HOUSE OF COMMONS

Home Affairs Committee

Oral evidence: Gangs and youth crime, HC 199

Tuesday 14 October 2014

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Written evidence from witnesses:

- Centre for Mental Health

Watch the meeting

Members present: Keith Vaz (Chair), Ian Austin, Mr James Clappison, Michael Ellis, Paul Flynn, Lorraine Fullbrook, Dr Julian Huppert, Yasmin Qureshi, Mr David Winnick.

Questions 103 – 126

Witnesses: **Dr Charlie Howard**, MAC-UK, and **Lorraine Khan**, Centre for Mental Health, gave evidence.

Q103 Chair: This is the Committee's continuing inquiry into gangs and youth crime, which we began before the recess. I welcome to the dais Dr Charlie Howard and Lorraine Khan from the Centre for Mental Health. Thank you for coming. We have approximately three more sessions on gangs and youth crime, and we hope that we will be able to produce our report as soon as practicable to assist the Government with its various schemes. Thank you very much for coming here.

Could I ask any members if they have anything to declare, other than what is on the Register of Members' Interests in respect of this subject? Good.

Perhaps I could start with you, Dr Howard. Until we began this inquiry I was not really aware that there was a mental health dimension to the whole issue of gang crime. In fact, it has come as a complete surprise to me that so much work has been done by your organisation, in particular, in this very important area. How many young people involved in gangs do we estimate are subject to mental health issues?

Dr Howard: The first thing I would say is that I do not think we know enough about exactly how many young people have mental health issues. Previous research suggests that it is one in three; our research would suggest that it is higher than that. What we do know is that we are dealing with young people who come from, in many cases, highly complex and challenging backgrounds, and it would be a wonder if they did not have thoughts in their head that were disturbing them. Young people that witnessed their friends get murdered, shot, or grow up in environments of domestic violence, in many cases have absent parents; I am sure the Committee will be aware of some of these things.

In our experience, even those who do not reach a diagnostic threshold would often sit just below a clinical threshold, so they have needs that are very close to tipping over into being clinical disorders. We know that this group are not accessing services, they are not coming into contact with the right people who can refer them, and even if they do, they do not want to go. There is massive mistrust of professionals; they do not want to talk to people they do not have a relationship with. Often it is as simple as the clinic is in the wrong part of their postcode and that is why they will not go. There is also a huge stigma for this group, which is often made up of young men, in being seen to seek help for their mental health. The thing that has most struck me in the research and the work that we have been doing at MAC-UK is the disproportion of young men suffering from depression, but it is presenting as highly aggressive behaviour. So we are not stopping and asking them the right questions at the right time.

Q104 Chair: Lorraine Khan, when did you first notice this as a major issue, as far as gang crime was concerned?

Lorraine Khan: I personally became interested in it through some work that we were doing at point of arrest to try to screen young people for health issues. It is a new Government initiative and we started working with the Department of Health in 2007-08 to develop that screening process. We have now had around 10,000 to 12,000 young people go through that process and we held the data for that initiative.

We began to look at that data in a bit more detail, and what began to jump out at us was that there were certain groups of young people on that database who seemed to have much greater needs, far more needs and also indications of longer-standing need than other young people. One of those groups was actually young women disclosing a gang association, but we also noticed a similar pattern with young men disclosing a gang association. Young women generally who come into the youth justice system—and this is what we were talking about in the early stages of coming into the youth justice system—are more likely to have higher levels of mental health difficulty. But these young women were probably three or four times more likely to have a high likelihood of mental health difficulty and presentation.

To give you an example of that, one of the most common childhood mental health difficulties is often overlooked because it presents as behavioural difficulty. About 5% of young people will have an early starting behavioural difficulty. We know from longitudinal research that has been done that this is an indicator of very poor outcomes across that child's life as they grow into adulthood. So 5% usually experience that difficulty, and 20% will have conduct problems and they will just be underneath that threshold, as Charlie mentioned. We found that 40% of the young women that we were screening had these difficulties before secondary school age—conduct problems—and around the same number of young men who were disclosing gang associations as well.

