Women and girls at risk

Evidence across the life course

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Foreword

We know that a combination of structural and individual risk factors in childhood and adulthood lead too many women and girls into very difficult lives. We see these women and girls in the criminal justice system, prison and secure psychiatric accommodation becoming chronic users of drugs and alcohol, or getting trapped in street sex work and homelessness. The risk factors for such women and girls are multiple and frequently extreme, and the services that aim to support them too often fail. At their worst, services can have the effect of reinforcing earlier traumatic experiences and causing further harm.

Of course, many women do overcome early problems to lead fulfilling lives, and we know that the best services can provide exemplary support.

The Corston Independent Funders' Coalition (CIFC) is a collaboration of trusts and foundations. It was established to press for the full implementation of the recommendations of the 2007 Corston Report,[1] an independent review of vulnerable women in the criminal justice system commissioned by the Home Office and led by Baroness Jean Corston.

Barrow Cadbury Trust, LankellyChase Foundation and the Pilgrim Trust have commissioned this wide-ranging literature review as part of their work to broaden the approach of the CIFC to look beyond criminal justice to the underlying causes of risk and disadvantage for women and girls. We have been supported by a committed Transitional Steering Group chaired by Liz Hogarth (former head of the Ministry of Justice's Women's Strategy Unit), which comprises Clinks, Women's Breakout, User Voice and a range of frontline delivery organisations.

The report is critical to the development of a new alliance of organisations which will bring together a shared narrative and create energy to take action on these issues. The Alliance has evolved from the work started under the CIFC and aims to highlight why gender is an important variable, to enable all those who work with women and girls to think more holistically about the high prevalence of trauma and how to help women overcome it, and to influence the mainstream to understand the interconnected nature of the issues.

Looking across the life course of women and girls, this review demonstrates to the emerging Alliance the importance of having a strong gendered narrative and an understanding of the effect of inequality, violence and abuse. It will ensure that the Alliance has a sound basis for action.

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1 Home Office (2007) *The Corston report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system, http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf.*

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Introduction

The purpose of this review

The purpose of this review is to inform a new cross-sector strategic alliance focused on women and girls with complex needs. It reviews the evidence base for the underlying hypotheses of the initiative:

- There are groups of women and girls with similar clusters of extreme vulnerabilities in very damaging circumstances and systems.
- For some women the trajectories towards these highly damaging outcomes appear to be driven by unaddressed or unresolved trauma (defined broadly to include abuse, neglect, exploitation and disrupted attachment). Other risk factors, such as personality type, genetics and family history, may also play a role.
- Girls may begin to exhibit the behavioural manifestations of this early experience in different ways from boys in adolescence (which is also when service responses begin to differ).
- Some women have been failed as children and as adults by the services meant to protect them, to support their resilience and to assist their recovery.
- There are opportunities to address these issues and support women and girls by taking a 'life course' approach, looking holistically at a structural, social and cultural context.

The review is based on a search of a broad range of evidence sources including: published research, theoretical literature, data available on UK government websites and 'grey literature' such as organisational reports and websites.

The parameters of the search strategy have been literature published in the English language since 2000, supplemented by a selective review of significant literature since 1980 (identified primarily through citations).The review has explored available research and other sources of data on the characteristics and risk factors of women or adolescent girls who experience negative outcomes, including those:

- In contact with the criminal justice system as adults or young women
- Experiencing homelessness
- Involved in prostitution or sexual exploitation
- Experiencing severe mental health problems
- With serious drugs and/or alcohol problems.

We consider the relationship between these outcomes and the prevalence or accumulation of negative and abusive experiences across the life course, including physical abuse, sexual abuse, neglect, disrupted or poor attachments, domestic violence, negative school experiences and being in care, highlighting differential impacts by gender.

We also review the available evidence on the characteristics of interventions that succeed in interrupting these pathways, and increase resilience and the possibility of recovery at different points of the life course, for example drug and alcohol and mental health interventions, education and training, maternity and parenting provision, and housing and criminal justice responses.

Background

Since 2008, a group of funders with an interest in a better criminal justice system has been collaborating through the CIFC to improve the response of statutory services to women and girls either in, or at risk of entering, the criminal justice system. In its first phase, CIFC focused on community alternatives to custody, but more recently it has been reflecting on whether to broaden its scope away from women already in the criminal justice system, and to look at how to prevent women and girls entering it in the first place. CIFC has been reviewing the changing landscape, and in partnership with Clinks (the infrastructure organisation for the criminal justice voluntary and community sector) has carried out extensive consultation about this change of focus with practitioner organisations working with vulnerable women and girls.

Funders and practitioners recognise that going into custody is just one of a range of negative outcomes for vulnerable women and girls. We know that a constellation of structural and individual risk factors in childhood and adulthood lead too many women and girls to the criminal justice system and prison, secure psychiatric accommodation, chronic use of drugs and alcohol, street sex work, homelessness and other poor life trajectories. We know that the risk factors for such women and girls are multiple and frequently extreme, and the services that aim to support them too often fail; at worst, some services can have the effect of reinforcing earlier traumatic experiences and causing further harm. We also recognise that many women overcome early problems to lead fulfilling and successful lives, and that some services provide exemplary support.

Following its consultation with Clinks, CIFC's view that that the focus of work over the next few years should be moved 'upstream' has been confirmed. It recognises that if the number of women and girls ending up in negative life trajectories is to be reduced, it needs to look at not only the criminal justice system, but also a broad network of systems and interventions.

The consultation demonstrated that there was widespread support among practitioner organisations for this broader focus, and an appetite for developing an alliance of funders, practitioners and others to identify or develop an evidence base of effective practice, and to create a convincing case for systems change so that the needs of vulnerable women and girls can be met at an earlier stage, and where interventions fail, health, criminal justice and other statutory services are improved so that they are able to break negative cycles.

The structure of the review

There has been a recent growth in the popularity of taking a life course approach to analysing risk factors and what might be effective in addressing them across a range of domains from health inequalities[2] to reducing offending.[3] This approach helps us to think about the risk factors that occur at different life-stages and to recognise the accumulation of risk that can build up across people's lives increasing the likelihood of poor outcomes. It also helps us to identify the critical points where timely intervention might be most effective. Particularly strategic are key life transitions that mark movement from one life phase to another (starting school, moving from primary to secondary school, leaving school, becoming a mother) and points of 'crisis' (such as entry into care, first offence or occasion of going missing from home), which can also offer opportunities for intervention.[4]

For the purposes of this review we have divided the life course of girls and women at risk into the following groups:

- Pre-birth and early years (up to the age of 5)
- Primary years (5–11 years)
- The teenage years (12–15 years)
- Into adulthood (16+).

At each stage we briefly outline what the research suggests are the risk factors or indicators for poor outcomes and discuss their impact on girls and women. We go on to outline evidence we have been able to identify on how to intervene effectively to prevent or ameliorate negative outcomes.[5]

The nature of the evidence

Evidence about women and girls at risk tends to fall broadly into two categories:

- **Research on problems, consequences, correlates and causes:** The best of this sort of research provides evidence of the trajectories of girls and women at risk and the range of factors that influence outcomes at different stages of the life course. However, the major longitudinal studies which could be of most value have published very little about gender. Much of the research that has been conducted has been with specific populations of 'service user' – those in drug treatment or the mental health system. Its impact has been limited as a result of its containment within different specialist silos.
- **What works type evidence:** The interventions that are effective in tackling causes and ameliorating negative outcomes. The strongest of this evidence relates to interventions in childhood and tends to be undifferentiated by gender or to relate to outcomes for men or boys. Outcome focused evaluation of services for adult women at risk is very limited.

These limitations are in themselves a significant finding of this review with implications for how the literature can be interpreted and applied to girls and women, and for future research and data analysis.

It should also be noted that much of the research cited in this review focuses on sensitive or hidden social issues, which are difficult to measure. Prevalence rates may show absolute rates but can also indicate how hidden some issues are, or how difficult it is for people to disclose some of them. There is likely to be under-reporting of some issues by groups who are most difficult to access, by men because disclosure may undermine their masculinity, and by older people for whom naming or acknowledging certain issues may be less acceptable. Many of the issues discussed are problems for both men and women (men who are homeless or have mental health difficulties and so on are also at risk), but there are particular risks and outcomes faced by women due to their gender. It is the lack of gender-specific evidence, or the apparent gender neutrality of existing evidence, that makes this review so essential.

2 Marmot M et al (2010) *Fair society healthy lives: Strategic review of health inequalities in England, the Marmot review, London, UK: University College London.*

3 Piquero A and Mazerolle P (2001) Life-course criminology: Contemporary and classic readings, Belmont CA, USA: Wadsworth Thompson Learning.

4 Frieberg K and Homel R (2011) Preventing the onset of offending, in A Stewart, T Allard and S Dennison, *Evidence based policy and practice in youth justice, Sydney, Australia: Federation Press.*

5 These levels of early intervention are based on those defined by the National Audit Office (2013) *Early action landscape review.*

Part 1: **Gender matters**

Gender matters in the lives of women and girls at risk. In this part of the review we consider how three sets of gendered factors – social inequalities, the impact of negative life experiences (in particular violence and abuse) and gender expectations – shape risks across the life course of women.

Young people who grow up in unequal and disadvantaged circumstances, and whose difficulties are compounded by abusive life experiences, are at higher risk of negative outcomes. This much is obvious and well evidenced. There is also strong evidence of the greater impact of multiple risk factors: the more negative factors in a young person's life the higher the odds that they will face poor outcomes.[6] But what if the young person is female? How does growing up a girl interact with other factors to shape her life experience? Being female is a protective factor against certain negative outcomes: women are less likely to commit serious crime, end up in prison or become street homeless. On the other hand, girls and women are at greater risk of most forms of violence and abuse. And gender is relevant not only to understanding the nature of risks faced by women and girls, but also to understanding how they respond to those risks and the ways in which they are then viewed and treated by others.

Growing up unequal

Girls are born into a world structured by inequality – where by virtue of their gender they are likely to:

- **Earn less money than men:** Despite girls' educational attainment being higher than that of boys, data on lifetime earnings shows that women earn 20% less than men on average.[7]
- **Undertake certain kinds of paid work:** One explanation for the differential in earnings is the fact that women are still predominantly employed in a limited number of lower paid occupations and are less likely to be employed in skilled trades, science and technical jobs. Women make up 83% of people employed in personal services.[8] Occupations that are predominantly male pay higher wages than those that are predominantly female.[9]
- **Enjoy less progression at work:** Lifetime earnings are also affected by the responsibilities women frequently have for childcare (e.g. working part-time), which impacts on their choices about hours and location of work and their chances of promotion.[10]
- **Have less freedom and leisure than men:** Inequality in relationships between men and women in everyday life remains. It is still the case that the average woman does about three times the amount of housework as the average man.[11]
- **Spend more time looking after other people:** Women also tend to have more caring responsibilities for other family members including older relatives.[12]

Gender intersects with other kinds of inequalities, particularly with poverty and race. There is considerable evidence that women are more likely to be poor than men, particularly those who are lone parents or in later life.[13] Women who experience poverty in childhood are more likely to become mothers at a young age and lone parents than those who do not.[14] Poor women who are in paid work are most likely to be in service jobs that mirror domestic work and which are low status and low pay. Households headed by women are also more likely to live in overcrowded or substandard homes than those headed by men.[15]

6 Feinstein L and Sabates R (2006) *Predicting adult life outcomes from earlier signals: Identifying those at risk, London, UK: Centre for Research on the Wider Benefits of Learning, Institute of Education, University of London.*

7 Johnson P and Kossyk Y (2008) *Early years, life chances and equality: A literature review, Equalities and Human Rights Commission.*

8 Equality and Human Rights Commission (2010) *How fair is Britain? First triennial review.*

9 Walby S and Olsen W (2003) The UK gender wage gap and gendered work histories, paper presented to the Conference of the British Household Panel Survey, July, Colchester, UK, Institute for Social and Economic Research.

10 Valcour PM and Tolbert PS (2003) Gender, family and career in the era of boundarylessness: Determinants and effects of intra- and inter-organizational mobility, *International Journal of Human Resource Management, 14 (5) 768 – 78; Kirchmeyer C (2002) Gender differences in managerial careers: Yesterday, today, and tomorrow, Journal of Business Ethics, 37 5 – 24.*

11 Gershuny J (2004) Time, through the lifecourse, in the family, in J Scott, J Treas and M Richards (eds), *The Blackwell companion to the sociology of families, Oxford, UK: Basil Blackwell, 158 – 77; Gershuny J, Bittman M and Brice (2005) Exit, voice, and suffering: do couples adapt to changing employment patterns?, Journal of Marriage and Family, 67 656 – 65; Hundley G (2001) Domestic division of labor and self/organizationally employed differences in job attitudes and earnings, Journal of Family and Economic Issues, 22 (2);* Coltrane S (2000) Research on household labor: Modeling and measuring the social embeddedness of routine family work, *Journal of Marriage and the Family*, 62; Stevens D, Kiger G and Riley P (2001) Working hard and hardly working: Domestic labor and marital satisfaction among dual-earner couples, *Journal of Marriage and the Family, 63.*

12 Mooney A, Statham J and Simon A (2002) *The pivot generation: Informal care and work after fifty, York, UK: Joseph Rowntree Foundation.*

13 Darton D and Strelitz J (2003) *Tackling UK poverty and disadvantage in the twenty-first century, York, UK: Joseph Rowntree Foundation.*

14 Blanden J, Gregg P and Macmillan L (2006) Accounting for intergenerational income persistence: Non-cognitive skills, ability and education, London, UK: London School of Economics.

15 Equality and Human Rights Commission (2010) *How fair is Britain?, op cit.*

Some groups of women are much more likely to be poor than others. Ethnic minority women – particularly Black, Pakistani and Bangladeshi women –are far more likely to be unemployed than white women. This applies particularly to Pakistani and Bangladeshi women: 20.5% are unemployed compared with 6.8% of White women, and 17.7% of Black women are unemployed. The unemployment rate of Black women has remained at roughly double that of white women since 1972.[16] Some migrant women, including those seeking asylum in the UK, suffer appalling levels of poverty and are unable to meet their basic needs for food, clothing and shelter – many such women have escaped conflict, trafficking, abuse and torture.[17]

Growing up with violence and abuse

Violence and abuse is a risk factor for negative outcomes and it is a more common experience for girls and women. Prevalence research shows that severe maltreatment by a parent during childhood happens to 17.5% of girls and 11.6% of boys, and identifies 17.8% of girls and 5.1% of boys as having experienced contact sexual abuse.[18] The sexual abuse of girls is more likely to be perpetrated by family members, to begin at an earlier age and to occur repeatedly than the sexual abuse of boys. The sexual abuse of boys is more likely to be perpetrated by non-family members, to occur later in childhood and to be a single incident.[19]

In Britain, 1 in 4 women experience physical violence perpetrated by a partner at some time in their lives and domestic violence accounts for one-quarter of all violent crime.[20] Their children frequently witness such violence: a recent UK study found that almost 1 in 4 young adults had been exposed to domestic violence during their childhood.[21] Domestic violence is experienced by women of every class and ethnicity. However, abused women in the lowest income groups and living in the most deprived neighbourhoods are likely to suffer more extensive physical violence from a partner than those in more privileged circumstances.[22]

Although there is no conclusive evidence about higher prevalence of domestic abuse in specific communities which are more or less male dominated and restrictive of women, current information indicates that in the UK South Asian and Middle Eastern women and girls are the most likely victims of forced marriage and honour-based violence (HBV).[23] Suicide rates are up to three times higher among South Asian women than for other women and high rates of self-harm have been documented connected to abuse and oppression within the family.[24] One study, cited in a paper by the Equality and Human Rights Commission in 2007, found that 61% of married English Gypsy women and 81% of Irish Travellers had experienced domestic abuse.[25]

Women are far more likely to be victims of sexual violence than men: it is estimated that 85,000 women (0.5% of the population) are victims of the most serious offences of rape or sexual assault by penetration each year. Among men, less than 0.1% (around 12,000) are estimated to be victims of the same types of offences. Around 1 in 20 women has been a victim of rape or sexual assault involving penetration since the age of 16.[26]

The impact of gender on the experience of abuse and violence

The worst outcomes of violence and abuse are experienced by those who suffer serious and persistent forms of abuse – what Finkelhor terms 'poly-victimisation'.[27] Studies show that the abused children at greatest risk of developing mental health problems are those who have experienced multiple forms of victimisation.[28] Children who are subject to clusters of negative factors in childhood are at particular risk of developing severe behavioural problems. There is evidence that this is particularly the case for girls.[29]

16 All Party Parliamentary Group on Race and Community (2014) *Ethnic minority female unemployment: Black, Pakistani and Bangladeshi heritage women, London, UK: Runnymede Trust.*

17 Pettitt J (2013) *The poverty barrier: The right to rehabilitation for survivors of torture in the UK, Freedom from Torture.*

