GREATERLONDONAUTHORITY

Violence Reduction Unit Partnership Reference Group

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Title of report:	**Progressing a Public Health Approach to Violence Prevention and Reduction, Appendix A: Proposed Public Health Approach**
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1 Executive Summary

1.1 This paper is the output of a rapid scoping exercise to inform how a public health approach could be used to further progress efforts to prevent and reduce serious violence affecting young people in London.

1.2 It describes what a public health approach is and why it is helpful; what is known about the nature and scale of violence affecting people under the age of 25 in London; the causes and the triggers for violence; further evidence-based approaches that could be explored; and suggests further roles for local and regional organisations. It also highlights gaps in our knowledge, and where future discovery would be helpful.

3 Background and Context

3.1 A public health approach is rooted in good multiagency working and close working with communities, focuses on prevention, and is informed by the systematic use of evidence. It looks at who is affected by violence, how they are affected, and the relationship between violence and health inequalities. It uses data and evidence to understand and tackle the root causes of violence and to prevent or mitigate its impacts in defined populations.

3.2 Violence reduction is amenable to a public health approach because violence affects people's health and wellbeing at an individual and community level, it can spread and reoccur, and it is preventable. The risk factors for violence impacting on a young person overlap with risk factors for other adverse physical and mental health outcomes. Therefore, tackling violence could have also have substantial benefits for young people's life chances, health and wellbeing.

3.3 Key lines of inquiry were identified to initiate an epidemiological analysis of serious youth violence in London, using existing data sets focused on people aged under 25 years. The WHO definition of violence is 'the intentional use of physical force or power, threatened or otherwise, against another person or against a group that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'. However, data used in this report reflects the availability and definitions used within the various data sources.

3.4 The preliminary epidemiological analysis in this report draws on multi-agency data on serious youth violence from different front-line services (Metropolitan Police serious youth violence crime offences, British Transport Police violent crime offences, London Ambulance assault call-outs, hospital A&E data and admission episodes for assault), and borough data on a range of risk and protective factors from a variety of sources.

3.5 Preliminary analysis suggests an increase in levels of serious youth violence, seen in offences recorded by the Metropolitan Police, hospital admissions, and a more recent small increase in ambulance attendances. There is also evidence of an increase in incidents involving the use of knives (but not guns) in both ambulance call-outs to incidents and hospital admissions. There are however challenges to understanding the longer-term trends in serious youth violence, as the data are affected by organisational changes to front-line services and other factors.

3.6 Available data at borough level show a significant statistical association between rates of serious youth violence and several known drivers of health inequalities. Work will continue to fully document and quantify the relative impact that these factors may be having on serious youth violence, and how the various factors interact.

3.7 When working with individuals there is good evidence on the impact of early trauma and adverse childhood experiences (ACEs) as risk factors for involvement in violence. At a community level, youth violence is often more prevalent in areas of higher socio-economic deprivation, as well as areas with illicit drug trade, and where there is a gang presence.

3.8 There was broad consensus that victims and perpetrators can be the same population of people who were vulnerable to being drawn into involvement in violence. There was possibly a third grouping within the vulnerable population of witnesses/bystanders, with individuals switching between these roles at different times. The consequences of violence were varied, and the impacts of exposure could be lifelong.

3.9 A large evidence base already existed from a range of countries and settings. Highlights have been summarised. The Youth Violence Commission has commissioned a literature review which will be published soon. The challenge will be to support local areas to implement the recommendations in a way that meets the needs of their communities, for example through their Community Safety Partnership Action Plans, and Health and Wellbeing Strategies.

3.10 Discussions with partners revealed consensus that the drivers and prevention of violence should be at the heart of a serious youth violence strategy, and that knife crime should be viewed as just one element of a broader issue (albeit one that requires an urgent response. Partners spoke about the need to avoid gender and racial bias or discrimination in developing a strategic approach, and the need for responsible reporting of the issues in the media and for improved communication with professionals.

3.11 The report concludes with recommendations on how a partnership approach to violence prevention could be progressed in London. The proposals build on existing action delivered through the London knife Crime Strategy that is summarized in this report.

3.12 Immediate multiagency opportunities for intervention include work on knife carriage, diversionary and out of school activity, work in urgent care and trauma centres, keeping people in education, and tackling exclusions. Opportunities to embed violence reduction within GLA programmes include the London Healthy Schools and Healthy Early Years programmes, Young Londoners Fund, and through working with transport and housing teams.

4 Summary of key findings

4.1 London has a young population. 2.8 million (31 per cent) of Londoners are aged under 25. This proportion is in line with other metropolitan cities in England such as Greater Manchester and Liverpool, as well as New York.

4.2 A high proportion of young Londoners are living in deprivation. 26 per cent (718,000 young Londoners) live in areas in the top quintile of deprivation according to the English Indices of Multiple Deprivation (IMD), and a further 32 per cent in the next most deprived quintile.

4.3 Ethnic diversity among under-25s is high compared to the wider population. There is evidence from front-line services that levels and rates of SYV have increased across London in recent years:

- SYV incidents recorded by the Metropolitan Police increased by 46 per cent from 2013 to 2017;
- The proportion of hospital admissions involving a sharp instrument or knife injury for those aged under 25 has increased from 25 per cent in 2013 to 38 per cent in 2017;
- Ambulance data for young people showed an increase in knife-related call-outs for assaults of 32 per cent since 2013.

4.4 TfL data for assaults on their travel networks shows a different trend, with the number of assaults rising between 2012 and 2015, before falling in both 2016 and 2017 (all ages).

4.5 Although there is significant evidence of an increase in the proportion of incidents involving the use of knives, this is not replicated for gun crime (where the ambulance data shows the rate of call-outs has remained steady, and the number of incidences declined).

4.6 The longer-term trends in serious youth violence shows some fluctuation, and these data are affected by a number of organisational changes to front-line services and other factors. Serious youth violence covers a broad range of assault types beyond those which are weapon-related. Recent ambulance data suggests that 14% of call-outs are for weapon-related assaults.

4.7 For the Metropolitan Police offences, serious wounding offences comprise 55 per cent of SYV, followed by personal robberies (30 per cent). Domestic violence and abuse featured in 12 per cent of all SYV offences.

4.8 There is a temporal pattern of SYV by age, with the violence affecting school age children taking place in the afternoons/early evenings and during the week, whereas for those aged 18-24, violence was more prevalent between 6pm and midnight, peaking on Saturdays and Sundays.

4.9 Serious youth violence takes place across the capital but is not equally distributed across London boroughs. For this analysis, boroughs were divided into four equal groups based on SYV offence rates in 2017. The top quartile of boroughs were Westminster, Lambeth, Southwark, Camden, Haringey, Islington, Hackney and Newham. Most of these boroughs also had the highest number of SYV offences. Overall, Croydon had the highest number of SYV offences, but had a lower rate once the size of the local youth population is controlled for.

4.10 At a lower geographical level, wards with high levels of SYV offending were more likely to be in the top quintile of the Vulnerable Localities Index indicating a priority neighbourhood for community safety.

4.11 Seventy-six per cent of SYV victims were male, increasing to 86 per cent of assault hospital admissions for the same age group. 83 per cent of victims were aged 15-24 years. 10 per cent of victims were repeat victims within the previous 12 months.

4.12 Sixty-eight per cent of victims of SYV domestic violence and abuse were female, of whom 25 per cent were repeat victims in the previous 12 months. 13 per cent of victims of domestic violence and abuse offences were categorised as being vulnerable.

4.13 Eighty-seven per cent of suspects being prosecuted for SYV were male. Their ages ranged from 10 to 77 years, but half of whom were aged 14-21 years.

4.14 Forty-one per cent of SYV victims were from a white ethnic background, and 27 per cent were black. Black young people make up 17 per cent of the population and so are over-represented as SYV victims. This over-representation was stronger for offenders, of whom 46 per cent were black young people (2.7 times their representation in the population)

4.15 People in contact with the criminal justice system shared many of the root cause risks for violence and were at particularly high risk of involvement:

- Two in three of 13 to18 year old young offenders in London came from families that had broken down,
- 50% of persistent offenders had been victims of abuse, and nine out of ten had been excluded from school at some point
- one in two young people in custody were looked after children.

4.16 Analysis of a large range of borough level protective and risk factors shows a significant statistical association with borough rates of SYV offending for the following factors (in order of strength of correlation):

- Proportion of children aged under 20 living in poverty
- Positive Life Satisfaction amongst 15-year olds
- Index of Multiple Deprivation (IMD)
- Estimated prevalence of emotional disorders amongst 5 to16-year olds
- Social integration as measured by voter registration rates
- Proportion of 10 to17-year olds who were given a custodial sentence
- Estimated prevalence of conduct disorders amongst 5 to16-year olds
- Rate of Looked-After Children (LAC)
- Proportion of residents aged 18 to 24
- First time entrants into the criminal justice system (10 to 17-year olds)
- Social, Emotional, Mental, Health Needs (SEMH)
- Persistent absentees from school
- Hospital admissions for self-harm (10 to 24-year olds)

1 The purpose of this paper

This paper sets out how a public health approach could be used to further progress efforts to prevent and reduce serious violence affecting young people in London. It describes why a public health approach is helpful; what is known about the nature and scale of violence affecting people under the age of 25 in London; the causes and the triggers for violence; further evidenced based approaches that could be explored; and suggests further roles for local and regional organisations. It also highlights where gaps are in our knowledge, and where future discovery could be helpful.

The audience is primarily the Greater London Authority (GLA) and the Mayor's Office for Policing and Crime (MOPAC). It is recognised that a wider audience will also be interested in the findings.

2 Background

This section sets out the background to the work and why it was initiated. It also discusses the public health approach and its application to violence prevention in London.

The population of London is relatively young and diverse compared to most cities and regions in UK, with notable population mobility and transience.

Reducing gun and knife crime has been a priority in London for a long time, with several strategies and initiatives deployed. New concerns include the younger age at which young people are being affected, and escalating gang activity. This is an issue for all organisations involved in community safety, not just for the police.

The Mayor has a Police and Crime Plan for London which includes measures to reduce crime and disorder and to improve police services across the city. This is overseen by the London Crime Reduction Partnership, which he chairs.

MOPAC has prioritised gun and knife crime within the Police and Crime Plan. A strategy was published in 2017 based on an analysis of what is known about knife crime in London. The strategic intentions include:

a. supporting alignment with existing child and adolescent mental health services: working closely with the GLA and health partners to jointly commission better provision and lobbying for more powers and the budget to do so from central government
b. Supporting a trauma informed approach to interventions when commissioning rehabilitation services.

Examples of current work include;

- The London Knife Crime Dashboard (https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/data-and-statistics/weapon-enabled-crime-dashboard).
- Bespoke knife crime action plans in each London Borough created in partnership with the Met police and London Councils.
- The London Knife Crime Summit on 27th June 2018, led by the Mayor and attended by leaders from across the public and third sectors.
- An 'Information Sharing to Tackle Violence programme' (ISTV) which includes data sharing from emergency departments on injuries caused by violence and sexual exploitation after an incident.
- Allocating £45m to the Young Londoners Fund, supporting voluntary sector,
- Locating youth workers in major trauma centres across London to work with victims to prevent further incidents

- Allocating £2m to the London Gang Exit programme to provide bespoke services that support exit from gangs.
- Allocating £3m to tackle County Lines, drug distribution and the exploitation of young people through the *Out There Response & Rescue service*
- Development of a toolkit for actions in the aftermath of knife crime incident, aimed at teachers, healthcare workers, faith and community groups to recognise trauma in those affected
- Working with child and adolescent mental health services, and delivering mental health first aid training
- Distribution of knife wands to London schools
- London Needs You Alive: Toolkit launched. www.london.gov.uk/lnya-toolkit
- A new sentencing option for knife crime offenders, being piloted at Thames Magistrates' Court.

The system of public services across London is also working through several other violence prevention issues that touch on the lives of children and young people in London - including violence against women and girls, child sexual exploitation, gang-related violence, county drug lines, acid attacks, dangerous dogs and modern slavery. There are needs assessments planned and strategies being developed at a local level

There was interest in testing the view that knife crime is a particularly serious element of a broader youth violence issue. The brief for this work was therefore serious youth violence affecting under 25-year olds in London, incorporating knife crime, but not exclusively focused on it.