Q105 Chair: Dr Howard, what further action do you think the Government can take to help on this issue?

Dr Howard: We need to turn the way that that we think about and do mental health on its head. I think that the services that we provide work for some young people. My experience and research would show that what we are currently providing absolutely is not reaching or working for young people who are gang involved. Often these young people have brilliant relationships with professionals on the front line, such as youth workers, support workers and others; they trust them, and yet those workers do not have the resources to begin to address mental health

needs. We need to add value and capacity build the front-line workforce, so that they feel confident and equipped to begin to identify and have basic-level mental health conversations. That would be the ground-up approach.

Then there also needs to be a top-down approach, where the services that we do provide are much more flexible; they go out to see young people where they want—on benches, buses, stairwells. They are flexible around chaotic lives, so they are not saying, "You need to come at 2.00 pm, and if you do not turn up three times in a row, you are discharged". Instead they say, "I'll be sitting at McDonalds for the afternoon, between 2.00 pm and 6.00 pm. It is up to you when you come". We need to radically rethink what we do. I do not think it is hugely expensive, I think it is about using existing resources in new ways.

Q106 Mr Clappison: I was very interested in this expression of girls in gangs. I was going to come to you later, but now might be a convenient moment since you so very properly touched upon it. You mentioned the mental health difficulties of girls. Could you be a little bit more specific about what these are?

Lorraine Khan: Yes. As I say, early starting behavioural difficulties, which are very rare in young woman—they are rarer than in young men—was a major finding. They are more likely to self-harm, about four times more likely to self-harm than other girls coming into the youth justice system. There were indications of eating disorders and sleeping problems as well, which are often a sign of underlying mental health difficulty.

It was not something that we were able to drill into in the health screening work that we were doing, because it was at a very early stage of our contact with these young women, but the literature highlights a high prevalence of post-traumatic stress disorder among young women. Some girls' experience in gangs tends to be high exposure to sexual violence and exploitation; it is difficult to know whether it is as a result of that exposure to those high risk and damaging situations. There is also some literature that suggests that these girls have higher levels of exposure to sexual abuse before they enter gangs, and they often enter gangs in order to protect themselves from those experiences.

Q107 Mr Clappison: I want to ask you about what form of intervention is best for girls once they have joined gangs. Is it your position that more could be done to perhaps pinpoint girls who are at risk of joining gangs and give an intervention to help them desist from doing that?

Lorraine Khan: Without a doubt, and this is the same for young men as well. What we ought to be thinking of is a child and youth development approach to preventing young people drifting into gang involvement. We are still learning about the risk factors for gang involvement, but they are crystallising to an extent. We know certainly that when they start to multiply, that increases the chance of a young person ending up being involved in gangs and also getting stuck in gangs.

When we are talking about risk factors, they occur at various different levels. On an individual level, the earliest sign might be early behavioural difficulties. It might also be that there are parenting difficulties—there is a lack of positive parenting in the family that is also creating some of those behavioural difficulties and adding to them. It may be that that young person lives in a community or goes to a school where there is a high level of threat and risk of violence. We know that prolonged exposure to violence has a very negative effect on young women's mental health and young men's mental health. From our analysis of this data and also the literature review, what we picked up is that there are a range of gender-specific risks as well. You cannot just assume that the risks that are relevant for young men will transfer to young women.

Q108 Mr Clappison: Can you give us an example of what sort of intervention would be successful once a girl has joined a gang and become involved in that?

Lorraine Khan: In a lot of ways they are similar to what has been described already. What young women need is easy access to relationships that are safe, that model positive behaviours, that build up their self-esteem—because low self-esteem has been associated with increased chance of gang involvement—and offers them a safe exit route, because for young women, leaving gangs is a high-risk activity in itself. It can be for young men as well, but it is for young women. We need to think about that and safe housing. I think relationships are at the core of young women's exit routes, and making sure that they have the proper input to deal with the trauma that they have experienced and to move forward from that.

