2018/19

Serious Youth Violence in Lambeth

Evidence Review

Dr. Madhumita Shrotri - Public Health Registrar
Public Health Team London Borough of Lambeth
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Thank you to colleagues within Lambeth Council and other partners for contributions to this evidence review.

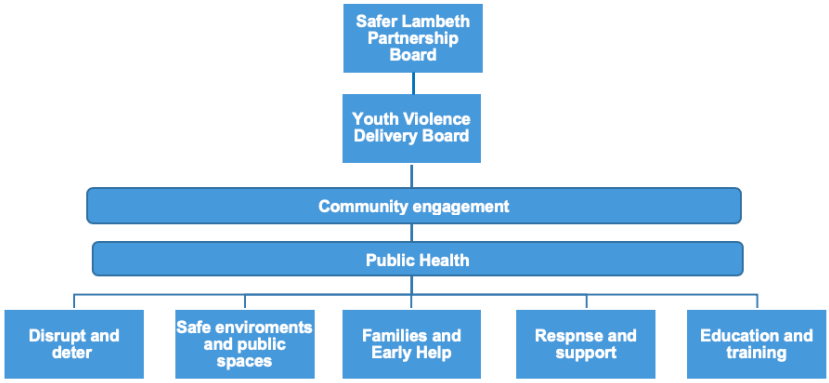
Executive Summary

This evidence review constitutes the first part of an update of Lambeth's 2015 Violence Needs Assessment, but with a narrower focus: serious youth violence. The second part of the update is a report on the epidemiology of youth violence and its risk factors, as per the findings of this review, within Lambeth.

An update has been undertaken because the field of violence prevention research has evolved rapidly in the last five years, bringing some significant developments in our understanding of the factors that contribute to violent offending. Additionally, the recording of data relating to violence has improved both locally and nationally, giving us a richer picture of the trends and patterns of community-based violence and its impact on health and wellbeing.

These two reports, taken together with the older Violence Needs Assessment, are designed to inform Lambeth's 10-year strategy to prevent youth violence, which is currently in development.

Lambeth's approach to strategy development is structured in the following way:



The themed work-streams divide the programme intro strategic categories of work in a way that fits with the wider Borough context and ensures comprehensive programme delivery. Therefore, the evidence review identifies particular work-streams that would be best suited to leading on specific intervention themes or would need to be involved in some capacity.

As with the older report, these update reports both advocate for and embody a public health approach to violence prevention.

There are a number of reasons why violence, and particularly serious youth violence, can be considered a health issue, and therefore amenable to a public health approach. Some of the key reasons are:

- Serious youth violence has serious, wide-ranging impacts on the health of victims, perpetrators, bystanders and their families and friends
- It shows a strong inequality gradient as it disproportionately affects those in society who are already marginalised or disadvantaged
- It can be prevented, and its impact reduced through appropriate interventions across the life-course

The public health approach requires 'whole-system, cultural and organisational change supported by sustained political backing' (UK Youth Violence Commission). The London Violence Reduction Unit describes a public health approach as having the following key features:

- Focus on a defined population
- With and for communities
- Not constrained by organisational or professional boundaries
- Focus on generating long-term as well as short-term solutions
- Use data and intelligence to identify the burden on the population including any inequalities in levels of risk
- Rooted in evidence of effectiveness to tackle the problem

In order to develop a local strategy based on the public health approach, data on violence and its risk or protective factors and existing evidence of what works should be appropriately utilised to enable intelligent commissioning and development of services and interventions. It is essential to appreciate, however, that the field of violence prevention research is still developing. In this context it makes sense to talk about evidence-informed rather than evidence-based policies and practices. It is also essential to ensure effective stakeholder consultation, community engagement and co-production within the wider approach.

Risk and Protective Factors for Youth Violence – Key Messages

- Risk factors may be age-specific and occur at all levels - individual, family, peers, school, community

- Risk factors have cumulative effects – the more risk factors an individual has, the greater the likelihood of being engaged with youth violence

- Many risk-factors for youth violence overlap with those for gang involvement as well as other types of violence

- Protective factors can act directly or act as buffers for co-existing risk factors; they can also have cumulative effects

Effective Interventions for Preventing Youth Violence - Key Messages

Implementing specific, highly-researched interventions with fidelity will be limited in Lambeth by resource constraints, applicability to the local context, socio-cultural acceptability, and feasibility within existing commissioning arrangements. This review has taken the approach of collating evidence on intervention themes and looking for evidence on key generic characteristics of successful interventions. In this way, evidence-based intervention themes can be moulded into

locally suitable interventions, co-produced with the community and incorporating key characteristics predictive of success.

- There are many well-established effective interventions for preventing youth violence at all levels of prevention. Not all of these have been tested in settings similar to Lambeth, therefore they should be used only if they address local needs. The evidence should be carefully examined prior to implementation to determine an appropriate level of fidelity to original design, adapting where required, and interventions should be always carefully monitored and evaluated.

- There are many promising interventions at all prevention levels that require further evaluation. These can be implemented if they match local needs provided there are robust mechanisms in place for monitoring and evaluation.

- Where it is not possible to implement established interventions with high fidelity, for example due to resource constraints, or there are no interventions to match a specific area of need, there is substantial evidence for key principles of effective interventions which can be used to design innovative interventions at a local level.

- Interventions with mixed results should be implemented with caution and only after careful examination of the available evidence to understand if the intervention would be likely to succeed or fail in the local context. In cases where fidelity to original specification is the key determinant of success, then the intervention should be used only if there is capacity and resource for high fidelity implementation; careful monitoring is essential.

- There is a gap in the evidence with regards to effective strategies for gang involvement. It would be advisable to focus on violence prevention in the local authority context, where capacity to design and rigorously test innovative gang prevention strategies will be limited.

- There is some relevant NICE guidance for prevention and management of the health-related risk factors associated with violence. These are a starting point for ensuring a baseline offer for children and young people at risk of violence.

Youth Violence Prevention: Whole Programme Design – Key Messages

- Programmes should be carefully planned by assessing local needs using relevant data, assessing local capacity for programme implementation and involving communities and young people from an early stage

- Partnerships with academic institutions may be highly valuable for the purposes of collecting and analysing data to understand needs, for technical support with intervention design and implementation, and for accessing resources for high-quality monitoring and evaluation.

- It is important to develop close collaborations across sectors for comprehensive program delivery, as well as to co-ordinate prevention efforts across different types of violence. However, capacity for co-ordination and collaboration may be limited due to the inherent complexity involved in convening multiple stakeholders with different agendas, therefore

this should be done judiciously, treating capacity for collaboration as a finite resource.

- Programmes should be designed in partnership with the community, balancing the need to be evidence-based with the requirement to tailor interventions to local needs and preferences.

- Ideally, programmes should be comprehensive in their approach by offering different levels of prevention, addressing different risk and protective factors and covering different thematic areas for highest impact.

Useful Resources

The following resources provide useful sources of further detail on specific evidence-based interventions for impacting on serious youth violence.

- UK Youth Violence Commission – interim report published, final report awaited.

- Evidence summaries and guidelines by the World Health Organisation, the US Centre for Disease Control, Public Health England and National Institute of Clinical Excellence (NICE).

- Evidence clearinghouses: Early Intervention Foundation Guidebook, Youth Justice Board Resource Hub, STRYVE Strategy Selector, Crime Solutions.

- Policy and practice resources released by the Scotland VRU, the London VRU, the National Implementation Service and the US Centre for Disease Control (CDC).

Glossary

ACEs – Adverse Childhood Experiences

CDC – Centre for Disease Control

CYP – Children & Young People

DARE – Database of Abstracts of Reviews of Effects

EIF – Early Intervention Foundation

NICE – National Institute of Clinical Excellence

NIHR - National Institute for Health Research

PHE – Public Health England

STRYVE – Striving to Reduce Youth Violence Everywhere (CDC programme)

SYV - Serious Youth Violence

USAID – United States Agency for International Development

VRU – Violence Reduction Unit

WHO – World Health Organisation

YVPC – Centres of Excellence in Youth Violence Prevention (CDC initiative)

Serious Youth Violence and the Public Health Approach

Serious Youth Violence

The WHO defines violence as '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'.[1]

Serious youth violence has a much narrower definition and involves first defining 'youth violence' in terms of the age of those involved, and then defining what constitutes 'serious' within that.

There are many varying definitions of youth violence, particularly with regards to age-ranges, for example the WHO use 10-29 (victims and perpetrators)[2], the Met Police use 1-19 (victims only) and the National Government's 'Ending Gang and Youth Violence' programme used 13-24 (victims only). Some studies use terms such as 'community violence' or 'street violence' interchangeably with youth violence[3] though this fails to sufficiently define the age of the population in question.

As there is a plethora of available definitions, it is prudent to use the definition that best fits the purpose at a local level. To maintain consistency with previous local work the definition used by Lambeth's 10-Year Youth Violence Strategy group, and consequently this review, is - **violence by or against a person aged 10-25, involving significant physical injury or involving a weapon**, excluding domestic, intimate partner, dating and sexual violence as well as child abuse (as these are addressed by other strategies).

Violence as a Health Issue

- **Serious youth violence has serious, wide-ranging impacts on the health of victims, perpetrators, bystanders and their families and friends**

  → Physical injuries both fatal and non-fatal, some causing long-term disability
  → Health risk behaviours such as smoking, alcohol misuse and substance misuse
  → Mental ill-health including anxiety, depression and suicide
  → Educational under-achievement or unemployment and subsequent health disadvantages

  Violence can also affect entire communities through impacts on mental wellbeing and quality of life; for example, it can prevent people using outdoor space and public transport and inhibit the development of community cohesion.[4] Additionally, the risk factors for violence overlap with those for many other adverse health outcomes including mental ill-health, substance misuse and cardiovascular disease[2]. Therefore, acting to reduce the risk factors for violence has the potential to yield multiple benefits for the health and wellbeing of the population.

[1] WHO World Report on Violence and Health 2002
[2] WHO Preventing Youth Violence: an overview of the evidence 2015
[3] Abt, Thomas P - Towards a framework for preventing community violence among youth 2017
[4] PHE Protecting People, Promoting Health - A public health approach to violence prevention in England 2012

- **Violence shows a strong inequality gradient**

  Violence disproportionately affects those in society who are already marginalised or disadvantaged in multiple other ways. It mostly affects people living in poor and disadvantaged neighbourhoods and especially those where gangs and illicit drug markets thrive. The Murder in Britain study found that a fifth of men convicted of murder began offending before the age of 13 and this group had extremely disadvantaged backgrounds: 30% had been physically abused, 17% sexually abused and 45% had been taken into care before the age 16.[5] Additionally, a study looking at 80 convicted firearms offenders in England found that most came from disrupted family environments and over half reported being excluded from school.[5] Individuals from such disadvantaged circumstances also carry the burden of multiple other health inequalities and can become trapped in cycles of disadvantage through mechanisms such as substance misuse and violent crime.

