced. Around 2 in 5 children develop a substance (drug and alcohol) problem and girls who have experienced CSE are 2.5 times more to have a criminal record, because their behaviour is criminalised rather than being seen as an indicator of additional need\textsuperscript{36}.

**Loss and bereavement: Death of parent, primary carer or sibling in childhood**

Over 3 in 100 young people experience the death of a parent, primary care giver (such as a carer or grandparent) or sibling\textsuperscript{37} before the age of 16 years\textsuperscript{38}. Bereaved children are 1.5 times more likely than their peers to be diagnosed with a mental health condition\textsuperscript{39}. Within this group, children who lose their parents or carers when they are very young, or to death from external causes (such as suicide, accident or homicide), are at a higher risk or depression in childhood and adolescence\textsuperscript{40}.

Studies suggest that a bereaved child has three times the risk of depression than their peers irrespective of the cause of death\textsuperscript{41}.

Understandably, children who experienced more than one death, or consecutive death, of a close family member or friend have increased depressive symptoms as a result of the adversity they have faced\textsuperscript{42}.

**Dis- or re-location: Looked after children**

Just under 1 in 100 children are looked after by the State, and are living in care\textsuperscript{43}. Research suggests that children who are looked after (including those who are fostered\textsuperscript{44}), are around four times more likely to have a diagnosable mental health condition than their peers\textsuperscript{45}.

The higher risk of poor mental health can be seen in 2 in 5 looked after children having a diagnosed behavioural condition\textsuperscript{46} and 3 in 5 more having some form of emotional and mental health problem\textsuperscript{47}. As a consequence of their experiences and the lack of support they frequently face during life transitions, looked after children and care leavers are between four and five times more likely to attempt suicide in adulthood\textsuperscript{48}.

**Adult responsibilities: Young carers**

At least 2 in 100 children and young people aged between 5 and 17 years of age provide care to a parent, family member, adult or a sibling. The adult may need care because they are ill, disabled or misuse drugs or alcohol. Almost 1 in 5 of these young carers provide 20 or more hours of care each week\textsuperscript{49}.

The Census found that young carers are five times more likely to report their health as ‘not good’ compared to their peers who have no caring responsibilities. Research suggests that 2 in 5 young carers have a mental health problem\textsuperscript{50}, and almost half of young carers report additional stress relating to the care they provide or the lack of support they receive\textsuperscript{51}. 
**Bulling and victimisation: LGBT youth**

Estimates of the numbers of lesbian, gay, bisexual, transgender (LGBT) children and young people are very unreliable, however it has been suggested that at least 1 in 100 would identify as an LGB young adult. Although, a recent poll found that half of the young people surveyed reported they were not exclusively heterosexual.

LGB children and young people are at higher risk, than their heterosexual peers, of experiencing poor mental health and lower wellbeing, harming themselves and considering suicide as a consequence of the prejudice they face. The risk is even higher for those who are both LGBT and from a Black or Minority Ethnic (BME) community and/or have a learning disability. Studies by the charities Stonewall and Metro both found that over half of LGBT youth reported deliberately harming themselves, and 44% had considered suicide. Trans young people are also at higher risk of depression, self harm, substance misuse, and suicide.

It has been estimated that 7 in 10 trans young people would experience transphobia in the form of harassment and 1 in 10 threatening behaviour in public, and 2 in 5 LGB youth have either deliberately harmed themselves or thought about taking their life directly because of homophobic bullying. Worryingly, 1 in 4 of the youth homeless population are LGBT, with many becoming homeless as a result of prejudice (within the family or community).

**Violence: Children experiencing and witnessing domestic violence**

Around 1 in 5 children and young people have been exposed to domestic abuse, including domestic violence, and the same number of teenagers and young adults have been physically abused by their boyfriends or girlfriends. Domestic violence has specifically been identified as a factor in 60% of all serious case reviews, which investigate child deaths relating to maltreatment, abuse and neglect.

Many children who are at risk of domestic violence are already known to public services. The primary reason for half of all children identified as being ‘in need’ is due to ‘abuse or neglect’, with ‘family dysfunction’ being the second. Importantly, in the majority of cases (48.2%), the primary factor creating this need was domestic violence, with the mental health of the child or other adults in the family being a close second (32.5%). UNICEF has similarly found that 40% of victims of child abuse also reported domestic violence in the home.

Experiencing or witnessing domestic violence can have a significant impact on children’s mental health and emotional development. For example, witnessing domestic violence is the most frequently reported form of trauma for children. Research using neuroimaging has shown that experiences of domestic violence in childhood can change brain structures (in a way that is akin to soldiers who have trauma following armed conflict), resulting in additional risk of mental ill health.

Whilst, many young people who have experienced or witnessed domestic violence do not engage in violence themselves, research shows that domestic violence is strongly associated with offending and anti-social behaviour. Some respond to the distress of experiencing domestic violence by exhibiting these behaviours with others in the family, or later on in their young adult relationships. Finally, domestic violence is a shared risk factor for poor mental health and gang-affiliation.
d. Commonality of experiences across childhood adversities and complexities

From the illustrative examples above, we can begin to summarise the commonalities that exist between these groups of children who face a wide range of adversities and complexities in their childhood and/or adolescence.