Q109 Mr Clappison: My last question on this is: how would you go about making contact with a girl in all these gangs, to get them to accept help?

Lorraine Khan: We started from the point of view of when young people were coming into the youth justice system, which is too late. But the positive headline from our analysis was that around two-thirds of those young women accepted help at that stage. So that is a positive message. What it relies on is making sure that there is an infrastructure of support outside that initial screening to refer young women on to. That is to services, like Charlie's, which are very outreaching, and which go to see young women where young women feel comfortable, in the right place at the right time, and approach young women in the right way.

Mr Clappison: Thank you very much.

Q110 Dr Huppert: Thanks to both of you for coming. I think one of the things we have picked up from what you have written and what you have said is just how important mental health is to this, like so many other things. We do need to prioritise looking at mental health issues. I have a number of specific questions, but can I start off by understanding a bit more about the MAC project? You have outlined some of the ways in which you do different things: the street surgeries and so forth. You have said in an interview that I read that part of the aim is to change what the gangs are. That is an idea I have not heard presented elsewhere. You are actually trying to redirect the group, rather than break up the group. Could you say a bit more about that and how much success you have had on that?

Dr Howard: We have created a model called Integrate that is now being rolled out across four sites in London: two in Camden, one in Peckham and one in Haringey. What it does is it takes mental health off the door. We know that young people are more likely to engage if they are engaging in something that they are interested in. Mental health is not the sexiest thing for anyone to deal with, never mind a young person in a gang. We find that often young people want jobs, they want opportunities. That is what we put on the door. They lead those services themselves, they come for help with those things, and we wrap the mental health support around it.

We work in the context of the peer group. The reason for setting up Integrate was that these young people had been referred to just about every service going throughout their lives. For whatever reason, that service had not worked. If we turned up and said, "We want to help you" frankly, they would put two fingers up at you and tell you to go away. So we needed to find a way

of spinning help-seeking on its head. This is all framed around young people running their own projects. Through that they learn skills. We wrap around mental health but we engage them through the dynamics of the peer group, and this builds on some work David Kennedy has done in the States. If you can work with the police, community safety and the local community, and identify who the key influences are in the peer group and get them on board to come and lead a project, you can guarantee that all of their friends, who are on your list of young people you want to engage, will follow. This has now been replicated in four boroughs with four very different gang profiles.

We work in the context of the peer group, and they come to help us rather than to get help. If they say they are going to get help, their friends come after them; they think they are snitching, and it is stigmatising. However, they are coming to help Charlie to run a project that seems to be socially acceptable in their peer group. So collectively you build on the peer dynamics that exist, they come along, they run an activity, and you wrap mental health support around it, and gradually the collective behaviour of those peer group changes, almost without anybody noticing or having the conversation that they are moving from a world of antisocial activity into proactive activity.

Q111 Dr Huppert: It all sounds very good. I think you were cited as an example of best practice in the Home Office's evidence to us, which I hope you are pleased about. Has there been an independent evaluation of it, both of the effectiveness but also the cost effectiveness? For example, one could imagine various bits of the media getting very upset about the idea of helping gangs to do fun things.

Dr Howard: Yes. We are currently being independently evaluated by the Centre for Mental Health across our four sites. The research to date has shown that we are reaching young people with a higher level of mental health and social care needs than you would expect in an assertive outreach cohort, which is a very high tier of NHS statutory support. By working with them in this way, it reduces that need by 30% over a 12-month period.

We have just invested some funding into an economic analysis of our fourth and final project in Haringey, because we want more data around cost. From an initial look at expenditure against young people, it is about £3,000 a head. If you compare that to statutory treatment or work putting somebody into a young offender's institute it is very cost effective and highly replicable. I have to say it has taken us two years to get control offending data from the Government for our research. We went through ethical clearance via all the ethics panels and young people consented to having matched control data. So getting the data that we needed has been an uphill struggle. There is one thing the Government could do to help. They are saying, "We want evidence-based models." Well, it is hard to do evidence-based models if the data is not available to help you to do that. We were having a discussion that if data could be collectively gathered by practitioners or collectively provided by Government we could begin to create a much more powerful evidence base.