18 Radford L, Corral S, Bradley C, Fisher H, Bassett C, Howat N and Collishaw S (2011) *Child abuse and neglect in the UK today, London, UK: NSPCC.*

19 Finkelhor D (1986) *A sourcebook on child sexual abuse, Thousand Oaks CA, USA: Sage; Kelly L, Regan L and Burton S (1991) An exploratory study of the prevalence of sexual abuse in a sample of 16 – 21 year olds, London, UK: University of North London: Child Abuse Studies Unit.*

20 Guy J, Feinstein L and Griffiths A (2014) *Early intervention in domestic violence and abuse, Early Intervention Foundation, http://www.avaproject.org.uk/media/148794/eif%20dva%20full%20report.pdf.*

21 Radford et al (2011) *Child abuse and neglect in the UK today, op cit.*

22 Scott S, Williams J, Kelly L, McNaughton Nicholls C, Lovett J and McManus S (2013) *Violence, abuse and mental health in England, London, UK: NatCen, http://www.natcen.ac.uk/media/205520/reva-strand-1-13th-may-briefing-report-2-.pdf*

23 Siddiqui H (2013) 'True honour': Domestic violence, forced marriage and honour crimes in the UK, in Y Rehman, L Kelly and H Siddiqui (eds), *Moving in the shadows: Violence in the lives of minority women and children, Farnham, UK: Ashgate.*

24 Siddiqui H and Patel M (2011) *Safe and sane: A model of intervention on domestic violence and mental health, suicide and self-harm amongst black and minority ethnic women, London: Southall Black Sisters.*

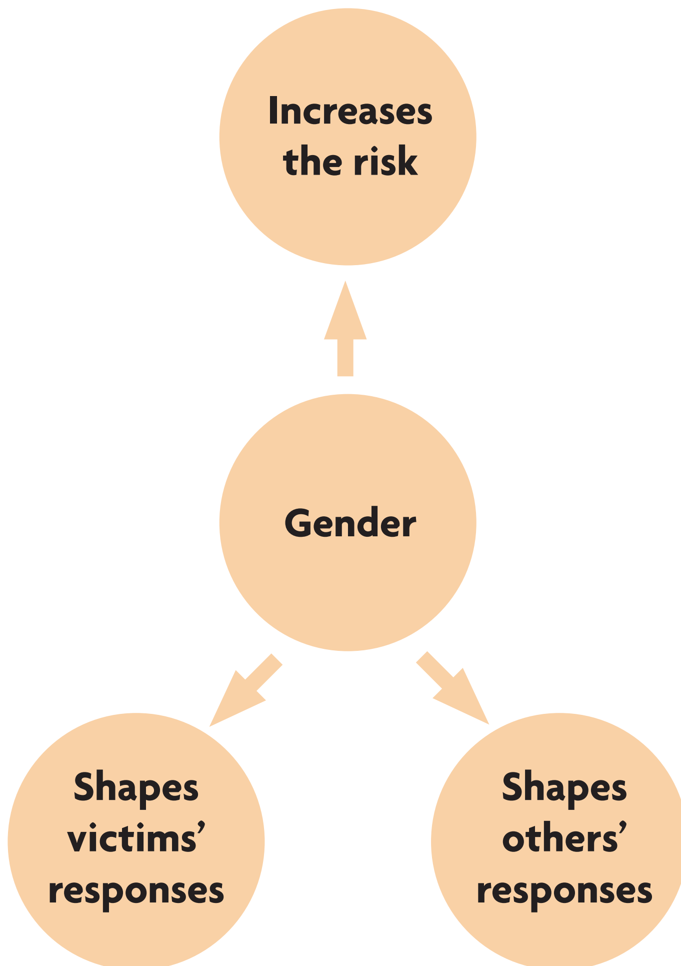
25 Cemlyn S, Greenfields M, Burnett S, Matthews Z and Whitwell C (2009) *Inequalities experienced by Gypsy and Traveller communities: A review, Inequality and Human Rights Commission.*

26 Ministry of Justice, Home Office and Office for National Statistics (2013) *An overview of sexual offending in England and Wales.*

27 Finkelhor D (2008) *Childhood victimization: Violence, crime and abuse in the lives of young people, New York, US: Oxford University Press.*

28 Ibid.

29 Murray J and Farrington DP (2010) Risk factors for conduct disorder and delinquency: Key findings from longitudinal studies, *Canadian Journal of Psychiatry, 55, 633 – 64; Murray J, Irving B, Farrington DP, Colman I and Bloxson AJ (2010) Very early predictors of conduct problems and crime: Results from a national cohort study, Journal of Child Psychology and Psychiatry, 51 1198 – 207.*



There is also an accumulation of risk over the life course and the poorest outcomes are for those who experience abuse and violence of different kinds as both children and adults. Recent analysis of data on lifetime experience of abuse and violence suggests that 84% of those who suffer extensive physical and sexual abuse as both children and adults are women.[30]

This accumulation of risk from violence and abuse also needs to be understood in relation to gender and other inequalities. Although abuse occurs across all social groups, girls in disadvantaged circumstances are at greater risk of some kinds of abuse, for example physical neglect associated with poverty.[31]

Poor women are more likely to experience more extreme domestic violence and to experience sexual and physical abuse as both children and adults.[32] Women in the least advantaged groups (as measured by level of education, income, home ownership and neighbourhood) are the most likely to suffer the most extensive abuse across the life course.[33]

Gendered violence and abuse does not occur by accident. It is a product of gendered power relations. Hence, some of the most severe abuse of girls and women occurs within the most male-dominated families, sub-cultures and coercive contexts – including trafficking[34] and gangs.[35]

Many of the negative outcomes of violence and abuse increase the risk of further victimisation. For example, women who become homeless, misuse drugs and/or are involved in criminality are highly likely to experience further violence.

From a young age, responses to adversity, including abuse, tend to be differentiated by gender, with boys more likely to externalise problems (and act out anger and distress through anti-social behaviour) and girls to internalise their responses in the form of depression and self-harming behaviours.[36] The distress of girls who respond in this way is often invisible to others – in large part because it is consistent with acceptable 'feminine' behaviour. This invisibility increases the likelihood of further abuse and long-term mental health difficulties.

Women and girls who respond in less traditionally gendered ways are likely to find themselves in the criminal justice system, where responses can be more punitive towards them than they are towards men and boys partly because they are viewed as flouting gender norms. Such girls and women can experience a sense of isolation from women in general by virtue of belonging to a marginal or criminal sub-culture. Their behaviour marks them out as 'improper' women because of their 'unnatural' involvement in a macho world of crime, violence and drugs, and can serve to isolate them from help. Violent women in particular are viewed as 'doubly deviant'. Not only have they violated the law; they have violated the norms and expectations associated with appropriate feminine behaviour.[37]

The responses of others are also tied up with gender expectations. There is a continuum of attitudes to violence against women which includes considerable social acceptance of some kinds of abusive behaviour (e.g. sexual harassment). Even where abuse is generally condemned, responses to the abuse of

30 Scott et al (2013) *Violence, abuse and mental health in England, op cit.*

31 Thoburn J, Wilding J and Watson J (2000) *Family support in cases of emotional maltreatment and neglect, London, UK: The Stationery Office.*

32 Scott et al (2013) *Violence, abuse and mental health in England, op cit.*

33 Ibid.

34 Turner J (2013) Violent intersections: Re-visiting the traffic in women and girls, in Y Rehman, L Kelly and H Siddiqui (eds), *Moving in the shadows: Violence in the lives of minority women and children, Farnham, UK: Ashgate.*

35 Beckett H et al (2013) *It's wrong... but you get used to it: A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England, Office of the Children's Commissioner; Firmin C (2013) Criminal gangs, male-dominated services and the women and girls who fall through the gaps, in Rehman et al (2013), Moving in the shadows, op cit.*

36 Green H, McGinnity A, Meltzer H, Ford T and Goodman R (2004) *Mental health of children and young people in Great Britain, London, UK: Office for National Statistics.*

37 Berrington E and Honkatukia P (2002) Evil monster and a poor thing: Female violence in the media, *Journal of Scandinavian Studies in Criminology and Crime Prevention, 3 (1) 50 – 72.*

girls and boys tend to be different: girls and women are often regarded as complicit in or to blame for their own abuse, for example criticised for not leaving violent relationships, putting themselves at risk, or behaving in 'provocative' ways.

Gender expectations

The concept of gender socialisation has become unfashionable. The idea that children simply 'absorb' and internalise gender norms through socialisation has been criticised as an entirely too passive representation of how gender identity is formed. However, what we learn as we grow up about what gendered behaviour and attitudes are expected of us remains relevant to an understanding of inequality at different stages of the life course. Gendered expectations are one of the ways in which gender inequalities are maintained among children, teenagers and adults. By shaping beliefs and attitudes about what it is to be a man and a woman, gender socialisation normalises inequality – it makes it simply the way things are.[38]

Gender expectations vary somewhat by class, culture and sub-culture particularly in the range of acceptable variations of lifestyle and behaviour which girls and women may adopt. It has even been suggested that in contemporary Western societies the possibilities of how to be a woman or a man have become so multi-various and 'trans-gender' that a binary distinction is no longer meaningful. However, there are a number of indications that in the 21st century gender differentiation has actually become increasingly retrenched. As legislative barriers to formal equality have been removed, the requirement to differentiate by gender appears to be stronger than ever.[39] And it starts early in life: for example, babies are enthusiastically colour-coded to remind everyone, including the child, of their gender categorisation.[40]

There is considerable evidence that girls and boys are treated differently from infancy and there are differences in how parents and others behave towards them.[41] Some US studies have even suggested that the gender of a child may affect parental choices concerning family structure, household stability and decisions regarding employment – those with sons being more likely to stay together, get married and their fathers increase their working hours and earnings.[42]

Commonly, parents and other adults create environments that encourage sex-typed play by selecting different toys for boys and girls even before the child can express her or his own preference. Through these means, children learn not just gender stereotypes but begin to experience anxiety about behaving in ways appropriate to their gender.[43]

Children do not simply learn there are gender differences; they also gather that such differences are hierarchical, natural and inevitable. One way of describing this is that in the course of early childhood, children begin to understand the world through 'gendered-lenses', which are created and reinforced by the surrounding culture. According to Sandra Bem there are three such lenses. The first – male-centeredness – sees men's experience as the standard or norm and women's experience as a deviation from that norm. The second lens, gender polarisation, differentiates almost all aspects of human experience, from modes of dress and social roles to ways of expressing emotion and sexual desire, according to gender. The third lens, biological essentialism, rationalises and legitimises the other two lenses by considering them as the natural consequences of the biological natures of women and men.[44] It is in the context of learning to look at gender in this way that children begin to construct conventional gender identities or resist cultural lenses and attempt to create gender-subversive identities.

There are certainly gendered hierarchies within children and young people's relationships discernible at an early stage in the playground,[45] and later in teenage relationships.[46] The pressure to conform to gender norms is pervasive in children's lives. In a recent UK study girls in primary school identify the limits on how they feel they can be and the difficulties of dealing with everyday sexism and sexual harassment.[47]

While gender roles continue to be promoted and validated by teachers, family and media, the changes in girls' behaviour and self-presentation as they enter their teens do not just occur because of reinforcement from adults: the real pressure comes from girls' own identification with, and policing of, normative forms of femininity and an individual and collective investment in gender difference, which can be more powerful than any amount of 'conditioning'.[48] Young people learn their roles as gendered actors, evaluate their performances and hold themselves and others accountable for how they 'measure up' as

38 Fine C (2010) *Delusions of gender: The real science behind sex differences, London, UK: Icon.*

39 See Pink Stinks campaign website, http://www.pinkstinks.co.uk/.

40 Eliot L (2010) *Pink brain, blue brain: How small differences grow into troublesome gaps – and what we can do about it, Oxford, UK: One World.*

41 Lytton H and Romney DM (1991) Parents' differential socialization of boys and girls: A meta-analysis, *Psychological Bulletin, 109 (2) 267 – 96.*

42 Heidemann B, Joesch J and Rose E (2004) More daughters in childcare? Child gender and the use of non-relative childcare arrangements, *Social Science Quarterly, 85 (1) 154 – 68.*

43 Pomerleau A, Bolduc D, Malcuit G and Cossette L (1990) Pink or blue: Environmental gender stereotypes in the first two years of life, *Sex Roles 22, 5 – 6.*

44 Bem SL (1993) *The lenses of gender: Transforming the debate on sexual equality, New Haven CT, US: Yale University Press.*

45 Thorne B and Luria Z (1986) Sexuality and gender in children's daily worlds, *Social Problems, 33 (3) 176 – 90.*

46 Firmin C (2013) Something old or something new: do pre-existing conceptualisations of abuse enable a sufficient response to abuse in young people's relationships and peer groups?, in M Melrose and J Pearce (eds), *Critical perspectives on child sexual exploitation and related trafficking, Basingstoke, UK: Palgrave Macmillan.*

47 Renold E (2013) Girls and boys speak out: A qualitative study of children's gender and sexual cultures, NSPCC and the Children's Commissioner for Wales.

48 Eckert P (1996) Vowels and nail-polish: The emergence of linguistic style in the pre-adolescent heterosexual marketplace, in N Warner, J Ahlers, L Bilmes, M Oliver, S Wertheim and M Chen (eds), *Gender and belief systems, Berkeley: Berkeley Women and Language Group, 183 – 90; Maybin J (2009) Airhostess legs and jealous husbands: Explorations of gender and heterosexuality in 10 – 11 year-olds' conversations, in P Pichler and EM Eppler (eds), Gender and spoken interaction, Basingstoke, UK: Palgrave Macmillan.*

girls or boys and men or women.[49] And for girls the performance of gender often involves both bodily restrictions and verbal constraints.[50]

Responses to non-compliance with gender expectations during this life-stage can be punitive. Girls experience harassment from both boys and other girls. Many girls report that boys tease and ridicule them on the basis of their appearance and sexual availability, while unique appearances and attempts to stand out among girls are regarded very negatively by other girls.[51] Such bullying serves to define and enforce gender boundaries and emphasises the overwhelming importance of appearance and sexuality for girls. Meanwhile, boys bully other boys in ways that are explicitly linked to normative forms of masculinity.[52]

When teenagers look forward to their futures their gender is hugely influential. Girls' expectations about future relationships and parenting influences their occupational and educational choices. Young women clearly anticipate potential conflicts between the demands of work and family and impacts on their current choices.[53] Their choices may also be influenced by the fact that men and women in occupations that do not conform to traditional gender stereotypes are considered less attractive as potential partners. The prospect of incurring a handicap in the romantic market place may well deter them from pursuing non-traditional career choices.[54]

As girls grow into women, gender expectations continue to encourage them to develop characteristics and competencies which are not well suited to exercising power, but which are compatible with a position of subordination. These include being useful, pleasing and compliant, and caring for others. (These same characteristics are also a risk factor for women's mental health – making it harder for women to look after their own interests and to respond to exploitation and life stress in ways that are healthy.[55]) In contrast, men continue to be encouraged to develop psychological characteristics that are consistent with the exercise of power.[56]

Of course, just because gendered expectations exist and influence how we see ourselves and others does not mean all women and girls necessarily comply with them. It is by no means impossible to reject 'femininities', 'girliness' or 'true womanhood' and adopt resistant identities – including as feminists.[57] However, it should be remembered that such rejection has consequences and the responses of others to the flouting of gender norms range from amused tolerance of 'tomboy' girls (although rather less of 'cissy' boys) to homophobic violence. There is therefore a 'double bind': to be 'girly' is to be seen to be lesser than men, weaker, less serious and so on; to resist this and go against the norm also attracts negative responses – so essentially women cannot win.

Implications for women and girls at risk

The inequalities associated with growing up a girl represent a risk for all women, but there is a gradient of gendered disadvantage with most white, middle class women high on the scale and poor, Black and minority women low down on it.[58] For more privileged women to earn as much as men and to have the same freedoms and choices as men, they have to overcome the persistent imbalance of power inherent in a patriarchal society. Women who are also subject to inequalities of race, class, poverty and/or being part of a particular minority group (such as a Traveller or migrant community) face multiple risks. In other words, when thinking about women and girls at risk, understanding gender inequality is absolutely essential – but alone it is not enough.

Violence and abuse is a common thread running through the lives of the vast majority of women who experience the poorest outcomes. Experiencing violence and abuse is a risk factor for poor outcomes, but the relationship is not a simple one. The level of risk depends on the nature and degree of abuse and on the other circumstances of the victim. Women who have single abusive experiences and have other protective factors in their lives are more likely to survive successfully than those who experience multiple and continuing forms of abuse without as many protective factors. And the risks operate in both directions: women who have serious and ongoing experiences of abuse are more likely to face negative outcomes, and those negative outcomes are highly likely to increase their experience of continuing abuse. Gender is pertinent in that it increases the risk of violence and abuse, shapes the ways in which victims respond, and affects the ways in which others perceive and respond to it.