The identifiable commonalities are:

- Social factors create additional adversity and complexity in these children’s lives.
- All have significant social, emotional and health needs arising from social factors in their lives.
- For some, these factors interact in a complex way and mean that they will face multiple adversities in their childhood and/or adolescence.
- Many children and young people, have existing interactions with state services and public authorities, but their full level of need may not have been identified or responded to.
- Some young people face additional complexity because they find it difficult to access or engage with public services and therefore receive additional support.
- These adverse childhood experiences and additional complexities increase the risk of mental ill health and emotional distress.
- For some children, this also increases the risk of poor physical and sexual health, and for others it can significantly increase the risk of exhibiting challenging and anti-social behaviour, which in turn could be criminalised by authorities.
Being able to identify and recognise the social, emotional and health needs that children who face adversity and additional complexity face is vital to early intervention and effective mental health provision. There is a plethora of different ways in which statutory bodies identify these needs, and we have set out the main approaches taken by local authorities and the NHS in England below.

a. Identifying complexity and adversity in childhood

Local authority safeguarding teams in England focus on identifying and assessing the needs of children and young adults who are at risk of, or experiencing, abuse, maltreatment or harm. They also are responsible for coordinating inter-agency working (including from education) to promote the welfare for children and young (vulnerable) adults.

To enhance this identification and assessment, there is additional statutory guidance for children who experience specific forms of abuse, including Child Sexual Exploitation. In addition, local authorities also have a broader responsibility to identify and assess ‘children in need’, including those who are at risk of poor mental health and emotional development. Likewise, tools are used by local authorities to identify the mental health and emotional wellbeing of specific groups, including looked after children, through the use of a Strengths and Difficulties Questionnaire (SDQ).

A similar approach is taken in youth offending, with teams specifically considering the risk of serious harm and mental ill health where an adverse childhood experience has been identified as contributing factor, and would increase the likelihood of poor outcomes. These identification methods and tools are not used consistently across the country and (particularly in youth offending) capacity for mental health assessment is low.

In areas where there is a known social problem in the community, sometimes the local authority and Youth Offending Team have undertaken additional programmes of work to identify those children who are at risk of a prevalent childhood adversity or additional complexity in their community, for example gang membership or substance misuse.

The Children Act of 2004 required local authorities to make arrangements to promote cooperation between local statutory partners to identify, assess and meet the needs of children who require additional support. Accompanying this, was a national policy called Every Child Matters, which aimed to align all agencies working with children towards achieving five core outcomes: 1. being healthy, 2. staying safe, 3. enjoying and achieving, 4. making a positive contribution, 5. economic well being.
Although the focus within each outcome was more weighted toward a specific group of children (i.e. *being healthy* – mental health problems, *staying safe* – risk of abuse and neglect, *positive contribution* anti-social behaviour, *economic wellbeing* – material deprivation, etc), the Every Child Matters framework was devised to ensure that services saw the commonalities between different childhood experiences and focused attention on achieving common outcomes, irrespective of the level of adversity or complexity they faced.

As part of the implementation of the Children Act of 2004 and the Every Child Matters policy, local authorities adopted a **Common Assessment Framework**
, which standardised processes across agencies so that they could identify the needs of children, including those who faced additional risk, adversity and complexity in their lives. A core intention of the new assessment framework was to give local agencies a common language to identify and describe the needs of these children. This is why many local authorities (despite the financial implications) and their partners, have continued to use Common Assessment Frameworks beyond the lifespan of the Every Child Matter’s policy, and the ending of a national pilot to collate local data.

Common Assessment Frameworks are now frequently used by local authorities as a tool for identifying the needs of children and families who would benefit from *‘early help’* as set out by the revised statutory guidance for safeguarding children and requirements in the Ofsted inspection framework. Ofsted’s definition of early help is targeted at *‘those children and young people at risk of harm (but who have not yet reached the “significant harm” threshold (as set out in the statute) and for whom a preventative service would reduce the likelihood of that risk or harm escalating)”*.  

Similarly, the new **Education, Health and Care Plans (EHCP)** introduced as part of the Children & Families Act of 2014, put an emphasis on multi-agency identification and coordination of services to meet the needs of children who have a SEND. Beyond this, children who have a level of need that is not deemed eligible for an EHCP, are meant to be given access to a local offer that enables their families to navigate the support that is available for them in the local community. This should include signposting to relevant children’s mental health services, if a need has been identified.

More recently, local authorities have been incentivised by central Government to focus on the needs of children living in families who experience significant complexity. The national Troubled Families Programme aims to support families who meet four of the following criteria,

1. have a family member involved in youth crime or anti-social behaviour, 2. have children who are regularly truanting or not in school, 3. have an adult on out of work benefits, 4. cause high costs to the taxpayer (because of the complexity of their need or interaction with services).

More than 117,910 families have been identified in this way and all receive multi-agency interventions to support their needs. Within this group of families are children who will have faced multiple adverse childhood experiences, which is further compounded by the complexity of their family life and interactions with local services. Moreover, the criteria used for the programme focuses on presenting factors or symptoms of underlying adverse and complex childhood experiences.

**b. Identification of adversity and complexity across health**

Directors of Public Health, in contrast, take a broader perspective, considering the social and environmental factors that contribute to higher risk of mental ill health – and in some cases determine premature mortality. Similarly, some Clinical Commissioning Groups (CCGs) and NHS mental health providers specifically target groups of children who are at additional risk, such as those involved in gangs, those who have life-limiting health conditions or those with learning disabilities.
Building on the reforms of the Health & Social Care Act of 2012, most areas now hold a shared profile of children’s health and care needs in their area. These are usually contained or summarised within their Joint Strategic Needs Assessment or Health & Wellbeing Plans, many of which derive from data compiled by Public Health England in their annual Child Health Profiles.