This project was undertaken as we finalised the London Health Inequalities Strategy and was informed by an inspiring visit to Scotland by MOPAC and the Metropolitan Police to understand their public health approach to violence reduction and its demonstrable results. The GLA and MOPAC jointly commissioned a rapid scoping exercise to explore how a public health approach could be further progressed across London to prevent and reduce violence. The work was initiated by the Deputy Mayor for Policing & Crime and the Mayor's Health Advisers but is relevant to many other portfolios including children and young people, social integration, and community engagement.

The scoping exercise had several strands:

I. Exploration of available data and information to initiate an epidemiological analysis of the issues in London

II. Identification of current and future prevention opportunities, with a particular focus on developing community resilience

III. Summary of the institutional landscape in London, and options to strengthen leadership and governance with the health and social care system for violence prevention in London

This work was time-limited and focused in order to feed into a London-wide conversation and inform next steps.

3 What is a public health approach to violence prevention and reduction?

How does a public health approach differ from **good multi-agency working focused on prevention and informed by a systematic use of evidence?** In practice a public health approach focuses on **working upstream and at scale, tackling the root causes of violence as well as preventing or mitigating its impacts in particular populations**.

The World Health Organisation[1] (WHO) describes a process of evidence-based decision making where information and intelligence are used to describe the problem, and evidence is used to design the approaches which are implemented, evaluated and developed as needed.

A public health approach cuts across organisational boundaries, working with whole populations as well as specific communities or individuals. It is evidence-based and is guided by data and intelligence. This may include analysis of outbreaks of violence, thinking systematically about the source and spread, or addressing the longer-term impacts of trauma or adverse experience on violent behavior. Key components are the involvement of communities in designing and evaluating interventions leading to system wide action driven by strong system leadership.

What do we mean by a public health approach to serious youth violence?

- **Focused on a defined population, often with a health risk in common**. Connectors could be geography, common experience, diagnosis or demographic characteristics, for example young people involved in gangs.
- **With and for communities.** Focused on improving outcomes for communities by listening to them and designing interventions jointly with them.
- **Unconstrained by organisational or professional boundaries.** People often do not neatly sit within a service user grouping and looking across organisations means that we can look across the system for solutions and not be too narrow in our approach.
- **Focused on generating long term as well as short term solutions.** Acting on the causes and determinants as well as controlling the immediate impact of the problem. Identifying actions to be taken now to put enduring solutions in place.
- **Based on data and intelligence to identify the burden on the population, including any inequalities**. Analysis of the differences between our population of interest and their peers gets to their real story and the challenges they face. It shows us who is particularly affected and where particular communities experience more of the burden than others. It also tells us about the impact across the system, the underlying causes and protective and risk factors.
- **Rooted in evidence of effectiveness to tackle the problem.** Learning where we can from the experience of others and evaluating new approaches. This is important, so interventions can be replicated if they work or revised if they don't. The evidence may not be water tight, particularly for system level interventions, but we can use what is available to guide our decisions and help us test new ideas.
- **Working on system level solutions delivered through system leadership.** Typically, successful solutions to complex issues will involve different public service bodies working together in an integrated fashion. This means not only working to common goals within organisations but collaborating on a deeper level with shared objectives and work programmes.

In the context of London and the English health and social care system, a public health approach is **not** limited to local authority-commissioned public health services, or a medical/clinical understanding of the issues. As well as being scientifically rigorous, it is rooted in close working with diverse communities to design and implement interventions.

[1] WHO reference

4 Why take a public health approach?

Serious youth violence is seen as being amenable to a public health approach because it affects people's health and wellbeing at individual and community levels. It is preventable if actions are implemented across the system of public services, and through wider social policy. The costs of violence to the health and care system, the criminal justice system, and wider society are potentially avoidable.

Freedom from fear of violence is fundamental for health and wellbeing and is a matter of social justice. Violence can cause ill-health through fear, injury and loss. It has a contagious element, and some see a public health approach to violence akin to controlling an outbreak of disease by preventing spread and recurrence.

The risk factors for violence often overlap with risk factors for other adverse physical and mental health outcomes. Tackling violence could therefore also have substantial benefits for young people's life chances, health and productivity.

Violence is an inequalities issue disproportionately affecting some populations more than others[2], and is a priority in the London Health Inequalities Strategy.

And finally, violence is preventable, not inevitable, with a growing evidence base from other cities that we can learn from in London.

5 The role of enforcement in preventing violence

Although a public health approach does not rely on law enforcement as the 'solution' to tackling violence, enforcement remains a key element as it is here that the manifestation of current violence is contained and reduced. Enforcement activity can present opportunities to prevent future violence affecting an individual (for example, using the 'teachable moment' to refer to services or support), or people around them at risk of being drawn into violence or crime (for example peers, siblings, or children) through prevention and early intervention.

Enforcement also ensures that victims, witnesses, communities and the wider public see that where serious violence does take place it is addressed, safety and wellbeing are prioritised, and communities are protected from further violence. This in turn contributes to feelings of safety and security within communities, and the reassurance that the state is undertaking its responsibilities in terms of public protection and justice.

In practice this is not always achieved, and the opportunities outlined above aren't utilised as well as they could be. Broader historical and societal issues including relations and trust between communities and public services like the police, schools, social care and health, as well as the disproportionate representation of some communities within the criminal justice system, place strain on the ideals outlined above.

The role of enforcement is also frequently reduced to the process of arrest and charge, but there are many more elements;

Police enforcement includes visible patrol reassurance, response, arrest, interview, detention into police custody, investigations, charging, out of court disposals, civil powers and injunctions. Violence prevention opportunities here include: police referrals into interventions for those involved in violence; triage/ liaison & diversion schemes within police custody suites, training of police officers in understanding adverse childhood experiences and mental health; procedural justice; community involvement in policing through engagement; safer schools officers; referral to victim services etc.

[2] https://www.gov.uk/government/publications/a-public-health-approach-to-violence-prevention-in-england

Criminal justice system activity includes trials, sentencing, detention into custody/ probation or youth offending team interventions, electronic monitoring, custody rehabilitation programmes, and resettlement. Violence prevention opportunities here include stronger integration of supportive and rehabilitative interventions alongside punitive activity (including drug and alcohol treatment), broader use of restorative justice, recruitment and training of those who have exited offending into peer mentoring and community leadership roles, and support for children with a parent in custody.

Local authority activity includes housing, anti-social behaviour, trading standards for retailers, civil powers and injunctions. Violence prevention opportunities here touch on a range of locally commissioned services, and leadership for local safeguarding arrangements for vulnerable adults and children, community safety partnerships, and health and wellbeing boards.

6 The demography of children and young people in London

In 2017, 2.8 million Londoners (31 per cent) were under 25 years of age. This proportion is in line with other metropolitan cities in England such as Greater Manchester and Liverpool, as well as New York. 1.1 million lived in inner London (39 per cent), and 1.7 million lived in outer London (61 per cent). At borough level, the number of residents aged under 25 ranged from 41,000 in Kensington and Chelsea to 125,000 in Newham. The proportion aged under 25 years was highest in Barking and Dagenham (39 per cent of residents) and lowest in Kensington and Chelsea (26 per cent). London's under-25 population is expected to grow to 3 million by 2027.

Based on the 2016 Index of Multiple Deprivation[3], 26 per cent (718,000) of young Londoners lived in an area in the top quintile of deprivation. A further 32 per cent lived in the next most deprived 20 per cent of areas. 75 per cent of under 25s lived in an area classified in the worst 40 per cent in England for crime deprivation (a measure of the risk of personal and material victimisation). 77 per cent lived in an area in the 40 per cent worst in England for access to housing and 69 per cent in the worst 40 per cent for quality of living environment.

Ethnic diversity among young Londoners is high – the under-25s have a diversity index score[4] of 6.5 compared to 4.4 for the 25 and over group. Over 52 per cent of this age group were BAME. There wide variation in the level of diversity among boroughs – 79 per cent of under 25s have a BAME ethnicity in Newham, while in Richmond upon Thames the proportion is 21 per cent. The white ethnic groups comprised 46 per cent of the population, and the Black ethnic groups, a total of 17 per cent[5].

On average, 60% of Londoners reported positive life satisfaction aged 15. The lowest was Westminster (50 per cent) and the highest was Havering (65 per cent). An estimated 6 per cent of young Londoners aged 5-16 have a conduct disorder, and 4 per cent an emotional disorder.

7 Methods

This section describes how the information was gathered to inform the findings of the report.

[3] Ethnicity data taken from the GLA 2016-based ethnic group population projections, deprivation data from the 2015 Indices of Multiple Deprivation (MHCLG) and 2016 Small Area Population Estimates (ONS)

[4] *Simpsons Diversity Index score out of 17 where 17 constitutes an evenly distributed population across all ethnic groups and 1 represents the presence of only 1 ethnic group*

[5] These groups are shown here for comparison with the ethnic breakdown available for SYV offences

7.1 Exploration of available data and intelligence

Key lines of inquiry were identified for an epidemiological analysis of serious youth violence in London (appendix 1). This analysis necessitated the bringing together of data and information from crime, health, justice and local authority sources over time, and there was a recognition that the analysis would go as far as possible within the short time available.

The overarching question was: can we develop a comprehensive picture of the characteristics of victims and perpetrators of SYV under the age of 25 in London? In particular, how are the risk and protective factors distributed across all children and young people in London? What is the best use of data and intelligence for epidemiological purposes? And what is the best use of data to drive the programme forward?

Contact was made with key intelligence sources, including the GLA Strategic Crime Team, the MOPAC Evidence and Insight team, Transport for London, and the Public Health England (PHE) Health & Justice Team. Existing reports were reviewed, and data sources identified.

The GLA Strategic Crime Team obtained selected data from a range of sources, including publicly available data sets, MPS crime data retrieved through MOPAC, Hospital Admission Data from PHE (derived from hospital episode statistics from the Health and Social Care Information Centre), and London Ambulance Service attendance data to conduct a broad epidemiological analysis of the incidence of violence in London. The aim was to describe the patterns and known risk factors for violence in terms of time, person and place, and to raise questions for further discovery.

7.2 Identification of current and future prevention opportunities with a focus on developing community resilience

There were many published summaries of evidence, which were used to identify prevention opportunities for London that could form part of a public health approach. These were sourced on line and through recommendations from the conversations with key stakeholders and experts. In some cases, it was possible to speak with researchers about work soon to be published.

A series of conversations were held with expert practitioners working in violence prevention, to source their views on approaches that could be of assistance in London. These were planned in some cases, and opportunistic in others. This covered a range of organisations and bodies, including local authorities, the GLA, MOPAC, NHS England, London Councils, London-wide networks for statutory officers, PHE, and voluntary organisations.

Information from events was also gathered. These included a GLA community engagement event focused on young people and the Youth Violence Commission, and another with community groups engaged in preventing violence; a local authority violence reduction workshop; and a Ministry of Justice meeting on victim support.

Discussion papers were prepared for key fora including the London Health Board, Association of Directors of Public Health, and London Funders, a network of philanthropic organisations; and their feedback was gathered and used.

7.3 Summary of the institutional landscape, and options to strengthen leadership and governance with the health and social care system for violence prevention in London

Through online research, reviewing of papers and minutes, and a series of planned conversations, a mapping exercise was completed of those organisations and bodies with a potential role to play in reducing violence in London.

In depth conversations were held with the West Midlands Reducing Violence Partnership Officers and the Health & Justice Team at PHE exploring factors that assisted or hindered the progress of their partnership work.

8 Findings

This section brings together the outputs of the scoping exercise. It describes what violence is; the consequences of violence; what appears to increase some people's risk of becoming involved and not others; and what has been shown to be effective in reducing and preventing violence in London and other places.

8.1 What we mean by serious youth violence

There is no one accepted definition of serious youth violence. For the purposes of this scoping work the population of interest was people under 25 in London, and the WHO definition of violence was used where possible, namely "the intentional use of physical force or power, threatened or actual, against another person or against a group that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation"[6].

This scoping work was confined to current data reporting methods and systems.

The issue of violence was broader than crime or the use of weapons and the consequences were greater than injury and deaths. PHE West Midlands noted that only around 40 per cent of violent incidents were known to the Police[7]. Figure 1 helpfully illustrates the potential scope of serious youth violence. The size of the circles is **not** representative of their prevalence.