Gendered expectations shape the experience of women and girls as they do those of men and boys. Gender influences how girls

49 West C and Zimmerman D (1987) Doing gender, *Gender and Society, 1 (2) 125 – 51;* see also Butler J (1990) *Gender trouble: Feminism and the subversion of identity*, Routledge.

50 Cameron D (1995) *Verbal hygiene, London, UK: Routledge; Youdell D (2005) Sex-gender-sexuality: How sex, gender, and sexuality constellations are constituted in secondary schools, Gender and Education, 17 (3) 249 – 70.*

51 Eder D (1995) *School talk: Gender and adolescent culture, New Brunswick, US: Rutgers University Press.*

52 Martino W and Pallota-Chiarollo M (2005) *Being normal is the only way to be, Sydney, Australia: University of New South Wales Press.*

53 Crockett LJ and Beal SJ (2012) The life course in the making: Gender and the development of adolescents' expected timing of adult role transitions, *Developmental Psychology, 4 (6).*

54 Badgett MVL and Folbre N (2003) Job gendering, occupational choice and the marriage market, *Industrial Relations, 42 (2).*

55 Williams J (1996) Social inequalities and mental health: Developing services and developing knowledge, *Journal of Community and Applied Social Psychology, 6 (5) 311 – 16.*

56 Connell R (2011) *Confronting equality: Gender, knowledge and global change, Cambridge, UK: Polity; Seguino S (2007) Plus ça change?: Evidence on global trends in gender norms and stereotypes, Feminist Economics, 13 (2) 1 – 28.*

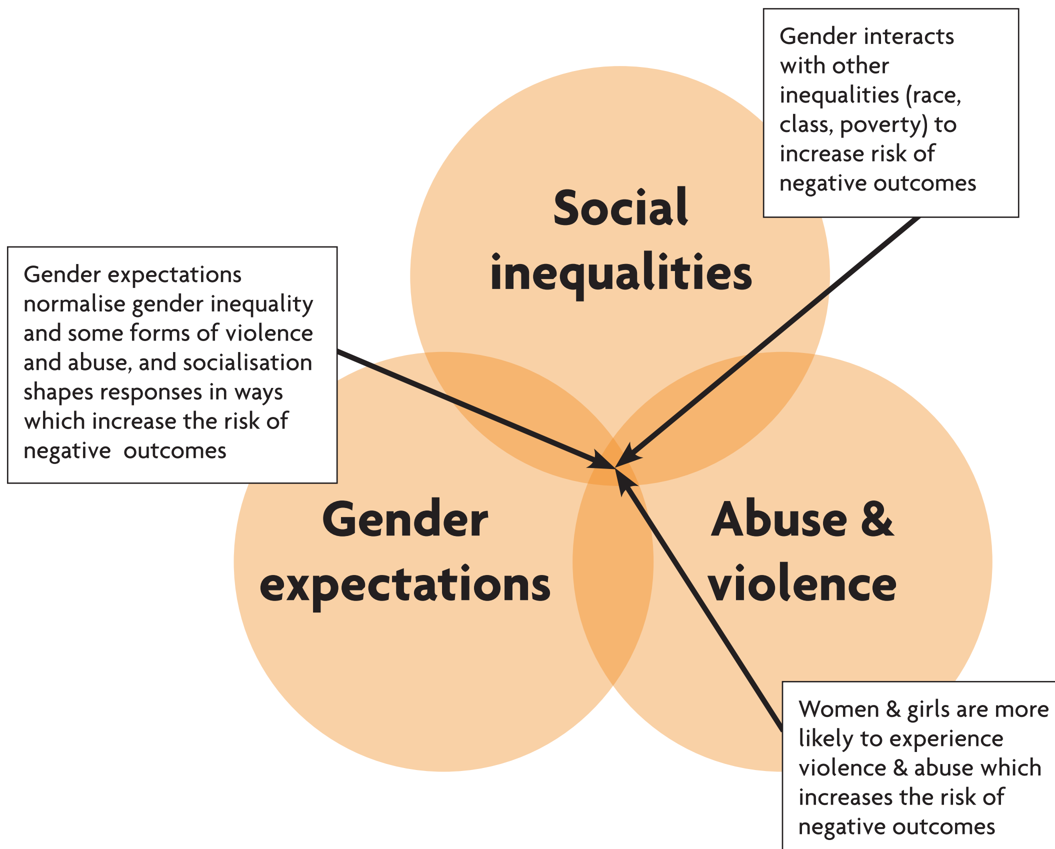
57 Moore H (1994) The problem of explaining violence in the social sciences, in P Harvey and P Gow (eds), *Sex and violence: Issues in representation and experience, London, UK: Routledge.*

58 Nandi A and Platt L (2010) *Ethnic minority women's poverty and economic well, London, UK: Government Equalities Office; Bullock H (2013) Women and poverty, Wiley Blackwell.*

and women respond to negative life experiences: they are less likely to express anger directly and more likely to experience shame, self-blame and depression than men. It is one of the reasons why many women at risk are to be found in mental health services rather than in the criminal justice system. Women who do not conform to gender expectations and behave more 'like men' are likely to experience the double whammy of being treated more punitively not only because of what they have done but because of the deviant form of womanhood they represent.

The focus of this review is women and girls at risk of the most negative outcomes, for example those who are in prison or a secure psychiatric hospital, homeless, dependent on drugs and/or alcohol, or gang-involved, or who have long-term mental health difficulties. As we outline in subsequent chapters, there are common risk factors in the lives of these women, often beginning in early childhood and accumulating across the life course. Prominent among these risks are factors associated with social inequality. The links between poorer life-chances and poverty are well documented and for women and girls the risks are compounded by gender inequalities.

Gender inequality increases the risk of women and girls experiencing violence and abuse. Violence and abuse are common factors in the lives of women and girls at greatest risk. At the same time, either meeting or not meeting gender expectations shapes the way women and girls respond to negative experiences and the responses of others towards them – including family, peers and the 'helping' systems they encounter.



Part 2: **Gender and risks across the life course**

Section 1: Pre-birth and the early years

Inequalities evident in early life tend to persist across the life course. People born into poorer families are more likely to experience poorer life-chances, including worse health, fewer educational qualifications and lower income as adults. Studies based on data from longitudinal cohorts (the National Child Development Study for those born in 1958, and the British Cohort Study for those born in 1970) have shown that the life-chances of individuals are closely related to the socioeconomic characteristics of their families, such as parental income, socioeconomic status and parental education. For example, children from low-income families are more likely to earn below-average wages when they grow up than children from more affluent families, and studies comparing data over time show that the gap has widened.[59]

Policy attempts to break this pattern of 'intergenerational persistence' have frequently focused on the importance of cognitive and social development in the early years. This emphasis is based on strong evidence that good cognitive and social abilities are associated with better later outcomes including educational attainment and higher income,[60] and reduced likelihood of being involved in criminal activity.[61] Cognitive and social difficulties that emerge in the early years become harder to redress as children get older.[62]

Studies have shown that the development of children's cognitive and social abilities is strongly dependent on their family background and parenting.[63] Persistent poverty in the early years is a particularly significant factor. Analysis of data from the Millennium Cohort Study of children born in 2000 shows that living continually in poverty through their early years has a cumulative negative impact on children's cognitive development.[64]

Alongside poverty, parental factors in early life are key influences on later outcomes, including maternal health and education, attachment, parenting and the home-learning environment.[65] Pre- and post-natal maternal health affects children's development. Longitudinal studies have shown that mothers' psychological well-being is particularly important,[66] but studies have also found clear associations between the general health of mothers and children's learning, development and behaviour. In particular, poor health affects parental engagement and caregiving.[67]

There is good evidence that parenting influences children's life-chances[68] and is an important driver of social inequalities in early cognitive development.[69] Good parenting and early development can also play a protective role for children growing up in otherwise disadvantaged settings.[70] Measures of the 'home-learning environment', which look at the frequency of reading and playing with children and the amount of books and activities children have, have been more strongly associated with children's later well-being and attainment than have family income, parental education or the school environment alone.[71] Nevertheless, there is clearly a link between parenting and poverty: more affluent parents can invest more in activities and resources for their children, and parents with more education themselves expose their children to a much wider vocabulary.[72] It is harder to be a 'good parent' when you are poor.

Attachment in the early years has been shown to affect later outcomes. Bowlby linked patterns of attachment developed in early life to people's resilience to stressful life events.[73] This is believed to be because children who experience their parents as a comfort when they are hurt or distressed have a secure base from which to explore, learn and develop independence.[74] Securely attached children learn ways of managing their own

59 See for example Blanden J, Goodman A, Gregg P and Machin S (2004) Changes in intergenerational mobility in Britain, in Corak M (ed), *Generational income inequality, Cambridge, UK: Cambridge University Press.*

60 Feinstein L and Duckworth K (2006) *Development in the early years: Its importance for school performance and adult outcomes, London, UK: Centre for Research on the Wider Benefits of Learning, Institute of Education, University of London.*

61 Carneiro P, Crawford C and Goodman A (2007) *The impact of early cognitive and non-cognitive skills on later outcomes, London: Centre for the Economics of Education, London School of Economics.*

62 Hertzman C and Power C (2003) Health and human development: Understandings from life-course research, *Developmental Neuropsychology, 24 (2 – 3) 719 – 44.*

63 Galindo-Rueda F and Vignoles A (2002) Class ridden or meritocratic? An economic analysis of recent changes in Britain, Centre for the Economics of Education discussion paper 32 and IZA discussion paper 677, Bonn, Germany: Institute for the Study of Labour.

64 Dickerson A and Popli G (2012) Persistent poverty and children's cognitive development, evidence from the UK Millennium Cohort Study, IOE working paper 2012/2.

65 Waldfogel J (2004) Social mobility, life chances, and the early years, CASE paper 88, London, UK: London School of Economics.

66 Kiernan KE and Mensah FK (2009) Poverty, maternal depression, family status and children's cognitive and behavioural development in early childhood: A longitudinal study, *Journal of Social Policy, 38 (4) 569 – 88.*

67 Mensah FK and Kiernan KE (2010) Maternal general health and children's cognitive development and behaviour in the early years: Findings from the Millennium Cohort Study, *Child Care, Health and Development, 37 (1) 44 – 54.*

68 Duncan G and Murnane R (eds) (2011) *Whither opportunity? Rising inequality, schools and children's life chances, New York, UK: Russell Sage Foundation.*

69 Waldfogel J and Washbrook E (2010) *Low income and cognitive development in the UK: A report for the Sutton Trust, London, UK: The Sutton Trust.*

70 Gutman L and Feinstein L (2007) *Parenting behaviours and children's development from infancy to early childhood: Changes, continuities, and contributions, Research Report 22, London, UK: Centre for Research on the Wider Benefits of Learning, Institute of Education, University of London.*

71 Ibid; Sylva K, Melhuish E, Siraj-Blatchford I and Taggart B (2007) *Promoting equality in the early years: Report to the Equalities Review, London, UK: Cabinet Office.*

72 Bradbury B, Corak M, Waldfogel L and Washbrook E (2012) Inequality in early child outcomes, in J Ermisch, M Jäntti and T Smeeding (eds), *From parents to children: The intergenerational transmission of advantage, New York, US: Russell Sage Foundation.*

73 Bowlby J (1979) *The making and breaking of affectional bonds, London, UK: Routledge; Bowlby J (1988) A secure base: Clinincal applications of attachment theory, London, UK: Routledge.*

74 Moullin S, Waldfogel J and Washbrook E (2014) *Baby bonds, parenting, attachment and a secure base for children, London, UK: The Sutton Trust.*

distress and understanding and relating to others. Insecurely attached children may not learn to manage their feelings but may instead minimise expressions of negative emotions and needs, or exaggerate them in an attempt to engage their parent or other carers.

The estimated proportions of children with insecure attachment vary, but overall studies tend to find that between a third and a half of children are insecurely attached.[75] Parents who are living in poverty, have poor mental health or are young are also more likely to struggle with parenting and have insecurely attached children. The vast majority of abused children are estimated to be insecurely attached.[76] However, the concern over attachment is not entirely supported by the evidence. Only specific attachment styles have been associated with negative outcomes -specifically insecure-disorganised attachment is associated with an increased risk of later externalising behaviours. [77] Even in this case the effects are not strong and the pattern of findings is different for boys and girls with disorganised attachment associated with *fewer* externalising behaviours in girls.

The evidence on the importance of cognitive and social development, parenting and attachment in the early years has underpinned successive policies to 'narrow the gap' between poor children and their better off peers by intervening as early as possible in children's lives. The concept of early intervention has been around for a long time, but in recent years its advocates have increasingly drawn on neuro-science to support the urgency of their call. There is compelling evidence that adverse experience *in utero* and severe neglect in early childhood affect the developing brain in ways that are difficult to ameliorate.[78] This is widely cited to support the argument that action needs to be taken as early as possible, within the 'window of opportunity' before irreparable damage is done.[79] However, the interpretation and policy implications of this evidence are contested, with some arguing that claims being made on the basis of the new 'brain science' are deterministic, de-politicise the causes of poverty and ultimately blame poor mothers for inadequate parenting that stunts their children's brain development.[80]

Gender and the early years

Most of the evidence about the above factors and their effects is not differentiated by gender. In fact, one of the most striking features of the research in the early years is just how little reference is made to gender, as though the pre-fives are gender-neutral.

Given that the UK birth cohort studies have provided such important evidence for early years policy, it might be expected that these studies have been thoroughly analysed to explore differences by gender. However, surprisingly few of the published papers deriving from these studies focus on gender. Indeed, a recent report on childhood deprivation and social exclusion drawing on these studies specifically notes that 'the gender dimension has not been analysed in this study. It therefore represents an important issue that needs to be further investigated'.[81]

Reports which have included some analysis of the effects of childhood disadvantage by gender have found very similar effects for both women and men.[82] However, the gendered differences that do emerge show women to have the greater legacy of such disadvantage, across a range of socioeconomic outcomes (low income, benefit receipt, living in social housing, and being in a low status occupation),[83] becoming a parent,[84] and health and well-being outcomes.[85] Recent analysis of a Swedish birth cohort reports similar findings.[86]

The largely ungendered analysis relating to children in the early years also extends to the adults involved. Here the literature frequently refers to 'parents' even when closer scrutiny makes

75 Andreassen C and West J (2007) Measuring socioemotional functioning in a national birth cohort study, *Infant Mental Health Journal, 28 (6) 627 – 46.*

76 Van Ijzendoorn MH, Schuengel C and Bakermans-Kranenburg M (1999) Disorganized attachment in early childhood: Meta-analysis of precursors, concomitants, and sequelae, *Development and Psychopathology, 11 (2) 225 – 49.*

77 Fearon RP, Bakermans-Kranenburg MJ, van Ijzendoorn MH, Lapsley AM and Roisman GI (2010) The significance of insecure attachment and disorganization in the development of children's externalizing behavior: A meta-analytic study, *Child Development*, 81 (2) 435 – 56.

78 Shonkoff JP and Garner AS (2012) The lifelong effects of early childhood adversity and toxic stress, *Pediatrics, 129 (1) 323 – 46.*

79 See for example the Allen Review: Allen G (2011) *Early intervention: The next steps*, London, UK: Department for Work and Pensions and Cabinet Office, https://www.gov.uk/government/publications/early-intervention-the-next-steps—2; Leadsom A, Field F, Burstow P and Lucas C (2013) *The 1001 critical days: The importance of the conception to age two period, cross-party manifesto, http://www.andrealeadsom.com/downloads/1001cdmanifesto.pdf.*

80 Edwards R, Gillies V and Horsley N (2014) Policy briefing: The biologisation of poverty, policy and practice in early intervention, *Discover Society, 4; Rose S and Rose H (2012) Genes, cells and brains: The Promethean promises of the new Biology, Verso.*

81 Peruzzi A (2013) From childhood deprivation to adult social exclusion: Evidence from the 1970 British Cohort Study, Institute of Education working paper 2013/5, London, UK: Institute of Education, University of London.

82 Hobcraft JN (2003) Towards a conceptual framework on population, reproductive health, gender and poverty reduction, in UN Population Fund, *Population and Poverty: Achieving Equity, Equality and Sustainability, New York, US: United Nations Population Fund, 127 – 35; Hobcraft JN and Sigle-Rushton W (2005) An exploration of childhood antecedents of female adult malaise in two British birth cohorts: Combining Bayesian model averaging and recursive partitioning, CASE paper 95, London, UK: Centre for Analysis of Social Exclusion, London School of Economics.*

83 Hobcraft J, Hango D and Sigle-Rushton W (2004) The childhood origins of adult socio-economic disadvantage: Do cohort and gender matter?, London, UK: Centre for Analysis of Social Exclusion, London School of Economics.

84 Hobcraft JN and Kiernan KE (2001) Childhood poverty, early motherhood and adult social exclusion, *British Journal of Sociology, 52 495 – 517;* Hobcraft JN and Kiernan KE (2005) The timing and partnership context of becoming a parent: Cohort and gender commonalities and differences in childhood antecedents, paper presented at the Annual Meeting of the Population Association of America.