The diversity of ways in which local health agencies identify and recognise children who face adversity and complexity is reflected in an analysis by the Children’s Society, of 36 specialist child and adolescent mental health providers. Their study found wide discrepancy in the way that providers described and identified ‘vulnerable’ children and young people.

More recently, an independent Taskforce recommended a wholesale transformation of mental health support for children and young people (including Child & Adolescent Mental Health services – CAMHS). The Government endorsed the findings of the report (Future in Mind and subsequently The Five Year Forward View for Mental Health) and committed additional funding to support this transformation.

Most local areas have now captured this data in their Local Transformation Plans (LTPs) which have been developed by CCGs in partnership with local agencies.

Whilst there is a welcome focus in many of the plans on looked after children and children at risk of sexual exploitation (reflecting national concerns about the care and treatment of these groups), there are notable absences.

The discrepancy in recognition and identification of children who face adversity and complexity, is echoed in a recent an analysis for NHS England of all the LTPS in England (Graph A). Similarly, a review of LTPs by the NSPCC, which found that 1 in 3 plans do not recognise the mental health needs of children who have been neglected or abused (Graph A).

Importantly, in forthcoming analysis it will be suggested that at the very least almost a fifth of all local areas are not sufficiently covering children who face adversity and complexity in their lives. This seems to be contra to the explicit guidance to local areas from NHS England, which states that ‘the scope of Local Transformation Plans should cover the full spectrum of service provision and address the needs of all children and young people including the most vulnerable, making it easier for them to access the support they need when and where they need it’.

Finally, somewhat belatedly, there have been attempts to create a common language for the identification of need across local commissioning and providers meeting the mental health needs of children and young people. The Anna Freud Centre and The Tavistock and Portman NHS Foundation Trust developed the THRIVE model, which describes children's mental health needs in five domains, and signals the kind of interventions that might meet this need. Within the model, it is suggested that children who have adverse childhood experience and face complex lives are more likely to be found in the ‘Getting More Help’ and ‘Getting Risk Support’ groups.
c. Recognising the impact of adversity and complexity

The diversity of methods and labels for identifying adversity and complexity in childhood, can mean that the full needs of the young person are not recognised by professionals. Despite the focus in the assessment tools described above in identifying multiple needs, young people and families tell us that professionals and agencies frequently consider the presenting needs (usually the one that prompts interactions with a services) over the wider social, emotional and health needs they have.

As a consequence, a child may find that they are ineligible for the support they need – either because their need is not deemed high enough (as the complexity is not identified), or they do not have the diagnosis required to access support.

We know that 3 in 4 children with a diagnosable mental health condition do not get access to the support they need\(^{10}\), and we anticipate that this is higher for children who face additional adversity and complexity. This might be because they already have significant interactions with services (so their full need again is hidden) or because their community or family is significantly marginalised (meaning that accessing is more complex).

A major US study\(^ {109}\) of Adverse Childhood Experiences (ACE)\(^ {110}\) demonstrated significant overlap between different ACEs, and uncovered a strong relationship with risk factors for ill health and poor wellbeing. Research in both England\(^ {111}\) and Wales\(^ {112}\) replicated these findings and suggested that ACEs are strongly associated with adverse behavioural, health and social outcomes in childhood, adulthood and later life.
All these studies were based on an evidence-based, conceptual framework for thinking about the impact of ACE on a child over the course of their life. This model demonstrates that there is a progression of outcomes, which ultimately leads to poorer mental and physical health (known as increased morbidity) and dying at an age than would otherwise be expected (known as premature mortality). Below is an adapted version of the ACE framework:

**d. Experiencing childhood trauma**

Before the impacts of ACEs are explored in more depth, it is important to understand the relevance of childhood trauma contained within these experiences of adversity and complexity.

As we have described earlier, children may experience one traumatic event (i.e. losing a parent) or face a series of simultaneous or sequential traumas (i.e. experiencing both sexual abuse and involvement in gang violence). Psychological trauma is the emotional response children and young people may have to experiencing these distressing, adverse experiences. Importantly, trauma does not always result from a single, identifiable traumatic event or life adversity. The cumulative impact of adverse environments, events and relationships can have a traumatic impact on the development of a child or young person.

Throughout childhood and adolescence brains go through significant stages of development, and so experiencing trauma can epigenetically disrupt our neurological, psychological and emotional development. This is especially the case in children who face multiple complexities and adversity, resulting in complex trauma.

Experiencing trauma has a substantive and wide-ranging impact on a child’s ability to manage their emotions and make sense of the adversity they have faced. It can change their mood and emotions they feel, as well as challenge or corrupt beliefs or memories they have about their childhood.

Additionally, childhood trauma can be exacerbated (as well as caused) by experiences of prejudice, discrimination and other forms of adversity.

**Source:** adapted from the CDC-Kaiser ACE Study [1998]
such as sexism, homophobia, racism and disabling. This prejudice not only intensifies the trauma they have faced, but discrimination, stigma or social marginalisation means they are also more likely to have only limited access to support and treatment. Our own research into the experiences of black and minority ethnic groups, found evidence of significant racism within mental health services, which restricted access to services and jeopardised young people’s recovery.

Ultimately, it can effect how they see themselves, shifting the ways in which they explore their identities and impacting the relationships they have with their changing bodies and peer groups. In this way, some young people internalise the adversity they have faced and self-traumatise through self-hate, self-blame and low self-esteem.