[6] Krug E, Dahlberg L, Mercy J, Zwi A, Lozano R. World report on violence and health. Geneva: World Health Organisation. 2002

[7] https://publichealthmatters.blog.gov.uk/2015/07/02/preventing-the-disease-of-violence/

Figure 1[8] - What could be included as Serious Youth Violence?

There was broad consensus across the police and policy makers that perpetrators and victims could be from the same population of people who were vulnerable to being drawn into involvement in violence. There was possibly a third grouping in this population of people vulnerable to violence, namely bystanders/witnesses, with individuals switching between each of the three roles at different times.

8.2 The impact of serious youth violence

The consequences of violence are varied. Physical effects include cuts, wounds and scratches, scarring, broken bones and head injuries and in some, more extreme cases, death. There are also emotional consequences including fear, anxiety, depression and post-traumatic stress.

The impact of exposure to violence can be lifelong[9]. There are direct impacts on health such as physical injuries, mental health problems, increased incidence of communicable diseases, and risk-taking behaviour that increases prevalence of non-communicable disease, e.g. tobacco, alcohol and other substance misuse.

As well as the impact on individuals and their loved ones, communities also suffer when violence is present. People can become fearful of places where young people gather or of going out after dark. Communities become used to violence, tolerating certain places as unsafe, and considering them 'no go' areas. This means that communities' vital role in maintaining safety within their own localities can be compromised, increasing the risk further.

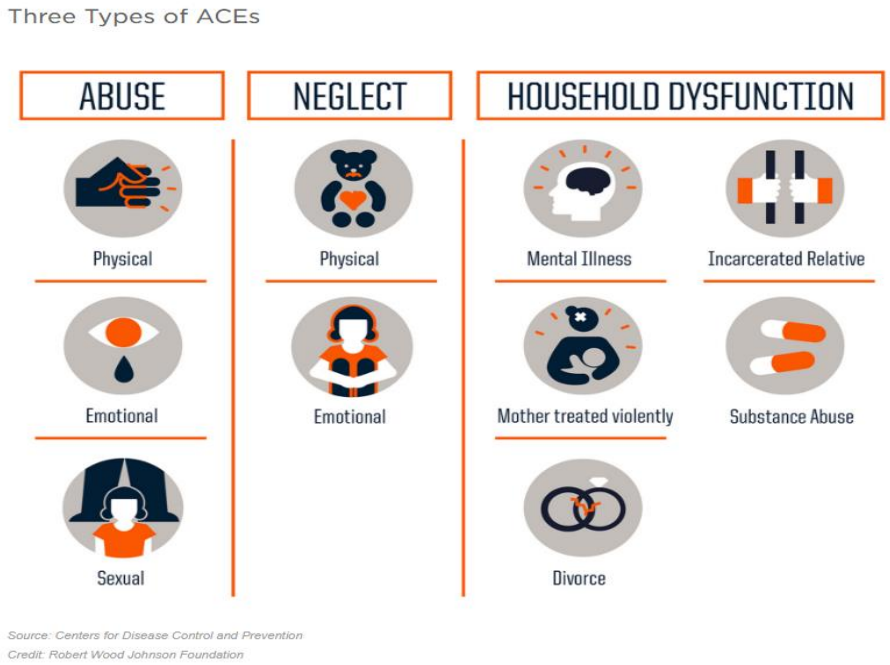
[8] Slide taken from Serious Youth Violence – A Contextual Account of the evidence base. Presentation given at Serious Youth Violence Away Day, LB Enfield 11/5/18 by Dr Carlene Firmin, University of Bedfordshire

[9] Taken from INSPIRE: seven strategies for ending violence against children.2016 available from http://yvcommission.com/wp-content/uploads/2017/08/World-Health-Organisation-WHO-INSPIRE-Seven-Strategies-for-Ending-Violence-Against-Children-2016.pdf

8.3 What are the risk factors for involvement in violence?

The literature identified a series of risk factors more prevalent in individuals who had become involved in violence. At an individual level, there was interest in the role of early trauma or adverse childhood experiences (ACEs), summarised in figure 2, as risks for involvement in violence. Strong associations were shown indicating a cumulative effect of adverse experiences such as death of a parent or close friend, household criminality, exposure to domestic abuse, substance misuse or bullying, and difficulties with health, communication or learning. When information from multiple reviews were combined, children with four or more ACEs were around eight times more likely to be involved in violence than their peers. [10] They were also more likely to attempt suicide and develop illnesses such as diabetes and heart disease.

Figure 2: Types of Adverse Childhood Experience[11]



This should not be interpreted as showing that all children who have ACEs become violent or become criminals. Despite ACEs not being uncommon, as shown in table 1, violent behaviour remains rare. Positive childhood experiences such as having a positive ongoing relationship with an adult, a trusted friend you could talk to, or a teacher who believed in you, acted as buffers, were protective, and increased resilience to the possible negative consequences of ACEs.[12]

One line of inquiry that was not explored in depth within the time available for this scoping exercise was the relationship between poor mental health and SYV in London. In the context of the need to address the stigma attached to mental illness, stakeholders highlighted the risk of pathologizing young people experiencing violence, while also calling for measures to ensure their mental health needs were appropriately identified and addressed.

Individual risks were not the whole picture. It is known that violence is more common in some places and some communities than others. Increased levels of violence, particularly severe

[10] Hughes K et al The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis www.thelancet.com/public-health Vol 2 August 2017
[11] Taken from https://www.npr.org/sections/health-shots/2015/03/02/387007941/take-the-ace-quiz-and-learn-what-it-does-and-doesnt-mean?t=1530692737473
[12] WHO Preventing youth violence: an overview of the evidence.2015

violence, were more common where there was gang involvement and around the illicit drug trade[13].

Certain forms of violence were shown to be more prevalent in areas of higher socio-economic deprivation and where general criminality in the population was higher[14].

Overcrowded housing meant that there might be no place indoors where young people could gather, so outside space became the place where people congregated. The design of the place had an influence on violence, with places that were 'owned' by groups being potential flashpoints. Places without exit routes that were not overlooked were more common venues for violent behaviour. Design improvements had been made in some communities that had reduced violence and other crimes.[15]

The WHO evidence review noted that some communities and cultures were more accepting of violence as a manner of settling disputes and instilling discipline, and violence was more common when this was the case.

Concern was also expressed as to whether the 'normalisation' of violence in films, TV and gaming had an influence on violence being seen as a solution to situations where there was disagreement or conflict.

Current opinion was that the gang situation had evolved over the last decade in London. It was now much less about volunteers joining to defend a geography or group. It was more about making money and protecting business interests, often drug related and not necessarily confined to a specific location[16]. It was not uncommon for youths to be coerced into gang membership, through threat of violence to themselves or family members, or artificial generation of a situation of indebtedness where the individual owed money. In these cases, gang membership came with an offer of protection or a means to pay a perceived debt. ACEs could increase vulnerability to grooming in this way.

People in contact with the criminal justice system, including young offenders and prior offenders, shared many of the root cause risks for violence and were at particularly high risk of involvement. Two in three of the 13 to18-year old young offenders in London came from families that had broken down, 50 per cent of persistent offenders had been victims of abuse, nine out of ten had been excluded from school at some point, and one in two young people in custody were looked after children.

The common causal links between vulnerability and exposure to violence came together in looked after children. A recent comprehensive review of London's children's services' response to violence in London[17] noted that looked after children in England were five times more likely to be cautioned or convicted than children who were not looked after, and 37 per cent of children in young offender institutions have a history of being looked after.

Incidents of being missing suggested an increased risk of becoming involved in, or affected by, crime (including violence).

Availability of weapons increased the risk of them being used. The factors that drove people to carry weapons were multi-factorial. A recent MOPAC report examining the evidence base on weapon carrying concluded that much of the research pointed to self-defence and protection as key reasons why young people carried knives. Furthermore, protecting themselves from others carrying weapons was more important than getting caught.

13

14

15 https://www.designcouncil.org.uk/resources/report/creating-safe-places-live-through-design

16 From postcodes to profit, how gangs have changed in Waltham Forest UCL 2018

17 Association of London Directors of Children's Services The response of London Children's Services to serious youth violence and knife crime – May 2018

Adolescence was an important risk factor in itself, as so many of the people harmed were young adults. Adolescence was described as the perfect storm for violence with a desire to become more independent; immature emotional regulation; an over-investment in short term gains compared to the longer term; and an increased appetite for risk and active desire for excitement and thrills.

Alcohol was well documented as a risk factor for violence. It lowered inhibition and the ability to pick up social and communication cues and prevent escalation of conflict, although the prevalence of alcohol in serious youth violence was less than in some other forms of violence which affected older age groups. Alcohol misuse was also more common in victims of recurring violence.

The role of social media received attention with concern about its use to escalate disputes and convene groups at very short notice. It had an almost universal reach into communities of young people, rendering it a potentially significant, but not well understood risk.[18]

The WHO Violence Prevention Unit recommended that risks were viewed, prevented and managed at different levels – at individual and the relationship level, in communities and in society. This is illustrated in Table 1 below, which was developed by ScotPHN using the WHO ecological model.

Figure 3: Risks for Violence and WHO Ecological Levels[19]

Ecological level			
Individual	**Relationship**	**Community**	**Society**
Victim of child abuse	Poor parenting practices	Poverty	Economic inequality
Psychological/ personality disorder	Marital discord	High unemployment	Gender inequality
Delinquent behaviour	Violent parental conflict	High crime levels	Cultural norms that support violence
Alcohol consumption/ drug use	Low socioeconomic household	Local illicit drug trade	High firearm availability
	Delinquent peers	Inadequate victim care services	Weak economic safety nets

9 The pattern of violence in London

This section explores the magnitude and pattern of serious youth violence across London, including an examination of the trends over time, the geographical and temporal characteristics of the incidents, and the relevant victim and offender profiles.

To date, no comprehensive examination of the epidemiology of serious youth violence in London has been undertaken, but many bodies have looked at elements of the issue. Different organisations have defined violence in different ways and examined different elements of the issue. For example, MOPAC looked at knife crime in some detail, whilst others looked at crime victims or perpetrators. Some looked at causal factors for disadvantage, not only for

[18] https://www.theguardian.com/uk-news/2017/mar/28/beyond-the-blade-the-truth-about-knife-in-britain
[19] https://www.scotphn.net/wp-content/uploads/2015/10/Report-Violence-Prevention-A-Public-Health-Priority-December-2014.pdf

involvement in violence. PHE is currently collating and analysing the evidence for preventing and mitigating adverse childhood experiences. Some looked at the consequences of violence, and the Major Trauma Centres are currently conducting in-depth audits of their trauma cases. Some areas, such as Waltham Forest were concentrating on gang involvement. The new National Violence Strategy[20] excludes modern slavery, domestic violence and child sexual exploitation as these are covered in other government strategies, so concentrates on a subset of violence.

WHO recommended that a range of data sources should be used to examine youth violence looking at fatal and non-fatal outcomes. These included: health data on diseases, injuries and other health conditions; self-reported data on attitudes, beliefs, behaviours, cultural practices, victimisation and exposure to violence; community data on population characteristics and levels of income, education and employment; crime data on the characteristics and circumstances of violent events and violent offenders; economic data related to costs of treatment, social services and prevention activities; policy and legislative data.

This data could come from a variety of sources including individuals, agency or institutional records, local programmes, community and government records, and population-based and other surveys, as well as special studies. All these sources would be useful in understanding the problem and illustrate why multisectoral actions and partnerships should be key elements of the public health approach.

The GLA, MOPAC and TfL have been collaborating to examine routinely available data to get a better picture of serious youth violence across London. Specific datasets relating to young people were created and interrogated for this report. A more detailed data pack was developed to support the work going forward. These will be subject to discussion in a range of partnership forums to confirm their validity and generalizability.