- **Violence can be prevented, and its impact reduced**

  Many risk factors that predict future violence can be identified in childhood, for example, exposure to multiple adverse childhood events is a strong predictor of future involvement in violent crime.[6] Other examples are school exclusions and being a looked-after child.[7] Although most adolescents involved in violence only exhibit antisocial behaviour during adolescence, a significant minority, often those committing the most serious violence, continue violent behaviour well into adulthood.[8] Through early identification and support for at-risk populations, the onset of violent behaviour could be prevented and the life-course trajectories of persistent offenders could be re-directed.

  Another important consideration is that the risk factors for street-based youth violence overlap considerably with those for domestic and sexual violence. Data from London showed that the predictors of domestic violence and street violence were similar and that individuals who perpetrated both types had the most risk factors overall.[5] This means effective preventative interventions could be expected to have benefits across the different types of serious violence.

[5] UK Government Serious Violence Strategy 2018
[6] Hughes, Karen, et al. - The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis 2017
[7] Vicky Hobart, Tessa Lindfield – Serious Youth Violence in London - Interim Findings 2018
[8] WHO Preventing Youth Violence: an overview of the evidence 2015

The Public Health Approach

Public health concerns itself with promoting the health and wellbeing of the population, and particularly reducing inequalities in health and wellbeing within the population. As outlined above, violence is both unequally distributed and contributes to significant inequalities in health, therefore a public health approach has been recognised as an effective strategy for the purposes of prevention and harm-reduction.

The public health approach has been implemented by successful programmes in the USA, Scotland, Wales and elsewhere.

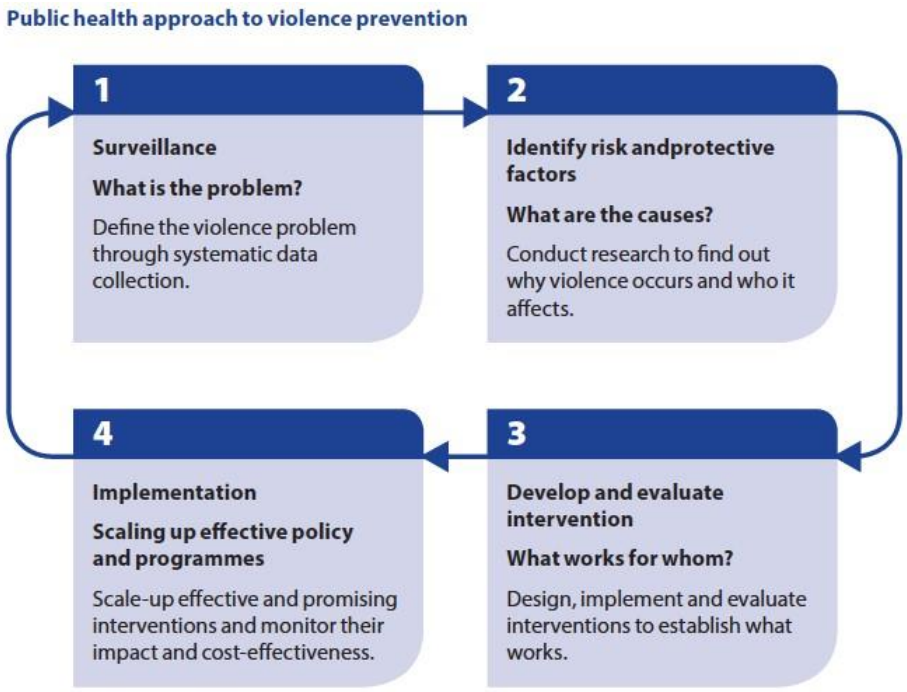


Fig. 1 Key elements of the Public Health Approach from the WHO Preventing Youth Violence report

Figure 1, produced by the WHO outlines the basic tenets of the public health approach to violence. It is important to note that this diagram relates to the overall approach for developing the knowledge-base within this field, rather than being specific to policy-makers in local government; therefore, it assumes capacity for academic research and does not sufficiently highlight some key policy-making approaches at the local level, such as stakeholder consultation, community engagement and co-production, which will be key elements of Lambeth's approach to youth violence prevention.

Both the Youth Violence Commission interim report[9] and the newly established London Violence Reduction Unit (VRU) also advocate the use of the public health approach as the basis for youth violence prevention.

[9] Youth Violence Commission - Interim Report 2018

The London VRU defines the public health approach as[10]:

- **Focus on a defined population, often with a health risk in common** - Connectors could be where they live, common experiences, a health condition, or demographic characteristics, like age.

- **With and for communities** - Focus on improving outcomes for communities by listening to them and jointly designing interventions with them.

- **Not constrained by organisational or professional boundaries** - People often do not neatly sit within a service user grouping. Developing partnerships with and between organisations means that we can look across the system for solutions and not be too narrow in our approach.

- **Focus on generating long-term as well as short-term solutions** - Acting on the root causes and determinants as well as controlling the immediate impact of the problem. Identifying actions to be taken now and putting solutions in place for the future.

- **Use data and intelligence to identify the burden on the population including any inequalities in levels of risk** - Analysis of the differences between the group of people we are looking at and their peers gets to their real story and the challenges they might be facing. It tells us about the impact that these challenges have in different areas of people's lives, like school, work or family. It also tells us about 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.

In order to develop a local strategy based on the public health approach, existing evidence of what works should be appropriately utilised to enable intelligent commissioning of services and interventions. It is essential to appreciate, however, that the field of violence prevention research is still developing, and this, combined with the extremely complex nature of this social problem, means it is often difficult to find robust evidence that is universally applicable. In this context it makes sense to talk about evidence-informed rather than evidence-based policies and practices. Evidence can only take policy-makers so far, and to progress beyond that point it is essential to build consensus with stakeholders over gaps in the evidence and innovate based on local need, ensuring innovation is evaluated as robustly as possible.

[10] London VRU website - https://www.london.gov.uk/what-we-do/mayors-office-policing-and-crime-mopac/violence-reduction-unit-vru/public-health-approach-reducing-violence

Risk & Protective Factors for Youth Violence

A rapid review was undertaken of the current evidence-base around factors associated with violence. The purpose was to inform the more detailed review on 'What Works' for prevention and to inform the epidemiological analysis of youth violence on a local level.

Only up-to-date evidence summaries and reviews were used in order to collate a list of well-evidenced associations.

Definitions

Risk factors are variables that are positively associated with youth violence and can usefully predict an increased likelihood of involvement in youth violence.

Protective factors are variables that are negatively associated with youth violence i.e. reduce the likelihood of involvement in youth violence for the individual.

Protective factors can theoretically be further broken down into factors which have either a direct or a buffering effect. Direct protective factors predict a low probability of future problem behavior without taking other factors into account. Buffering protective factors predict a low probability of a negative outcome in the presence of risk factors. This terminology refers to the moderating or interaction effects of the factors.[11] Based on the available evidence however, it is difficult at this stage to reliably categorise protective factors in this way. Further research is required to make this distinction with confidence.

It is important to be clear that use of the terms risk and protective factor does not mean that these are established as direct causes of violence but rather that they are signals of risk for the outcome, and that the association is based on probability at a population level i.e. the presence of a 'risk factor' for an individual does not necessarily mean that that particular individual will inevitably be violent. Establishing causality between risk factor and outcome is a difficult process and involves fulfilling multiple criteria across several study types.

Strong Association

Strength of association is discussed in the context of risk factors only, due to the lack of evidence on this with regards to protective factors.

Some risk factors indicate a higher probability of involvement with serious youth violence than others. Stronger risk factors are no more likely to be causal (directly causing violence) than weaker risk factors.

Different studies and reviews use varying criteria for defining the strength of association with youth violence, which makes it difficult to use a universal approach when collating evidence from different sources. The resources used in this rapid review are all distinct in their approach. For example, the Early Intervention Foundation (EIF) uses highly stringent statistical criteria as reported in individual research studies, the WHO report 'Preventing Youth Violence' does differentiate between strong

[11] Lösel, Farrington et al. - Direct protective and buffering protective factors in the development of youth violence 2012

and weak associations but does not go into detail about how these are defined, whilst the CDC does not make any distinction at all. Based on the EIF and WHO reports as well as evidence from more recent high-quality studies[12], risk factors with a strong association with youth violence are highlighted in the table below (see table key).

Ecological Levels

Risk and protective factors for many health and wellbeing outcomes are often grouped into the socio-ecological levels of influence. To provide a more nuanced analysis in the context of youth violence, 'relationships' can be further broken down into 'family', 'school' and 'peers'; the 'community' and 'societal' levels may be grouped together for simplicity.

Fig. 2 Risk factors ecological categories, from the EIF review of risk and protective factors[13]

Age Groups

The age categories used in the table below are based on the evidence from WHO and EIF reviews but have been modified to be less rigid (by not providing numerical age brackets) in order to reflect the heterogeneity and imprecision in the evidence-base. Based on the existing evidence, some risk factors are age specific and their importance does change over time. However, as the evidence base develops this picture will continue to evolve. It may be that particular risk factors have not been studied for all age groups or in a way that is broken down into sufficiently narrow age brackets, and as further evidence emerges the age boundaries for risk factors may change.

Gang Involvement

The EIF review also examines risk factors for youth gang involvement and discusses the overlap between the risk factors for youth violence and those for gang involvement. The risk factors common to both are highlighted in the table below (see table key).

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[12] Hughes, Karen, et al. - The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis 2017

[13] Early Intervention Foundation Preventing gang and youth violence: A review of risk and protective factors 2015

Risk Factors

Table 1. The established risk factors for youth violence by life course and ecological grouping

RISK FACTORS	Early Years	Early School Years	Adolescence	Young Adulthood
Individual	**Male gender**			
	Traumatic Brain Injury			
	Perinatal trauma			
	Foetal exposure to alcohol / tobacco / drugs			
	Low intelligence			
	Conduct disorder **Hyperactivity** **Troublesome behaviour**			
	Aggression socio-emotional needs			
	High daring, Low self-control			
	High psychopathic features Lack of guilt and empathy			
	Low self-esteem			
			Antisocial behaviour/delinquency	
			Positive attitude towards delinquency	
			Alcohol or drugs misuse	
			Unemployment	
Family	**Disrupted family life**			
	Teenage conception			
	Parental alcohol/substance misuse Parental mental health issues			
	Low emotional attachment or involvement with parents			
	Childhood maltreatment Family violence and abuse			
	4+ Adverse Childhood Experiences			
	Harsh or inconsistent discipline			
		Poor parental supervision		
	Family anti-social behaviour			
	Family unemployment Family poverty			
School		**Low academic achievement**		
		Low commitment to school **Frequent truancy**		
		Expulsion/suspension/exclusion from school		
Peer Groups		Peer rejection Bullying/victimisation		
		Delinquent peers		
			Gang membership	
Community		Neighbourhood disorganisation		
	Poverty Poor economic opportunities			
	Inequality			
	Exposure to drugs and illicit drugs markets			
	Access to alcohol			

Bold = *strong association with youth violence*
Grey = association with YV, not necessarily strong
Bold Orange = *strong association with YV and association with gang involvement*
Orange = *association with both youth violence and gang involvement*

Protective Factors

Table 2. The known protective factors for youth violence by ecological grouping

PROTECTIVE FACTORS	
Individual	**Social/moral beliefs, intolerance for deviance** **Prosocial attitudes** **Low impulsivity** Highly developed social competencies and planning skills Above average intelligence Low ADHD symptoms Low emotional distress
Family	**Good family management, use of strategies of constructive coping** **Stable family structure** **Infrequent child-parent conflict** Close, supportive relationship with parents, ability to discuss problems, frequent shared activities Good parental supervision, presence and involvement Parental disapproval of aggressive behaviour Above average socio-economic status
School	**Good academic achievement** High educational aspirations, reaching higher education Commitment to school (an investment in school and in doing well at school) • Exposure to school climates that are characterised by: • Intensive supervision • Clear behaviour rules • Consistent negative reinforcement of aggression • Engagement of parents and teachers
Peers	Social acceptance or popularity Close relationships with non-deviant peers Membership in peer groups engaging in conventional behaviour / do not condone antisocial behaviour Involvement in pro-social activities Involvement in religion and religious groups
Community	**Low economic deprivation** Neighbourhood cohesion, interaction and support Nonviolent neighborhood

Key Points

Useful points to note regarding risk/protective factors:

- It has been observed that the probability of violence decreases as the number of protective factors increases (a dose–response relationship) and vice versa for risk factors.