Existing psychiatric diagnoses recognise the traumatic impact of adverse childhood experiences on children’s mental health and emotional wellbeing. The most well known is Post Traumatic Stress Disorder (PTSD), which originates from exposure to adverse and traumatic events, and results in significant distress in recalling the traumatic event(s), accompanied by behaviours and ways of thinking that avoid confronting the trauma, are self-destructive or affect the mood of the young person.

The latest version (fifth edition) of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) describes the symptoms and suggested treatment for PTSD and includes a consideration of manifestations of PTSD in children who are six years old, or younger. There is also a new ‘dissociative subtype’ of PTSD, which focuses on feelings of disconnectedness and detachment from one’s body or experiences.

Similarly, the International Classification of Diseases (ICD 10) contains a specific classification of PTSD (with a similar aetiology and symptomology as the diagnosis in the DSM - 5) and also references a second classification that refers to a ‘transition to an enduring personality change’. The ICD 10 is currently in the process of being revised for an eleventh time and it has been suggested that this associated classification be renamed ‘complex PTSD’, which has a higher threshold of adversity, including experience of disaster, prolonged possibility of death, and exposure to life threatening situations.
The impact of trauma on the developing brain

The **limbic system** remembers the information the child associates with a threat (for example a smell or clothing similar to those of a violent parent) and acts as an early warning signal to suggest that a threat is close by.

Within the **limbic system**, the **amygdala** acts as the centre for emotions, emotional behaviour, and motivation in the brain. The amygdala is attuned to perceive and recognise a threat and is responsible for triggering our ‘fight, flight or freeze’ responses.

Once an alarm is raised by the amygdala a neural message is sent down the spinal cord to the **adrenal glands** to release a surge of **adrenaline** and **noradrenaline** into the bloodstream, which prepares the body for urgent action (fight, flight or freeze) and causes our hearts to beat faster.

At the same time the **hypothalamus** (which receives information through our senses) also sends a signal to your **pituitary gland** at the bottom of your brain, telling it to release a stress mitigating hormone called **cortisol**. This hormone helps the body to enact the fight, flight or freeze response, ensuring that muscles get a temporary increase in the energy they will need to respond, and surpassing the immune system to enable this.

The **hippocampus** (also part of the limbic system) plays an important part in controlling our emotional and hormonal response to a threat. It relates the new information it receives about a threat to our memory of past experiences (including traumas) and feelings, before passing the information onto other parts of the brain responsible for controlling our behaviour. These behavioural responses might include shaking and trembling.

Repeated adversity and trauma in childhood results in the overstimulation of hormones (cortisol) that are intended to help mitigate stress. Over-exposure to these stress hormones can suppress the response of the hippocampus (affecting both memory and behavioural responses) and significantly impact the areas of a child’s brain that are still developing.

This includes impairing the **prefrontal cortex**, which continues to develop during childhood and adolescence, and is responsible for making sense of executive thought and cognition. As such, children who experience adversity and trauma create new neural pathways in the brain that are highly sensitive to threats and heighten children’s arousal.

**See endnotes for references and suggestions of further reading on trauma and brain development**.⁴
Despite, relative clinical agreement about the nature and presentations of PSTD, there are many children and young people who have experienced significant adversity and resulting trauma, although not a specific traumatic event (such as a natural disaster or being a victim of torture). Consequently, their need is not recognised as PSTD and they may not receive access to the required mental health and support services.

It is estimated that around 1 in 6 children and adolescents develop PTSD after being exposed to a traumatic event (as defined in DSM-5). This means that some do not get a clinical diagnosis or are misdiagnosed as their presenting symptoms are not seen in the context of wider adverse experiences in childhood.

In response to these concerns, Dr Bessel van der Kolk and colleagues have proposed the introduction of a new classification of ‘Developmental Trauma Disorder’, which would specifically recognise trauma resulting from Adverse Childhood Experiences. Despite being considered for the most recent revision of the DSM-5, and significant support from practitioners working with children who faced childhood adversity, it was not included as a new classification.

We do not advocate in this report either for or against introducing new clinical diagnoses. We agree that there is an important need to recognise that trauma can specifically result from Adverse Childhood Experiences and that this group of children should also be able to access mental health and support services - irrespective of whether or not they have a relevant diagnosis.

e. Acquiring and/or exhibiting social, emotional and cognitive problems

Children’s brains are highly responsive to threats in their environment. Experiencing adversity and trauma during childhood or adolescence can result in some children ‘resetting’ their usual (baseline) state of arousal to anticipate a threat, even when none is present. As a result, some children will experience significant feelings of a threat, but will not be able to locate the threat they perceive in their environment nor make sense of it.

This means that they spend a significant amount of time in a state of hyperarousal, facing significant emotional distress, which adversely changes a young person’s ability to regulate their emotions (also known as affect dysregulation).

Experiencing psychological trauma can also create a hypervigilance, in which the young person is continually looking to identify and detect threats in their environment. This is associated with problems, including sleeping as the child grows older. As such, many children who experience trauma find it difficult to calm themselves, and return to a ‘window of tolerance’, which represents a safe and optimum level of arousal.