Key sources of data in London used for this report include

- Metropolitan Police Service recorded data for Serious Youth Violence, referring to violence against the person offences[21], where the victim(s) were aged 1 to 24 years, with the addition of offences involving a knife or gun if they were used in the commissioning of a robbery, violent or sexual offence. Therefore, simple possession offences were excluded from the analysis. The serious youth violence definition used in the report analysis had cross-overs with the police SYV offence classification/definition but extended the age range of the victims from 1 to 19 years to 1 to 24 for analysis of the geographic and temporal patterns and victim and offender profiles. Due to the availability of the data, the longer-term trend and ward analysis adhered to the police definition of SYV, only including offences in which the victims are aged 1 to 19 years
- London Ambulance Service data included all assault call-outs where the patient was aged 1 to 24 years
- Hospital data was based on finished hospital episodes for assault admissions in London trusts in which the patient was aged 1 to 24 years. These data are provisional and may be revised. They were published by the Health and Social Care Information Centre and were supplied for this analysis by Public Health England.

[20] Serious Violence Strategy 2018 Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

[21] Attempted Murder, Murder, Intentional destruction of viable unborn child, Causing death by dangerous driving, Causing death by careless driving when under the influence of drink or drugs, Causing death by careless or inconsiderate driving, Assault with intent to cause serious harm, Endangering Life, Assault with Injury (more serious GBH offences), Racially or religiously aggravated Assault with Injury (more serious GBH offences), and Causing death by aggravated vehicle taking.

- Hospital A&E attendances and British Transport Police data were based on assaults (note these data were for all ages)
- Transport for London data refers to Driver Incident Records for assaults (for all ages)
- Public Health risk factors were derived from a range of published sources.

Some data sources were only available for comparison back to 2012 whereas others dated back further.

9.1 Multi-agency frontline service data to understand trends in London

The national context based on survey data was that, over the long term, crime levels were falling and in the shorter term, they remained stable. However, across the country, there were notable increases in higher harm but less frequent offences such as those involving knives or guns.[22]

However, national survey-based data was insufficient to provide trend analysis or detail on rates of serious violence among specific age groups in individual regions such as London. To understand the trends, the picture provided from analyzing data from a range of frontline services was more appropriate, even bearing in mind some of the organisational factors which could affect reported trends from individual sources. A more robust picture could be obtained by triangulating data rather than looking at an individual service in isolation.

It was estimated that less than half of violent incidents came to the attention of the police, so crime data only formed part of the picture. Ambulance data gave us information about assaults with serious enough consequences to warrant immediate emergency health care, which may or may not have been recorded as crimes, however it may not have captured violence if it did not result in serious injury or an ambulance was not called. Hospital data could fill in some gaps where a proportion of victims were taken directly to hospital for emergency care without calling out an ambulance. The hospital admission data may or may not have featured in both, or either, of the ambulance and crime data sets. None of the datasets were mutually exclusive of one another.

9.2 The magnitude and trends of violence in London

The national picture of recent increasing numbers of violent events was borne out by analysis of data from multi-agency frontline services in London (Figure 4).

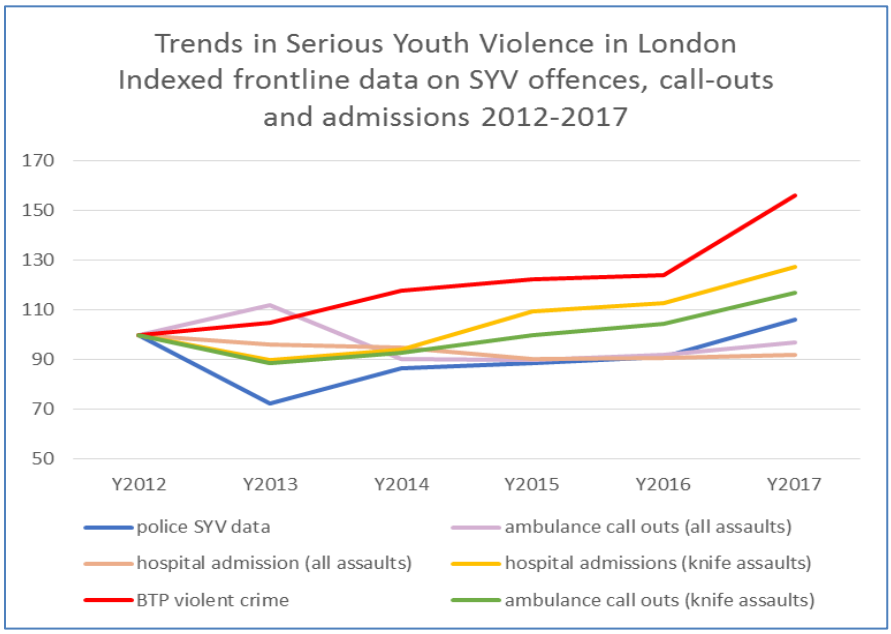
- SYV incidents recorded by the police increased by 46 per cent from 2013 to 2017
- Hospital episodes showed a 42 per cent increase in admissions resulting from assault with a sharp object over the same period
- The proportion of hospital admissions for under 25s involving a sharp instrument or knife injury increased from 25 per cent to 38 percent over the same period (Figure 5)
- The proportion of ambulance call-outs for youth assaults related to knives have increased from 6 per cent in 2002 to 9 per cent in 2017 (an increase from 658 to 886 call-outs)
- British Transport Police data showed an increase in recorded violent crime on the train network in London, although this was for all ages not young people. Transport for London data on assaults for all ages showed a fall in 2016 and 2017.

[22] ONS available from: https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingdecember2017#main-points

There was considerable evidence of a shift towards the use of knives, although this was not replicated for guns. Ambulance data showed the rate of gun-related call-outs had remained steady at 0.65 per cent, and the actual number of incidences had declined.

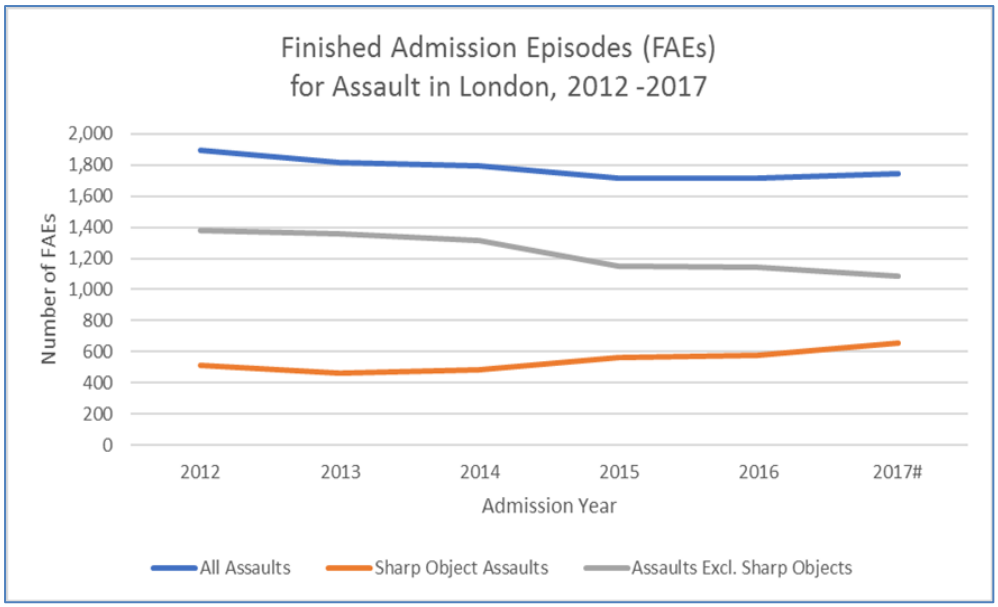
The longer-term trends in serious youth violence painted a more complex picture, as the data could be affected by organisational changes to front-line services, changes in data recording and other factors.

Figure 4 Trends in Serious Youth Violence in London



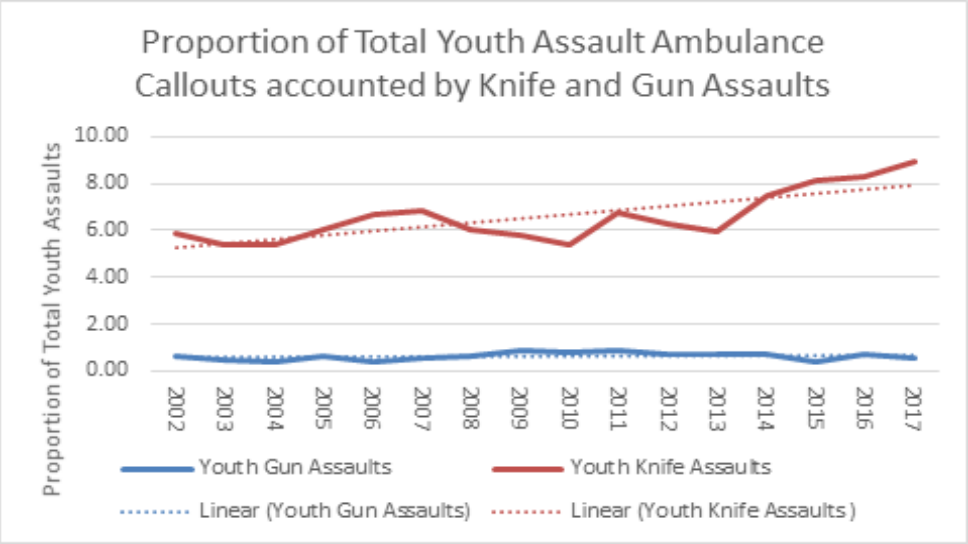
Indexed data on trends from 2012 to 2017 (where 2012=100) showed evidence of an increase in SYV especially between 2016 to 2017, with more noticeable increases shown in the knife-enabled subsets of the ambulance and hospital admission data than for the overall assault datasets.

Figure 5 Trends in hospital admissions for assault on 1 to 24-year olds



While overall hospital admissions for young people were falling as were those for assaults which excluded sharp objects, admissions for assaults involving sharp objects had increased by 42 per cent.

Figure 6 Trends in proportion of ambulance call-outs for knife and gun assaults for those aged 1 to 24 years



Since 2002, the proportion of youth assault ambulance call-outs accounted for by gun injuries remained consistently below 1 per cent. Whereas, the proportion accounted for by knife injuries had increased, from 2002 (6 per cent) in to 2017 (9 per cent), with a notable upward trend shown from 2013 (6 per cent) through to 2017 (9 per cent).

9.3 The nature and severity of serious youth violence

The majority of SYV offences in 2017 were serious wounding offences (55 per cent), followed then by personal robberies (30 per cent); with murders accounting for less than 1 per cent of the total. Injuries were sustained in 60 per cent of offences, within which 16 per cent were a serious or fatal injury[23]. Less than one per cent were fatal.

In addition to the picture provided by frontline service data, police colleagues reported[24] that there was an increase in the severity of violent crime. They noted more recently victims were being stabbed multiple times, with larger and more dangerous knives, and being attacked by groups of people rather than individuals. Anecdotal reports from trauma departments described their distress in seeing very severe injuries and deaths previously seen in adults but now in increasingly younger children in their early teens.

9.4 The characteristics of victims of serious youth violence

Based on police offence data, around 3/4 of victims were male, but this rose to 86 per cent of hospital admissions for assault.

[23] There may be a difference in the seriousness of the recording of an offence and the recording of injuries. The recording of injuries is made by a police officer, but the full extent of injuries may not be known at that time by either party. Some injuries may only be discovered when the victim seeks medical care.

[24] Presentation by AC Martin Hewitt, Knife Crime Summit 27 June 2018

Hospital admission data suggested a strong link to area deprivation with 36 per cent of sharp object-related youth admissions accounted for by individuals residing in areas in the top quintile of deprivation, and a further 26 per cent in the next quintile.

One in ten SYV victims had been a repeat victim within the previous 12 months. Four per cent of the total victims were recorded on the crime report as being vulnerable. Seventy-three per cent were victimised in their home borough.

Eighty-three per cent of victims of SYV were aged 15 to 24 years. There was a view, consistent with the perception of the decreasing age of victims, that increasingly younger people were carrying weapons. The Guardian[25] quotes Chief Constable Alf Hitchcock, who leads the National Police Chiefs Council taskforce on knife crime, that the "peak age" for carrying knives is "getting younger" and is currently between 13 and 17 years.

Forty-one per cent of SYV victims were of white ethnicity – the largest affected group. Black young people were over-represented, making up 17 per cent of the young London population, but 27 per cent of victims. This over-representation was stronger for offenders, where 46 per cent were black young people (2.7 times their representation in the population) [26]. Black victims of SYV recorded by the police tended to be slightly younger (15 to 20 years) than White victims (18 to 24 years). The caveats with frontline service ethnicity data are detailed below.