Q112 Dr Huppert: That is very helpful. Ms Khan, you are currently doing the assessment. When is that likely to be completed? Would it be something you could share with us when it is done?

Lorraine Khan: Yes. I am not personally leading it, but the centre is. When is the finish date?

Dr Howard: We started them in 2008, and they roll through to 2017. There was a year delay between each project so that learning could bridge from one borough to the other. The Camden report should be published by the end of this year, the Southwark one by the end of next year,

and so it goes on. We have interim findings already. We have met with the MOJ now around control data, and they are finally analysing some data for us.

Q113 Dr Huppert: That is very helpful. But £3,000 is a fair amount of money. I agree it is less than the cost if things go more badly wrong. How does it compare to interventions for the bulk population at schools, for example, as being resilience or wellbeing training? There is a whole range. I should declare that my mother works in this area. What is the balance between those two?

Dr Howard: We need to think about who it is that we are talking about. We are talking about the hard-end young people who do not want to engage in anything, so they are the ones who cost the state a disproportionate amount, compared—

Q114 Dr Huppert: Absolutely, but if you could move the entire population distribution over, you would reduce that tail quite substantially as well. How effective is it to move the entire population by school-based resilience learning, and how much is it effective to target the tail?

Lorraine Khan: I can possibly add some light to that. Without doubt, school-based interventions are much cheaper per capita, and what you will be able to do is reduce some young people's propensity to end up in a gang, but you will always end up with a small number who will need more intensive outreach. What we ought to be comparing this type of intervention with is something like multisystemic therapy, which is an equally intensive wraparound therapeutic intervention for young people with high-risk behavioural difficulties; or custody, which is the alternative that we use at the moment, which is much more expensive. A cost-benefit analysis is going to rely on longer-term analysis and longitudinal data will be important for that, so there is a need for more research and more tracking of outcomes for the young people who engage with projects like this.

Dr Howard: Can I add one more point to that? It can also be delivered in different ways that do not need to be up-front costs. In order to found the model and grow it from the ground up, we have had to do it all ourselves and employ people to be able to do that. What we are starting to do is to work with the NHS, so that we can train up existing clinicians who can then work in this way, so we are using existing resource but allocating it in new ways. That is how we are going to solve this problem. We need to be redesigning the way that a proportion of the mental health workforce works.

Often you have frustrated practitioners in the NHS who are saying, "We can't reach these kids. We're not ticking our boxes". I have gone around saying, "Okay, we can help you tick your boxes. You give the staff and everyone is benefiting". It has been effective. Camden has now put out a tender for a new service that is based on this way of working and it would be an NHS-run provision.

Chair: Mr Clappison has a question.

Q115 Mr Clappison: Lorraine, you mentioned custody a moment ago as an alternative to the systematic intervention that you described. Am I right in taking it that that has been custody following conviction and sentencing of an offender—if somebody has committed an offence, custody? A custodial sentence, going into a young offender's institution or prison or something?

Lorraine Khan: Yes.

Q116 Mr Clappison: Would I be right in thinking that is probably not a terribly effective way of dealing with a gang member in terms of getting him out of a gang?

Lorraine Khan: I would say there is some research that has been done in America and also that has been done here. The Washington State Institute for Public Policy have created a league table looking at the effectiveness of various interventions, both to reduce recidivism but also to address mental health difficulties and other difficulties. It is quite clear that there are other interventions that are of much better value and much more effective than custody.

Q117 Mr Clappison: Would your message to sentencers be that, unless it was an offence that was so very serious that there had to be a custodial sentence, they should give a young person a chance first to work through one of the other interventions before sending them to custody, which might make things worse?