An alternative response to trauma is disassociation, by which a child might try to separate their emotions from the overwhelming feelings of distress they experienced at the time of the adversity. These children may feel unconnected with their body or a specific body region or area associated with the trauma. They may also feel an emotional numbness and significant cognitive fatigue if they try to recall or remember anything related to the experience – this is also known as being in a state of hypoarousal. Sometimes it seems as if the child has spaced out or is emotionally absent. Some of these young people consequently are unable to experience pleasure as a result of activities that would usually be pleasurable, such as music, social interaction or sexual encounters (also called anhedonia).
As a result of trauma, children who face adversity and complexity are unable to effectively engage in important learning experiences that help to shape child development\textsuperscript{137}. For example, they may not feel safe enough to play with their peers, might feel ambivalent towards family, friends and siblings, or may be mistrustful of, and distressed by, authority figures in formal education. This is especially the case of those experiencing a trauma in early childhood.

\textbf{f. Adoption of risky and challenging behaviours}

In the face of significant adversity and complexity, many children and young people adopt risky or challenging behaviours to cope with or make sense of the trauma they have experienced, for example this might include highly sexualised behaviour and substance misuse. These behaviours can quickly become labelled as problematic by professionals and families. Some are seen as signs of being ‘anti-social’, having a problem with one’s ‘conduct’, and being oppositional, defiant or disruptive towards a carer or authority figure (i.e. a parent, teacher, doctor or social worker)\textsuperscript{138}.

Ultimately the problem is seen as being the child’s, and much of the attention is focused on correcting their behaviours, rather than identifying the cause of it. Echoing this, the Royal College of Psychiatrists recently found that antipsychotics are being routinely prescribed for people who have behaviours that challenge, but with no record of having an enduring mental illness\textsuperscript{139}. The rate of prescription increased if the young person had a learning disability.

\textbf{g. Acting out}

Clinical research suggests that it is common for children and young people who have experienced adversity and trauma to ‘act out’ - exhibiting self-destructive, conduct disordered behaviours. These are attempts by the child to make sense of their experiences\textsuperscript{140}, or cope with the trauma they have acquired. It can also be a way of communicating something that is not yet conscious, or that perhaps cannot yet be verbalised\textsuperscript{141}. Other behavioural responses might include children attempting to self-calm and self-soothe, but in a self-harming or regressive way\textsuperscript{142}. This might include violent rocking, chanting, scratching their face or body or biting themselves, or banging their hands against walls or objects.

Whilst sometimes difficult for others to watch, challenging behaviour acts as a method of reducing tension and can play a role in the child attempting to protect themselves from, or avoid, what they perceive to be a threat or a continuation of the trauma\textsuperscript{143}. Presentations of anti-social behaviour in relation to Adverse Childhood Experiences are more prominent amongst boys and young men\textsuperscript{144}, possibly because of gendered ideas about displaying emotions\textsuperscript{145}.

Similarly, children who engage in significant risk-taking can be understood to be both finding ways to make sense of the adversity and trauma they have experienced, and avoiding the need to address and resolve the trauma. Such children are at additional risk of being labelled as having a clinical disorder (such as \textit{oppositional/defiant disorder} and \textit{conduct disorder}), rather than having the adversity identified\textsuperscript{146}. Additionally, these children as more likely to be known to the authorities, because they are engaging in anti-social or criminal behaviour\textsuperscript{147}. 

YoungMinds - Beyond Adversity
h. Young Offenders

There are clear mental health needs and experiences of childhood adversity that are not being addressed amongst young people who offend. The Chief Medical Officer noted that 2 in 5 children and young people on Community Orders have emotional and mental health needs. Approximately the same proportion have experienced neglect, abuse or homelessness, and half have themselves been a victim of crime.\(^{148}\)

i. Gang membership

In the context of gang membership, an evidence review for the Ministry of Justice reported that a ‘social value of violence’ was established amongst members. A history of family violence helped to maintain a bond between young members.\(^{149}\) Thus, the aggressive behaviour seen in gang initiation and gang membership may in fact be acting out gang loyalty, as much as using the experience of violence to be a template in order to establish a bond with peers.

This sentiment is recognised in a Home Office evidence review: young people who become involved in gangs or violent lifestyles are some of the most vulnerable young people in our society and may have experienced adversity from a very young age. They should be seen and treated first and foremost as children and young people in need of support.\(^{150}\)

In conclusion, it is vital to understand the meaning of both challenging and risk-taking behaviours, as for many children they will represent a response to the adversity, complexity and trauma they have experienced in childhood. Moreover, being further labelled, stigmatised and confronted by professionals who are unaware of their adversity, can trigger memories and emotions relating the trauma they have experienced. This can have the effect of escalating their behaviour and emotional distress, and risks re-traumatising the young person or sustaining a secondary trauma.\(^{151}\)

j. Increased morbidity and premature mortality

In previous sections of this report we demonstrated that statistically, children who have experienced adversity and complexity in their lives are overrepresented in populations with mental ill health and those exhibiting emotional distress. Additionally, we saw how these experiences increased risk of exhibiting behaviour which is perceived as anti-social and challenging to others.\(^{152}\)

Research has clearly shown that experiencing adversity and complexity in childhood can have a substantive impact across the life course.\(^{153}\)

Childhood adversity increases the risk that in adulthood these children will have poorer health and possibly die earlier from natural and non-natural causes (including suicide).\(^{154} \text{155} \text{156}\) As we have noted previously, adversity and complexity is accompanied by lower levels of mental wellbeing, enduring mental health problems and poorer life satisfaction in adulthood, as well as an increased risk of mental health problems (i.e. experiencing psychosis).\(^{157} \text{158} \text{159}\) Subsequently, children who have faced adversity are more likely to use psychiatric medicines that have an adverse impact on long-term physical health.\(^{160}\)

Worryingly, there is a correlation between the specific form of adversity that a child has experienced and any associated self-harming behaviour they are more likely to engage in on reaching adulthood.\(^{161}\) A recent study found that children who had lived with someone who was
suicidal were more likely to have tried to end their life; if they were sexually abused, they were more likely to engage in risky or underage sex; and if they lived in households with significant substance misuse, they were more likely to misuse substances.