- Family-specific factors are particularly important in early life, but their importance appears to diminish with age.

- From school age onwards, individual level factors are often the most powerful predictors.

- Factors relating to past behaviour tend to be stronger predictors than 'explanatory' risk factors e.g. previous delinquency or substance misuse are more powerful predictors than childhood maltreatment or family poverty.

- Comparisons of findings from longitudinal studies from various countries suggest that there are more similarities than differences in risk/protective factors for serious youth violence; this implies good generaliseability of the findings from studies across the world

- There is growing evidence that risk and protective factors are also similar across generations.

- There are several factors that predict both youth violence and gang involvement however not all of them are strong risk factors for either outcome, although in a context such as London where a high proportion of serious youth violence may be linked with gang activity, these factors may be particularly key to address.

- There has been no rigorous analysis of risk factors in the specific context of London, however evidence from government surveillance; small-scale observational studies done by local public bodies; and qualitative information from key stakeholders can provide very useful intelligence. There is growing evidence to suggest that school exclusion, use of social media and racial discrimination may be significant in the UK context.

Challenges in talking about risk/protective factors in this context:

- Definitions and measures of risk and protective factors as well as the outcomes of interest will vary widely with each study. Unlike health conditions which are rigorously classified (in the International Classification of Disease), social and behavioural factors have no universal system of classification. Measuring behaviour and relationships is very difficult to do in an objective, consistent and generaliseable way.

- More robust study designs carry significant resource and ethical implications. There are very few randomised controlled trials measuring the impact of risk and protective factors due to ethical barriers. The next best design, longitudinal observational studies (those looking at populations over long periods of time, with no intervention) are highly resource- and time-intensive therefore there are few of these, especially from the UK. Case-control, retrospective cohort or cross-sectional studies (observational studies that are carried out in the short-term) are not as robust in their design and therefore results must be pooled and

evaluated for validity (using meta-analytic approaches) to provide reliable evidence. Even in this case it is impossible to definitively demonstrate a cause-and-effect relationship.

- As stated above, risk and protective factors are merely predictors of youth violence and not necessarily causative agents unless multiple causality criteria are met.

- Even in instances where there are underlying causal mechanisms, the interplay of risk and protective factors can be extremely complex. It is possible that many show buffering (harm-mitigating) or potentiating (harm-increasing) effects when they occur together - these can only be observed and understood if specific combinations of factors are studied in isolation.

Preventing Youth Violence

Scope of Review

The purpose of this review is to collate the most robust evidence available on what works to prevent serious youth violence, through the prism of what is most relevant for local authority-based commissioning in Lambeth.

A significant proportion of the available evidence has been generated in the USA and other foreign settings, and many of the most successful interventions have been commoditised; thus, implementing specific, highly-researched interventions with fidelity will undoubtedly be limited in Lambeth by resource constraints, applicability to the local context, socio-cultural acceptability, and feasibility within existing commissioning arrangements. Therefore, we have taken the approach of collating evidence in a thematic way as well as looking for evidence on key generic characteristics of successful interventions. In this way, evidence-based themes can be moulded into locally suitable ('Lambethised') interventions, co-produced with the community and incorporating key characteristics predictive of success.

With this purpose in mind, the key questions asked by this review of the global evidence-base, were:

1. Which **types of interventions** have the most and highest quality evidence for **directly preventing youth violence**, or for acting on some of the key risk and protective factors to **indirectly prevent youth violence**, in high-income settings[14]?

2. Are there any **key principles or characteristics of successful interventions,** in terms of preventing youth violence in high-income settings (directly or indirectly), for the purposes of locally designing interventions?

3. Are there any national guidelines or standards relating to violence or its risk factors that we should be following and benchmarking against (i.e. NICE guidelines)?

4. What is the existing evidence or guidance for **programme and policy design and constructing comprehensive packages of interventions** for preventing serious youth violence in high-income settings?

5. What are the **main gaps in the evidence base** that may be relevant for guiding controlled innovation with regards to youth violence prevention strategies on a local level?

In light of the multitude of published small-scale, quasi- and non-experimental studies, as well as the rapid pace of innovation in this field, the focus was on reviewing the highest levels of evidence, i.e. guidance from national accredited bodies (NICE) or UK governmental agencies (PHE), international accredited bodies (WHO, CDC, USAID), high-quality evidence clearinghouses (e.g. Early Intervention

[14] World Bank Income Classifications valid as of July 2014 (gross national income per capita in 2013): high-income countries (HICs) = US$12,746 or more.

Foundation), critically appraised systematic reviews (e.g. NIHR / DARE, Cochrane) and evidence collated for regional or national strategies.

A limited number of other review papers and primary research studies were included if they were published from 2016 onwards (which was the publication year of the most up-to-date WHO evidence review) or if they addressed evidence gaps that may be of particular relevance for Lambeth. Some grey literature was reviewed where it addressed gaps in published academic literature or was of particular relevance to Lambeth.

For each intervention theme, the particularly notable or high-impact interventions have been identified and discussed in further detail. This is usually with the aim of highlighting best practice, but also occasionally with the aim of highlighting low-quality or mixed evidence for interventions that may be well-known and assumed to be good practice.

Preventing Youth Violence – Effective Interventions

Definitions

Intervention Categories

As in any area of preventive science, interventions for youth violence prevention can be broadly categorised into primary, secondary and tertiary prevention, where primary interventions are available to all or most of the population and tertiary to a small higher-risk sub-population. This is a universally accepted method of classification, is understood across organisational and professional boundaries, and is similar to the approach used by the Scottish Violence Reduction Units.[15]

However, the traditional model does fail to cover some key types of prevention strategies that public health advocates for such as those occurring at legislative and societal levels. We have based our approach on a related model that includes 'contextual prevention' (see Fig. 4) - those measures that prevent the emergence of risk factors through action on environmental, legislative, economic, social and cultural levels.[16] Contextual prevention includes interventions that seek to change the contextual conditions within which youth violence tends to emerge.

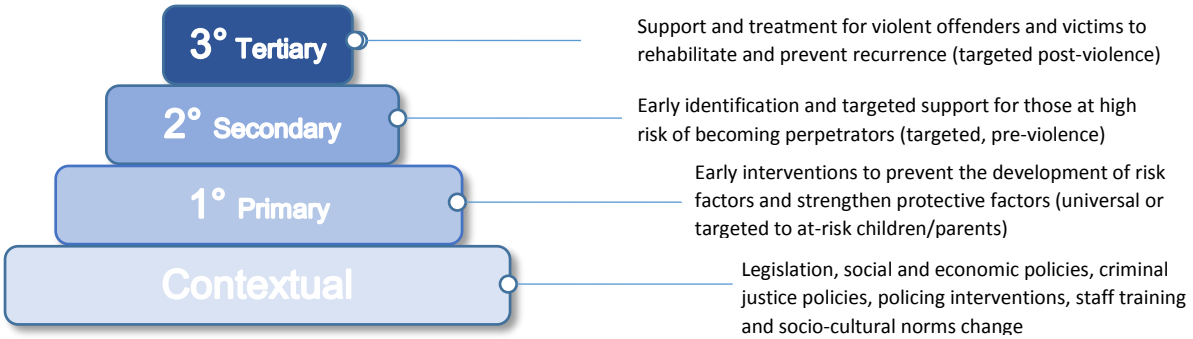


Fig 3. Prevention model used by this review

Evidence Ratings

The evidence summary tables are colour-coded according to the evidence base for effectiveness as outlined below:

Effective	Positive effect from >1 rigorous evaluations in high-income settings; **bold** = featured in multiple high-quality evidence reviews or clearinghouses
Promising	Positive effect from 1 rigorous study (+ other evaluations) or multiple non-experimental evaluations in high-income settings
Mixed	Multiple rigorous evaluations with discordant results in high-income settings
Evidence Gap	Seems prudent or some preliminary evidence from generalisable settings

Table 3. Evidence rating classifications (adapted from WHO, EIF and Crime Solutions evidence ratings)

[15] Scottish Violence Reduction Unit 10 Year Strategic Plan (publication date unknown)
[16] Last - Dictionary of Epidemiology 2008

Type

These are sub-categories of interventions within contextual prevention and refer to the different policy areas or levers within the broader 'contextual' category.

- **L** = legislative
- **HSE** = health, social and economic policies
- **CJ** = criminal justice policies
- **P** = policing strategies
- **E** = environmental modifications
- **T** = training for staff and public
- **SN** = socio-cultural norms change

Coverage (primary prevention)

This classification is valid for primary prevention only and differentiates between interventions that are applicable to the whole population (within particular age brackets or in specific settings) and interventions that are targeted towards those identified as being at risk of violence. It does not apply to the other prevention categories as contextual is by its nature universal and secondary and tertiary are by their nature targeted.

- **U** - universal (applicable for whole population)
- **AR** - at-risk (intended for targeted application to at-risk sub-populations)

Mechanism of Action (primary and secondary prevention)

For primary and secondary prevention, the following classification identifies whether the intervention has been shown to act directly to prevent violence or proven to act indirectly on violence via effects on the known risk factors for violence.

- **D** - direct (known effect on violence perpetration)
- **I** - indirect (known effect on risk or protective factors for violence)

UK Implementation

Specific programmes known to be implemented in the UK (as per the evidence considered by this review) are highlighted in purple font within the tables.