Lorraine Khan: I think that is right. That is what the evidence tells us: that if we want to be effective, that is what we need to do. Increasingly, the other difficulty with a lot of youth justice secure settings is that you import your gang difficulties into those settings, which then creates a problem both in those settings but also on release again. It does not do anything to unpick some of those drivers for gang involvement.

Q118 Paul Flynn: We have a long experience in people coming along with new solutions and they usually have multiples in them. We have multisystemic, multiple agency, multiple discipline. Often they appear to work, and often they fall apart. You get some dedicated individuals, some inspired individuals, and you might find some figures that show they are right, and then afterwards it all disappears and everything gets back to normal. I read a book called "Invisible Women" some years ago, about women you are describing. It is a book about a prison in London and how women, very much as you describe, were treated in prison with Largactil, with neuroleptic drugs, and turned into zombies. But there was no solution there. What is your solution? What do you think there is about what you are suggesting—you come to us very well recommended—that really is unique and will be something that will continue to work in the hands of other people?

Dr Howard: It is interesting, I still do half a day a week on the front line but I stopped doing more than that because we wanted to see whether this approach could be run by others. Three of our sites are being run in partnership with workers from the NHS and the local authority and the results have been the same, if not better, by them being run by those staff. From a governance perspective, it was a much more challenging way to roll out and evaluate a new model. But we did not want people to turn around at the end and say, "Well, it worked because MAC-UK did it" or it worked because I was involved or anyone else was involved. So, through the way that we have been piloting, we have deliberately tried to move it away from individuals.

What I do think we need to think about, when we are looking at how we address the needs of gangs and mental health more specifically, is how we change the way that services deliver and work. That requires capacity building of the workforce on the front line. It requires working with managers to provide the structures that allow those front-line workers to provide flexible services, and it requires a strategy that sits above that to make that possible. Integrate has been very bullish at going into boroughs and saying, "We will only work in this way if you have all three of those things in place". Too often things fail because we deliver at the front line and we forget the governance and the things that need to wrap around that to make an approach sustainable.

Q119 Paul Flynn: I think you have used "Wrap around" twice and Ms Khan has used it again. It is a new bit of jargon, I feel. It is lovely, it is comforting and everybody likes to have things wrapped around them. But, if you pardon a bit of cynicism on this, we have heard it all before in different language. I do not want you to spend all your time trying to assess what you are not doing rather than what you are doing, but when you discover that this is not just a problem of wicked people, and that they have mental problems, what can you do then, apart from offer them drugs that might prove to be addictive to them or damaging, or possibly in rare cases talking therapies? How can you deal with depression?

Dr Howard: One of the things that is different about the way that Integrate works, which I think has not been done before, is that it takes what we know would work from a clinical setting and delivers it in a highly flexible way on the front line. The team meets every morning and would think about each young person that they are engaging with, and they would say, "Okay, if we bump into Dan today on the estate what conversation is it that we want to have, based on the needs that we know that he has, that links back to an evidence base that we know works?" It is a whole team approach because the reality is these young people are not going to turn up, to be honest, even if it is in McDonalds between 2.00 pm and 5.00 pm. It is about putting workers out into communities, walking around on the streets, often opportunistically bumping into young people.

So Integrate looks at: what is the evidence base and how can we collectively deliver it across our team? It does not matter if it is me bumping into the young person, or a support worker, or a youth worker; we are all having consistently the same conversation. What we have not done is reinvent a new way of doing talking therapies. We have not invented a new therapy. We have NICE guidelines that tell us what works. What we are doing is delivering some of those things in highly flexible ways, and that is what needs to change.

Q120 Paul Flynn: Describe the highly flexible ways.