One third of the female SYV victims were victims of domestic violence and abuse (DV-A). A higher proportion of victims of DV-A than all SYV were repeat victims in the previous 12 months (25 per cent of victims). 13 per cent of victims of DV-A were classified on the police crime records as being vulnerable.

9.5 The characteristics of offenders of serious youth violence

Less was known about SYV offenders than victims from the recorded crime data. Based on data for those accused of an offence 87 percent of offenders were male, and 76 percent of victims were male and half were aged 14 to 21.

A higher proportion of offenders than victims were recorded as being of Black ethnic origin at 46 per cent. MOPAC reported that in 2016, 30% of suspects for possession of knives were Black males aged under 25.

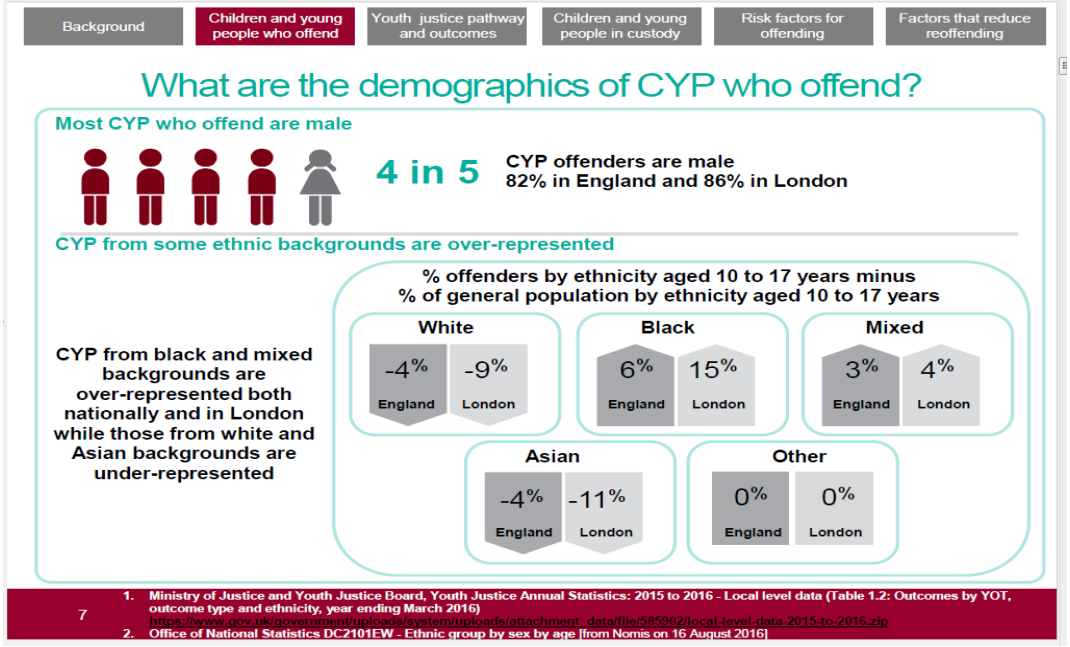
Data taken from a Public Health England scoping review on children and young people with offending behaviour, illustrates the issue of representation by ethnic group, with fewer people from Asian backgrounds than expected and more with Black and mixed ethnicities[27].

Figure 7 Public Health England: demographics of children and young people who offend

[25] https://www.theguardian.com/uk-news/2017/mar/28/beyond-the-blade-the-truth-about-knife-in-britain

[26] There are serious issues with the quality of frontline service data on ethnicity. The ethnicity of victims, perpetrators and witnesses is important contextual information for a range of purposes including equalities duties, and prevention. The Census ethnicity categories are used by most public services to record ethnicity. However, the ethnicity categories recorded by the police in the offence data used here are based on the observation recorded by an officer rather than supplied by the victim. Self-defined ethnicity is collected by the police where possible but is missing for about 70 per cent of cases. There are also issues with ethnicity data from the other services analysed in this report – it was not available for the ambulance data and missing for a high proportion of cases in the hospital data. The reality of delivering an emergency frontline service makes accurate recording of ethnicity more challenging than for other services. These quality issues should be considered when interpreting the over-representation of groups in relation to SYV.

[27] Children and young people in London with offending behaviour –A scoping review Magdalene Mbanefo-Obi PHE February 2018



Despite acknowledging that there will be instances of cross-overs between the victims and offenders, the current available data did not allow an analysis of the extent to which individuals involved in SYV were both victims and offenders.

MOPAC analysed data from 2016[28] on victims and perpetrators of gang-related knife crime. This was less common but tended to be more serious. It reported that this population was more likely to be exclusively male, under 25 and from a BAME background (92 per cent male, 80 per cent under 25 and 77 per cent BAME) with young BAME men (aged between 16-20 years) accounting for a third of all victims. Gang-related crime analysis was subject to caveats around completeness and subjectivity, due to the reliance on crime report flags in the data collection phase.

9.6 The temporal pattern of SYV

The temporal pattern of SYV varies by age. For school age children, violent incidents were most likely to take place between 3pm and 10pm, Monday-Friday, and between 6pm and 11pm on Saturday and Sunday. The peak day was Friday, with the weekend being the quietest days.

For those aged 18-24 years, incident patterns more closely reflected the night-time economy and associated activities. Violent incidents for those over 18 were most likely to be between 6pm and midnight across the full week. Saturday and Sunday were the clear peak days, with increased call-out activity continuing on these days until 3am the next day.

9.7 Young people and custody

The Public Health England review cited above also reported that across England between 2005/6 and 2015/16 there was a 67% drop in custodial places commissioned for children, resulting in a custodial population with higher rates of vulnerabilities, and exposure to challenging behaviours including violence. Sentence lengths are increasing with an average of 16.1 months. There are higher rates of learning disability, and physical and mental ill health in this group.

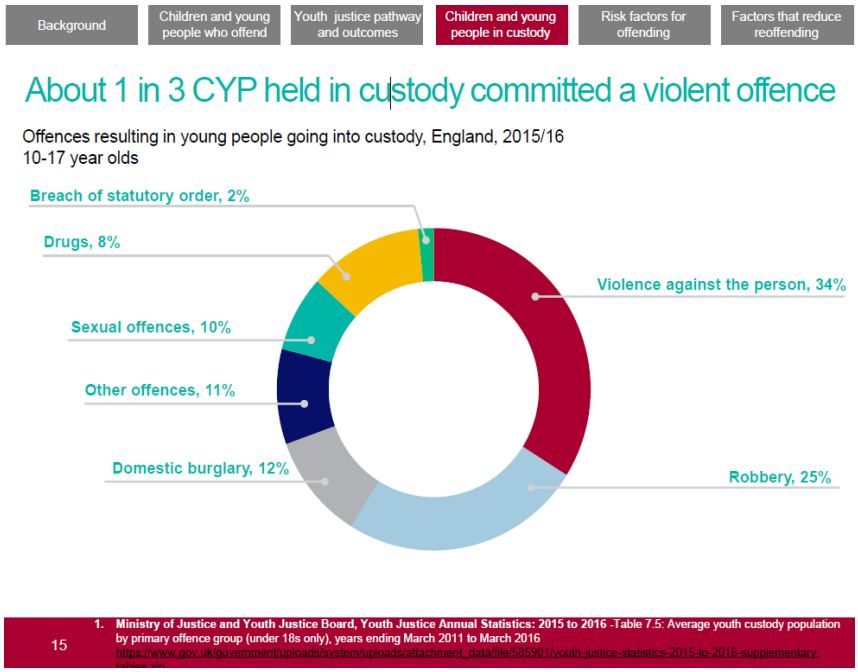
[28] What we know about knife crime in London – MOPAC March 2017

This is particularly relevant for London as 24% of the arrests of 10 to 20-yearolds were in the capital. Violence was a common reason for incarceration, as shown in figure 10 below, with around 1 in 3 young people who have committed a violent offence held in custody. On average London offenders spend 16 months in custody.

London offenders are more likely to reoffend than their peers in other parts of the country with a third to a half going on to reoffend. The overall numbers hide marked differences in reoffending from 14% in Wandsworth compared with 2% in Greenwich.

Concern was raised that the numbers of people in custody for short periods may increase[29]. Mandatory minimum sentences for offences such as carrying a knife or other offensive weapon mean it will become increasingly rare to get any type of sentence other than immediate custody of at least six months.

Figure 10: Offences resulting in custody for 10-17-year olds 2015/16 in England



9.8 Homicide

Less than 1 per cent of offences were recorded as murder, or an offence where the victim sustained fatal injuries. Young men were more likely to die as a result of violence than young women, indicating a difference in severity, accounting for 85% of the total homicide victims in 2017. MOPAC analysis from 2016 shows that 25% of homicide victims in 2016 came from a BAME background (all ages).

ONS homicide data tells us about the most serious outcome from violence. Nationally, although rare, homicide increased by 8% in the year to March 2017 (excluding the 96 deaths attributed as a result of the events at Hillsborough in 1989). The number of male victims has increased at a faster rate than females in recent years with male victims of homicide increasing by 33% to 433 from 325 in the year ending March 2015, ending a generally downward trend. The number of female homicide victims has remained broadly flat over the last five years (fewer than 200), with the rate for males more than double that for females.

[29] https://www.sentencingcouncil.org.uk/news/item/new-sentencing-guideline-introduced-for-the-possession-of-weapons-and-threats-to-use-them/

National data also tells us that women were far more likely to be killed by partners or ex-partners (50% of female victims aged 16 and over compared with 3% of male victims aged 16 and over), whereas men were more likely to be killed by friends or acquaintances (32% of male victims aged 16 and over compared with 10% of female victims aged 16 and over). The most common method of killing was by knife or other sharp instrument with 215 victims killed in this way, accounting for 30% of homicides.

Homicide data from the Metropolitan Police Service crime dashboard (figure 8) shows a variable picture in London over the last 2 years. The small numbers make accurate trend analysis difficult, but numbers are higher than they have been. MOPAC report that during 2016 half of all homicides were fatal knife crime with one in five of these related to domestic abuse.

Figure 8: All age homicides in London April 2016 – April 2018[30]

9.9 Where does violence occur?

Data shows us that violence is occurring across the capital but is not equitably distributed across London boroughs. This is to be expected as there is considerable variation in several factors that will determine the level of SVY in a borough, including the size of the youth population, distribution of known risk factors, individual vulnerabilities, and protective factors across London.

The table below shows the relative ranking of boroughs based on rates of SYV offences recorded by the police, and how this compares to the overall level of SYV recorded in each borough.

[30] MOPAC crime dashboard

Table 2 Classification of borough rates and levels of SYV by location of incident

Borough	SYV offence rate (per 1000 1-24 years)	Borough	SYVC Offences 2017
Westminster	11.1	Croydon	811
Lambeth	8.9	Newham	808
Southwark	8.3	Lambeth	783
Camden	8.1	Southwark	762
Haringey	7.8	Westminster	722
Islington	7.7	Tower Hamlets	656
Hackney	7.1	Haringey	645
Newham	6.8	Brent	635
Croydon	6.8	Enfield	631
Tower Hamlets	6.6	Camden	594
Hammersmith and Fulham	6.3	Hackney	579
Brent	6.2	Lewisham	552
Lewisham	6.1	Ealing	540
Havering	6.1	Islington	527
Greenwich	6.0	Greenwich	527
Kensington and Chelsea	6.0	Waltham Forest	467
Enfield	5.9	Redbridge	458
Barking and Dagenham	5.8	Barking and Dagenham	451
Waltham Forest	5.4	Havering	449
Ealing	5.2	Bromley	449
Wandsworth	5.1	Hillingdon	422
Bromley	4.9	Wandsworth	418
Redbridge	4.7	Barnet	411
Sutton	4.4	Hounslow	350
Hillingdon	4.3	Hammersmith and Fulham	313
Hounslow	4.2	Bexley	299
Bexley	4.0	Sutton	259
Kingston upon Thames	4.0	Harrow	242
Merton	3.7	Kensington and Chelsea	235
Barnet	3.5	Merton	217
Richmond upon Thames	3.3	Kingston upon Thames	216
Harrow	3.3	Richmond upon Thames	182

The boroughs with the highest rates of SYV offences are Westminster, Lambeth, Southwark, Camden, Haringey, Islington, Hackney and Newham.