For more detailed information on specific interventions or programmes and their evidence base, please refer to programme websites or the following evidence clearinghouses:

- Early Intervention Guidebook https://guidebook.eif.org.uk/
- Youth Justice Resource Hub https://yjresourcehub.uk/effective-practice/library-of-effective-approaches.html?start=14
- CDC STRYVE Strategy Selector https://vetoviolence.cdc.gov/apps/stryve/strategyselector
- Crime Solutions database https://www.crimesolutions.gov/advsearch.aspx

Lambeth Strategic Themes

Lambeth's approach to Youth Violence prevention is structured in the following way:

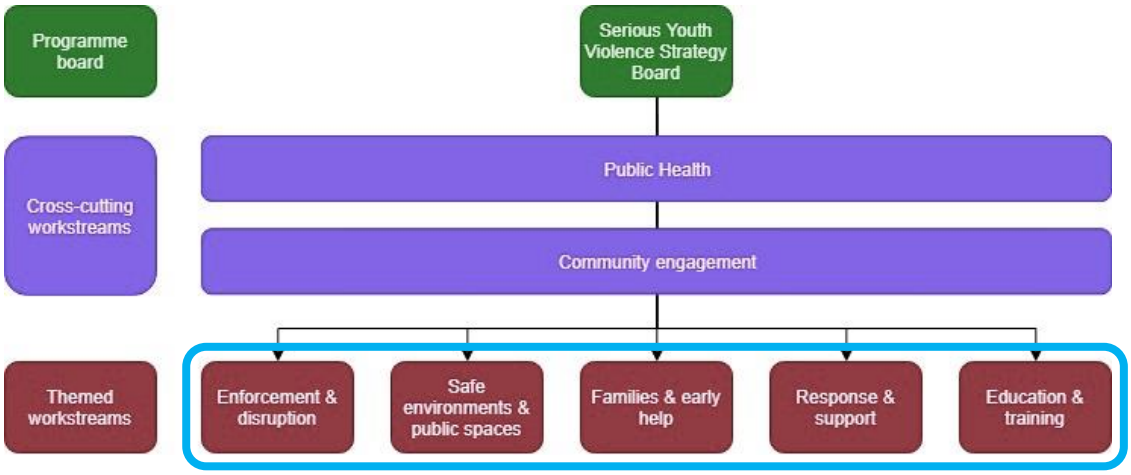


Fig. 4 Lambeth council's youth violence strategy development structure

The themed work-streams divide the programme intro strategic categories of work in a way that fits with the wider Borough context and ensures comprehensive programme delivery. The work-streams are defined in the following way:

- Enforcement & Disruption (ED) - implementation and enforcement of laws to prevent violent behaviours, reduce excessive drug and alcohol use, and limit youth access to firearms and other weapons

- Safe environments & public spaces (S) - Create and sustain safe streets and other environments where children and youth gather and spend time

- Families & early help (F) - Improve families' economic security and stability, reduce child maltreatment and intimate partner violence. To improve parenting practices where necessary and create positive parent-child relationships.

- Response & support (R) - Improve access to good-quality health, social welfare and criminal justice support services for all children who need them – including for reporting violence – to reduce the long-term impact of violence

- Education & training (ET)- Increase children's access to more effective, gender-equitable education and social-emotional learning and life-skills training, and ensure that schools know how to refer into the relevant agencies, what is available and that environments are safe and enabling

Across all prevention categories, each intervention theme is assigned to a work-stream that would lead on implementation, denoted by ● in the relevant column; and work-streams that should be involved, but not in lead capacity, are indicated by ● in the relevant column(s).

Contextual Prevention

Contextual prevention interventions are either universal or targeted interventions that act on systems, environments and communities rather than individuals or families. They can be subcategorised as follows:

- Legislation - national or local (bylaws) restricting practices that contribute to violence (**L**)
- Health, social and economic policy - addressing poverty and inequality and other socioeconomic factors (**HSE**)
- Criminal justice policies relating to violent offenders and victims (**CJ**)
- Policing strategies (**P**)
- Environmental modifications - built or social environment (**E**)
- Training for staff or public - those who may encounter violence perpetrators/victims as part of their job or in their community (**T**)
- Socio-cultural norms change (**SN**)

Table 4. Contextual prevention evidence summary table

Intervention Theme	Type	Purpose	Key Examples (***bold*** = well-evidenced *purple* = UK implementation)	Lambeth Workstream				
				ED	S	F	R	ET
Alcohol access policies	L	Preventing alcohol misuse Preventing interpersonal violence and abuse related to intoxication	**Restricting outlet density and location** **Restricting outlet opening hours, days** Increasing minimum unit price Increasing taxation Increasing minimum purchase age	●	●			
Weapons access policies	L	Preventing violence involving weapons Reducing physical harm as a result of violence	**Restricting access to firearms** Restricting access to knives Restricting access to acids and chemicals	●				
Data sharing approaches	L HSE P	Rapid and targeted response to violence	**Cardiff Model**	●	●		●	
Targeted policing	P	Increase neighbourhood safety Interrupt local spread of violence Improve social cohesion and community participation	**Hotspots policing** (+ data-sharing e.g. in Cardiff Model) Community-oriented policing Problem-oriented policing Disorder policing *Hotspots policing is often implemented jointly with …OP or POP*	●	●		●	
Environmental modification	E	Increasing safety and quality of environments to reduce risk of violence and other crime Increasing economic opportunity	**Crime prevention through environmental design (CPTED)** **Business Improvement Districts (BIDs)**		●			
Focused deterrence	P SN	Community-oriented multi-agency task force to suppress and interrupt violence through combination of enforcement and engagement methods	Pulling Levers *Various other focused deterrence strategies*	●			●	
Gender norms change	SN	Reducing all types of violence perpetrated by men	Coaching Boys into Men Safe Dates The Fourth R			●		●

		Reducing victimisation of women and children						
Poverty de-concentration	E	Increasing social cohesion Reducing inequality and increasing economic opportunity	Moving to Opportunities			●		
Staff training	T	Screening and early identification for those at risk Supporting those with traumatic experiences	Safe Environment for Every Kid (training for healthcare workers) Trauma-informed care training for staff involved w/ CYP *+ other teacher/staff training around attachment and trauma*				●	●
Bystander training	T	De-escalation of conflict and preventing violence	Bringing in the Bystander Green Dot				●	●
Restorative justice	CJ	Preventing re-offending and mitigating harms caused by violence	*Restorative justice approaches in youth courts*				●	
Household economic strengthening		Reducing family poverty, unemployment	Earned Income Tax Credits			●		
Street outreach, community norm change	SN	Community-oriented approach to engagement, conflict resolution and behaviour change to prevent violence	Scotland VRU Navigators Cure Violence model *some evaluations have shown significant negative violence outcomes*	**N/A**				
Control of drug markets	L CJ P	Reducing youth violence and gang activity due to the drugs economy Reducing risk of substance misuse	Decriminalisation Regulated legal supplies *Intensive law enforcement has been shown to increase drug-related violence*					
Social media								

Spotlight on a Well-Evidenced Intervention for Contextual Prevention

Cardiff Model

The Cardiff model for the prevention of violence involves collecting anonymized data on the "who, what, when, where and how" of violence-related injuries treated in hospital emergency departments and combining these with data on violence-related incidents recorded by police. The combination of health and police data allows for the more accurate prediction of future patterns of violence and the identification of violence hot spots, and is used to design and direct policing and other interventions such as:

- targeted policing, whereby the deployment of police units is aligned with the time and location of violence hot spots
- targeted police deployment to alcohol premises that are associated with increased incidents of violence
- alcohol licensing policies
- reducing the risks associated with specific weapon types (e.g. enforced use of plastic glasses, reductions in bottle availability, knife amnesties)
- public health and social strategies including drugs and alcohol services

An outcome evaluation of the Cardiff model found the strategy led to a 42% reduction in hospital admissions relative to comparison cities, and a 32% comparative reduction in woundings recorded by police. The evaluation also found a 38% comparative increase in violence not causing injury ("common assaults") reported to the police, which the authors suggest may have been due to faster and more frequent police intervention in assaults and their precursors (such as arguments), and increased reporting of common assaults by witnesses and victims and subsequent recording by police *(8)*. Furthermore, cost-effectiveness analysis of the Cardiff model estimates that it reduced the economic and social costs of violence by £ 6.9 million in 2007 compared with the costs Cardiff would have experienced without the programme. The cumulative social benefit-cost ratio of the programme from 2003 to 2007 was £ 82 in benefits for each pound spent on the programme.

The data-sharing component of the Cardiff approach has been officially adopted through a United Kingdom government Information Standard for Tackling Violence (ISTV). Case studies outlining use of data-sharing approaches are on www.publicinnovation.org.uk/Data_Sharing.html.

Primary Prevention

Primary prevention interventions can be either universal: interventions for children and their families to prevent onset of risk factors; or they can be targeted: early interventions for at-risk children to prevent onset/development of further risk factors or mitigate impacts of existing risk factors.

Table 5. Primary prevention evidence summary table

Intervention Theme	U / AR	D / I	Risk/Protective Factor	Key Examples (***bold*** = well-evidenced *purple* = UK implementation)	Lambeth Strategy Theme				
					ED	S	F	R	ET
Home visiting	AR	I	ACEs Maternal factors	**Family-Nurse Partnership** **Early Head Start** Healthy Families Model			●		
Home-based therapies	AR	I	ACEs Childhood maltreatment Social, emotional needs	**Multi-Systemic Therapy** Child First Homebuilders Parent-Child Interaction Therapy *Various multi-level psychosocial interventions for mother-child exposed to domestic violence*			●		
Pre-school skills development	U	D	Behavioural factors School factors Peer factors	**Sure Start** **Early Head Start** **Child-Parent Centres** **Perry Preschool** Let's Play in Tandem			●		●
Parental screening and intervention (domestic/ intimate partner violence, substance misuse)	AR	I	ACEs Domestic violence Parental substance misuse	Safe Environment for Every Kid (SEEK)			●	●	
Attachment interventions	AR	I	ACEs, attachment Behavioural factors	**Child-parent psychotherapy**			●		
Parental abuse education	U AR	I	ACEs	Shaken baby prevention project			●		●
Parenting / family skills programmes	U AR	D	ACEs Behavioural factors Family factors	**Incredible Years** **Triple P** **Families & Schools Together** **Positive Action** **Family Foundations** **Parent Management Training** **Oregon Model** **Coping Power** **Family Check-up for Children** **Parent Corps** Parents/Families Matter Guiding Good Choices ***Other trauma-informed parenting interventions***			●		●
Parenting for children with high behavioural needs	AR	I	Behavioural factors	**New Forest Parenting Programme (ADHD)** Helping the Noncompliant Child Strengthening Families 10-14 Empowering Parents, Empowering Communities INSIGHTS into Children's Temperament			●		●
Foster care interventions	AR	I	ACEs Behavioural factors	Kinship foster care KEEP			●		

School-based social, emotional development	U AR	D	Behavioural factors School factors Peer factors	**Incredible Years** **PATHS** **Positive Action** **Steps to Respect** Second Step FRIENDS suite First Step to Success			●		●
Bullying prevention	U	I	Peer factors	**Olweus** **Kiva** **Steps to Respect**			●		●
Classroom management	U AR	I	Behavioural factors School factors	**Incredible Years** Good Behaviour Game			●		●
School-based preventative training (alcohol, substance misuse, sexual and dating violence, abuse)	U AR	I	ACEs Substance, alcohol misuse	**Life Skills Training (LST), Advanced LST** Safe Dates Real Consent BASICS Lions Quest Skills for Adolescence Stay Safe Towards No Drug Abuse					●
Literacy skills	AR	I	School factors	**Reading Recovery** Raising Early Achievement in Literacy The Communicate Project Success for All					●
After-school enrichment	AR		School factors Social/emotional factors	After School Matters LA's BEST	**N/A**				
Peer mediation	AR		Peer factors	*Various peer mediation programmes*					
Gang involvement prevention									

Spotlights on Well-Evidenced Interventions for Primary Prevention

Family Nurse Partnership (FNP)

FNP is a home visiting programme for vulnerable young mothers expecting their first child.