Dr Howard: So it is a Wednesday afternoon, it is 2.00 pm, I have worked closely with police colleagues and they have just given me a phone call to say three of the young people in such and such a gang are sitting down on the stairwell on the estate. We would say, "Okay, there is an opportunity here for us to go and engage those young people". Then two of the team, someone that has a mental health qualification paired with somebody who is a youth worker, go off down to the estate and they sit on the stairwell and they start to have a conversation with that young person that links back to what they discussed in the morning meeting about how they would direct that young person.

Often it might start off with the young person saying, "I want to get a job" and you have a conversation and you say, "What is it that is stopping you?" "Well, I've been referred to four employment skills courses and none of them have worked and now I have to go again". When you start to unpick that and get under it you find that they say, "There is no point in me going, no one in my family has ever worked and if I go I am going to fail. I fail at everything". We would work with that belief.

Chair: Thank you very much. Michael Ellis has the final question.

Q121 Michael Ellis: Thank you for coming in. I want to ask you about policing and mental health in this way: the Committee is carrying out this inquiry into policing and mental health and I am

particularly interested in your views on where these two subjects overlap. What are your views on Government initiatives like triage and liaison and diversion—is that what it is called?—in the context of gangs and mental health? Do you find that these are working? It is clearly a challenging area, because a lot of the front-line police officers would not pretend to be qualified in dealing with these mental health issues, or not highly qualified. Who do you think is best to identify mental health or learning disabilities in young people as they enter the youth justice system, particularly when it might be late at night, or in very traumatic circumstances, confused or busy circumstances? How do you address those issues?

Lorraine Khan: I do not think liaison diversion or these health screenings at the point of arrest are a starting point. It needs to be seen as another safety net to pick up young people with vulnerabilities. I think it cannot just rely on health professionals, but health professionals are very important to this process. Every contact counts and we need to make sure that all professionals have more developed antennae to pick up the outward signs. We are not asking other professionals to pick up mental health diagnoses, but what are those outward signs that suggest that we need to look a bit more closely at a young person?

One of the things that we created for the police at point of arrest was a list of things that would tell us that a young person needed further investigation. A history of running away and involvement in a gang is now one of those, as is suspected involvement in a gang, early starting behavioural difficulties, and school exclusion history. It is those kinds of issues that the police need to be alert to, and then they need to bring in a health professional. Talking about it not being a starting point, there are some very innovative initiatives that are starting up called "street triage", where the police have a direct contact on the phone. Perhaps sometimes they can be supported directly by a health professional when they are dealing with a young person or an adult who is worrying them or troubling them in some way. So I think we need to think about that.

I think there are some golden missed opportunities in schools. In America they started off a lot of the health screening work, and one of the lead proponents of health screening in America is now looking at trialling better identification and support, and non-stigmatising but better identification in schools, so that we can pick these things up before there is a crisis, whether that is a behavioural crisis or a mental health crisis.

Q122 Mr Winnick: I was interested in this survey that was carried out by Professor Coid at Queen Mary. It was a survey of 4,600 men aged between 18 and 14 years. As you probably know, 108 men said that they had gang association. The breakdown is: of those 108 men, well over 85% had antisocial personality disorders, 25% had psychosis and nearly 60% had an anxiety disorder. What is very alarming is that 34% have attempted suicide. Did any of that come as a surprise to you?

Dr Howard: No, it did not. I have met with Professor Coid since the research was published, and I think what we need is more research that builds on the back of what he has done. It is no surprise to people working on the front line with these cohorts; those are the kinds of things that we see very often. The one that most surprises me is actually early onset psychosis; young people growing up in chaotic environments, perhaps also using cannabis from a young age, are starting to hear voices that influence their behaviour. What we need is much larger-scale national research, because those are very useful findings, but it is a very small sample. The Government need to invest more funding into understanding some of these things at a wider level.

Mr Winnick: One third had actually tried to commit suicide?

Dr Howard: Yes.

Q123 Mr Winnick: That perhaps is the most alarming figure of all. When we have looked at gangs previously—as the Chair and other colleagues who were involved in the inquiry at the time know—one of the facts that came across, time and time again, was not simply that the household in which the gang members lived were, in the main, along the lines you mention, but it was a one-parent household and basically there was an absence of a male figure, namely the father. Do you go along with the view that in many instances that just produces, certainly in low-income households, that much more difficulty both for the person concerned and for society as a whole?