85 Hobcraft JN and Mensah F (2006) The childhood origins of adult health and well-being: Do cohort and gender matter?, paper presented at the Annual Meeting of the Population Association of America.

86 Bäckman O and Nilsson A (2011) Pathways to social exclusion: A life course study, *European Sociological Review, 27 107 – 23.*

it clear that the research actually relates almost entirely to mothers. As noted above, there is research on the link between maternal health and education on child outcomes.[87] There is also research on the factors that increase the likelihood of girls becoming mothers at an early age and of being lone parents. Poverty remains a key risk factor for both, with early motherhood clearly associated with many poor socioeconomic outcomes for women.[88]

There are a few studies which highlight different effects of attachment and of parenting behaviour on girls.[89] For example, studies into drivers of youth crime and risky behaviours have found that attachment to fathers is relatively more important for boys, while attachment to mothers is more important for girls.[90]

An important gendered issue in the early years is domestic violence. Studies have shown that domestic violence may begin or increase in pregnancy.[91] Domestic violence during pregnancy puts a pregnant woman and her unborn child in danger. Stress *in utero* is toxic for a developing baby. It increases the risk of miscarriage, premature birth, low birth weight, foetal injury and foetal death. Domestic violence can increase a woman's chances of becoming pregnant and the number of children she has, because the woman may be coerced into sex and may be prevented from using birth control.[92] UK prevalence of domestic violence during pregnancy has been estimated at 3.4%.[93] Incidence rates are higher for teenagers and the incidence rate for low-income, teenage mothers in the US has been found to be as high as 38%.[94]

Evidence for intervention in the early years

Screening for domestic violence

It has been shown that routine enquiry or screening by trained staff during pregnancy can increase disclosures three-fold and that the act of disclosure can reduce children's experience of violence and lessen its impact.[95] Research indicates that most survivors of violence and abuse welcome being asked about a possible abuse history. A systematic review of qualitative studies found that survivors of domestic violence want to be asked by health professionals.[96] However, a comprehensive NHS screening programme is not currently recommended by the National Screening Committee in the UK because there is no evidence to date that screening projects have resulted in a reduction in levels of violence or positive health outcomes.[97] However, these screening programmes have been accompanied by extremely limited interventions (an information leaflet, brief counselling or a 30-minute appointment with a GP) and it would therefore be surprising if they had been successful in achieving positive outcomes for abused, pregnant women. Disclosures elicited by screening or routine enquiry need to be followed up with appropriate levels of information, support and signposting if they are to be of value in ending domestic violence.[98]

Promoting attachment

It is possible to help parents and infants develop secure attachment relationships effectively and many interventions focused on reducing parental stress and improving parent–child interaction impact positively on attachment. A recent UK review identifies such programmes as including the Family Nurse Partnership and The Incredible Years' baby and toddler parent training, and identifies three other well-evidenced programmes that explicitly focus on attachment security for children under 3 – Circle of Security, Minding the Baby and Child-Parent Psychotherapy – alongside two promising programmes

87 Kiernan and Mensah (2009) Poverty, maternal depression, op cit.

88 Hobcraft and Kiernan (2001) Childhood poverty, early motherhood and adult social exclusion, op cit.

89 Webster Stratton C (1996) Early onset conduct problems: Does gender make a difference?, *Journal of Consulting and Clinical Psychology, 64 (3) 540 – 51.*

90 Hoeve M, Stams GJJM, van der Put CE, Dubas JS, van der Laan PH and Gerris JRM (2012) A meta-analysis of attachment to parents and delinquency, *Journal of Abnormal Child Psychology, 40 (5) 771 – 85.*

91 Torres S, Campbell J, Campbell DW et al (2000) Abuse during and before pregnancy: Prevalence and cultural correlates, *Violence & Victims, 15 (3) 303 – 21; Bacchus L, Mezey G, Bewley S and Haworth A (2004) Prevalence of domestic violence when midwives routinely enquire in pregnancy, BJOG: An International Journal of Obstetrics & Gynaecology, 111 (5) 441 – 5.*

92 Krug EG (2002) *World report on violence and health, Geneva, Switzerland: World Health Organization, 102.*

93 Bacchus et al (2004) Prevalence of domestic violence when midwives routinely enquire in pregnancy, op cit.

94 Parker B, McFarlane J, Soeken K, Torres S and Campbell D (1993) Physical and emotional abuse in pregnancy: A comparison of adult and teenage women, *Nurse Researcher, 42 (3) 173 – 8.*

95 Feder G, Agnew Davies R, Baird K, Dunne D, Eldridge S, Griffiths C, Gregory A, Howell A, Johnson M, Ramsay J, Rutterford C and Sharp D (2011) Identification and referral to improve safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: A cluster randomised controlled trial, *Lancet, 13 October; Johnson M (2010) 'Herding cats': The experiences of domestic violence advocates engaging with primary care providers, Domestic Abuse Quarterly, Winter.*

96 Feder G, Hutson M, Ramsay J and Taket AR (2006) Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies, *Archives of Internal Medicine, 166 (1) 22 – 37.*

97 Spiby J (2013) *Screening for domestic violence: External review against programme appraisal criteria for the UK National Screening Committee, UK National Screening Committee.*

98 Scott S and McNaughton-Nicholls C (2014) *Why asking about abuse matters to service users: A briefing for mental health professionals, London, UK: NatCen.*

developed in the UK: the Reflective Parenting Programme delivered by Parents Early Education Partnership (PEEP) and the Oxford Parent Infant Project (OXPIP).[99]

Home visiting

There are some widely cited and well-evaluated interventions in the early years including home-visiting programmes such as the Family Nurse Partnership, which has been well evaluated in the US since the mid-1980s.[100] In the UK the government recently doubled the number of Family Nurse Partnership places being trialled, aiming to reach 16,000 new mothers by 2015, and these are currently the focus of a randomised control trial by Cardiff University.[101] The Family Nurse Partnership begins as early as possible during pregnancy and continues through the child's second birthday. Trained and well-supervised nurses work with low-income pregnant mothers bearing their first child to improve the outcomes of pregnancy, infant health and development, and the mother's personal development through instruction and observation during home visits. Programme content includes education about influences on foetal and infant development (including the effects of smoking, alcohol and drugs) and the involvement of family members and friends in the pregnancy, birth, early care of the child, and support of the mother. Improving attachment relationships through building mothers' sense of efficacy and sensitivity is thought to be an important factor behind the long-term developmental benefits of the programme.

The effects of this time-limited intervention are considerable. It has been shown to reduce unplanned pregnancies and domestic violence, increase the interval between first and second births, and reduce arrest rates among mothers. It has direct impacts on the emotional well-being and cognitive development of infants – particularly those born to mothers with low psychological resources. In later childhood impacts have been shown on educational achievement and internalising mental health problems, and in the teenage years on arrests and convictions, number of sexual partners, and substance use. In young adulthood there is some evidence that girls may benefit more from the programme than boys as the latest longitudinal research suggests that at age 19 the positive effects of the Family Nurse Partnership were maintained for girls (who had fewer lifetime and current arrests and convictions) but not for boys.[102]

Pre-school education

The positive effects of high-quality pre-school education on the life-chances of disadvantaged children are well evidenced and evaluations of different programmes demonstrate that the long-term benefits for girls (particularly in total years of schooling) are stronger than those for boys.[103]

The HighScope pre-school programme has evidenced particularly powerful effects. The HighScope curriculum is based on the promotion of active learning, which enables children to initiate their own activities and take responsibility for completing them. Most children attend the programme for two years at ages 3 and 4. The classroom programme is supported by weekly home visits by pre-school teachers. The staff to child ratio is 1 adult for every 5 or 6 children. Positive effects include reducing the likelihood of children being placed in special education programmes, reduced crime and delinquency in the teenage years, significantly better educational outcomes, being employed at age 19, significantly fewer lifetime criminal arrests, and higher average earnings at age 27.[104]

The long-term HighScope evaluators studied a sample of African American children and results showed significant gender differences in the most pronounced effects. The pattern of treatment response by gender varied with age: with the intervention having greatest impact on the education and early employment of women (at ages 19 and 27) and on the later-life income, employment and criminal activity of men (at ages 27 and 40). The general pattern is of strong early treatment effects for women – with men catching up later in life.[105]

In the UK, the development of Sure Start drew heavily on the evidence base from the US, but as there was no single intervention model delivered across children's centres and poor targeting of those in need, there were limitations to what the national evaluation could measure.[106] However, the evaluation team reported four positive effects of Sure Start local programmes at age 7, two of which applied across all children involved with the programme. Mothers were found to be engaging in less harsh discipline and were providing a more stimulating home-learning environment for their children. They were also providing a less chaotic home environment for boys (though this was not a significant finding for girls) and those who were lone parents and/or in workless households reported having better life satisfaction.[107]

99 Moullin et al (2014) Baby bonds, op cit.

100 Olds DL (2006) The nurse – family partnership: An evidence-based preventive intervention, *Infant Mental Health Journal, 27 (1) 5 – 25.*

101 See The Family Nurse Partnership Programme in England, Department of Health, http://fnp.nhs.uk/research-and-development/published-research.

102 Eckenrode J et al (2010) Long-term effects of prenatal and infancy nurse home visitation on the life course of youths, *Archive of Pediatric and Adolescent Medicine, 164 (1) 9 – 15.*

103 Anderson ML (2008) Multiple inference and gender differences in the effects of early intervention: A reevaluation of the abecedarian, Perry preschool, and early training projects, *Journal of the American Statistical Association, 103 (484) 1481 – 95; see also response: Heckman JJ, Moon SH, Pinto R, Savelyev PA and Yavitz AQ (2010) The rate of return to the High/Scope Perry Preschool Program, Journal of Public Economics, 94 (1 – 2) 114 – 28.*

104 Schweinhart LJ, Barnes HV and Weikart DP (1990) Significant benefits: The High/Scope Perry preschool study through age 27, Ypsilanti MI, US: The HighScope Press.

105 Schweinhart L, Montie J, Xiang Z et al (2005) Lifetime effects: The High scope/Perry pre-school study through age 40, Monographs of the High Scope Educational Research Foundation 14, Ypsilanti MI, US: The HighScope Press; Heckman J, Moon SH, Pinto R, Savelyev P and Yavitz A (2010) Analyzing social experiments as implemented: A reexamination of the evidence from the HighScope Perry Preschool Program, *Quantitative Economics, 1 (1) 1 – 46.*

106 Eisenstadt, N (2011) *Providing a sure start: How government discovered early childhood, Bristol, UK: Policy Press.*

107 National Evaluation of Sure Start (2012) *The impact of Sure Start local programmes on 7 year olds and their families, London, UK: Department for Education, DfE Research report DFE-RR220.*

Section 2: The primary years

In the primary years (when children are aged between 5 and 11) many of the early indicators of poor life trajectories become visible. Poverty and disadvantage remain key determinants of future outcomes and even poor children who are doing well in the early years often lose ground in the primary years. A clear example of this is in relation to cognitive development. Children who have low cognitive scores at 22 months of age but who grow up in families of high socio-economic position improve their relative scores as they approach the age of 10. By contrast the high scores of children at 22 months who grow up in families of low socioeconomic position deteriorate as they approach age 10.[108]

The primary years are also vital for social development. Negative experiences within the home or at school can have a damaging effect on the development of core cognitive and emotional skills. Risks to mental health include family violence or conflict, bereavement, physical and sexual abuse and long-term illness. Children with a parent who has a mental illness or substance use disorder are at a high risk of experiencing family discord and mental health problems. Poor housing or living conditions may be seen by children as shameful and may reduce opportunities for productive learning and social interaction. In addition, difficulties at school, including bullying and a low sense of connection or belonging, can impact powerfully on children's well-being and have a telling effect on subsequent choices and opportunities in adolescence.[109]

Gender and the primary years

During this life-stage children are most likely to be identified as having emotional and/or behavioural problems and these tend to be manifested differently in boys and girls. Prevalence research shows that girls are less likely than boys to have a recognised 'mental disorder' (8% of girls compared with 11% of boys). Most of this is accounted for by the fact that conduct disorders (which are diagnosed on the basis of a child's behaviour including stealing, lying, being oppositional or aggressive) are around twice as common among boys than girls and hyperkinetic disorders (such as attention deficit hyperactivity disorder) are four times more common in boys than in girls. The rates of emotional disorders (anxiety and depression) are similar for boys and girls.[110]

It is likely that conduct disorders (particularly ADHD) in girls are under-identified and treated.[111] This may be because the kinds of behaviours that girls display are less extreme and may not be taken as seriously as those displayed by boys.[112] This could be important given that children identified with a conduct disorder are likely to perform poorly at school, suffer from social isolation, and in adolescence become involved in substance misuse and criminal behaviour.[113] If their angry and uncooperative behaviour in primary school alienates such girls from their female peers this could well put them at particular risk of school drop-out and involvement with anti-social boys a few years on. It could also be important because higher rates of psychiatric comorbidity have been observed in long-term follow-ups of girls with conduct disorder than in boys.[114]

By adolescence there may be little difference in rates of conduct disorder by gender among young people in trouble.[115] However, studies of conduct problems in girls are rare. Most have either excluded girls from the sample or included them but failed to take gender into account as a relevant factor. A rare comparative study found that although boys with conduct disorder were more physically aggressive and destructive than girls with conduct disorder, their verbal aggression and oppositional behaviour was the same. What is different is that the gap between the behaviour of these girls and that of their normative same-sex peer group is much more extreme than for boys. Boys with conduct problems are still boys – just 'bad boys'; girls who behave in the same ways are not behaving 'like girls' at all.[116]

Other risk factors in the primary years are girls' experience of abuse and neglect. Children subject to abuse in this age group are more likely to continue to be abused and potentially experience multiple forms of abuse as they approach their teenage years. The primary years life-stage is therefore a critical point for intervention, particularly as there is evidence that the response to a child's disclosure of sexual abuse is a crucial mediator of long-term impacts. The child who is believed, supported, made safe and helped to make sense of their experience is much more

108 Feinstein L (2003) Inequality in the early cognitive development of British children in the 1970 cohort, *Economica, 70 3 – 97.*

109 Walker S, Wachs TD, Grantham-McGregor S, Black M, Nelson C and Huffman C et al (2011) Inequality in early childhood: Risk and protective factors for early child development, *Lancet, 378 1325 – 38; Foresight Mental Capital and Wellbeing Project (2008) Final project report – executive summary, London, UK: Government Office for Science; World Health Organization (2012) Risks to mental health: An overview of vulnerabilities and risk factors, background paper by WHO Secretariat for the Development of a Comprehensive Mental Health Action Plan.*

110 Meltzer H et al (1999) *The mental health of children and adolescents in Great Britain, London, UK: Office for National Statistics.*

111 Biederman J et al (1999) Clinical correlates of ADHD in females: Findings from a large group of girls ascertained from pediatric and psychiatric referral sources, *Journal of the American Academy of Child and Adolescent Psychiatry*, 38 (8) 966 – 75.

112 Keenan et al (2010) Age of onset, symptom threshold and the expansion of the nosology of conduct disorder for girls, *Journal of Abnormal Psychology, 119 (4) 689 – 98.*

113 Fergusson D, Horwood J and Ridder E (2005) Show me the child at seven: The consequences of conduct problems in childhood for psychosocial functioning in adulthood, *Journal of Child Psychology and Psychiatry, 46 (8) 837 – 49; Green H, McGinnity A, Meltzer H, Ford T and Goodman R (2005) The mental health of children and young people in Great Britain, 2004, Basingstoke, UK: Palgrave.*

114 Dalsgaard S, Mortensen PB, Frydenberg M and Thomsen PH (2002) Conduct problems, gender and adult psychiatric outcome of children with attention-deficit hyperactivity disorder, *British Journal of Psychiatry, 181 416 – 21.*

115 Fazell D (2008) Mental disorders among adolescents in juvenile detention and correctional facilities: A systematic review and metaregression anlaysis of 25 surveys, *Journal of the American Academy of Child and Adolescent Psychiatry, 47 (9) 1010 – 19.*

116 Webster Stratton (1996) Early onset conduct problems, op cit.

likely to avoid long-term mental health problems and formal therapeutic support can be effective.[117]

Again, responses to abuse tend to be gendered with girls more likely to 'internalise' and to seek control and manage distress in ways that are harmful to their own well-being, as in eating disorders and self-harm; while boys more often 'externalise' their anger and pain in ways that impact on others as well as themselves through aggressive and anti-social behaviour.[118] As the expectations of appropriate behaviour are different for boys and girls, girls who respond to abuse or mistreatment 'more like boys' may find themselves doubly stigmatised – both for being naughty and disruptive and for not being 'good girls'.

Girls' experience of domestic violence is a further risk factor. In the most recent UK research, 12% of children aged under 11 years had witnessed at least one incident of domestic violence or threatening behaviour in the previous year.[119] There is good evidence that girls exposed to domestic violence are more likely to become victims themselves in later life.[120] However, there is also good evidence to show that harm can be dramatically reduced if the domestic violence stops.[121] Again, this suggests that interventions to identify and stop domestic violence while children are in the primary years should be a priority.