Mothers enrol in the programme early in their pregnancy and receive visits from a family nurse on a weekly basis just before and after the birth of their child and then fortnightly until their child's second birthday. During these visits, mothers learn about their child's health and development and receive support for their own wellbeing. A trained family nurse delivers FNP through up to 64 home-based weekly, fortnightly, or monthly sessions, to young first-time mothers. Each session lasts 60-90 minutes.

Home visits are structured and delivered using a wide range of materials and activities that build self-efficacy, change health behaviour, improve care giving, and increase economic self-sufficiency.

FNP has established evidence from 5 randomised controlled trials demonstrating significant benefits for the mother and child relating to youth violence (later in life) and its risk factors, including preventing arrests and convictions in adolescence, preventing substance misuse, preventing child maltreatment, reducing behavioural problems in childhood and improving school achievement.

The Triple P – Positive Parenting Program

Triple P is a multi-level system of parenting interventions that aims to prevent behavioural, emotional, and developmental problems in children and enhance the knowledge and skills of parents.

Different levels of Triple P are available from universal implementation through to delivery targeting at-risk and high-risk children. For example, Standard Triple P is for parents with a child between 0 and 12 years old who have concerns about their child's behaviour. With Standard Triple P, parents attend ten one-to-one weekly sessions with a therapist, lasting approximately one hour. Parents learn up to 17 different strategies for improving their children's competencies and discouraging unwanted child behaviour. Learning is supported through role-play and homework exercises. A group-based version is also available, which involves group discussions of video-based examples of effective parenting strategies.

Standard Triple P has been implemented in the UK and has established evidence from several randomised controlled trials of improving child behaviour and parent competence.

Incredible Years suite (all have been implemented in UK)

Incredible Years Basic Parent Training Program (IY-Parent)

IY-Parent is a group-based parent training intervention for parents with concerns about the behaviour of their child aged 1-3 (toddler), 3-5 (preschool), or 6-12 (school age). Tailored to the age group of the child, it aims to improve parenting skills and children's behaviour, to prevent the development of conduct problems, anti-social and other problem behaviours in the long term.

Typically, groups of 10-14 parents attend weekly 2-hour group sessions for 12-20 weeks, delivered by a trained and accredited lead practitioner and co-practitioner. Sessions include video clips of real-life situational vignettes to support training and simulate parenting group discussions, problem solving, and practice exercises such as role-play (acting out situations as the parent or child). It can be delivered in children's centres, health centres, schools, and other community settings.

This programme has good evidence of providing long-term benefits for parents and children, such as reduced conduct problems among children and improved parenting practices

Incredible Years Teacher Classroom Management (IY Teacher)

IY-Teacher has initial evidence of improving children's prosocial behaviour, reducing conduct problems, and increasing school attendance.

For this programme, teachers attend 6 workshops where they receive training from trained and accredited IY Group Leaders, delivered throughout the school year. Group leaders learn how to improve teachers' classroom management strategies to support children's school readiness and prosocial behaviour. Group leaders also learn strategies for improving communication between parents and teachers.

This programme has initial evidence of short-term improvements in children's behaviour at home and in the classroom from several randomised controlled trials.

Incredible Years Child Training Programme – Dinosaur Curriculum

This is a "pull out" curriculum for children between the ages of two and eight.

Small groups of six to eight pupils with behavioural problems attend weekly two-hour therapist-led sessions where they learn strategies for managing their feelings, friendships, and behaviour at school. During the programme, children engage in fun activities that allow them to practise and improve their empathy and perspective-taking skills, interactions with friends, anger management, and ability to follow school rules. Teachers and parents receive weekly letters explaining the concepts taught to children and suggestions for strategies that can be used in the classroom or at home. Children are assigned activities that they can complete with their parents at home. The parent and teacher complete weekly good behaviour charts for each child.

This programme has initial evidence of short-term improvements in children's behaviour at home and in the classroom from several randomised controlled trials.

Families and Schools Together (FAST)

FAST is a multi-family group programme for any parent or carer of a child between the ages of three and eight, designed to build protective factors for children, empower parents to become more effective family leaders, build positive relationships between families, schools, and communities, and prevent child problem behaviours, school drop-out, substance misuse, and anti-social behaviour.

Programme begins with an active outreach phase to engage and recruit families from schools. A trained FAST team made up of representatives from the school and community deliver the programme. Each FAST team can support up to 10 families, and schools can have up to 4 FAST teams, meaning it is possible for up to 40 families to attend a programme if the groups are run together. Initially, parents and children attend 8 weekly group sessions, lasting 2.5 hours each, where they learn how to manage their stress and support their child's development. Includes parent–child activities with coaching and homework assignments to practise skills at home. After parents "graduate" from the 8-week programme, parents have the opportunity to attend small parent group monthly meetings for 2 years.

This programme has been implemented in the UK and has established evidence from multiple trials, demonstrating both short- and long-term positive outcomes on child aggression and other problem behaviours.

Positive Action

Positive Action is a school-based curriculum developed to support children's prosocial behaviour, school performance, and family functioning. Different versions of the Positive Action curriculum are available for different age groups, beginning with reception and ending with Year 11

Teachers deliver Positive Action in sessions lasting between 15 and 20 minutes, which are fully integrated into the mainstream curriculum for all students. Pupils typically receive 35 hours of Positive Action curriculum in a school year. Additional counselling support is available for children with more complex needs. There is also a family kit available to parents who wish to deliver the curriculum to their children. Sessions consist of teaching, as well as activities such as role-playing, songs, and games.

The curriculum covers 6 topics: self-concept and making positive choices; nutrition, exercise and good hygiene and sleep habits; empathy and respect for others; exercising self-control and control over resources i.e. time and money; goal setting and persistence; and honesty and how to resist the impulse to rationalise their actions or blame others when they have made a mistake.

Positive Action has been implemented in the UK and has established evidence from a number of RCTs of significant short- and long-term reductions in substance misuse and anti-social behaviour (including serious violence) and improvements in children's academic achievement.

Secondary Prevention

Secondary prevention involves targeted interventions for children/young people and families with established risk-factors to prevent progression of risk and mitigate harmful effects.

Table 6. Secondary prevention evidence summary table

Intervention Theme	D / I	Risk/Protective Factor	Key Examples (***bold*** = *well-evidenced* *purple* = *UK implementation*)	Lambeth Strategy Theme				
				ED	S	F	R	ET
Behavioural / skills-building interventions	D	Behavioural factors Social/emotional factors Peer factors	**SNAP Under 12 Outreach** **Aggression Replacement Training** **Reasoning and Rehabilitation** Second Step Ether Programme Wipers (for BAME)			●		●
Therapeutic foster care	I	ACEs Delinquency	**Multi-Dimensional Treatment Foster Care (aka Treatment Foster Care Oregon)**			●		
Substance misuse interventions	I	Substance misuse Behavioural factors	**Multi-systemic Therapy for Substance Misuse** **Drug dependence therapies e.g. methadone** **Functional Family Therapy** **Adolescent Community Reinforcement Approach** Contingency Management Interventions for Substance Use Disorders			●	●	
Therapeutic approaches for trauma	I	ACEs Social/emotional factors	**Trauma-focused CBT** **Cognitive Behavioural Interventions for Trauma in Schools** Psychotherapy for sexual abuse/assault Support for Students Exposed to Trauma (SSET)				●	
Family-based therapies	D	ACEs Family factors	**Multi-systemic Therapy** **Multidimensional Family Therapy** Positive Family Support Strong African American Families			●	●	
Restorative Justice and Diversion	D	Delinquency	Youth Justice Liaison & Diversion Scheme Triage, Enhanced Triage Youth Restorative Intervention Adolescent Diversion Project (Michigan)				●	
Vocational training	D	Unemployment	*Various vocational training programmes*	N/A				
Mentoring programmes	D	Peer factors Behavioural factors	**Big Brothers Big Sisters of America** Spark2Life Scotland VRU Mentors in Violence Prevention					
Sports-based programmes	D	Behavioural factors	*see London's Project Oracle evaluation*					
Gangs Diversion								
Alternatives to school exclusion								
Truancy and dropout prevention								

Spotlights on Well-Evidenced Interventions for Secondary Prevention

Multidimensional Treatment Foster Care – Adolescent / Treatment Foster Care Oregen Adolescent

MTFC-A is for families with a child between the ages of 10 and 17 who is at risk of an out-of-home placement in foster or residential care because of delinquent behaviour and/or serious emotional problems.

Children are placed with a "treatment foster family", who are trained in the MTFC-A model, for an average period of a year. Within these warm and structured family environments, children receive positive and consistent reinforcement for appropriate behaviour and negative consequences for inappropriate behaviour. The young person receives therapy, as does the biological (or adoptive) family, if the plan is for the child to be reunited with them. Family therapy usually continues for three months after the child is reunified with their family or placed in a permanent home.

MTFC-A has been used in the UK and has established evidence from multiple randomised controlled trials reducing children's behavioural problems, their future arrests, and their use of illegal drugs and suggesting that children placed in MTFC homes are significantly less likely to be rearrested and run away from home

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

TF-CBT is a therapeutic intervention for children and families who have been exposed to a traumatic event. Children and their parents attend between 12 and 18 sessions where they learn cognitive strategies for managing negative emotions and beliefs stemming from highly distressing violent or abusive experiences.

TF-CBT is delivered by a highly trained psychologist to parents and their children via weekly sessions, typically over 12 to 18 weeks depending on the severity of the child's symptoms and the family's needs. Parents and their children attend separate 30 to 45 minute sessions during the beginning phases of the therapy. This provides a safe therapeutic environment where, for example, the child learns to manage negative feelings and behaviours and parents learn strategies for communicating with their child and managing their child's behaviour.

This programme has been implemented in the UK and has established evidence from several randomised controlled trials demonstrating short- and long-term improvements in the psychological symptoms associated with traumatic experiences, improving the symptoms of PTSD as well as reducing negative child behaviours.

Multidimensional Family Therapy (MDFT)

MDFT is for families with a child between the ages of 13 and 18 who are experiencing behaviour or substance misuse problems.

MDFT is delivered by a trained therapist who works with the adolescent, parents, and family through separate and joint sessions that last between 30 and 90 minutes each. MDFT sessions take place one to three times a week, depending on the needs of the family and service delivery setting. Families work with the therapist for a period typically lasting 4-6 months. Individual sessions with the adolescent promote problem-solving skills and resiliency. Sessions with the parents aim to improve parents' own emotional life; increase their involvement with their adolescent; improve the parent–adolescent relationship; enhance their parenting skills (especially their ability to monitor their adolescent's activities and peer relationships); clarify expectations; and set limits on problematic behaviour. Family sessions aim to improve communication and family problem-solving skills and decrease conflict.