Westminster, Lambeth, Southwark, Newham, and Haringey are in the top quarter of boroughs for both rates and levels of SYV.

While Croydon, Tower Hamlets and Brent would be in the top quarter of Boroughs for overall levels of violence, once controlled for population size, they are in the group below.

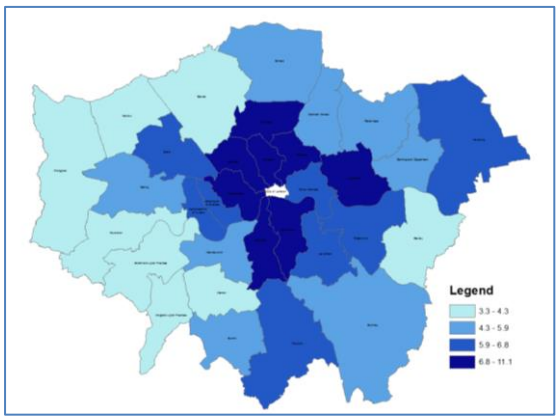
Camden, Islington, Hammersmith & Fulham, and Kensington & Chelsea have a higher rate of violence relative to their population size, compared to their overall level of SYV. This is because SYV in these boroughs is less localised (a higher than average proportion of victims are from outside the borough). This tends to be related to the roles of their respective night time economies.

Enfield, Ealing, and Waltham Forest appear in the top half of boroughs for levels of violence but once population size is accounted for, are in the bottom half in terms of SYV rates. These boroughs have a high rate of localised violence.

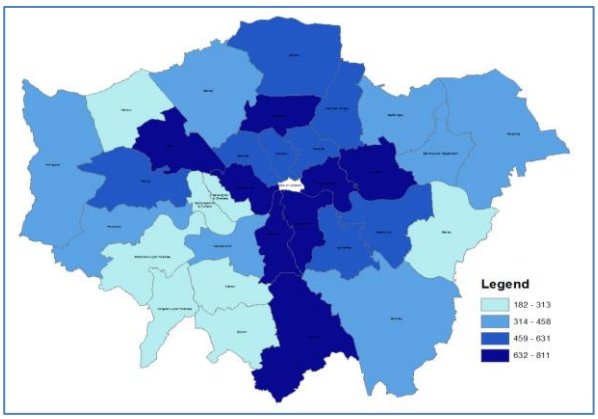
Figure 9 shows this data mapped. Even at borough level the pattern bears resemblance to the Vulnerable Localities Index (see below). The boroughs with the highest rates of SYV offences are similar to the geographical profile for the ambulance assault call out data.

Figure 9 Maps of borough variation in SYV violence in London rates and levels (2017)

Borough SYV rates



Borough SYV levels



Ward level data on levels of SYV are available for those aged 1-19. Table 3 below shows the top 10 wards in London for 2017/18, and the number of offences committed in each. The ward totals, can be influenced by the existence of both night- and day-time economies, as well as the size and location of town centres. Stratford and New Town in Newham was the top ward for SYV, recording over 100 offences in 2017 (101), compared with 77 offences in the second highest (Fairfield in Croydon).

Table 3 Top 10 wards for SYV offences, 2017/18

Ward Name	Owning Borough	SYVC Offences
Stratford and New Town	Newham	101
Fairfield	Croydon	77
West End	Westminster	63
Romford Town	Havering	58
Bromley Town	Bromley	55
Broad Green	Croydon	54
Grove	Kingston upon Thames	48
Coldharbour	Lambeth	47
Woolwich Riverside	Greenwich	47
Camden Town with Primrose Hill	Camden	46
		596

Overall, the top ten SYV offending wards accounted for 7 per cent of the SYV total offending in 2017/18.

Looking at the top 10 per cent of SYV offending wards shows a link with vulnerable localities, with 44 per cent of these wards featuring in the top quintile of the Vulnerable Localities Index (VLI). The VLI is a tool developed by the GLA, MOPAC and UCL to identify residential neighborhoods which require prioritised attention for community safety.

9.10 Localisation of violence

The proportion of victims who were targeted in their own borough of residence ranged from 56 per cent (Westminster) to 79 per cent (Enfield) see Table 4 below.

The 5 per cent of victims who resided outside of London were most likely to be assaulted in Westminster, Camden and Lambeth, which suggests links to the night-time economy.

There was a slightly greater range in the proportion of offenders who offended in their borough of residence, ranging from 49 per cent (Sutton) to 83 per cent (Tower Hamlets), Table 5.

The 4 per cent of offenders who reside outside of London were most likely to offend in Westminster, Camden and Bromley.

Table 4 Boroughs with highest and lowest proportion of localised victimisation

Boroughs with the highest % of localised victimisation

Offence Borough	Percentage of Victims Local to the Offence Borough
Enfield	79%
Barking and Dagenham	78%
Croydon	78%
Waltham Forest	78%
Hillingdon	77%

Boroughs with the lowest % of localised victimisation

Offence Borough	Percentage of Victims Local to the Offence Borough
Hackney	37%
Kingston upon Thames	40%
Camden	42%
Kensington and Chelsea	45%
Westminster	56%

Table 5 Boroughs with highest and lowest proportion of localised offending

Boroughs with the highest proportions of localised offending

Offence Borough	Percentage of Offenders Local to the Offence Borough
Tower Hamlets	83%
Newham	80%
Lewisham	79%
Croydon	79%
Enfield	77%

Boroughs with the lowest proportions of localised offending

Offence Borough	Percentage of Offenders Local to the Offence Borough
Kensington and Chelsea	40%
Westminster	46%
Kingston upon Thames	47%
Islington	49%
Sutton	49%

9.11 What frontline data tell us about the correlation between SYV and public health risk and protective factors

The epidemiological key lines of enquiry identified several risk and protective factors for SYV in London. A broad range of factors were examined using borough-level data to compare with borough-level offence data ie focused on the location of the offence/ ambulance call out.

This analysis found a significant statistical association with borough rates of SYV offending for the following factors (in order of strength of correlation)

- The proportion of children aged under 20 living in poverty
- Positive Life Satisfaction amongst 15-year olds
- The Index of Multiple Deprivation (IMD)
- The estimated prevalence of emotional disorders amongst 5 to 16-year olds
- Social integration as measured by voter registration rates
- Proportion of 10 to 17year olds who were given a custodial sentence

- The estimated prevalence of conduct disorders amongst 5 to -16-year olds
- The rate of Looked-After Children (LAC)
- The proportion of the resident population 18 to 24-year olds
- First time entrants into the criminal justice system (10 to 17-year olds)
- Social, Emotional, Mental, Health Needs (SEMH)
- Persistent absentees from school
- Hospital admissions for self-harm (10-24 years)

This analysis shows a significant relationship between each individual factor and SYV offending rates. To fully quantify the relative importance of each factor further modelling is needed with access to a more granular dataset. This requires lower level data for both offences and public health, or even matched individual data across the different services. It was not possible to explore correlations with the home borough of the victim and/or offender within the scope of this work, but this would add further insight if undertaken in future.

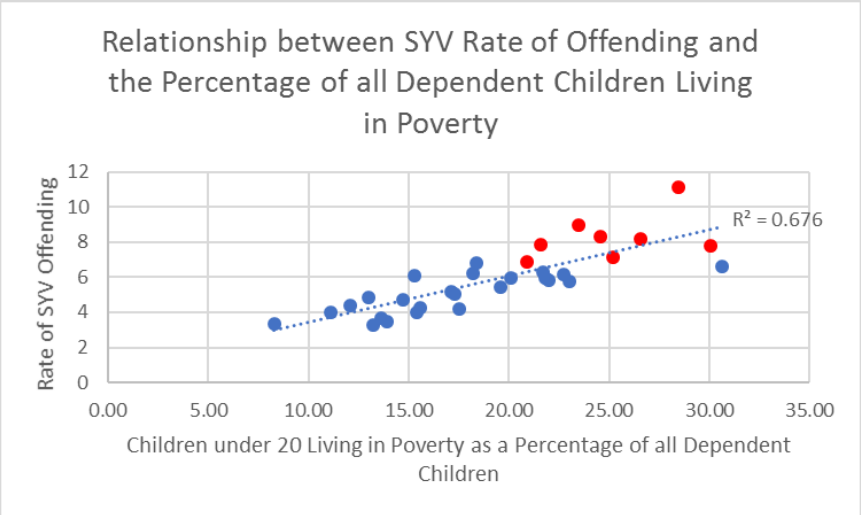
At Borough level, some of the factors that might be expected to correlate with SYV are not currently showing as significant (e.g. school exclusions). In the case of school data, this is likely to be due to the high proportion of pupils who attend a secondary school outside of their home borough of residence, as well as the fact that the location of one's school may hold no bearing on the location of the offending; the offender data included victims above school age; and it may be that the link between offending and school exclusions is more pertinent that for victims and exclusions.

This illustrates the issues with modelling at this level of geography, and why more in-depth analysis is required to fully establish the relationships between public health factors and crime.

The next section discusses some of the individual independent factors which were found to have the strongest correlation with SYV. Those related to the criminal justice system and custodial sentences have been excluded as they are unlikely to be independent of the violence itself. In the charts, red dots represent the top 8 boroughs for rates of SYV offences, with blue dots representing the other 24 boroughs.

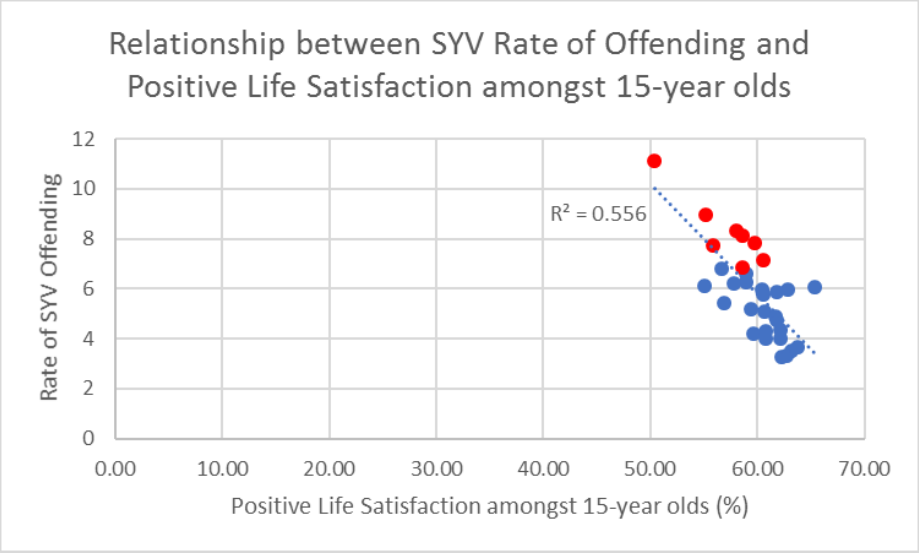
9.12 SYV and poverty

Within London, the proportion of dependent children aged under 20 living in poverty ranges from 8 per cent (Richmond) to 31 per cent (Tower Hamlets). All the boroughs with the highest rates of SYV offending had a proportion of dependent children under 20 living in poverty above the London average.