Evidence for intervention in the primary years

Domestic violence

Direct specialist support to mothers and children post-domestic violence has been shown to improve safety, health and well-being outcomes. Recent research findings show there is a clear relationship between the cessation of domestic abuse and cessation of direct harm to children. Latest data from the Co-ordinated Action Against Domestic Abuse (CAADA) UK dataset show that 69% of domestic abuse ceases at the point of case closure after women receive support from a domestic violence specialist.[122]

Specialist children's services not only address the physical risks children face but also give critical early support to help children understand what has happened and that they are not responsible. Many children require long-term therapeutic help to overcome the trauma they have experienced, but very few children receive support from Child and Adolescent Mental Health Services following domestic violence (only 9% at intake to specialist services).[123]

Interventions with parents

The evidence for parent-training programmes is well established for children with conduct disorders aged 11 years and younger, with well-developed models for the delivery of care – but this evidence relates largely to boys.[124] Almost nothing is known about differential treatment responses to conduct problem interventions for boys and girls. Most randomised controlled trials do not have large enough samples to show effects by gender, because boys presenting for treatment substantially outnumber girls. However, one analysis which combined data from multiple studies found no differences in treatment response. It might therefore be assumed that well-evaluated interventions for conduct problems may be equally effective for both sexes.[125]

In the UK the National Academy for Parenting Research (NAPR) has a considerable research programme and has produced a toolkit for commissioners summarising and star rating the strength of evidence on the effectiveness of 51 different parenting interventions.[126]

Effective interventions in the primary years also include family and school-based programmes such as The Incredible Years, which emphasise working with both child and family, with some programmes also involving schools. The Incredible Years series is a set of interlocking group training programmes for parents, teachers and children with the goal of preventing, reducing and treating behavioural and emotional problems in children aged 2 to 12. The evidence for effectiveness is strong with randomised control group evaluations[127] showing reductions in conduct problems at school and at home and, importantly in relation to girls, reduction of internalising and depressed mood symptoms.[128]

117 Allnock D and Hynes P (2011) *Therapeutic services for sexually abused children and young people: Scoping the evidence base, London, UK: NSPCC.*

118 Boys' responses to abuse may mark them as a risk to others, and part of the problem, rather than as an indication they have been abused, so gendered attitudes have negative implications for boys and girls.

119 Guy et al (2014) *Early intervention in domestic violence and abuse, op cit.*

120 Ibid.

121 CAADA (2014) *In plain sight: The evidence from children exposed to domestic abuse – key findings, Co-ordinated Action Against Domestic Abuse.*

122 Ibid.

123 Ibid.

124 NICE (2013) *Antisocial behaviour and conduct disorders in children and young people: Recognition, intervention and management, http://www.nice.org.uk/guidance/cg158/chapter/2-Research-recommendations.*

125 Beauchaine TP, Webster-Stratton C and Jamila Reid M (2005) Mediators, moderators, and predictors of 1-year outcomes among children treated for early-onset conduct problems: A latent growth curve analysis, *Journal of Consulting and Clinical Psychology, 73 (3) 371 – 88.*

126 NAPR (no date) An evidence based approach to improve practice, strengthen families, improve children's lives and target cost-effective interventions that work, National Academy for Parenting Research, http://www.parentingresearch.org.uk/.

127 UK evaluations of incredible years include Hutchings J, Bywater T, Daley D, Gardner F, Whitaker C, Jones K, Eames C and Edwards R (2007) Parenting intervention in Sure Start services for children at risk of developing conduct disorder: Pragmatic randomised controlled trial, *British Medical Journal, 9 March; Little M, Berry V, Morpeth L, Blower S, Axford N, Taylor R, Bywater T, Lehtonen M and Tobin K (2012) The impact of three evidence-based programmes delivered in public systems in Birmingham, UK, International Journal of Conflict and Violence, 6 (2) 260 – 72.*

128 Webster-Stratton C and Herman, KC (2008) The impact of parent behavior-management training on child depressive symptoms, *Journal of Counseling Psychology, 55 (4) 473 – 84.*

Parent–child interaction therapy has been developed and well evaluated in the US. It is an intervention for children aged 2–12 years (although many of the evaluations have focused on pre-school children) and their parents or care-givers. It focuses on decreasing externalised child behaviour problems, increasing positive parent behaviours, and improving the quality of the parent–child relationship. It teaches parents' traditional play-therapy skills to improve parent–child interactions and problem-solving skills to manage new problems. Parents are taught and practise communication skills and behaviour management with their children in a playroom while coached by therapists.

The Raising Healthy Children programme, an elementary-school-based intervention, is designed to improve family bonding with the school while also building children's competencies for resisting risk.[129] Long-term results from the Seattle Social Development Project showed positive programme effects:

- There were improvements in school bonding and achievement and reductions in grade repetition, lifetime violence and heavy alcohol use at age 18.
- There was improved positive functioning in school and/or work, more high school graduates, better emotional and mental health, fewer with criminal records, fewer involved in selling drugs, and fewer females who had been pregnant or had given birth by age 21.
- There was improved educational and economic attainment, improved mental health and reduced lifetime sexually transmitted infections, but no significant effects on crime or drug use at ages 24 and 27.[130]

As already noted, evaluations of initiatives such as these often provide scant information on gender differences. However, this long-term follow up of the Raising Healthy Children programme showed that the programme was particularly effective for girls, who had significantly higher increases in pro-social skills than boys.

School-based interventions

A universal primary-school-based intervention promoting emotional and social competencies and reducing aggression and behaviour problems in elementary-school-aged children is the Promoting Alternative Thinking Strategies (PATHS) curriculum. PATHS is designed to be taught two to three times per week across the primary years with daily activities to support behaviour. Multiple high-quality evaluations of PATHS conducted since the early 1980s have shown positive results including a lower rate of conduct problems and externalising behaviours; lower internalising scores and depression; improvements in social problem solving, emotional understanding and self-control; better ability to resolve peer conflicts; and greater empathy for others.[131] There is also high-quality evidence that the classroom management strategy Good Behaviour Game decreases disruptive behaviour; this may be combined with an enhanced academic curriculum.[132]

Most of the above interventions and their evaluations emanate from the US, although some of the parent-training programmes and PATHS have been evaluated in the UK too. Most UK programmes have not been subjected to the same level of evaluation, but this does not mean they are not positive interventions. Examples of support to children in the primary years include school-based initiatives to promote emotional well-being such as nurture groups for children with social, emotional, behavioural and learning difficulties. Although the first groups were established over 30 years ago, growth in the number of nurture groups in the UK has been exponential over the past ten years. A national study found statistically significant improvements in social, emotional and behavioural functioning for nurture group pupils. This study suggested that nurture groups are a highly promising form of provision.[133] Another example is support to primary aged children provided in some schools by Place2Be, which provides an open access lunchtime drop-in service with a counsellor open to all pupils in the school, and weekly counselling for those with higher levels of need. Place2Be's impact reports show that there is a higher take-up of their support by girls.[134]

Section 3: The teenage years

The early teenage years are a critical point of transition for girls. It is a time of considerable change as they move from primary to secondary school, usually developing an extended peer group, increasing their independence and experiencing the physical and emotional changes associated with puberty. This can be a positive and exciting time, but if girls are already experiencing problems in the family and/or school, issues frequently come to a head.

This time of transition can be difficult even for girls who have relatively few risk factors in their lives. As well as coping with

129 Catalano RF, Mazza JJ, Harachi TW, Abbott RD, Haggerty KP and Fleming CB (2003) Raising healthy children through enhancing social development in elementary school: Results after 1.5 years, *Journal of School Psychology, 41 (2) 143 – 64.*

130 Hawkins JD, Kosterman R, Catalano RF, Hill KG and Abbott RD (2008) Effects of social development interventions in childhood 15 years later, *Archives of Pediatrics & Adolescent Medicine, 162 (12) 1133 – 41.*

131 UK evaluations of PATH include Curtis C and Norgate R (2007) An evaluation of the promoting alternative thinking strategies curriculum at key stage 1, *Educational Psychology in Practice, 23 33 – 44; Little et al (2012) The impact of three evidence-based programmes delivered in public systems in Birmingham, op cit.*

132 Lee S, Aos S, Drake E, Penucci A, Miller M and Anderson L (2012) *Return on investment: Evidence-based options to improve statewide outcomes, April 2012 update, http://www.wsipp.wa.gov/rptfiles/12-04-1201.pdf; Bradshaw CP, Zmuda J, Kellam S and Ialongo N (2009) Longitudinal impact of two universal preventive interventions in first grade on educational outcomes in high school, Journal of Educational Psychology, 101 (4) 926 – 37.*

133 Cooper P and Whitebread D (2007) The effectiveness of nurture groups on student progress: Evidence from a national research study, *Emotional and Behavioural Difficulties, 12 (3) 171 – 90.*

134 Lee RC, Tiley CE and White JE (2009) The Place2Be: Measuring the effectiveness of a primary school-based therapeutic intervention in England and Scotland, *Counselling and Psychotherapy Research, 9 (3), http://www.place2be.org.uk/impact-evidence/research-publications/.*

the challenges of a new and bigger school, and the changes in relationships with parents associated with greater independence and separation, girls in the early teens have to negotiate new ways of relating to peers of both sexes. They often begin to experience more pressure to comply with gender roles; they become more concerned with how women are 'supposed to behave' and with their own physical and sexual attractiveness. Although research shows that self-esteem decreases for both sexes after the primary years, the drop is more dramatic for girls. Compared with boys of the same age, adolescent girls are more anxious and stressed, suffer from increased depression, and experience more body dissatisfaction and distress over their looks.[135] Some studies suggest girls who experience early puberty may face particular risks due to alienation from their peers and the premature expectations of others.[136]

Friendships between girls of this age can be a major source of strength and support, but they can also be a source of hurt and confusion. Peer pressure can tip over into bullying behaviour. Studies suggest that bullying tends to peak during the early teens,[137] with girls particularly susceptible to verbal and emotional bullying (e.g. isolating the victim from the friendship group).[138] While much of this bullying goes on in school, the increase in cyber-bullying (bullying via social media, mobile phone and so on) means that it frequently extends well beyond the school walls.[139]

At this age girls can be particularly vulnerable to sexual harassment and abuse from boys within their year group and older. This commonly includes 'sexting' (e.g. boys soliciting intimate pictures of girls via text).[140] They can feel pressured into getting involved in relationships without having the confidence to negotiate how they are conducted. A UK study of intimate teenage relationships found that a third of teenage girls suffered an unwanted sexual act and 25% of girls and 18% of boys had experienced some form of physical partner violence. Girls reported greater incidence rates for all forms of violence, experienced violence more frequently and described a greater level of negative impacts on their welfare than boys. The research found that associated factors – for experiencing and instigating teenage partner violence – included previous experiences of abuse and neglect, domestic violence in the family and aggressive peer networks. When girls had an older partner, and especially a 'much older' partner, they were likely to experience the highest levels of victimisation. Girls with a history of family violence had an increased likelihood of having an older partner. Overall, 75% of girls with a 'much older' partner experienced physical violence, 80% emotional violence and 75% sexual violence.[141]

Evidence suggests that girls who already have a number of risk factors in their lives reach a 'breaking point' between the ages of 12 and 14.[142] It is at this age that underlying vulnerability factors (childhood abuse and neglect, domestic violence, parental mental health and substance use, and family breakdown) meet a constellation of immediate risk factors, such as those outlined above. A study of girls in the US youth justice system found that this was the age at which girls were most likely to report becoming sexually active, first being sexually assaulted, beginning to use alcohol and drugs, running away and being suspended from school for the first time.[143] It is also during the early teens that girls are most likely to start offending (the peak age for offending behaviour for girls is 15).[144]

Mental health problems are more likely to become apparent during the early teens. Risks to mental health in adolescence are similar to those earlier in childhood and include family violence or conflict, negative life events, and lack of a sense of connection to school. There has been an increase in the proportion of young people reporting frequent feelings of depression or anxiety. This figure doubled between the mid-1980s and the mid-2000s. For boys aged 15–16, rates increased from approximately 1 in 30 to 2 in 30. For girls they increased from approximately 1 in 10 to 2 in 10.[145] The Nuffield Foundation's otherwise excellent briefings on time-trends in adolescent well-being has little analysis of gender or the potential for different impacts of social change on the well-being of young men and young women.[146]

The onset of substance misuse typically occurs during the teenage years. Young people with family problems or who have behavioural difficulties are more likely to engage in substance misuse, which may be reinforced by peer pressure. In addition

135 American Psychological Association (no date) *Beyond appearance: A new look at adolescent girls, https://www.apa.org/pi/families/resources/adolescent-girls.aspx.*

136 Berkout O et al (2011) Mean girls and bad boys: Recent research on gender differences in conduct disorder, *Journal of Aggression and Violent Behavior, 16 503 – 11.*

137 Pepler D, Craig W, Yuile A and Connolly J (2004) Girls who bully: A developmental and relational perspective, in M Putallaz and KL Bierman (eds), *Aggression, antisocial behavior, and violence among girls: A developmental perspective, New York, US: Guildford.*

138 Stassen Berger K (2007) Update on bullying at school: Science forgotten?, *Developmental Review, 27 90 – 126.*

139 Smith PK, Mahdavi J, Carvalho M, Fisher S, Russell S and Tippett N (2008) Cyberbullying: Its nature and impact in secondary school pupils, *Journal of Child Psychology and Psychiatry, 49 376 – 85.*

140 Phippen A (2012) *Sexting: An exploration of practices, attitudes and influences, London, UK: NSPCC, http://www.nspcc.org.uk/Inform/resourcesforprofessionals/sexualabuse/sexting-pdf_wdf93254.pdf.*

141 Barter C, McCarry M, Berridge D and Evans K (2009) *Partner exploitation and violence in teenage intimate relationships, London, UK: NSPCC.*

142 Acoca L (1999) Investing in girls, a 21st century strategy, *Juvenile Justice, 6 (1) 3 – 12.*

143 Ibid.

144 Ministry of Justice and Youth Justice Board (2014) *Youth Justice Statistics 2012/13 England and Wales,* www.gov.uk/government/publications/youth-justice-statistics.

145 Collishaw S, Maughan B, Natarajan L and Pickles A (2010) Trends in adolescent emotional problems in England: A comparison of two national cohorts twenty years apart, *Journal of Child Psychology and Psychiatry, 51 (8) 885 – 94.*

146 Hagell A (2012) *Changing adolescence: Social trends and mental health, Bristol, UK: Policy Press; Hagell A (2012) Changing adolescence: Introducing the final report; Nuffield Foundation (2009) Time trends in adolescent well-being: Update December 2009, Nuffield Foundation, http://www.nuffieldfoundation.org/sites/default/files/Time%20trends%20in%20adolescent%20well-being%202009%20update.pdf.*

to the risks to health, substance use in adolescence is linked to lower educational outcomes, more risky sexual behaviour and heightened violence.[147]

Outcomes for girls who displayed severe adolescent behavioural problems (or conduct disorder) are significantly poorer than those of other girls. An analysis of longitudinal data showed these young women had higher rates of physical health problems, suicide and mortality. This analysis found that 46.3% of the girls with conduct disorder were pregnant by age 21, compared with 18.1% of the healthy, 30% of the depressed and 23% of the anxious girls.[148] Another study followed up girls with conduct disorder for two to four years after they were discharged from an in-patient unit; it noted that 6% of the girls died violently – a vastly higher proportion than the normal rate for girls their age, which was only 0.034%.[149]

If girls become disengaged from education, begin to run away from home and perhaps enter the care system, they can rapidly face multiple risks. They can become disconnected from the majority of their peers, from normal routines and from the prospect of college and employment. They are at higher risk of meeting adults involved in drugs and crime who may offer somewhere to be and a sense of acceptance and belonging. This may result in being propelled into a premature adulthood with the associated risks of sexual exploitation and/or being drawn into gangs.[150]

In recent years, there has been an upsurge of policy concern about gangs in general (particularly following the riots in the UK of August 2011[151]) and the role of girls in gangs, in particular. As a recent report from the Centre for Mental Health acknowledges, we still know little about how many girls are involved in gangs, the extent of the problems they face, or how best to tackle this issue.[152] More is known about risk factors for gang involvement; they include family breakdown, domestic violence in the home, a lack of positive role models and low self-esteem. Girls may get involved in gangs through relationships with male gang members; they may be attracted to the 'bad boy' image of gangs and be drawn in by the excitement, financial benefits and sense of belonging and protection gangs can provide. A recent study of girls disclosing gang involvement entering the youth justice system found they were more likely to have had early behavioural problems, multiple needs and a parent in prison than other girls involved in the youth justice system.[153] US research has noted links between low levels of self-esteem in girls and gang involvement whereas low self-esteem appeared to protect males from joining gangs.[154] Studies have explored the different roles that girls can play in criminal gangs; although these vary, it is clear that gangs present a major risk for violence and sexual exploitation for many girls and young women.[155] Girls in gangs operate within a massively male-dominated context but that does not mean that they do not have some agency within gangs. As Carlene Firmin points out, one of the greatest challenges of intervening with girls in gangs is to reconcile the idea that many will have both victimised others as well as been victimised themselves, so those working with them need to seek to reduce the risk that they face and the risk that they pose.[156]

Interventions intended to protect girls at risk can be experienced as punitive and unhelpful. Most of the children placed in secure accommodation on welfare grounds are girls, especially those who have repeatedly run away from home or institutional care.[157]

Girls do not fare well in youth justice systems designed around young men (nor do many vulnerable young men). Girls often develop internalising disorders (e.g. depression, anxiety) that are easily overlooked and ultimately untreated. Without appropriate treatment, they are locked in a cycle of depression, self-destructive behaviour and delinquency – each feeding the other and increasing a girl's sense of shame and self-blame. Further, girls and young women who express their sadness and anger overtly and exhibit disruptive behaviours may incur inappropriate responses by staff, who misinterpret them as manipulative or delinquent. In response to these behaviours, they may be placed in restrictive settings, which may be re-traumatising for previously abused girls.[158]

147 World Health Organization (2012) Risks to mental health, op cit.

148 Bardone AM, Moffitt TE, Caspi A, Dickson N, Stanton WR and Silva PA (1998) Adult physical health outcomes of adolescent girls with conduct disorder, depression, and anxiety, *Journal of the American Academy of Child and Adolescent Psychiatry, 37 594 – 601.*

149 Pajer KA (1998) What happens to 'bad' girls? A review of the adult outcomes of antisocial adolescent girls, *American Journal of Psychiatry, 155 862 – 70.*

150 Beckett H et al (2013) It's wrong… but you get used to it: A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England, Office of the Children's Commissioner.