MDFT has established evidence from multiple randomised controlled trials demonstrating short- and long-term improvements in young people's substance misuse, delinquent behaviour, and school performance.

Spotlight on a Promising London-based Intervention for Young People from BAME Backgrounds

Ether Programme (run by Wipers)

The programme aims to support young people from BAME background to increase personal development and leadership skill. The target group is male 10-17 year-olds from BAME backgrounds. The programme is 8 weeks long, with each session lasting 90 minutes. Some of the core components of the Programme include: identity and perception of self, self-esteem and confidence, attitude and behaviour, independent thinking

Wipers run the programme on behalf of the Service, on site (or where deemed appropriate) and also complete pre- and post-questionnaires with young people to track any changes.

Camden YOT have a Session Worker that attend together with the Wipers team to support and co-facilitate the Ether sessions. The staff that attends from the YOT is a staff member that is also from a BAME background, in keeping with the ethos of the programme. Camden YOT pay for the programme, which runs on average twice yearly, via the YOT budget. Hammersmith and Fulham, also commission the training through the YOT budget as well as match funding opportunity with Wipers.

Both Hammersmith and Fulham YOS and Camden YOT overall have both received positive feedback from the young people and staff around the programme. Wipers, complete an evaluation at the end of the programme with the Services and provide that information.

Tertiary Prevention

Tertiary prevention involves interventions designed to support individuals who are already involved in serious youth violence and try to positively impact their future behaviour and life trajectories.

Table 7. Tertiary prevention evidence summary table

Intervention Theme	Purpose	Key Examples (***bold*** = *well-evidenced* *purple = UK implementation)*	Lambeth Strategy Theme				
			ED	S	F	R	ET
Therapeutic interventions for victims	Harm reduction and support Prevent victimhood → perpetration	**Trauma-focused CBT** **Cognitive Behavioural Intervention for Trauma in Schools** Prolonged Exposure Therapy Trauma Affect Regulation: Guide for Education & Therapy (TARGET)				●	
Therapeutic interventions for perpetrators	Prevent future violence Mitigate harms caused by perpetration and associated factors	**Multi-Systemic Therapy** **Multidimensional Treatment Foster Care** **Functional Family Therapy** Aggression Replacement Training *+ other CBT-based and counselling/skills-training-based approaches*				●	
Hospital-based interventions	Identification and intervention in the A&E setting for young people engaging in interpersonal violence to reduce both victimisation and perpetration by making use of a 'teachable' or 'reachable' moment	**SafERteens** RedThread Oasis Project SYNC Caught in the Crossfire ***Case management interventions*** *Brief interventions in ED*				●	
Risk assessment tools	Prediction or risk assessment for future violent behaviour	SAVRY Youth Level of Service/Case Management Inventory (YLS/CMI) Hare Psychopathy Checklist Violence Risk Appraisal Guide (VRAG) Historical, Clinical, Risk management-20 (HCR-20)				●	
Youth offender multi-agency rehabilitation	Comprehensive resettlement support including addressing substance misuse, accommodation, mental health issues, and education or employment needs and mediating with families and peers to prevent re-entry into custody.	Resettlement Support Panels (Wales) Resettlement Consortia (England)				●	
Youth court-based early intervention	Multi-agency early intervention and support, including referrals for training, education, learning disabilities, substance misuse, debt counselling, mental health issues and guidance on effective parenting, for youth and families attending court to prevent further offending.	Problem-Solving Approach Blackburn Youth Court				●	
Vocational training	D	*Various vocational training programmes*	N/A				

Spotlights on Well-Evidenced Interventions for Tertiary Prevention

Multi-systemic Therapy (MST)

MST is for families of young people between the ages of 12 and 17 who have exhibited serious anti-social and delinquent behaviour.

MST therapists provide the young person and their parents with individual and family therapy over a four to six-month period with the aim of doing "whatever it takes" to improve the family's functioning and the young person's behavior.

A therapist delivers MST to individual families, typically in their home. The therapist is available to the family 24/7 and carries a caseload of three to four families at a time. Therapy sessions typically last between 50 minutes and 2 hours. The frequency of sessions varies depending on the needs of the family and the stage of the treatment, typically ranging from three days a week to daily, over an average of 4-6 months. The MST model views the parents as the primary agents of change. Each family's treatment plan therefore includes a variety of strategies to improve the parents' effectiveness and the quality of their relationship with their child. It is essential that these strategies "fit" with each family's unique set of strengths and weaknesses.

A key aim of the intervention is to help families assume greater responsibility for their behaviours and generate solutions for solving their problems.

MST has been implemented in the UK and has established short- and long-term evidence of improving family functioning, decreasing anti-social behaviour and reoffending rates, the need for imprisonment, and the need for out-of-home care from over 20 international studies.

Functional Family Therapy (FFT)

FFT is for young people between 10 and 18 years involved in serious anti-social behaviour. The young person is typically referred into FFT through the youth justice system at the time of a conviction.

The young person and his or her parents attend a one- to two-hour session with the FFT therapist on a weekly basis. Families with moderate needs typically require 8 to 14 sessions; families with more complex needs may require up to 26 to 30 sessions spread over a six-month period. The FFT model has five phases: engagement in change; motivation to change; relational/interpersonal assessment and change planning; behaviour change; and generalisation.

The primary goal of the initial phases is to increase family members' motivation for change by improving the quality of their communication and daily interaction. Therapists do this by "reframing" the young person's and parents' behaviour, so that family members have a better understanding of each other's actions and are less likely to attribute blame. New strategies for family interaction are carefully matched to the family's needs and capabilities, and include communication, problem solving, and mood management skills. During the final phase, family members learn to "generalise" the skills learnt to contexts outside the immediate family, including the youth's school, peers, and the wider family system.

FFT has been implemented in the UK and has established evidence of reducing young people's offending and other delinquent behaviours, where the programme was implemented with a high level of fidelity, from several randomised controlled trials.

CBT approaches for offenders

CBT focuses on changing the distorted thinking and behavior of criminal and juvenile offenders, including self-justificatory thinking, misinterpretation of social cues, displacement of blame, deficient moral reasoning, and schemas of dominance and entitlement, among others (Lipsey et al., 2007). CBT assumes that such deficits are changeable rather than inherent and works to correct them using a set of structured techniques including cognitive skills training, anger management, and various supplementary components related to social skills, moral development, and relapse prevention.

Anger control and interpersonal problem-solving components were associated with stronger effects, while victim impact and behavior modification components18 were associated with weaker effects. Sound implementation includes the limiting of treatment dropouts, careful monitoring of treatment implementation, and adequate training for treatment providers.

CBT was more effective when combined with other services, rather than when operating as a stand-alone intervention. Examples of such services included mental health counseling, employment and vocational training, and approach educational programs. Second, "brand name" versions of CBT did not outperform "generic" versions, meaning that it is "the general CBT, and not any specific version, that is responsible for the overall positive effects on recidivism." Third, CBT was as effective for juveniles as adults and could therefore be useful in both juvenile justice and criminal justice settings. Fourth, the setting of CBT treatment did not affect its performance. Offenders treated in prison performed as well as offenders treated in the community.

National Implementation Service

(https://www.evidencebasedinterventions.org.uk/about/national-implementation-service)

The National Implementation Service provides training and support for evidence-based programmes targeted to looked-after children, children on the edge of care or custody, adopted children, and their families. It provides support to children's social care, youth offending services and children's mental health teams.

The NIS is delivered by the South London & Maudsley NHS Foundation Trust (SLaM) and Central Manchester University Hospitals NHS Foundation Trust (CMFT) in collaboration with the Institute of Psychiatry, Kings College London. It is a member of the European Implementation Collaborative and has worked with the (UK) Department for Education, the Health and Education Authority in Scotland, the Government Outcomes Laboratory, and the University of Oregon.

The interventions supported by the NIS are Multisystemic Therapy (MST), Treatment Foster Care Oregon (TFCO, previously known as Multidimensional Treatment Foster Care), KEEP (Keeping foster and kinship carers trained and supported), RESuLT, AdOpt and TEND. These interventions are supported by the Department for Education, the Department of Health and the Youth Justice Board.

The NIS consists of various teams who oversee the interventions and are specifically responsible for programme set up, ensuring model fidelity and supervision and consultation with the partnerships either directly or in collaboration with the relevant programme developers. They work with 70 local authorities through 58 local partnerships (Lambeth is not currently one of these). Local authorities have demonstrated improved outcomes and integrated these programmes into their local service provision in a sustainable and cost-effective way. The programme has also supported the development of new commissioning and delivery models.

MST

Multi-systemic Therapy (see earlier)

FFT

Functional Family Therapy (see earlier)

AdOpt

AdOpt is a UK based parenting programme for adoptive parents. It is suitable for the adoptive parents of children aged 3 – 8 years - both pre and post adoption - and is designed as a preventative programme to help parents understand and respond to the complex needs of their children, getting them off to a healthy start.

The programme is a collaboration between Professor Phil Fisher (Professor of Psychology, University of Oregon) the National Implementation Service and the Department for Education (DfE), who commissioned the programme.

AdOpt groups are delivered by two trained facilitators, one with expertise in the adoption field, and the other with expertise in social care and social learning theory approaches. Sessions are 90 minutes long and run weekly for 16 weeks.

KEEP

Keeping Foster and Kinship Carers Supported is a 16- or 20-week training programme. It is delivered by two KEEP trained facilitators in 90-minute sessions to groups of 8-10 carers. KEEP is developed specifically by Oregon Social Learning Center for foster and kinship carers. In the UK Special Guardians also access the programme.

KEEP works as a prevention programme to:

- Increase the parenting skills of carers
- Decrease the number of placement disruptions
- Improve child outcomes
- Increase the number of positive placement changes for permanence (e.g. reunification, adoption)

RESuLT

RESuLT is a social learning theory-based programme for children's homes staff which enables them to develop the skills needed to respond appropriately to children, balancing behaviour management with helping young people develop self-efficacy and skills to be successful beyond leaving care.

RESuLT provides half-day training sessions over 10 weeks for children's home teams. The training is delivered by two facilitators; one from the Residential Child Care Sector and the other from Child and Adolescent Mental Health Services (CAMHS).
RESuLT aims to:

- Promote consistent child focused practice.
- Provide a shared practice language and methods of working.
- Increase 'within team' communication and staff motivation at work.
- Put theory to practice.
- Promote the idea that 'every exchange is a potential intervention'

TEND

The Training to Enhance and Nurture Development programme brings together understanding from attachment theory, social learning theory and brain science. TEND is an adaptation of Filming Interactions to Nurture Development which has been designed and continues to be developed at Oregon Social Learning Centre by Fisher and colleagues.