Having a mental health problem resulting from childhood trauma increases the risk of physical ill health as well early and avoidable death. It has been estimated that people with schizophrenia die up to 20 years younger than their peers, and adults (who experienced childhood adversity) have higher rates of the leading early adult deaths (such as heart disease, respiratory disease and cancer). Additionally, these experiences in childhood are associated with significantly higher risk of suicide in adolescence, adulthood and later life.

Women who had experienced one adversity had a 66% increased risk of premature death, and those who had experienced two or more adversities had a 80% increased risk compared to their peers. Men, in contrast, who had faced two or more adversities in childhood, had a 57% increased risk of early death compared to their peers.

k. Implications for reform

Important implications emerge regarding how services provide support to children who face adversity, complexity and trauma in their childhood or adolescence. The evidence suggests that reform must include:

- Consolidation of the diverse ways that the State and local services attempt identify adversity and complexity in childhood.
- Diversifying access to services to ensure that wider presentations of adversity and trauma, rather than clinical diagnosis, is the entry point.
- Understanding the meaning of presenting behaviours as these are not always what they seem - being either withdrawn, or exhibiting challenging or risky behaviour may be the way that a child communicates emotional distress and attempts to make sense of the adversity and complexity experienced.
- The identification of, and early intervention in, child adversity and trauma is crucial to avoid an unnecessary escalation of need, to reduce the likelihood of poor adult mental and physical health, and avoid early death. To do this we need to take a life-course approach to understanding the impact of adversity, complexity and trauma on children’s mental health and wellbeing.

Finally, implicit in what we have written is the concern that many of these young people (especially those with unidentified need) will remain in a social context (i.e. a school, home, neighbourhood) that is triggering for them and continues to expose them to, or remind them of, the adversity and trauma experienced. This triggering could be invalidating, as in the case of prejudice relating to a personal characteristic like race or sexuality. It could also be a context that remains threatening or dangerous, as in the case of being returned from a care placement to a home community where there is significant threat of violence.

Any reform must better understand the impact of returning children to a triggering environment and ensure this informs decisions that are made about appropriate placements and services for children to receive.
3. Moving beyond adversity

YoungMinds was part of the Government’s Children and Young People’s Mental Health and Wellbeing Taskforce, which made important recommendations in its report – Future in Mind – about the future of Child and Adolescent Mental Health services (CAMHS) in England. These recommendations were accepted by Government and embedded in the subsequent NHS England Five Year Forward View for Mental Health, NHS planning guidance for 2016/17 - 2020/21 and guidance on Local Transformation Plans (LTPs).

a. Principles for the transformation of services

Within the commitments in Future in Mind are a number of specific recommendations aiming to achieve better outcomes for children and young people who face additional adversity and complexity in their lives. The evidence-base and rationale for a focus on these children was devised by a Vulnerable Groups and Inequalities Task and Finish Group. The sub-report of this task and finish group sets out a set of reform and operating principles for future services and interventions to support the mental health and wellbeing of children who have faced adversity and complexity in their childhoods. We have summarised these reform and operating principles in short-form below.

As a result of the Future in Mind transformation, commissioners, services and interventions should be:

- **Increasing access for children who have faced adversity and complexity in their lives, which may not otherwise have been identified** – this would involve greater understanding of the signs of childhood adversity and routine enquiry (see the box on page 28) within services where a risk factor of adversity is already known or assumed.

- **Increasing access for children who have faced adversity and complexity in their lives, but who may not usually meet the thresholds set for child, adolescent or young adult mental health services** – this would include accepting the placement of child in a specialist therapeutic service, irrespective of whether or not a formal psychiatric diagnosis is in place.

- **Improving the referral and access where these are known to exclude children who have faced adversity and complexity in their lives** – this would include a mental health outreach service being collocated with a group specific intervention (such as those with gangs), establishing a specialist team that focuses on the needs of vulnerable and excluded groups, or creating a fast-track for looked after children to secure continuity of therapeutic care, as has been advocated by Parliament’s Education Committee.
• Ensuring that children who have faced adversity and complexity in their lives receive integrated support from a range of qualified and well-trained professionals across health, education, social care, youth justice, the police and the voluntary sector to ensure that their needs are met in a co-ordinated way - this would include effective communication and data-sharing between agencies to ensure that the whole of the child’s needs are met.

• Intervening early to prevent an escalation of need or avoid preventable exposure to additional adversity, complexity or trauma in children’s lives - this would include targeted support within universal services (such as schools) and at a moment of additional risk of mental ill health (such as a school exclusion), which has been recognised in part in the Department for Education’s recent advice for schools staff.

• Co-commissioned, possibly with a lead agency, to ensure that there is a consistency of pathways across and within the services and interventions that children who have faced adversity and complexity in their lives will receive - this would include the introduction of warm transfers of care between agencies, for example, to avoid a distressing delayed discharge from in-patient care by ensuring that looked after children have a safe environment to return to, and a continuity of support in the community into their adulthood.