151 Morrell G, Scott S, McNeish D & Webster S (2011) *Understanding young people's involvement in the August riots, NatCen/Cabinet Office*

http://www.natcen.ac.uk/media/769712/the%20august%20riots%20in%20england%20web.pdf

152 Khan L, Bryce H, Saunders A and Plumtree A (2013) *A need to belong: What leads girls to join gangs, London, UK: Centre for Mental Health.*

153 Ibid.

154 Esbenson F and Deschanes EP (1998) A multisite examination of youth gang membership: Does gender matter?, *Criminology, 36 729 – 828.*

155 Beckett et al (2013) It's wrong, op cit.

156 Firmin C (2013) Criminal gangs, op cit.

157 Goldson B and Jamieson J (2002) Youth crime, the 'parenting deficit' and state intervention: A contextual critique, *Youth Justice, 2 82.*

158 Veysey BM (2003) Adolescent girls with mental health disorders involved with the juvenile justice system, National Center for Mental Health and Juvenile Justice, http://www.ncmhjj.com/wp-content/uploads/2013/07/2003_Adolescent-Girls-with-Mental-Health-Disorders.pdf.

Effective interventions in the teens

While the early teens may trigger a 'breaking point' for girls at risk, this life-stage also offers opportunities to intervene positively to divert them from the most serious risks. At this age some girls may actively seek help or be more open to support than older teenagers or adult women are, when negative life patterns have become more established. Interventions to prevent disengagement from school, deter girls from going missing and maintain relationships either in their families or in stable alternative placements are particularly important.[159]

The literature suggests that effective work with teenage girls has a number of essential elements: there is a safe, nurturing, girl-only environment; there is an emphasis on positive relationships and relational safety; it addresses risks alongside strengths in the context of girls' lived experience; it promotes a positive version of girl or womanhood; and it incorporates work with families.[160]

Mental health

During this life-stage girls at risk may show signs of emotional or psychological harm so mental health support is important. Interventions may be preventive (e.g. universal mental health promotion programmes often delivered in schools) or targeted at young people already exhibiting difficulties.

There have been a number of reviews of the evidence for interventions to promote young people's mental health.[161] These demonstrate that school-based programmes that adopt a whole-school approach and are aimed at the promotion of mental health as opposed to the prevention of mental illness are effective.[162] The analysis of these programmes tends not to differentiate by gender.

The overriding problem for young people experiencing mental health difficulties is that there are few appropriate, easily accessible services which are able to intervene when there are early signs of problems.[163] There is also a lack of appropriate crisis services for young people who – not infrequently, and apparently increasingly – are admitted to adult in-patient units. In February 2014 freedom of information requests found that 350 under-18s have been admitted to adult mental health wards in the previous year – despite a Department of Health commitment to ending the practice by 2010. This is a particularly important issue for young women as there are very few women-only wards and considerable evidence that mixed acute wards can be frightening and unsafe for adult women.[164]

It is not easy for most young people to access advice, counselling or support. Youth services and voluntary organisations have been reduced or closed in recent years, provision in schools is patchy: Young Minds lists only half a dozen specialist services on its website.[165] In December 2013 the Children & Young People's Mental Health Coalition reported that 2 in 3 joint strategic needs assessments did not specifically address children and young people's mental health. It called for the Department of Health to commission a new national survey of child and adolescent mental health to establish the prevalence of mental health needs in this group (the last one was conducted in 2004) and to report findings in relation to five-year age bands to allow services to be commissioned based on children and young people's developmental needs [166].

There is again little evidence differentiated by gender about specific interventions to support young people experiencing mental health difficulties. Difficulties such as self-harm, eating disorders and depression often co-occur in girls at risk and may have their roots in earlier trauma. Treatment should therefore be holistic. Dialectical behaviour therapy adapted for adolescents (DBT-A) has been identified as a promising approach.[167]

Comprehensive programmes addressing multiple risks, including multi-dimensional treatment foster care,[168] and multi-systemic and functional family therapies, have been found to be effective for young men and women at risk.[169]

Offending

The peak age of girls offending is 15; 80% of girls who offend have 'criminal careers' lasting less than 12 months. However, identifying the 2 in 10 first offending girls who are at risk of ongoing involvement in crime should be a priority at this

159 Scott S and Harris J (2006) *Missing in London: Meeting the needs of young people who run away, Barkingside, UK: Barnardo's.*

160 Khan et al (2013) *A need to belong, op cit; Batchelor SA (2005)* 'Prove me the bam!': victimization and agency in the lives of young women who commit violent offences, *Probation Journal, 52 (4) 358 – 75.*

161 Tennant R, Goens C, Barlow J, Day C and Stewart-Brown S (2007) A systematic review of reviews of interventions to promote mental health and prevent mental health problems in children and young people, *Journal of Public Mental Health, 6 (1) 25 – 32.*

162 Wells J, Barlow J and Stewart-Brown S (2002) *A systematic review of universal approaches to mental health promotion in schools, Oxford, UK: Health Services Research Unit.*

163 Murphy M and Fonaghy P (2012) Mental health problems in children and young people, in CM Officer (ed), *Our children deserve better: Prevention pays, London, UK: Department of Health; Patel V, Flisher A, Hetrick S and McGorry P (2007) Mental health of young people: A global public-health challenge, The Lancet, 369 (9569), 1302 – 13.*

164 Mezey G et al (2005) Safety of women in mixed-sex and single-sex medium secure units: Staff and patient perceptions, *British Journal of Psychiatry, 187 579 – 82.*

165 See http://www.youngminds.org.uk/.

166 Oliva L and Lavis P (2013) Overlooked and forgotten: A review of how well children and young people's mental health is being prioritised in the current commissioning landscape, Children and Young People's Mental Health Coalition, http://www.cypmhc.org.uk/resources/overlooked_and_forgotten_full_report/.

167 Macpherson H et al (2013) Dialectical behaviour therapy for adolescents: Theory, treatment, adaptations and empirical outcomes, *Clinical Child and Psychology Review, 16 (1) 59 – 80.*

168 NREPP (2014) Multidimensional Treatment Foster Care (MTFC), National Registry of Evidence-based Programs and Practices, http://nrepp.samhsa.gov/ViewIntervention.aspx?id=48.

169 See Blueprints (2014) Multidimensional Treatment Foster Care (MTFC), http://www.blueprintsprograms.com/factSheet.php?pid=632667547e7cd3e0466547863e1207a8c0c0c549; NICE (2013) *Antisocial behaviour and conduct disorders in children and young people, op cit.*

life-stage, although there is limited firm evidence on why the majority of girls desist from offending but some do not.[170]

A number of programmes aim to prevent offending. Again, a lot of the most robust evaluative evidence comes from the US. Some school-based programmes aimed at preventing offending and improving outcomes for high risk groups have been found to be effective:

- **LifeSkills Training (LST):** a classroom-based universal prevention programme designed to prevent adolescent tobacco, alcohol, marijuana use and violence. Three major programme components teach students personal self-management skills, social skills and information and resistance skills specifically related to drug use. Across several studies, the intervention group showed significantly greater improvement than the control group in life skills knowledge, substance use knowledge, and perceived adult substance use, both at short-term and longer-term follow-ups.[171]

- **Positive Action (PA):** a school-based programme that includes school-wide culture change and an intensive curriculum on thoughts, actions and feelings. The programme is designed to reinforce the classroom curriculum by coordinating the efforts of the entire school in the practice and reinforcement of positive actions.[172]

The evaluations of these programmes have little to say on gender differences. However, there is evidence of promising gender-specific practice with girls at risk in this age group. This includes:

- **PACE:** a programme providing 17 centres across the US for girls, combining education and social support for girls at risk. PACE uses a holistic, strength-based and asset building model specifically responsive to the needs of girls, and reports positive results in preventing girls from entering the juvenile justice system.[173]

- **Big Brothers Big Sisters of America:** a community mentoring programme, which matches a volunteer adult mentor to a child, with the expectation that a caring and supportive relationship will develop. Evaluations have reported positive outcomes including reduced take-up of drug and alcohol use and reductions in truancy. Some gender and race differences have been reported: the programme has greater effects on school attendance for girls and on academic outcomes for Black and minority ethnic girls. UK mentoring schemes include Big Sisters,[174] based in Manchester, and The Girls Network[175] (though these have not been subject to evaluation).

Gender-responsiveness requires services to create adequate programme space for girls on a par with what is currently available for boys. Generic services should be strengthened by providing treatment and care that is sensitive to girls' experiences, styles of communication, need for empowering relationships, and common presenting problems. Few agencies have developed girls' only programmes, but the research suggests that this alternative may produce the best results, especially for girls with histories of physical or sexual abuse.[176] Gender-specific programmes aimed at reducing reoffending in girls have shown positive effects on other outcomes such as education, employment, relationships with family and friends, self-esteem, self-efficacy and other social-psychological outcomes (e.g. self-awareness, body image, social development) that may empower girls and improve their overall quality of life.[177]

Violence and abuse

In recent years there has been an expansion of programmes (usually school-based) aimed at preventing interpersonal violence and promoting healthy relationships. A NICE review on domestic violence describes two systematic reviews on the effectiveness of such programmes targeting young people.[178] Both highlight major deficiencies in the available evidence, but report that the limited evidence suggests the programmes have positive effects on knowledge and attitudes among young people, although it is unclear whether this results in changes in behaviour.[179] It has also been pointed out that more work is needed to determine the ability of these programmes to sustain change (whether attitudinal or behavioural) over any meaningful period of time.[180]

One US prevention programme has been the subject of a randomised controlled trial.[181] Safe Dates is a school-based universal adolescent dating violence prevention programme for 11–18 year olds. It is administered in ten 45–50 minutes sessions and aims to prevent dating violence perpetration by

170 Gelsthorpe L and Sharpe G (2006) Gender, youth crime and justice, in Goldson B and Muncie J (eds), *Youth crime and justice: Critical issues, London, UK: Sage.*

171 Blueprints (2014) Lifeskills Training (LST), http://www.blueprintsprograms.com/factSheet.php?pid=ac3478d69a3c81fa62e60f5c3696165a4e5e6ac4.

172 Blueprints (2014) Positive Action Model Program, http://www.blueprintsprograms.com/factSheet.php?pid=58f0744907ea8bd8e0f51e568f1536289ceb40a5.

173 See http://www.pacecenter.org/.

174 See http://www.girlsoutloud.org.uk/.

175 See http://thegirlsnetwork.org.uk/.

176 Fazell (2008) Mental disorders among adolescents in juvenile detention and correctional facilities, op cit; Smith D and McAcra L (2004) Gender and youth offending: The Edinburgh study of youth transitions; Douglas N and Plugge E (2006) *A health needs assessment for young women in the secure estate, London: Youth Justice Board.*

177 Zahn M et al (2009) Determining what works for girls in the juvenile justice system: A summary of evaluation evidence, *Crime & Delinquency*, 55 (2).

178 NICE (2013) *Domestic violence and abuse: Identification and prevention.*

179 Murray CE and Graybeal J (2007) Methodological review of intimate partner violence prevention research, *Journal of Interpersonal Violence, 22 (10) 1250 – 69; Whitaker DJ, Morrison S, Lindquist C, Hawkins SR, O'Neil JA, Nesius AM, Mathew A and Reese L (2006) A critical review of interventions for the primary prevention of perpetration of partner violence, Aggression and Violent Behaviour, 11 (2) 151 – 66.*

180 Stanley N (2011) Children experiencing domestic violence: A research review, https://www.safeguardingchildrenbarnsley.com/media/15486/domestic_violence_signposts_research_in_practice_-_july_2012.pdf.

181 Foshee VA, Bauman KE, Ennett ST, Linder F, Benefield T and Suchindran C (2004) Assessing the long-term effects of the Safe Dates Program and a booster in preventing and reducing adolescent dating violence victimization and perpetration, *American Journal of Public Health, 94 (4) 619 – 24.*

changing norms associated with partner violence, decreasing gender stereotyping, and improving conflict management skills. The evaluation found positive attitude changes in regard to dating violence norms, communication skills and responses to anger. At four-year follow up, adolescents who participated in Safe Dates reported significantly less physical and sexual dating violence than those in the control schools. Positive changes in attitudes towards gender stereotyping, conflict resolution skills and awareness of community services were also reported.

A key finding of the Safe Dates evaluation is that there was no positive effect on physical victimisation for those with prior experience as a victim or perpetrator of physical dating violence. This is important because such programmes are often targeted at older teenagers, but research suggests that younger teenagers are already getting involved in relationships and experiencing abuse. The authors of one recent study point out that to reach young people early enough, interventions need to target the under 13s.[182] Research suggests that young people themselves want to receive education on domestic abuse.[183] There are similar programmes in the UK such as those offered by Tender and Rape Crisis Scotland,[184] but although these have been positively evaluated the evidence is not at as high a level.[185] One key difference for most of these programmes is 'dosage' – most UK schools are not able or willing to accommodate an intervention on the scale of Safe Dates.

A report from the Early Intervention Foundation[186] describes some examples of potentially promising approaches (all from the US) for young people who are already identified as at risk of violence and abuse:

- **The Young Parenthood Programme:** a ten-week co-parenting counselling and interpersonal violence prevention programme, to support young couples (first-time mothers, aged 14 to 18 years and their partners) in managing unplanned pregnancy and parenthood, and prevention of violence.[187]
- **Love U2: Communication Smarts** is an early intervention programme for economically and socially disadvantaged youth, aged 11 to 18 years, who are at high risk of relationship violence. The curriculum, in seven modules, addresses healthy and unhealthy relationship patterns, communication and conflict resolution skills, and general problem solving.[188]
- **Strengthening Relationships:** guided by the social learning theory, this is designed to support parents in developing and maintaining healthy relationships by teaching interpersonal and relationship skills. It is targeted at pregnant and adolescent parents already enrolled in pregnancy, education, and parenting programmes.[189]

Sexual exploitation

Multiple placements have been shown to increase the risk of sexual exploitation for young women in the care system.[190] Responses to teenage girls who are identified as at risk of exploitation can be experienced as punitive and can be counter-productive, for example the use of secure accommodation.[191]

In the UK there are numerous services for sexually exploited young people, and those at risk, e.g. Safe and Sound, Barnardo's network of projects, and the Empower programme for girls at risk of gang involvement. Although the evaluation evidence is not extensive it suggests that intervention with these young people is feasible and worthwhile. In a two-year evaluation of outcomes for 557 young people (81% of them girls and young women) using ten of its services Barnardo's found that risk of sexual exploitation was significantly reduced – particularly for those young people at the highest risk. Outcomes included reduced missing episodes, improved relations with parents or carers, stable accommodation and increased risk and rights awareness. The core features of the model of practice that were considered to be essential to achieving successful outcomes were providing reliable, intensive relationships with an individual worker; easy to access, safe, pleasant centres; assertive outreach; and advocacy and brokerage in relation to other services.[192]

Teenage pregnancy

Evidence on the prevention of teenage pregnancy is more equivocal. Teenage pregnancy rates have fallen in recent years but there is little evidence of there being any effective educational interventions to prevent teenage pregnancy, though there are programmes that support teenage mothers.[193]

182 Fox CL, Corr M, Gadd D and Butler I (2014) Young teenagers' experiences of domestic abuse, *Journal of Youth Studies, 17 (4) 510 – 26.*

183 Mullender A et al (2000) *Children's needs, coping strategies and understanding of woman abuse: End of award report, Swindon, UK: Economic and Social Research Council.*

184 See http://www.tender.org.uk; Rape Crisis Scotland (2013) Preventing sexual violence: A resource pack.

185 McNeish D, Ludvigsen A, Scott S and Webster A (2010) *An evaluation of Tender's healthy relationship education in schools.*

186 Guy et al (2014) *Early intervention in domestic violence and abuse, op cit.*

187 Florsheim P, McArthur L, Hudak C, Heavin S, and Burrow-Sanchez J (2011) The Young Parenthood Program: A co-parenting counseling program for pregnant adolescents and young expectant fathers, *Journal of Couple and Relationship Therapy, 10 117 – 134, cited in Guy et al (2014) Early intervention in domestic violence and abuse, op cit.*

188 Antle BF, Sullivan DJ, Dryden A and Karam EA (2011) Healthy relationship education for dating violence prevention among high-risk youth, *Children and Youth Services Review, 33 (1) 173 – 9, cited in Guy et al (2014) Early intervention in domestic violence and abuse, op cit.*

189 Toews ML, Yazedjian A and Jorgensen D (2011) 'I haven't done nothin' crazy lately:' conflict resolution strategies in adolescent mothers' dating relationships, *Children and Youth Services Review, 33 (1) 180 – 6, cited in Guy et al (2014) Early intervention in domestic violence and abuse, op cit.*

190 Coy M (2009) 'Moved around like bags of rubbish nobody wants': How multiple placement moves can make young women vulnerable to sexual exploitation, *Child Abuse Review*, 18 254 – 66.