Dr Howard: Experience from interviewing young people we work with and speaking to them as a clinician is that there is a whole range of factors, and I know Lorraine has picked up on those. I would not want to isolate that as just one on its own. I think for some young people that is a strong reason why they end up in difficulty, but for others it might be something else. Indeed, not all young people in gangs grow up in single-parent households where they do not have support.

Lorraine Khan: I will add to that that the research generally suggests that it is not necessarily to do with having a single parent; it is the quality of the parenting in that situation. There is an issue about male role models and how one learns to be a man in that situation. There is less research into that, and that is an area that both Charlie and I are interested in. I think some of the workers who are involved in Charlie's schemes are sometimes the first positive role model outside of a gang, where they have had different kinds of role models. It is the first positive male role model that they have had. It is more to do with positive parenting, and there are good interventions that can support single parents to promote positive parenting.

Q124 Mr Winnick: When one reads—more so in London perhaps than elsewhere—of some sort of casual murder, there is a struggle going on for a mobile phone or whatever, and one or more of the gang knifes the person to death, in your view at any stage does the culprit understand what is likely to happen once they are apprehended: 10 to 15 years in prison at a minimum?

Lorraine Khan: There is some very new emerging knowledge at the moment—and it is neuroscientific knowledge—that when a young person has experienced trauma and violence, it embeds in a part of their brain that is not governed by rational thinking. Often what tends to happen in that situation is, if they are exposed to flight or fight situations, that that sort of buried traumatic experience results in a behaviour and activity that is extremely impulsive and often very dangerous to other people. So there is something that we need to understand about what happens to people who experience prolonged exposure to violence and trauma.

Going back to your point about self-harm and suicide, one of the most difficult things to accept sometimes is that, for example, those young people with early starting behavioural difficulties are troubled and troubling young people who are much more likely to commit suicide than other young people. This is in long-term studies where they have tracked them into adulthood; they are much more likely to commit suicide. Also, those who have experienced violence and who are also the perpetrators of violence are more likely—there have been studies in different countries that have tracked this—to commit suicide as well. There is something about that impulsiveness when people have been exposed to trauma that we need to get better at understanding.

Q125 Chair: We have looked at this issue before, and of course we are not the first Committee to be concerned about gangs and crime and youth crime. I wonder what we can do to break this cycle.

We have visited people in jail who have said that they are the sons of those who were in gangs and were also in jail. There is an economic case for dealing with these issues in the long run to all of us as taxpayers, but somehow we are not able to break this cycle of despair. Charlie Howard, if you were thinking of one thing that the Government could do to break this cycle once and for all—just one initiative, not good words but something practical—what would it be?

Dr Howard: It would pick up on something I have already said. I think that we need to put state of mind at the heart of all solutions. It is no good referring a young person to an employment skills course if they believe that they are going to fail. We need to deal with that belief first. It is no good sending young people on an education course if they have an undetected learning need because they have been hit around the head with a baton. The brain and the way that we think affects all of us, and at the moment mental health sits as a silo that gets referred into. It needs instead to straddle across all interventions.

Q126 Chair: Yes, that is very helpful. Lorraine Khan, one Government initiative, one thing that they can do?

Lorraine Khan: Investing in early intervention, so a child development and youth development trajectory to focus on preventing behavioural difficulties and preventing mental health difficulties.

Chair: Yes, early intervention. One of our colleagues, Graham Allen from Nottingham North, of course, is a great proponent of this and as a Committee we have looked very carefully at this over the years. It is certainly something that will be reflected in our report.

We are most grateful to both of you for coming in. We have a few more evidence sessions but if there are any issues that you want to raise with us, before we conclude our report, please do not hesitate to write to me about it. Thank you very much.