TEND is a 12-session group-based intervention for caregivers of small babies and children (0-4) and utilises video coaching, the "serve and return" framework and toolbox skills. TEND has been evaluated with foster carers and looked after children and is applicable to adoptive and birth families.

TEND can be run in partnership with local authority children's services and/or third sector organisations.

TEND tries to increase sensitive parenting to encourage secure attachment. It also tries to enhance positive parenting skills which supports healthy child development, reduce challenging behaviour, increase pro-social behaviour and reduce carer stress in the face of difficult behaviours. The intervention gives caregivers the opportunity to try to repair some of the effects of early childhood adversity on brain development by focusing on the minutiae of carer-infant interaction.

Cure Violence Model

An example of a widely implemented and highly-publicised intervention with mixed evidence

The Cure Violence model is a public health approach to gun violence reduction that seeks to change individual and community attitudes and norms about gun violence. It considers gun violence to be analogous to a communicable disease that passes from person to person when left untreated.

The CV model was developed by Dr. Gary Slutkin at the University of Illinois at Chicago and is still managed there. The CV program relies on three key elements to stop the transmission of violent behavior:

1. Interrupting transmission directly (by preventing retaliatory shootings, mediating ongoing conflicts, and continuing to follow up to keep the conflicts "cool.")
2. Identifying and changing the thinking of potential transmitters (i.e., those at highest risk of perpetrating violence)
3. Changing community norms regarding violence

Participants recruited to receive the treatment of CV must meet at least four of seven criteria: (a) gang-involved, (b) major player in a drug or street organization, (c) violent criminal history, (d) recent incarceration, (e) reputation of carrying a gun, (f) recent victim of a shooting, and (g) being between 16 and 25 years of age.

The mix of staff members in the CV model reflects the balance of program components. Some staff members are hired to stop violent incidents through direct intervention. These individuals, known as violence interrupters (VIs), are selected for their own experiences with crime and violence. They are hired for their ability to establish relationships with the most high-risk young people in the community, usually young men between the ages of 15 and 30. The VIs form relationships with high-risk youth and monitor ongoing disputes to learn about potential acts of retaliation before they happen. When someone is injured or shot, the victim's friends and associates are likely to seek revenge. The VIs from CV seek out those associates and try to "talk them down" or persuade them that there are other ways to negotiate the conflict without engaging in more violence that could risk their liberty and their own lives.

VIs must be carefully recruited. They need to be seen as credible messengers by the most high-risk young people in the community. Many VIs are former high-level or popular gang members who have changed their lives—often after a stint in prison. They need to know about the daily routines of people who are involved in criminal lifestyles. They cannot be judgmental or be perceived as outsiders, and they cannot be seen as police informants. Ideally, they should come from the same communities in which they are working, and they should demonstrate in their own lives and personal conduct that it is possible to be both law-abiding and respected in the neighborhood.

Another key position in the CV model is the outreach worker (OW). Outreach workers are similar to case managers. Like the VIs, the OWs need to have trusting relationships with the most high-risk individuals in the community, and it helps if the OWs have also had prior involvement with the justice system. OWs use their relationships with program participants to help connect high-risk individuals to positive opportunities and resources in the community, including employment, housing, recreational activities, and education. OWs carry caseloads of up to 15 participants.

While the VIs and OWs focus their efforts on the young people most at risk of transmitting violence, they and other CV staff work collaboratively with neighborhood partners to pursue the other key element of the CV model: changing social norms. The program does this using various activities, including media campaigns, signs and billboards, and public events such as antiviolence marches and post-shooting vigils. The CV program supports a wide range of activities that expose the community to effective antiviolence messages to build a general social consensus against violence. In this way, the CV model works at both ends of the spectrum of behavioral transmission: to both the senders and the receivers of social messages related to violence and the acceptance of violence. The program conducts outreach to faith-based organizations, neighborhood associations, tenant councils, and other community-based organizations in an effort to gain community support and facilitate an understanding of program goals. In addition, the program model includes building a relationship with law enforcement to assist with access to strategic information on crime patterns and to involve the police in the hiring of OWs and VIs.

While the model has garnered much attention and recognition, evaluation results of the various implementations of the model have been decidedly mixed[17]:

- Chicago, Illinois (Chicago-CeaseFire): mixed results, effective in 4/7 sites only

- Baltimore, Maryland (the Safe Streets program): mixed effects on shootings with large positive effects in some sites but not others; 3/4 sites showed significant positive attitude changes

- Brooklyn, New York City (Save Our Streets): no significant effects

- Phoenix, Arizona (the TRUCE program): reduction in assaults but increase in shootings

- Pittsburgh, Pennsylvania (One Vision One Life): zero positive effect, slight worsening of violent crime outcomes

Across the implemented programs and evaluations, investigators suggest mixed effects may be related to variations in the outreach workers, how well the program is managed and implemented, and other community contextual factors, such as shifts in gang violence and support from neighborhood organisations.

Despite challenges with implementation, the review authors do suggest that the model has a unique advantage - it is potentially very cost-efficient and places less demand on the resources of law enforcement and the criminal justice system, for which reason they advocate that the model merits further investment and investigation.

[17] Butts J. A. et al. - Cure Violence: A Public Health Model to Reduce Gun Violence 2015

Gangs

An example of a gap in the evidence

The Home Office Ending Gang and Youth Violence program[18] definition of 'gang' is:

> *A relatively durable, predominantly street-based group of young people who:*
>
> - *See themselves (and are seen by others) as a discernible group*
> - *Engage in criminal activity and violence*
>
> *And may:*
>
> - *Lay claim over territory (geographical or illegal economy territory)*
> - *Have some form of identifying structural feature*
> - *Be in conflict with other, similar gangs*

Gang-related violence is of particular interest to policy-makers in London (including Lambeth), as a significant proportion of youth violence, especially that involving the use of weapons and leading to fatal outcomes, is related to gang activity. Unfortunately, there is a significant gap in the evidence when it comes to effective interventions for preventing gang involvement or changing gang behaviour.

A 2012 report commissioned by the Department of Health also found the evidence-base on what works to prevent gang involvement to be very limited.[19] Three years on, in its 2015 review of early interventions to prevent youth violence and gang involvement, the EIF also reported a lack of robust, high-quality evidence for interventions relating to gangs, despite a range of strategies and interventions currently being used.[20] For example street outreach is often used as one of the primary mechanisms of engaging youth at risk of gang involvement, but rigorous and systematic evaluations of such programmes are a gap in the literature.[21] A systematic review focusing on cognitive-behavioural interventions for preventing youth gang involvement in 7- to 16-year olds found no research of sufficient rigor (randomised or quasi-randomised controlled trials) matching the inclusion criteria.[22]

Of the few reviews that have identified studies with higher-quality designs, it is often the case that there are too few studies to draw reliable conclusions, a lack of statistically significant impacts, and/or a focus on attitudinal changes rather than behavioural changes in terms of outcomes (EIF). A systematic review by Project Oracle synthesised 12 programme evaluations aimed at reducing gang and youth violence in London. Of these, only two evaluations included a control group, and most measured the attitudes of young rather than any changes in their behaviour.[22]

Additionally, the content of gang and street violence prevention programmes varies widely, making evaluation difficult. While a few individual studies show positive outcomes for gang violence

[18] UK Government Ending Gang Violence and Exploitation 2016
[19] PHE Protecting people, promoting health: A public health approach to violence prevention for England 2012
[20] Early Intervention Foundation What works to prevention gang involvement, youth violence and crime 2015
[21] Gebo, Erika - An integrated public health and criminal justice approach to gangs: What can research tell us? 2016
[22] Fisher H. et al. - Cognitive-behavioural interventions for preventing youth gang involvement for children and young people 2008

prevention, the evidence is far weaker when results are pooled across studies (WHO). A systematic review of 17 USA-based studies looking at comprehensive interventions for gang-related crime outcomes found no statistically significant effects overall though based on small positive effects across some studies, it did suggest that comprehensive interventions that combined elements of personalised case management, community involvement in planning and delivery of interventions, and the provision of incentives to gang members to change offending behaviour, were more effective than those that did not.[23]

In a 2012 review by Gravel et al. of gang control strategies across 38 studies, the heterogeneity of study prevented a quantitative analysis of results, however the findings did suggest that gang prevention strategies showed little signs of effectiveness because of an overly broad approach that included many young people who were unlikely to join a gang. The authors also found that comprehensive and holistic strategies were not effective at reducing gang activity but that strategies seeking to regulate the behaviour of gangs showed some signs of effectiveness, especially those adopting a focused deterrence approach. Programs strictly focused on providing prosocial alternatives to gang members were less effective than those focused on preventing specific gang behaviours.[24] A 2016 review by Erika Gebo[25] suggests that comprehensive approaches such as the Comprehensive Gang Model used by the US national government (whereby agencies engaged in secondary and tertiary prevention, including police and prosecution, work with the community towards gangs prevention) face major challenges in implementation fidelity, working collaboratively and effective data sharing. Gebo concludes that a public health violence prevention approach may be more successful than a gang-specific focus at the secondary prevention stage as much more is known about what is successful in preventing violence than what is successful in preventing gangs.

[23]Hodgkinson J. - Reducing gang related crime: a systematic review of 'comprehensive' interventions 2009

[24] USAID What Works In Reducing Community Violence 2016

[25] Gebo, Erika - An integrated public health and criminal justice approach to gangs: What can research tell us? 2016

Principles of Effective Interventions

Although all interventions will differ in their target group, exact specifications and intended outcomes, there is some evidence to indicate that there are key characteristics or principles shared by effective interventions. Some are generic and apply to interventions across all prevention levels, while others are specific to certain levels of prevention due to their impact on the target population.

All Prevention Levels

Determinants of success that are generaliseable across all intervention types:

- Specificity to people, places and behaviours at highest risk
- Proactive engagement with high-risk populations
- Utilising positive feedback loops between formal and informal social controls (e.g. police and community groups)
- Implementation with appropriate capacity and resources
- Involving a well-defined theory of change
- Active engagement and partnership between stakeholders

There are no specific recommendations around contextual prevention interventions other than the universal ones outlined above.

Primary or Secondary Prevention

Generally speaking, effective early interventions usually:

- Increase positive factors as well as reduce negative factors
- Use of trained facilitators (where facilitators are required)
- Work within the natural environments of youth
- Maintain high fidelity to original specification and have a good quality of implementation

Principles of effective UNIVERSAL INTERVENTIONS (primary prevention):

- Interventions using **both preventative and positive development goals** i.e. prevent/reduce negative factors and increase positive factors, do better those those focusing on only one type of goal

- Interventions **involving both schools and parents** with either written or in-person constructive interaction between the two, tend to do better than interventions where only one of the two are involved

- Interventions that are **group-based and interactive both in school and family settings** tend to do better than those which are individual-based

- Where facilitators are required, interventions using **trained facilitators who regularly work with young people and/or families** do better

- Interventions with **well-specified goals**, with **structured and/or manualised content**, tend to do better than those without

- Interventions involving **regular and frequent contact** with providers do better than those without

- Ineffective school-based programmes tend to have minimal staff input e.g. fully computer-based programmes or have children being asked to define their own goals and expectations.