191 Creegan C, Scott S and Smith R (2005) *The use of secure accommodation and alternative provisions for sexually exploited young people in Scotland, Barkingside, UK: Barnardo's; O'Neill T (2001) Children in secure accommodation: A gendered exploration of locked institutional care for children in trouble, Jessica Kingsley.*

192 Scott S and Skidmore P (2006) *Reducing the risk: Barnardo's support for sexually exploited young people, a two year evaluation, Barkingside, UK: Barnardo's.*

193 Asmussen K and Weizel K (2010) *Evaluating the evidence: What works in supporting teenage parents, London, UK: King's College: National Academy of Parenting Research.*

Results from the first UK-based systematic evaluation of school-based sex and relationship education were published in June 2002. The SHARE (Sexual Health And Relationships) random control trial found that a high-quality, experientially based programme was rated highly by the young people who received it, had a positive impact on knowledge, and reduced the level of reported regret over first sexual intercourse, but had no effects on contraceptive use and sexual behaviour. The results suggest that specific programmes on their own are unlikely to reduce conception rates.[194] This is supported by a Health Development Agency review of reviews, which concluded that the best way to reduce teenage pregnancies and improve sexual health is a multifaceted approach, which offers balanced sex and relationship education that recognises that many young people become sexually active in their teens, and appropriate, accessible confidential services to provide contraception and sexual health services.[195]

A recent randomised control trial of a school-based pregnancy prevention programme in the UK (Teens and Toddlers) enabling possibly at risk girls to spend time each week in a nursery setting and also to participate in a youth development course found no evidence of impact on the primary outcomes of increasing likelihood of contraceptive use and reducing the expectation of becoming a teenage mother. However, the programme was found to have helped prevent low self-esteem one year after it had finished: 15% of teenagers in the intervention group reported low self-esteem, compared with 23% in the control group.[196]

Section 4: Into adulthood

As young women enter their late teens they face another period of transition: they leave school, most leave home or care, and they enter the world of work (or worklessness). Young women at risk are those that are most likely to leave school with no qualifications and to become NEET (not in education, employment or training). Disconnected from alternative structures they are more likely to get involved (or further involved) in drug or alcohol misuse and continue to be victims of sexual exploitation. Some get pregnant and become mothers.

Young women who had shown signs of emotional and behavioural difficulties at earlier life-stages will by this point become involved in adult services (as they move from Child and Adolescent Mental Health Services to the adult mental health system). For young women in transition to adult services, provision also needs to be age-sensitive. As well as being treated inappropriately by services designed to meet the needs of men, young women are frequently thrust into equally inappropriate services geared to adults.[197]

Young women who have been in the care system may be at particular risk if they leave care with little ongoing support and either remain estranged from their families of origin or reconnect with very troubled families. There is an expectation of instant adulthood for care leavers; preparation for independent living is often poor and they have no option of going back home if things go wrong. This leads to a first experience of homelessness or very unstable living circumstances for some young women, which adds to the risk of them becoming dependent on others for accommodation and vulnerable to further exploitation and/or criminality. If young women have continued involvement with the criminal justice system, by this stage the system may have run out of non-custodial options.[198]

The only accessible and acceptable adult roles available to many young women at risk in this age group are those of girlfriend and mother. At this stage of life many at risk young women are parents themselves and either parenting alone or in unsupportive or abusive relationships. The highest prevalence of domestic violence is in the 16–19 age group (11.3%).[199] Where they are in contact with services the focus will often now be on their 'children's needs rather than on their own needs, and this group of young women is at greatest risk of having their children removed from them. On the other hand, there is also evidence that motherhood can be a protective factor – a major transition in a young woman's life that contributes to her turning her life around.[200]

Young women at risk are likely to experience multiple and interrelated difficulties. For example, a high proportion of women involved in street-based prostitution has substance use problems and vice versa. Indeed, drug use and prostitution can be said to be mutually reinforcing. Women who have substance use problems and are involved in prostitution also have high rates of mental health problems, and poor physical health. Risks for these women include assault, sexual health risks, arrest and imprisonment. Stigma also has a significant negative impact on self-esteem and mental health.[201]

There is growing recognition of the complex needs of women with dual diagnoses of substance abuse and mental health disorders. Research demonstrates that there are high numbers

194 Wight D, Raab GM, Henderson M, Abraham C, Buston K et al (2002) The limits of teacher-delivered sex education: Interim behavioural outcomes from a randomised trial, *British Medical Journal, 324 1430.*

195 Swann C, Bowe K, McCormick G and Kosmin M (2003) Teenage pregnancy and parenthood: A review of reviews, evidence briefing, London, UK: Health Development Agency, www.hda.nhs.uk/evidence.

196 Bonell C, Maiser R, Speight S et al (2013) Randomized controlled trial of teens and toddlers: A teenage pregnancy prevention intervention combining youth development and voluntary service in a nursery, *Journal of Adolescence, 36 (5)* 859 – 70.

197 Burman M and Batchelor SA (2009) Between two stools? Responding to young women who offend, *Youth Justice, 9 270.*

198 Stein M (2006) Research review: Young people leaving care, *Child and Family Social Work, 11 (3) 273 – 9.*

199 Guy et al (2014) *Early intervention in domestic violence and abuse, op cit.*

200 Alexander C et al (eds) (2010) *Teenage pregnancy – what's the problem?, Tufnell Press.*

201 DrugScope and AVA (2013) *The challenge of change: Improving services for women involved in prostitution and substance use, DrugScope and Against Violence & Abuse, http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/Challenge%20of%20change_policy%20briefing.pdf.*

of women in substance abuse treatment with histories of sexual and physical abuse, with rates ranging from 66% to 90% of the women entering drug treatment.[202] These women are not well served by the separation between substance abuse and mental health services.[203]

Similar patterns of problems are evident among homeless women. There is a high level of homelessness among street-based women sex workers.[204] Research in Glasgow found that 44% of women sex workers surveyed had slept rough.[205] Another study found that the majority had experienced housing difficulties and this usually led to recurring or continual housing problems.[206]

The risk factors associated with women becoming homeless and/or involved in street sex work are familiar: research commissioned by Crisis cited housing trends, unemployment and family fragmentation as key structural factors with other risk factors, including experiences of sexual or physical abuse, family disputes and instability, experience of the care system or prison, debt, drug or alcohol misuse, mental health problems, school exclusions and lack of qualifications, poor physical health and a lack of social networks.[207]

Parenting is more of a struggle for women with such multiple difficulties, and many women at risk experience temporary or permanent separation from their children, with the attendant issues of loss, grief, anger, guilt and a sense of failure as mothers. Motherhood is often a route back to contact with social services – but this time in the role as the one posing the risk. This very much colours the engagement and experience of young mothers who have other needs. In the UK over half of women prisoners have young children. Women are nearly always the primary care-givers and are often single mothers. Most children are living with their mothers before the woman's imprisonment and for many it is the first time they have been separated. Most see their mother once a month or less. Only 5% of children stay in their own homes once their mother has been imprisoned.[208] Babies and toddlers taken into care in a crisis are likely to move placements – often more than once. The implications for secure attachment are dismal. Sheila Kitzinger has called the enforced separation of mothers and babies 'another form of violence against women and an abuse of children'.[209]

Women offenders, especially those serving short sentences, often have multiple and interrelated emotional, social, economic and health problems. A Home Office study found that 66% of women prisoners were either drug dependent or reported harmful or hazardous levels of drinking in the year prior to custody[210] and research by the Women's Policy Unit concluded that half of all women in prison have experienced domestic violence and the majority have experienced some form of abuse, and that this abuse contributes to the risk of offending as well as to drug and alcohol problems, mental health problems and self-harm.[211] Such problems may lead to imprisonment directly, or indirectly through attempts to secure money for drugs by prostitution and theft, or through anti-social behaviour.

Approximately 3,853 women were in prison in England and Wales at the end of June 2013.The average number of female prisoners decreased by around 3% between 2002 and 2012, while the male prison population increased by 24% over the same period.[212]

Certain groups of women are over-represented in UK prisons, including Black British women and foreign national women. In 2010 foreign national prisoners made up 20% of the female prison population. They came from countries such as China, Ghana, Jamaica, Nigeria, Pakistan, Romania, South Africa, Vietnam and Zimbabwe. Research with 103 such women identified 43 as being victims of trafficking; five had entered the country independently, but had then been worked in slavery or servitude like conditions and ten had entered the UK in the hands of agents and been arrested following the theft of their relevant documents by their smugglers. All of those interviewed said that they had been victims of physical and/or emotional abuse, and 24 women had experienced multiple rapes. Many had committed offences under duress or in ignorance, and 31 had made applications for asylum in the UK.[213]

Gender in adult life

As we described in Chapter 1, there are powerful expectations of the behaviour and attitudes of men and women, which shape how people experience themselves and are related to by others. Childhood socialisation first encourages girls to take these expectations on board and as they grow up to develop a clearly gendered identity. Common expectations of women often include being 'feminine', deferential, concerned with others'

202 Hien D, Cohen L and Campbell C (2005) Is traumatic stress a vulnerability factor for women with substance use disorders?, *Clinical Psychology Review, 25 813 – 33.*

203 Covington S et al (2008) Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment, *Journal of Psychoactive Drugs*, 5 387 – 98.

204 Davis J (2004) *Off the streets: Tackling homelessness among street based women sex workers, London, UK: Shelter.*

205 Stewart A (2000) *Where is she tonight? Women, prostitution and homelessness, Glasgow, UK: Rough Sleepers Initiative.*

206 Hester M and Westmorland N (2004) *Tackling street prostitution: Towards a holistic approach, London, UK: Crime Reduction Project, Home Office.*

207 Reeve K with Goudie , R & Casey R (2007)Homeless Women: Homelessness Careers, Homelessness Landscapes. London: Crisis http://www.crisis.org.uk/data/files/publications/Homeless_Women_Landscapes_Aug07.pdf

208 Prison Reform Trust (2010) Bromley briefings: Prison fact file.

209 Kitzinger S (no date) Mothers and babies in prison, http://www.sheilakitzinger.com/Prisons.htm.

210 Borrill, J., Maden, A., Martin, A., Weaver, T., Stimson, G., Barnes, T., Burnett, R., Miller, S., Briggs, D., Farrell, M (2003). The substance misuse treatment needs of minority prison groups: women, young offenders and ethnic minorities. Home Office, Research and Statistics Directorate: London.

211 Hooper, C-A (2003), Abuse, interventions and women in prison: a literature review, Home Office and Prison Service: London.

212 Prison Population Statistics, Standard Note: SN/SG/4334, 29 July 2013.

213 Hales L and Gelsthorpe L (2012) *The criminalisation of migrant women, Cambridge, UK: Institute of Criminology, University of Cambridge.*

feelings, fond of children and animals, and more emotional and less rational than men, and not appearing too clever or competent.

There are implications for women of meeting, or trying to meet, such expectations. These include women not feeling entitled to express their own needs or have them met, finding it difficult to act on their own behalf, being vulnerable to exploitation by others, not being able to express anger directly, and not feeling in control of their lives. There are also implications for women who do not meet, or actively reject, these expectations: they may feel guilt or shame at their 'failure', have poor self-esteem in relation to not being 'a real woman', be excluded or rejected by family and peers, and have to cope with discrimination and harsh judgement by professionals and services.

In addition to the implications of fulfilling, or not fulfilling, such gendered expectations there are specifically unflattering characterisations of at risk women within services they encounter. Research in prisons and mental health services has shown that many staff regard anti-social behaviour as doubly deviant in women. Staff frequently describe the women they work with as difficult, demanding, manipulative, attention seeking, aggressive and lacking in motivation, and contrast them with male prisoners and patients whom they describe as being less troublesome and emotional, and more self-contained and straightforward to deal with.[214]

As women grow older their gendered experience changes. Some find that gendered expectations of their behaviour become less troublesome; some have left earlier violent and abusive relationships behind. Older women often experience themselves as socially 'invisible'. Class and race also determine the nature and experience of ageing, and older Black and minority ethnic women are particularly disadvantaged by the triple jeopardy of ageism, sexism and racism.[215]

Older women who have experienced long-term mental health problems or who grew up in care will have experienced considerable change in services and may well have a history of trauma directly connected to institutional care or abuse in services.

Ageing brings its own risks of declining health, poverty and social isolation but these are amplified by the accumulation of abuse and risks across a lifetime. A history of abuse, drug or alcohol dependency, homelessness and the fragmentation of family make older women at risk particularly vulnerable to chronic illness, disability and poor mental health.[216]

Service responses and effective interventions

By the time women at risk reach adulthood their lives may well have been on a negative trajectory for some time and opportunities to intervene have either been missed or had a limited impact. On the other hand, as young women encounter adult services for the first time, there is another opportunity to engage with them and to prevent them from becoming entrenched in poor outcomes. (There is emerging evidence from neuro-science that because of the way the brain develops in adolescence, intervention during the teenage years can be particularly effective.[217]) However, it is also likely that many adolescent women will have developed a serious mistrust of helping professionals who have failed them in the past, so for early adult interventions to be successful some different approaches may be required. Sometimes trauma in adulthood (often very serious domestic violence) coupled with low income has set young women into a crisis trajectory and they encounter services for the first time as adult women.

Whatever adult service they are encountering, young women at risk almost certainly have multiple risk factors in their lives. They may come to the attention of drug services, homelessness services, mental health services or the criminal justice system, but they almost invariably have issues in their lives which cut across all of these. Effective interventions with young women therefore need to be cross-cutting and holistic, and reflect the whole reality of women's lives; adult services have failed to do this in the past.

When women enter services it is often because of something that is wrong with them – their drug use, offending behaviour, prostitution or mental illness – rather than because of what has happened to them, and in the process they are categorised in ways that often render their lived experience invisible. For example, women in prison are not a special category of 'prisoners': they are survivors of child abuse and domestic violence, care leavers and young mothers; some have been sexually exploited and almost all have failed at school. Most of their needs arise directly from their experiences and only services prepared to address such experiences are likely to meet their needs.[218]

When the nature and origins of people's difficulties go unrecognised, services can be re-traumatising rather than helpful. The use of isolation, observation or restraint is liable to trigger intense distress if it is reminiscent of prior abuse. This is particularly true for many women as post-traumatic stress disorder is twice as common in women as men, the difference being largely accounted for by rape – which is one of the highest risks for development of PTSD.[219]

214 Williams J, Scott S and Waterhouse S (2001) Mental health services for 'difficult' women, *Feminist Review, 68 89 – 104.*

215 Arber S and Ginn J (1991) *Gender and later life, London, UK: Sage.*

216 Milne A and Williams J (2003) *Women at the crossroads: A literature review of the mental health risks facing women in mid-life, Mental Health Foundation.*

217 Johnson S, Blum W and Giedd J (2009) Adolescent maturity and the brain: The promise and pitfalls of neuroscience research in adolescent health policy, *Journal Adolescent Health, 45 (3) 216 – 21.*

218 Scott S (2004) Opening a can of worms? Counselling for survivors in UK women's prisons, *Feminism and Psychology, 14 (2) 256 – 61.*

219 Spitzberg BH (1999) An analysis of empirical estimates of sexual aggression and victimisation, *Violence and Victims, 14 241 – 60.*

Findings from studies carried out over a number of years suggest that mental health and criminal justice workers rarely have training that encourages them to make links between social inequalities and the problems in the lives of those they work with. Few have any training on the effects of sexual or domestic violence or on working with survivors of trauma and abuse.[220] They therefore often fail to recognise the importance of the social context of women's lives. This may lead to women being labelled either as vulnerable victims or as monstrous women, rather than being recognised as struggling survivors of appalling adversity.[221]

Routine enquiry about experiences of violence and abuse in mental health assessments is an essential prerequisite to providing appropriate treatment.[222] Lack of training may lead to blaming women for behaviour that is the result of a history of trauma, and increasing the likelihood of placement in secure settings.