• Ensuring all services and interventions are ‘trauma focused’ or ‘trauma informed’, meaning that there is a good understanding of trauma relating to Adverse Childhood Experiences and additional complexity, and that the treatment and care young people receive is informed by this - this would involve significant building of capability and skills within mental health services to better their understanding of childhood complexity and adversity, as well as supporting other local agencies to better understand the impact of trauma on a child’s mental health and wellbeing. Such approaches might (for example) enhance existing NICE guidance on looked after children, which suggests that social workers, teachers and carers all understand the signs of trauma and the impact on social and emotional development.

• Meaningfully engaging and involving children who have faced adversity and complexity in their lives in decisions about their treatment, care and futures – this would include decisions about whether and how they would prefer to manage a mental health condition (including the use of medicine).
Some of the studies exploring the relationships between Adverse Childhood Experiences (ACEs) and adulthood outcomes in England, were based in Lancashire. The studies demonstrated that experiencing ACEs significantly increased the risk of poorer health, social, emotional and economic outcomes in adulthood.

Building on the outcomes and learning from the studies, Blackburn with Darwen Local Authority and Lancashire Care NHS Foundation Trust undertook a scoping exercise to explore how health professionals’ and practitioners’ confidence to routinely enquire about childhood adversity could be increased. This scoping exercise aimed to understand the viability of bringing a greater understanding of ACEs into interventions in the local area.

In recognition of the challenges services face in low likelihood of disclosure, lack of professional enquiry or confidence they created a public health approach called REACH (Routine Enquiry about Adversity in Childhood) to routinely ask people during a health assessment about traumatic or adverse experiences in their childhood. They found that the processes encouraged disclosure, helped practitioners to respond appropriately to what is heard and plan more impactful interventions, which in turn improve their health and wellbeing in the long-term.

The Trust initially trained 100 staff within the Early Intervention Service in the REACH method before rolling it out to the wider teams (Health Visitors, School Nurses, Children’s Services Family Support Team, Substance Misuse Practitioners, etc). Their intention is for the routine enquiry to be embedded across their service portfolio, enabling identification of need and early intervention or access to services.

They encouraged services to become ‘ACE’ aware and advocate for community residency in their interventions. This is reflected in the refreshed Blackburn with Darwen Joint Health & Wellbeing Strategy for 2015-18 that also contains a priority of embed[ing] routine enquiries about childhood adversity into everyday practice.

Subsequently, the importance of the approach has been recognised elsewhere. At a local level it has been introduced to new areas (for example Greater Manchester) and has been expanded to new service types (including domestic abuse services, GPs, and in building a trauma informed school environment). At a national level, Future in Mind recognised the value of routine enquiry and highlighted that the Government would be embedding this into its response to concerns about Child Sexual Exploitation (CSE) following the Casey inspection of the handling by the council in Rotherham. Routine enquiry relating to sexual exploitation, domestic violence and abuse will is in place for young people aged over 16 years, and is being expanded to targeted services, including child and adult mental health, sexual health and youth and adult substance misuse, during assessment.

England is not alone in pursuing routine enquiry, and other countries in the UK have developed similar approaches. For example, the Scottish Government, being an earlier adopter of the approach, made the development and implementation strategy for a programme of routine enquiry across a range of NHS Scotland health services a core part of its National Domestic Abuse Delivery Plan for Children and Young People.

For more information about the REACH programme visit: www.lancashirecare.nhs.uk/REACH
b. The importance of resilience

The importance of resilience in childhood can be mitigated by building the resilience of children and young people. Resilience has been described by psychologists as the ability to develop despite growing up in high risk environments or facing difficult circumstances. It describes the cognitive skills a children or young people can learn, and the social support they can access, to make sense of the difficulty they have faced and to bounce back to a place of positive mental health and wellbeing.

In this way, young people can be helped to bounce back from adversity by being helped to balance the risk factors that they have in their life with protective factors that will build their resilience. For example, for a child living in a violent home, a protective factor like persistence, might include a mentor, or a safe school, and would enhance the child's psychosocial wellbeing.

Interestingly, some researchers and clinicians have suggested that exposure to childhood adversity can strengthen and transform a young person's level of resilience, equipping them with coping mechanisms to deal with life challenges in adolescence and adult life.

Expert Working Group for Looked-After Children, which is being chaired by Alison O'Sullivan, former president of the Association of Directors of Children's Services, and Professor Peter Fonagy. The new expert working group is exploring how best to improve access to mental health and wellbeing services for children in, and leaving, care and will consider the 'most appropriate models of care for these groups with the aim of recommending care pathways and a quality standard for them'.

We very much welcome the commitment to continuing the momentum on transforming support for looked after children and care leavers, however are concerned that this work is being done in isolation of the wider group of children who have adverse experience and additional complexity in childhood. Future in Mind and the Five Year Forward View on Mental Health both recommended looking across the needs of these groups of children as well as identifying specific models of care and pathways for them. Without equal attention being given to the commonalities between these groups, we are concerned that the opportunity for the Future in Mind transformation to be sensitive to both adversity- and trauma, may be missed.

c. Securing momentum for change

To ensure the full ambition of the Future in Mind transformation is embedded in its implementation, the NHS' Five Year Forward View on Mental Health called for the establishment of an 'expert group to examine [children who face adversity’s] complex needs and how they should best be met'.

Since the publication of the Forward View, NHS England and Department of Health’s focus has been on improving access for looked after children, echoing concerns in Parliament and amongst regulators about the inadequacy of support for their mental health needs. This recently culminated in the Department of Health establishing an

d. Next steps

This report has focused on bringing attention back to the common needs of children who face adversity, trauma and complexity in their lives.