9.13 SYV and Positive Life Satisfaction among 15 year old Londoners

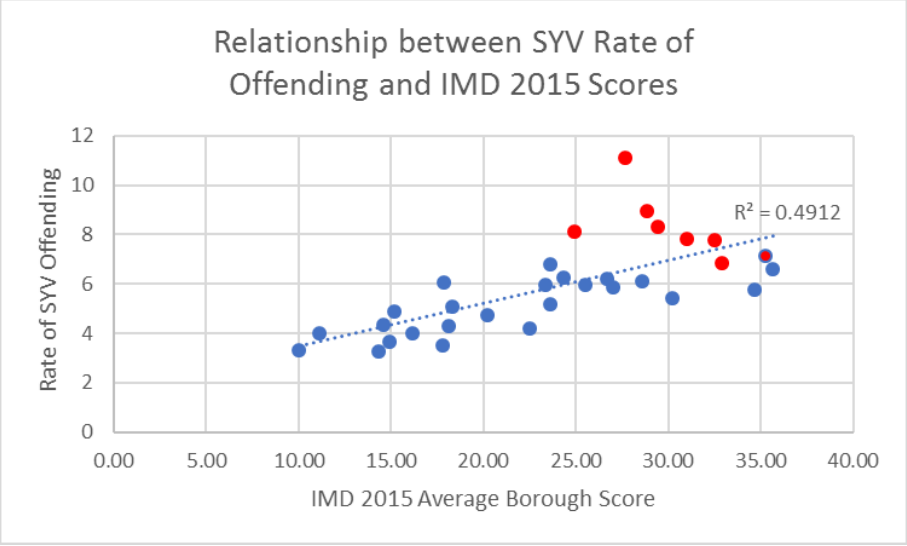
On average, 60% of 15-year old Londoners reported positive life satisfaction. The lowest level of satisfaction was in Westminster (50 per cent) and the highest was in Havering (65 per cent). Other than Hackney, the boroughs with the highest rates of SYV had lower than the London average levels of positive life satisfaction.[31]



9.14 SYV and Indices of Multiple Deprivation

Six of the top SYV offending boroughs have an IMD score which is in the top ten for London boroughs (Westminster was 11th and Camden 15th).

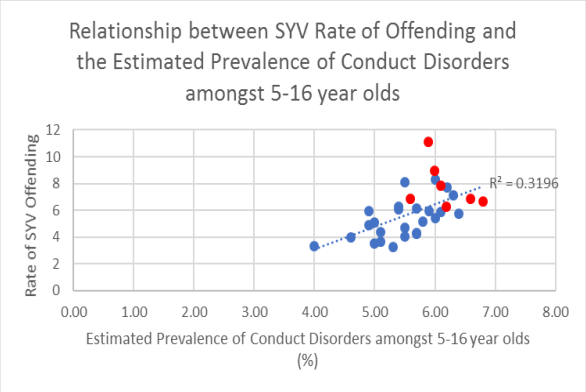
As individual factors, both the proportion of dependent children aged under 20 and the borough deprivation score correlate with rates of SYV offending. These two factors also correlate strongly with each other (poverty is one of the components of deprivation), although the IMD includes a wide range of other factors.

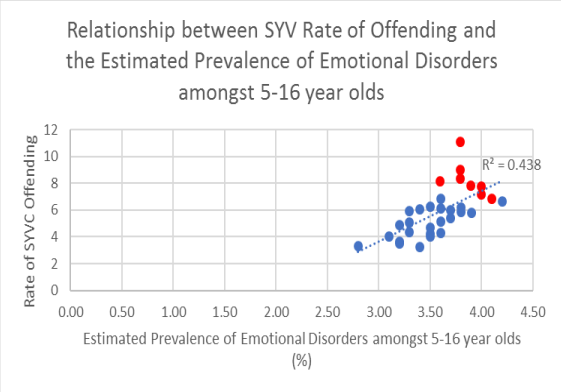


[31] Positive Life Satisfaction estimates based on a Public Health England survey answer to the question 'How satisfied are you with your life nowadays?'

9.15 SYV and Conduct/Emotional Disorders

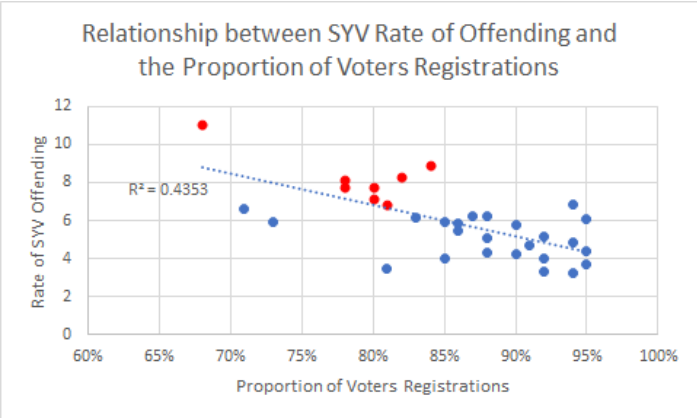
An estimated 6 per cent of Londoners aged 5-16 have a conduct disorder and 4 per have an emotional disorder. All the boroughs with the highest rates of SYV except Camden had higher rates of children with conduct disorders than the London average. This was also true for borough rates of emotional disorders, except for Westminster and Camden.[32]. However these findings should be treated with caution as they are based on modelled estimates.





9.16 SYV and Social Integration

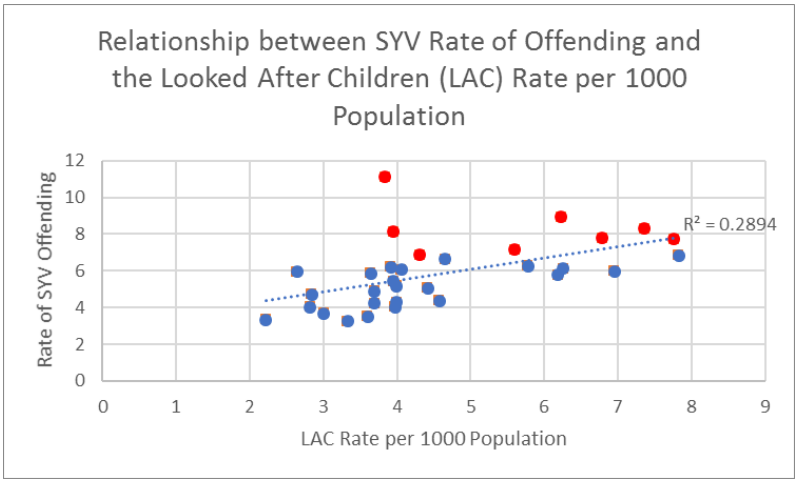
Three measures of social integration were tested for correlation with SYV. Of these, borough voter registration rates showed a significant association but measures of neighborhood trust and the extent to which people from different backgrounds got on did not. On average, 86 per cent of eligible voters were registered in London. All 8 of the boroughs with the highest SYV offending rates had voter registration rates that were below the average, ranging from Westminster (68 per cent) to Lambeth (84 per cent).



9.17 SYV and Looked After Children

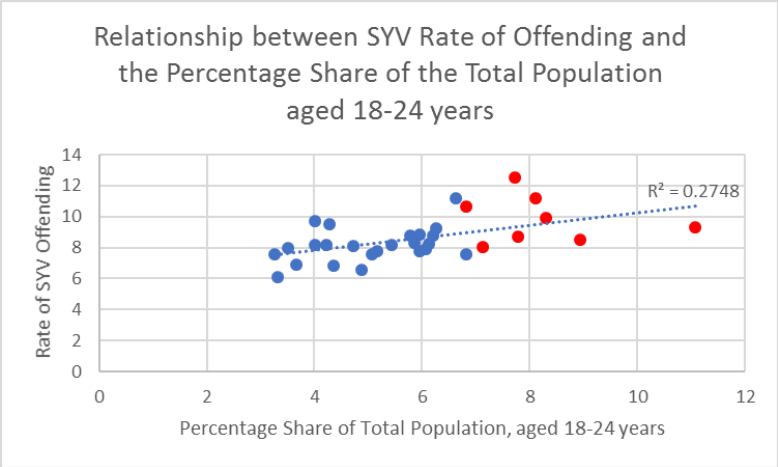
On average, five per cent of children under 18 are under the care of the borough. Five of the 8 boroughs with the highest SYV offending rates had a proportion of Looked After Children that was higher than the London average - Lambeth, Southwark, Haringey, Islington and Hackney. The boroughs with the highest rate of Looked after Children within London were Croydon and Greenwich (8 per cent).

[32] A conduct disorder is defined as defiance, aggression and anti-social behaviour. An emotional disorder was considered as an anxiety disorder or depression



9.18 SYV and proportion of population aged 18-24

Several population age factors correlated with SYV at borough level but the strongest of these was the proportion of the population aged 18 to -24. Within London the percentage of this age group ranged from 6 per cent in Richmond to 13 per cent in Islington. Of the top offending boroughs, Newham, Camden, Southwark, Westminster as well as Islington all had an above average proportion of this age group. In terms of actual population size for this age group, Newham had a 18-24 population 3 times as large as some of the boroughs with the fewest in this age group.



10 Recommendations for further analysis

The following recommendations for further analysis address gaps in the data highlighted in this analysis and suggest how better/linked data would enable improved modelling of the relationship between serious youth violence and public health

- Detailed analysis of geographic patterns below borough level linked to public health data to better highlight problem areas
- Create a more sophisticated area classification accounting for different volumes/severity/characteristics of SYV/demography/public health data
- Modelling of public health data available at lower geographic levels to quantify the relative importance of the different public health factors

- Targeted spatial analysis: around specific points of interest, including educational establishments, transport hubs, and town centre networks
- Analysis of victim/offender dynamics: to look at repeat offending, disproportionality, repeat victimisation, the cross-overs between offending and being victimised, group offending, and combined victim/offender demographics
- The creation of linked police/health and ambulance datasets

11 Organisations and bodies involved in preventing violence

Details of the exploration of the institutional landscape are included in Appendix 2. The focus was on the health and social care landscape, but other sectors were included such as academia. It was clear that there was a great deal of work going on across London both as part of the routine business of organisations and as dedicated work programmes on this specific area.

Opportunities were identified in national, regional, and local bodies. The table below summarises the results

Table 2: Examples of bodies involved in tackling youth violence

Body	**Opportunities**	**How to engage?**
Government Departments & Agencies	Influencing policy in support of a public health approach	via the GLA health team.
Inspection & Standards agencies	Ensuring educational establishments and health services contribute effectively	Through regional structures; mayoral meetings, pan London Boards with CQC and OFSTED membership; national advocacy.
London Partnerships	Inspiring and driving coherent system change across health and social care, crime reduction and children and young peoples' agendas.	via the GLA support structures to the Boards
London wider review of 2017 knife crime homicides	Integrating the learning from reviewing knife crime homicides with that from other violent deaths, incidents and injuries	Through CDOP networks and the London Knife Crime Homicide Review project.
Academia	Generating and testing new interventions and approaches in a scientific manner; to share learning.	Through existing partnerships and via the GLA health team and MOPAC
Local Authorities	Designing and maintaining safe places; reaching local populations; through work of Health & Wellbeing Board and community safety workplans; local Information analysis; Education services; Services for vulnerable children and adults; Safeguarding boards and CDOPs; as key local employers	Through LHP and LHB London Councils' Local Authority Chief Executives Board, Leaders Group of London Councils; lead officer networks such as SALC, ADPH London, London DCS network, ADASS London, London Heads of Community

Body	Opportunities	How to engage?
		Safety. Through events and programmes
NHS Organisations	CCG's; Hospitals and other clinical services - clinical interventions to reduce harm and risks, reach into vulnerable communities; as local employers; data to spot emerging trends in violence	Via Healthy London Partnership, GLA Head of Health membership of the Association of Directors of Public Health for London, Health & Wellbeing Board Chairs. PHE, also via STP and other UEC networks, London Trauma Network.
Voluntary & Community Sector	To promote coherence of the approach and support evidence-based practice. Some groups have access to considerable funds of their own - there to add significant value to a programme.	Through GLA and MOPAC programmes of engagement, linking with local peak bodies and organisations such as London Funders. The MPS have a strong programme of engagement also, including around 5,000 police cadets

12 Discussion

This section aims to distil the issues that the information gathering has raised. There is evidence of an increase in serious youth violence events in London since 2013, although the longer-term trends paint a more complex picture. There is also evidence of a modal shift, namely the increasing use of knives in violent incidents among young people.

Certain principles underpin the work in places that have achieved success using a public health approach:

- Belief that violence is preventable.
- Commitment to a system wide approach underpinned by mature and committed partnership arrangements.
- Interventions are guided by evidence of effectiveness where it is available and developing the evidence base where it is absent.
- Victims and perpetrators and sometimes bystanders are viewed as members of the same population, vulnerable to involvement in violence.
- Programme interventions are trauma informed and viewed through a lens of adolescence, understanding that the influences and opportunities for behaviour change are different from childhood to adulthood.

A report on the impacts of economic downturn on health inequalities in London highlighted evidence that violence might increase during recession, and that the strain on families caused by a recession might increase family violence and neglect[33].