Women with multiple problems frequently experience difficulty in accessing the support they need in the community. A chaotic lifestyle and a marginalised status often exacerbate this. When women do access support they do not always find it helpful. Indeed the familiarity and informal support women get from others in a similar situation may feel preferable to the bureaucratic responses of service staff. Making the transition into a more stable life also requires women to develop a new identity and sense of self. Not surprisingly a 'yo-yo' effect, whereby women move in and out of negative situations in an ongoing cycle, is common.[223]

Factors that have been identified as important for services for women involved in prostitution and substance use include providing outreach services and facilitating opportunities for peer support, women-only provision and childcare provision; enhancement of standard programmes to make them more specific to their needs; and integration of provision or strong case management to deal with the full range of issues experienced by women.[224] Such accessible community-based support services are increasingly rare. Many have closed down for lack of funding and those that still exist tend to have considerable waiting lists.

Mental health services that work for women are those that are safe, respectful and take their lives and experiences seriously.[225] In recent research with survivors of sexual and domestic violence using many mental health and support services, good services were defined as 'holistic', 'integrated' and 'seamless', and those that gave survivors some genuine control, were not time-limited and managed endings well. At their best services were able to recognise the importance of survivors' relationships and include non-abusive friends and family so they could be helped to understand the issues and support the individual as well. Survivors were positive about having a number of different kinds of support and therapy in both statutory services and voluntary agencies. They emphasised that particular therapeutic approaches mattered much less than that the dynamics and impacts of abuse were understood by staff. Survivor groups were most frequently cited as transformative. Formal therapeutic groups, self-help, drop-ins and psycho-educational groups were praised for the same core elements: providing safe contact with others and helping them understand the commonality of their experiences, inspiring people with what others had achieved while allowing people to move forward at their own pace, and enabling them to support others and 'give something back'.[226]

It has been argued that women are more likely to respond to an 'emotionally intelligent' approach to their needs.[227] Gelsthorpe et al set out 'nine lessons for good practice' with women offenders in the community, including women-only provision; integration with non-offenders; fostering of women's empowerment, self-esteem and problem-solving abilities; holistic and practical services; links with other agencies, especially health, housing and employment; flexibility to allow women to return for 'top up' support; arrangements for personal support on leaving the project; and practical support such as transport and encouragement to re-establish links with children. Projects such as Inspire[228] and Solace Women's Aid,[229] and one-stop women's centres such as Anawim[230] and WomenCentre,[231] show promise as they fulfil these principles.

There is very little by way of substantial evidence from evaluation about the effectiveness of models of working or interventions with women at risk in the UK. Specialist services in the women's voluntary sector have rarely had the resources to commission evaluations with a robust methodology and a clear

220 Scott S and Parry-Crooke G (2001) Gender difference matters, *Mental Health Today, October, 18 – 22.*

221 Barnes M, Davies A, Guru S, Lewis L and Rogers H (2002) Women-only and women-sensitive mental health services, London, UK: Department of Health.

222 Read J, Hammersley P and Rudegeair T (2007) Why, when and how to ask about childhood abuse, *Advances in Psychiatric Treatment*, 13 101 – 10.

223 McNaughton C and Sanders T (2007) Housing andtransitional phases out of 'disordered' lives: The case of leaving homelessness and street sex work, *Housing Studies, 22 (6) 885 – 900.*

224 DrugScope and AVA (2013) *The challenge of change, op cit.*

225 Williams J, LeFrancois B and Copperman J (2001) Mental health services that work for women: Survey findings, Canterbury, UK: Tizard Centre, University of Kent.

226 Scott S and McNaughton-Nicholls C (2014) What do survivors of violence and abuse have to say about mental health services? A briefing for commissioners, London, UK: NatCen.

227 Covington S (2001) *A woman's journey home: Challenges for female offenders and their children*, Center for Gender & Justice, http://aspe.hhs.gov/hsp/prison2home02/covington.htm; Home Office (2007) *The Corston report, op cit; Gelsthorpe LG, Sharpe S and Roberts J (2007) Provision for women offenders in the community, London, UK: Fawcett Society.*

228 Easton H and Matthews R (2012) Evaluation of the Inspire Women's Project.

229 Kelly L, Sharp N and Klein R (2014) *Finding the cost of freedom, London, UK: Child & Woman Abuse Studies Unit, London Metropolitan University, http://cwasu.org/filedown.asp?file=Finding-the-Costs-of-Freedom-Executive-Summary(1).pdf.*

230 Doal J (2008) How Corston style 'one stop shop' women's centres can be rolled out nationally including an action plan based upon the experience of Anawim, http://www.anawim.co.uk/documents/Rolling_out_Womens_Centres_Based_on_Anawim.

231 Duffy S and Hyde C (2011) *Women at the centre: Innovation in community, Sheffield, UK: Centre for Welfare Reform.*

focus on outcomes over time. Most evaluation of such services that has been undertaken can tell us little more than if they are acceptable to, and appreciated by, their clients.

Statutory services with more considerable research and development budgets have rarely been interested in the implications of gender. For example a systematic review of the literature on women and secure psychiatric services found that no service model had been evaluated for its impact on women; few papers had been published addressing the question of treatment regimes specific to women; no papers discussed the impacts of discrimination or oppression; and many papers did not give data separately for women.[232]

Evaluations that have been carried out in the UK have highlighted the value of providing holistic services to women offenders in women-only settings, particularly for those who have suffered sexual and physical violence. A recent study of the development and impact of community services for women offenders, based on a review of existing evidence and an evaluation of six women's centre services, found that the emotional and practical help provided (including peer support and access to various services) was highly valued by the women who attended. A number of women had moved on from the centres into mainstream adult education settings, volunteer placements and work. However, the report notes that there continues to be little evidence of impact of these services on reoffending outcomes, in part because there is no common system for defining or measuring outcomes.[233]

Borderline personality disorder is a diagnosis frequently given to at risk women in mental health services who have histories of childhood trauma (frequently, but not exclusively, including sexual abuse) and who are described as angry, self-harming, suicidal, intense, impulsive and dissociative. Dialectical Behaviour Therapy (DBT) is an established treatment that has been evaluated in seven randomised controlled trials. It attempts to teach emotional, interpersonal, behavioural, cognitive and self-management regulation skills; it addresses traumatic histories and includes mindfulness and acceptance components. However, it should be noted that Borderline Personality Disorder remains a highly contested diagnosis, which many women experience as stigmatising and unhelpful and DBT has been renamed by some 'Diabolical Behaviour Therapy' or 'Doing Bollocks Therapy'.[234]

With the emergence of feminist awareness of violence against women as traumatising of women in the same way that combat had been earlier recognised to traumatise men, new understandings of trauma were developed.[235] In the US a few specific gender sensitive, trauma-informed interventions have been implemented and substantially evaluated in a number of service settings (mental health, substance abuse, criminal justice). These include Stephanie Covington's trauma-informed approach,[236] Women's Integrated Treatment,[237] Seeking Safety[238] and the Trauma Recovery and Empowerment Model,[239] which was implemented originally with a predominantly African American population and developed culturally specific adaptations. The work of Maxine Harris and her colleagues has been a major influence on these trauma-informed interventions for women in the US and many have adopted or adapted the core values she identifies for trauma sensitive services: ensuring physical and emotional safety, maximising trust through consistency, being honest and providing clear boundaries, maximising client choice and control, collaborating and sharing power, and empowering survivors.[240] Similar values underpin the model of empowerment practice in many UK Rape Crisis and Women's Aid services. Williams and Watson have described them in a mental health context as 'practice informed by knowledge and understanding of the harm that can be caused by gender and other inequalities, which promotes a shared understanding that healthy relationships between staff and patients (clients) are at the heart of change'.[241]

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Part 3: Implications for the Alliance

The purpose of this review has been to inform the development of the Alliance by reviewing what research can tell us about women and girls at risk, the poor outcomes they experience and their underlying causes, as well as the evidence for effective interventions to interrupt negative trajectories at different stages of the life course.

There are broadly two sets of messages that can be derived from this review: what we can say *about and what we can learn from the evidence.*

Messages about the evidence

Empirical research tends to fall into three main categories:

- Research on presenting needs and problems and their consequences
- Research on underlying cause and correlates
- Research on what works in tackling causes and ameliorating negative outcomes.

Our conclusion from this review of the available evidence is that there are considerable gaps in all three categories for women and girls at risk. Some of the best evidence about risks and consequences across the life course can be provided by longitudinal research but publications from the UK cohort studies pay little attention to gender. Many studies have highlighted the associations between social inequalities and negative life experiences (particularly violence and abuse) and poor outcomes, but gender differences in the impact these factors have are much less commonly explored.

Moreover, there are two serious limitations for our understanding of effective interventions. The first is that the most robust evaluative evidence tends to be largely undifferentiated by gender or, in relation to some topics relates only to outcomes for men or boys. The second is that services working specifically with women and girls at risk have been subject only to very limited evaluation, which is unable to provide the most robust evidence for what works.

These limitations are a significant finding of this review and have implications for how the literature can be interpreted and applied to girls and women and for future research and evaluation. The Alliance may wish to consider the role they can play in:

- Creating a demand for gender differences to be more routinely analysed and reported in research findings
- Influencing the agenda of research funders to give a higher priority to studies that explore issues of gender and risk
- Influencing the agenda of research funders to give a higher priority to studies that explore issues of gender and risk and the experiences of different groups of ethnic minority and Black women and girls
- Investing in pilots of interventions based on the evidence of this review and the evaluation of which can contribute to the evidence base on effective services for women and girls
- Using the Alliance as a vehicle for developing and embedding the use of common outcome frameworks across services for girls and women at risk to enable more substantial evaluation to be implemented
- Developing wider use of feminist approaches to evaluation that measures what matters to women and girls and enables greater reflection of the realities of women's lives, e.g. Solace evaluation[242]
- Advocating for replication of evaluations which have already been robustly evaluated (largely in the US) to assess the extent to which they are transferable to the UK context and have a positive impact on girls and women
- Ensuring that work takes place to increase understanding of the experience and needs of women from Black and ethnic minority backgrounds, and attending to inequalities of race and ethnicity, alongside those of gender, in all aspects of the Alliance's work.

Messages from the evidence

Despite the limitations of the available research, there are some important messages from the evidence, which the Alliance can use to inform policy influence and service development.

There are key points about risk factors and what might be effective in addressing them at each stage of the life course. Some of the strongest evidence is in relation to the early years, including some findings which suggest that early years interventions may particularly benefit girls. However, interventions in both the early and primary years appear to be particularly 'gender-blind' in provision and evaluation. And although there are plenty of advocates of early intervention who point to the links between services for young children and families and outcomes in later life, the connections between these and services for adult women at risk seem particularly weak (despite the fact that in relation to mothers, they may well be working with the same women). At present one of the biggest policy and practice divides remains that between children's and adults' services.

There is evidence that many of those working in a range of services (including particularly mental health and criminal justice) are poorly supported to work effectively with women at risk. Their training contains little or nothing about the impact of inequalities or the effects of violence and abuse and does not prepare them for supporting and empowering women and developing services that avoid re-traumatisation and promote recovery.

In addition, while practitioners and researchers concerned with women who are homeless, drug-users, involved in sex work or

242 Kelly et al (2014) *Finding the cost of freedom, op cit.*

caught up in the criminal justice or mental health systems all tend to recognise the common trajectories of these women's lives, their work is often within 'silos' divided across different services, professional groups and academic fields. Therefore despite the efforts of the women's voluntary sector, there is no 'critical mass' of advocacy, research or large scale service development with a clear focus on girls and women at risk which can influence policy direction and lobby for appropriate commissioning and funding.

The evidence from service evaluations and research with women at risk supports a model of integrated, holistic, one-stop, women-centred services as effective in promoting and sustaining engagement and being highly valued by women at risk – even though the evidence for achieving specific outcomes is under developed.

The implications here may be for the Alliance to explore how it can:

- Influence the gender awareness of providers of services for children in the early and primary years
- Make explicit connections between policies and services for at risk women and those concerned primarily with children; the Alliance could play an important role in reaching across the adult–children service divide including through its own membership and networks
- Advocate for early interventions that are shown to have longer-term benefits for women and for more robust evaluation and explanation of these gender effects
- Encourage cross-sectoral working and research on services for women at risk
- Promote the need for staff in services to have training (including pre-registration and induction training) that gives them insight into the impacts of inequalities, violence and abuse on women's lives and enables them to work with women at risk in ways that are helpful and empowering
- Support, evaluate and showcase integrated, holistic women-centred services for women at risk.

A model to inform the Alliance

Policy and practice interventions for women and girls at risk need to take account of three interrelated sets of factors:

- The social inequalities (including gender inequalities and the interaction of these with inequalities of race and gender) that underlie the negative outcomes for women
- Girls' and adult women's experience of violence and abuse and its influence on their lives
- The gendered expectations prevalent in society that shape the ways women respond and cope with life experiences and the responses of others, including services.

This review provides a simple model setting out these three sets of factors and suggests some of the ways they interconnect to shape the lives of women and girls at risk. The factors are equally relevant at the levels of working to support individual girls and women, designing and developing services and shaping policy.

There is strong evidence from research of the significance of each set of factors independently, but taken together they provide a foundation on which the Alliance could build evidence-based influencing and service development objectives and a manifesto for change. The model is deliberately simple in order that it can be used as a communication tool to bring organisations and individuals together under a shared 'gender agenda'.

Appendix

Life-stage	Negative indicators	Prevention	Early intervention	'Amelioration'
Pre-birth	Poor maternal health and education Poverty Young unsupported or abused in pregnancy Low birth weight	Sexual health education Girls education Reduction of structural inequality	Health promotion, e.g. smoking cessation Home visiting, e.g. Family Nurse Partnership Preparation for parenting particularly for first child	Domestic violence support
Early years (birth to age 5)	Attachment difficulties Poor home environment Child neglect and abuse Unsupported parents	Parenting education Access to childcare and parenting support Decent homes Reduction of structural inequality	Home visiting, e.g. Family Nurse Partnership, Home Start Parenting programmes Early education and childcare Support for transition to school	Intensive family support Alternative care or adoption
Primary years (ages 5–11)	Poor school readiness Cognitive or developmental delay Behavioural or relational problems Poor peer relationships or bullying Parental conflict or breakdown Abuse and neglect	Whole-school approaches	Nurture groups Mental health support, e.g. Place2B Parenting programmes Incredible Years Home–school support Support for transition to secondary school	Domestic violence support Intensive family support
Early teens (ages 12–15)	Disengagement from school Drug or alcohol misuse Sexual exploitation Signs of emotional or psychological harm, e.g. self-harm, eating disorders Family difficulties Placement breakdowns or running away from home or care Involvement in gangs Offending behaviour Early pregnancy	Whole-school approaches Violence prevention Healthy relationship and drug education Communities that care	Missing services Cognitive behavioural therapy, social skills and multi-modal interventions for young offenders Gender sensitive risk assessment Relational security through stable foster care and high-quality, girls-only residential care Women mentors Functional family and multi-systemic family therapy Multi-dimensional treatment fostering	Sexual exploitation services Restorative justice Remand or treatment foster care Holistic mental health support – Harm reduction, DBT-A

Life-stage	Negative indicators	Prevention	Early intervention	'Amelioration'
Late teens and early adulthood	Leaving school with no qualifications Out of education, employment or training Drug or alcohol misuse Sexual exploitation Involvement in mental health system, e.g. borderline personality disorder diagnosis Family breakdown Homeless or unstable living circumstances Involvement with criminal justice system Young motherhood Unstable and/or abusive partnerships	Leaving care support Basic skills; return to learn access courses	Supported accommodation or tenancies Pregnancy support, home visiting and Home Start Domestic violence and sexual exploitation services	Gender-specific diversion from custody and probation work Women-only, trauma sensitive secure mental health services and resettlement support
Adult women	Prison Cyclical homelessness Problems as mothers, e.g. own children having problems; children being taken into care Domestic violence Persistent drug or alcohol misuse Long-term mental health service use	Routine enquiry for sexual and domestic violence in mental health and maternity services	Housing support and supported housing One-stop, open access, women-only services Parenting programmes	Holistic mental health and addiction services – gender and trauma sensitive One-stop, open access, women-only services Women-only wards Group work and peer support Exit support for sex workers

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The Pilgrim Trust