Through it we hope to raise awareness about the impact of a diverse range of adversities on children’s mental health, emotional wellbeing and futures.

We believe that we all have a responsibility to meet the needs of these young people – they must not be left out from the transformation of children’s mental health because they are seen as being too difficult to engage or as a burdensome adjunct to existing plans.
Our work on trauma and Adverse Childhood Experiences will continue, and YoungMinds will be convening a national policy summit and a national clinical summit later in 2016 to bring together decision makers (policy makers, commissioners and services providers) and people with experience of adversity and complexity together to co-develop recommendations that support the continued transformation of support for children’s mental health. These summits will build upon the emerging commonalities of experience and recommendations outlined in sections two and three of this report.

In the interim, we would encourage:

- The **Department of Health and Department of Education** to urgently establish a national expert group exploring the commonalities across all childhood adversities and build a consensus on models of care and practice – building on the existing commitments around looked-after children and care leavers.

- **NHS England** to undertake, or commission, a more detailed review of the refreshed (following the *NHS Five Year Forward View on Mental Health*) existing Local Transformation Plans (LTPs) and wider Sustainability & Transformation Plans (STPs) to assess the sufficiency of transformation to meet the common needs of children who face adversity in their lives. If collectively there is insufficient coverage of all childhood adversities, NHS England should provide additional advice and support to local areas to increase their understanding and actions in this area.

- **Local areas** (through Clinical Commissioning Groups) to ensure that their refreshed Local Transformation Plans meet the reform and operating principles for future services and interventions that arise from Future in Mind.

- **HM Government** to commit to a national focus in 2018/19 on tackling childhood adversity to create momentum at a local level and share good practice interventions.
### 4. Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>ACE</td>
<td>Adverse Childhood Experiences</td>
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<tr>
<td>BESD</td>
<td>Behavioural, Emotional and Social Difficulties</td>
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<tr>
<td>BME</td>
<td>Black and Minority Ethnic (<em>sometimes expressed as BAME – Black, Asian or Arab and Minority Ethnic</em>)</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CCG</td>
<td>Clinical Commissioning Groups</td>
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<td>CSE</td>
<td>Child Sexual Exploitation</td>
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<tr>
<td>DSM – 5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders (fifth edition)</td>
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<td>EHCP</td>
<td>Education, Health and Care Plan</td>
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<td>NHS</td>
<td>National Health Service (in England)</td>
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<td>ICD 10</td>
<td>International Classification of Diseases (10th revision)</td>
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<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual and Transgender</td>
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<td>LTPs</td>
<td>Local Transformation Plans</td>
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<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
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<td>SEN</td>
<td>Special Educational Needs and Disability</td>
</tr>
<tr>
<td>STPs</td>
<td>Sustainability &amp; Transformation Plans</td>
</tr>
</tbody>
</table>
5. References and Endnotes


6. The Health & Social Care Information Centre (HSCIC) has commissioned the Office for National Statistics (ONS) and NatCen to conduct a Survey of the Mental Health of Children and Young People in 2016, reporting in 2017. For information is available here: http://www.natcen.ac.uk/media/1131001/mhcypin2016-consultation-report_v2_for-publication.pdf


8. ibid.


27 Children’s Commissioner for England (2012b) I thought I was the only one. The only one in the world. *Inquiry into Child Sexual Exploitation In Gangs and Groups*. http://www.childrenscommissioner.gov.uk/sites/default/files/publications/I_thought_I_was_the_only_one_in_the_world.pdf


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The statutory definition of domestic violence was expanded to include victims aged 16 and 17 years old, and to include controlling behaviour and coercive behaviour. For more information see: https://www.gov.uk/government/publications/new-government-domestic-violence-and-abuse-definition. Section 120 of the Adoption and Children Act (2002) also extended the legal definition of ‘significant harm’ to children to include witnessing or overhearing abuse, which would include domestic violence. http://www.legislation.gov.uk/ukpga/2002/38/contents


ibid.


89 A brief overview of Early Help is available at: LGA (2013) *Must Know 5: What you need to know about early help*: http://www.local.gov.uk/c/document_library/get_file?uuid=50e58128-e1e3-4e66-bf6a-7cdd852a98d8&groupId=10180
92 ibid.
100 Health and Social Care Act [2012]: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
101 Child Health Profiles are available by local authority area and CCG at: https://www.chimat.org.uk/profiles, the data is also available through searchable, interactive content on the PHE Children and Young People’s Health Benchmarking (FingerTips) Tool http://fingertips.phe.org.uk/profile/cyphealth#/page/0


109 Further information on the Adverse Childhood Experiences (ACEs) studies coordinated by the Centers for Disease Control and Prevention is available at: http://www.cdc.gov/violenceprevention/acestudy/index.html


113 The Adverse Childhood Experiences (ACE) studies in the US and UK explore the impact of verbal, physical and/or sexual abuse, or childhood experiences of living in household containing adult mental illness, domestic violence, substance misuse, incarceration and parental separation.


119 Street, C., Stapelkamp, C., Taylor, E., Malek, M., & Kurtz, Z. (2005) Minority Voices: Research into the access and acceptability of services for the mental health of young people from Black and minority ethnic groups: http://www.dawsonmarketing.co.uk/youngminds/shop/PDF/MV.pdf


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164 Rethink (2014) 20+: Why people with schizophrenia are dying 20 years younger than average, and what needs to change: https://www.rethink.org/media/1178709/plus_twenty_report.pdf


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July 2016