Violence is not something we would want to tolerate as it is preventable. There is concern in the community, and among professionals that there is more to do across London to protect young people and their communities from the effects of violence. There is a body of literature and evidence on factors that increase one's risk of involvement in violence and on approaches to prevent it.

There is a consistent perception across services, reflected in health data, that victims are becoming younger and injuries more serious which is of concern. On the whole violence tends to occur within the home borough, particularly for the younger age groups and in the afternoon and evenings.

People in contact with the criminal justice system are at high risk of involvement and London has high numbers which may increase. It will be important to involve probation and other criminal justice colleagues in a London wide approach.

London level analysis to date has been descriptive of the victims and perpetrators. Different authors have used different population definitions and definitions of serious youth violence. There has not been a systematic comparison between the involved in violence group and the not involved in violence group in any detail to date.

Although some of the underlying causes for other forms of violence are similar, the prevention opportunities and victimology are somewhat different for domestic violence and abuse. There are also existing programmes in place for reducing domestic violence and whilst there will be overlap with serious youth violence, much of the work will be different and require specific attention.

Considerable high-profile work on serious youth violence in London has been focused on knife crime. There is consensus that knife crime should be viewed as one element of serious youth violence, albeit one that requires an urgent response. The drivers and prevention of violence itself should be at the heart of a serious youth violence strategy.

Partners have spoken about the need to guard against gender and racial bias and discrimination in understanding youth violence and its impacts in London. The ethnicity picture is complicated with black young people seemingly over represented in victim data, prosecutions, gang crime data and murder statistics. However apart from gang crime, they only form around a third of the group involved in violence, and there is an urgent need to explore features in common between various subgroups involved in violence to inform prevention strategies. Particular areas that require further investigation are around life chances and the availability of programmes that promote resilience and tackle the root causes of violence.

Stakeholders spoke about the need for responsible reporting of the issues in the media and communications with professionals, guarding against the bias referred to above and learning from the approaches taken in recent year to issues such as suicide prevention, and self-harm in children and young people.

There is interest and public commitment to further embedding a public health approach in London. Serious youth violence can be viewed as an outbreak with measures taken to control spread. Violence is seen to spread where risk factors proliferate causing susceptibility in the population, and where violence is seen as a viable means to achieve an outcome.

[33] The impact of the economic downturn and policy changes on health inequalities in London, UCL Institute of Health Equity, June 2012

Social media has been the subject of debate, and actions to mitigate its ability to escalate conflict and spread violence are needed. Through the Knife Crime Strategy, work has already begun in this area with social media providers and should be developed further.

A public health approach to prevention focuses at several levels with interventions aimed at individuals, relationships, communities and society[34]. Criminal Justice colleagues have used prevention, diversion and enforcement as categories for action. Others describe tackling the propensity for violence and tackling the triggers for violence. The populations of interest include victims, perpetrators, bystanders and wider communities.

Examples of primary prevention include tackling the root causes of violence by preventing adverse childhood experiences such as exposure to domestic violence and abuse. Secondary prevention is prominent in several places, working intensively with children at risk of exclusion from school because of disruptive home circumstances, or removing weapons from circulation.

There is emerging thinking that there may be a rapid escalation of risk for some young people, for example when they join a County lines drug operation or are being groomed for gang involvement, and that there are secondary prevention opportunities at this point. Tertiary prevention to reduce the impact of a violent incident would include police intervention to prevent retaliation and the response to bereaved relatives and friends and opportunities to divert previous offenders through new opportunities such as mentoring, training, preparation for employability, housing, health support. A table summarising interventions that have shown to be effective is included at Appendix 3.

There are multiple published reviews of the evidence behind interventions to reduce serious youth violence. There is evidence internationally and from other UK cities, notably Birmingham, Glasgow and Cardiff. Evidence based work has involved a wide range of partners across the health system, local government services, the criminal justice system and voluntary sector, throughout the life course, and across primary, secondary and tertiary levels of prevention.

A summary of the key sources is included at Appendix 4. Of note is the Youth Violence Commission, a Parliamentary Cross-Party group has commissioned a comprehensive and up-to-date review of the evidence, due for publication this summer.

The use of data and intelligence to inform the choice of interventions has been emphasised in the literature. For example, in Birmingham a comprehensive needs assessment was completed, and monitoring data was used to guide new interventions. In London the picture of violence and drivers of violence will vary across different places and in different communities, and boroughs or localities will need to use their own data to inform their approaches.

Adoption of a trauma informed approach has prominence in the literature and is a MOPAC priority. A trauma informed approach recognises the signs and impacts of adverse experience and trauma in childhood with services designed not only to address or treat trauma but also to prevent re-traumatisation. A key component is acknowledging that trauma occurs when events overwhelm, and that thresholds are personal, influenced by one's life experience and resilience. What is perceived as traumatic by each individual varies, with some people more vulnerable than others to traumatisation.

A striking feature of work in places that have been able to make an impact on violence, is the coherence, scale and intensity of work. How the interventions are put in place seems as important as what is put in place. This is highlighted in the evidence base where the same approach, for example peer mentoring, has been effective in some context but shown to be harmful in others.

[34] https://www.scotphn.net/wp-content/uploads/2015/10/Report-Violence-Prevention-A-Public-Health-Priority-December-2014.pdf

In Scotland, where the inspiration for this work came from, it is widely reported that they have focused on school exclusions. Visitors who have observed the programmes in action were struck by the extent of the work. They comment on the commitment across services of not tolerating exclusions, with visible support for health and wellbeing throughout school. There is an expectation that all students need help completing their education which normalises asking for support. Issues are viewed through the lens of the child. What might be seen as disruptive behavior in some settings is seen as a communication of distress that needs a response to alleviate the distress.

Where partnerships are mature, boundaries between organisations and budgets are blurred, police and criminal justice staff work in public health teams and vice versa, there are pooled budgets, police budgets are spent on what might be seen as health services, and health budgets fund activity to prevent or intervene early rather than wait for a threshold for care to be reached.

Work has taken place across the life course, for example on parenting in the early years. School age children have been a particular focus with effective prevention programmes starting early in primary school rather than waiting until children are older.

In some areas of violence prevention there are recognised risks if events are not reported ethically in the press. Guidelines[35] are in place for reporting violence against women and girls, domestic abuse, and suicide which could be viewed as violence against oneself. It may be worth exploring the impact of current reporting of serious youth violence – is it increasing public concern and weapon carriage, or presenting an unbalanced view of vulnerabilities in the victim or perpetrator?

The narrative in London on a public health approach to youth violence is not well developed, despite lots of good work being in progress. There is a need to develop a compelling narrative that inspires confidence in the use of evidence-based approaches, some of which are already under way. We need a way to easily communicate what we mean by a public health approach that is meaningful to communities.

13 A partnership approach for London

The mapping of opportunities across the London system demonstrated the large number and broad range of bodies playing a part in preventing and reducing youth violence.

The architecture is complex, far more so than in Scotland, with work cutting across Child & Adult Safeguarding Boards, Health & Wellbeing Boards, and local commissioning and service provision arrangements. At a London level, these issues also fall within the remit of the children and young people sub group of the MPA, the London Health Board and the London Safeguarding Children Board.

A key difference between London and other UK cities that have achieved success using a public health approach is the scale and complexity of the organisational landscape in London (The violence reduction group in the West Midlands has 8 local authorities round the table and a single police force), whereas London has 33 Authorities

There is flourishing community sector involvement with multiple organisations involved in this work, literally in the hundreds in some boroughs. The challenge is to harness their enthusiasm and commitment, whilst maintaining focus and rigour in the approaches used.

The energy to tackle Serious Youth Violence in a coherent way exists within the multiplicity of organisations, but there is a real risk of it being dissipated if partners can't learn from what

[35] https://www.nuj.org.uk/about/nuj-resources/nuj-guidelines/

works, misunderstand each other's remits or the actions they are taking, or by activity not being coordinated across the capital, reducing its effectiveness.

The scoping has identified some gaps in our understanding of the issues and opportunities to tackle violence in London that will need to be addressed. This should include improving the quality and flow of ISTV[36] and other data, to guide focussed prevention and enforcement, revisiting use guidance, improving completeness of data and ensuring use.

A violence reduction partnership could develop a vison and strategic approach across the system with links to all the relevant partnerships. It could also develop a Pan-London framework to support borough and 'hyper-local' responses, accelerating action and learning. The role would then be to coordinate the potential roles in the list above, to ensure that the issue remains high on partnership agendas and that the approach is coherent across London.

Governance arrangements will be operating in the context of complexity. In an article on the governance of complexity[37], the Centre for Public Scrutiny recommends a flexible approach that sometimes needs to be informal and focused on managing relationships as well as substantively on outcomes.

During this work, several organisations have highlighted a need to curate a collection of resources. London Councils has indicated that they have developed a webpage which could be valuable in shaping the London approach. This could include the range of work that has been mapped across the GLA to promote protective factors and resilience amongst young people, families and communities.

Other suggestions that have come to light during this work include development of a minimum dataset for local authorities and support for peer support and challenge – the Early Intervention Foundation have a gang and youth violence maturity matrix[38] for partnerships for example.

14 Next steps

The Violence Reduction Unit will progress a strategic approach for London, and actions for impact on defined population groups, in the short and longer term as both are needed to control and prevent further violence. A visual representation in the form of a simple model could be developed to easily communicate the approach.

The following interventions, some of which have already started, should be considered a priority:

The narrative

- Creating a confident narrative around serious violence in London and working with the media to promote ethical reporting that avoids harm

Data

- Coordinated analysis of data and intelligence, to include availability of lower level data, consideration of linked police/ambulance and hospital data records, and the case for GLA access to the new Emergency Care Dataset (ECDS)

[36] The London **Information Sharing to Tackle Violence (ISTV)** programme is a two year programme co-ordinated by the Mayor's Office for Policing And Crime (MOPAC) and funded through the Home Office Innovation Fund. The programme seeks to develop more effective data sharing between Community Safety Partnerships, health and other partners, using a new approach to collating and analysing anonymised Emergency Department (ED) data to inform community safety strategies and resourcing decisions across partner agencies.

[37] https://www.cfps.org.uk/blog-the-governance-of-complexity/[38] http://www.eif.org.uk/our-work/preventing-gang-youth-violence/

[38] http://www.eif.org.uk/our-work/preventing-gang-youth-violence/

- Improved hospital A&E data-sharing quality and use
- Working with London Councils to populate their planned resource hub

Targeted interventions

- Continue action to understand and prevent knife carriage
- Extending teachable moment interventions in A&E beyond the injured person to include their visiting peers
- Support the use of evidence-based 'diversion from criminality' programmes targeting people immediately at risk. (This is a focus of the Young Londoners Fund work).
- Supporting local authority plans for out of school and holiday activities for young people
- Identification of an early area for partnership focus – for example keeping young people in education and tackling exclusions.

Resources

- Increasing dedicated capacity within GLA/MOPAC to support further development of the public health approach to serious youth violence
- Developing a definition of and response plans for clusters of incidents.

There are also opportunities to embed work on preventing violence in other GLA work programmes:

- Healthy Early Years programme - family support, parenting for families at risk, help for children with behaviour, learning or communication disabilities
- Healthy Schools Programme – learning from Scotland and Wales on ending school exclusions
- Young Londoners Fund and other grants that focus on evidence-based interventions for prevention of violence
- School journey safety, working with TfL and the British Transport Police
- Community trust and confidence in statutory agencies that work to prevent violence, working with Communities and Engagement
- Working with housing, planning and regeneration design to design-out opportunities for violence and to eliminate no-go areas
- Creating safe places for children at immediate risk of harm such as safe havens and options for family rehousing
- Sharing learning on promising approaches e.g. contextual safeguarding
- Considering access to alcohol, working with licensing teams to address its availability
- Community support services for all people affected by violence, as well as the immediate victim(s)

Key enablers of a public health approach to tackling Serious Youth Violence include;

- A full description of the London epidemiology, identifying risks, inequalities, and opportunities for prevention
- Evidence reviews of violence reduction interventions to identify both quick wins and longer-term investments – the Youth Violence Commission work may inform this

- Engagement of relevant academic, research, charitable and philanthropic organisations in London
- Advocacy for resources for children's and other services that support families and communities

These will be built into the work plan for the violence reduction unit.