Principles of effective interventions for AT-RISK populations (primary OR secondary prevention):

- Interventions with both **preventative and positive goals for young people as well as their parents/families** do well. Compared to the universal programmes, successful targeted programmes tended to focus on family-level risk factors, and more of them contained parent/family training or home visiting and aimed to impact parenting outcomes, such as reducing harsh parenting practices, improving parenting skills, and increasing positive parent–child interactions and family functioning.

- Interventions requiring the **active participation of parents** in the context of family-school combined interventions did better than those not requiring this.

- Interventions using a **mix of formats** - group-based, small-group, and one-to-one – did better than those using single delivery formats.

- The use of **interactive and real-life examples** - involving engaging activities, skill demonstrations, and practice e.g. video-based vignettes – was a characteristic of successful training and skills-development interventions.

- Successful interventions had **well-specified goals with structured content** +/- an element of tailoring content to the participants.

- The use of **trained facilitators with a good level of education** e.g. teachers, mental health professionals, school counsellors, therapists, family nurses, and care coordinators, was a marker of more effective interventions.

- **High implementation fidelity** was a determinants of success for some types of interventions e.g. norms and values and mentoring interventions.

- For mentoring programmes, **one-to-one adult-to-youth mentoring with screened and trained mentors** tended to work better than peer or untrained mentors.

- Ineffective programmes were those with poor implementation fidelity, quasi-military themes and youths nominating their own mentor.

Principles of effective interventions for HIGH-RISK populations (secondary prevention):

- **Therapy-based approaches**, often delivered in structured but tailored formats, tend to work better than other types of approaches

- **Working with families** in a group-based format or combining joint family sessions with separate sessions for the young person and/or their parents was an effective approach. These interventions recognise that young people's attitudes and behaviour are often influenced by the wider "systems" within which they operate, the most immediate system being their family.

- **Interventions aiming to address multiple risk factors** and **acting beyond the level of the individual** young person, tend to do better than those addressing just one risk factor or acting only on the individual level.

- **Interventions that both prevent the recurrence of negative outcomes as well as increase positive outcomes** for young people and their parents/families do better.

- **The use of highly trained facilitators** such as therapists or other mental health professionals who are delivering the intervention as part of their profession, is a characteristic of many successful interventions.

- **Family therapies delivered in natural settings**, such as the home, do better than those which are delivered in healthcare or other such settings.

- **Implementation fidelity** is key for some programme types.

Tertiary Prevention

Principles of effective interventions targeted at violent offenders:

- **Skill-building approaches** i.e. those involving instruction, practice, incentives, and other activities aimed at developing skills for behavioural control or prosocial participation; the most successful being behavioural, cognitive-behavioural (e.g. CBT) or social skills training interventions (13-26% reduction in recidivism) [26]

- **Counselling approaches** i.e. involving a personal relationship between young person and responsible adult, with therapist-led group-based counselling or family counselling being most successful (13-22% reduction in recidivism), and peer-led counselling being least successful (upto 4% reduction only) [15]

- **Use of the Risk-Need-Responsivity framework** in rehabilitation interventions[27], with particular attention to the often-sacrificed responsivity element, especially with the youngest offenders[28]

- **High quality implementation** with fidelity to original specification

[26] Lipsey, M.W., The primary factors that characterize effective interventions with juvenile offenders: A meta-analytic overview 2009
[27] USAID What Works In Reducing Community Violence 2016
[28] Nee, Claire et al. - Addressing Criminality in Childhood: Is Responsivity the Central Issue? 2012

Preventing Youth Violence - NICE Guidelines

Recommended Interventions and Ways of Working

NICE guidelines relating to known risk factors for violence were reviewed for recommendations on specific interventions or on service design and ways of working pertinent to local authorities, with a focus on public health, social care and education teams. These recommendations provide a quality standard for benchmarking local policies and services against.

Key points:

- There are several recommended parenting and therapeutic interventions for children or families who are at risk of or affected by child abuse and neglect, stratified by recommended age groups, as shown below:

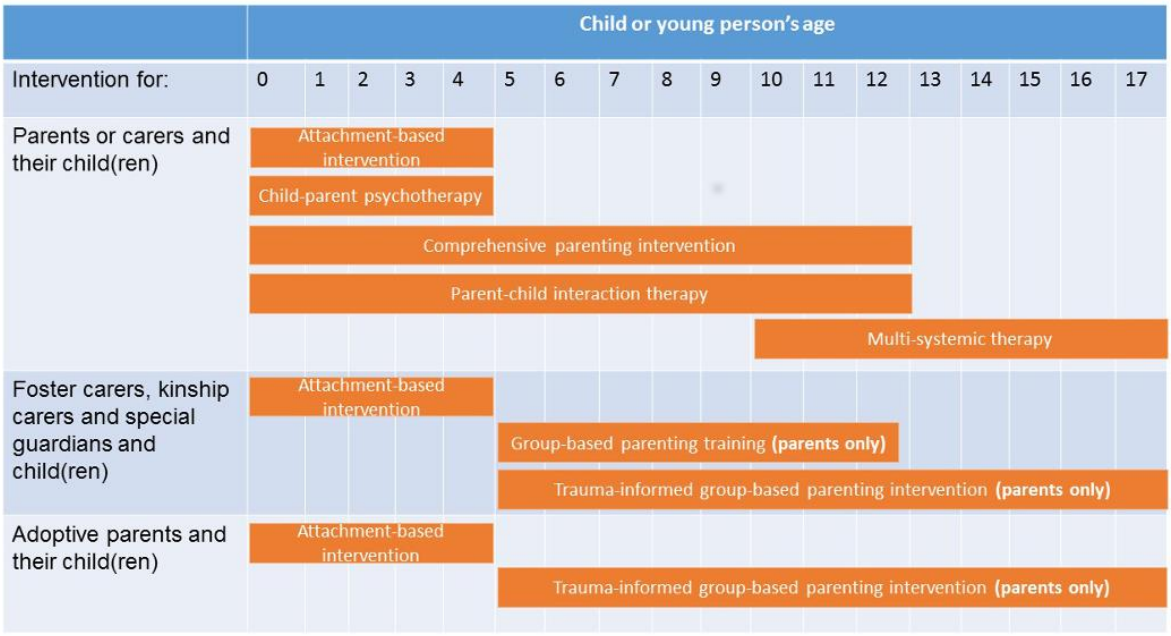


Fig. 5 - NICE - Recommended interventions for CYP following physical abuse, emotional abuse or neglect[29]

- There are several recommended interventions for children with or at risk of attachment difficulties and their families: **video feedback programmes, parental sensitivity and behaviour training, home visiting** and **parent-child psychotherapy**

- There are several recommended interventions for children at risk of conduct disorders, aggressive or anti-social behaviour and antisocial personality disorder: **classroom-based emotional learning and problem-solving programmes, group social and cognitive problem-solving programmes, multimodal interventions** e.g. Multi-systemic Therapy, **group-based cognitive and behavioural interventions** e.g. 'Reasoning and Rehabilitation'

- There are a few recommended interventions for vulnerable parents: **home visiting, parenting programmes, 'Parents Under Pressure'**

[29] National Institute of Clinical Excellence, guideline NG76 - Child Abuse & Neglect, published October 2017

- **Skills training** interventions are recommended for preventing drug misuse in children and young people

- There are some key common recommendations around supporting the social and emotional needs of children under 5 and around supporting children and young people affected by domestic violence: **use of JSNA and comprehensive service mapping tools, integrated commissioning and care delivery,** and **partnership with third sector agencies**

- There are some recommendations around services for supporting looked-after-children: **joint commissioning and co-location of services, adequate staff capacity and expertise including training on attachment and trauma, supporting positive personal identity development** and **assessing and adapting services to local diversity**

- Of particular note are the recommendations for looked-after black and minority ethnic children: **accounting for the impact of racism and discrimination** and **creating community links to reinforce a strong sense of personal identity**

- There is no guidance relevant to local authorities with regards to management and rehabilitation of traumatic brain injuries (TBI), though NICE do recommend that research needs to be done to investigate predictors of long-term sequelae of TBI, which includes cognitive and behavioural deficits such as those leading to violent behaviour. Additionally, NICE is currently in the process of putting together guidance relating to TBI rehabilitation for children.

Preventing Youth Violence - Programme Design & Implementation

Planning and Partnerships

In the WHO's 2015 manual preventing youth violence'[30], the authors make the case that the concept of violence being preventable can be unfamiliar to many stakeholders and therefore it is key to build appropriate foundations in order to successfully initiate a public health approach to the problem.

Accordingly, the authors outline six activity areas for national and local policy-makers, by which the readiness to implement a public health approach to youth violence prevention can be increased:

1. Raising awareness about prevention
2. Developing partnerships across sectors
3. Strengthening knowledge about the importance of data collection on fatal and non-fatal youth violence, and on risk and protective factors
4. Enhancing the capacity to evaluate existing prevention programmes
5. Establishing a policy framework
6. Building capacity for youth violence prevention

Of these six, the importance of developing partnerships stands out as being especially key for Borough-level strategies (i.e. Lambeth's current work).

Developing Partnerships

The WHO offers the following options for action (core options are based on capacity within a limited-resource setting, and desirable options on well-resourced settings such as the UK):

Options for partnership action

CORE	EXPANDED	DESIRABLE
Identify focal points for youth violence prevention from other sectors and organize an informal meeting with at least two other sectors. Share information about your current work and goals, identify common interests, and establish a mechanism to regularly exchange information. Develop a stakeholder map for youth violence prevention.	Establish a formal partnership with key sectors. Establish a coordination platform and terms of reference. Explore joint initiatives and projects that do not require substantial additional resources (e.g. joint mechanisms for data exchange).	Develop a partnership workplan, which is reflected in the annual workplans and budgets of the individual organizations that are members of the partnership.

Fig. 6 WHO recommendations for partnership working to prevent youth violence

[30] WHO Preventing Youth Violence: an overview of the evidence 2015

The CDC outlines the following phases of effective implementation for all types of violence prevention programmes[31]:

- **Planning** - assessing needs, resources, and capacity, and creating a comprehensive plan
- **Partnerships** - identifying and engaging stakeholders
- **Policy Efforts** - identifying potential roles for public health in the policy process
- **Strategies and Approaches** - choosing strategies and approaches that are likely to prevent violence
- **Adaptation** - changing approaches to fit needs while still producing intended outcomes
- **Implementation** - putting your plan into action
- **Evaluation** - tracking and measuring outcomes

The CDC's National Centers of Excellence in Youth Violence Prevention (YVPCs) and the Striving to Prevent Youth Violence Everywhere (STRYVE) programme have made substantial contributions to developing the evidence-base in programme implementation. Some key determinants of success collated from the CDC's resources[32] [33] [34] are:

- Taking into account the social and cultural context of communities and using data-driven processes to understand the unique needs of a community, as risk and protective factors can vary between environments and populations

- Collaboration between governmental and nongovernmental groups, particularly including community partners such as businesses, youth-serving organizations, and faith-based institutions, to facilitate sustained efforts

- Establishing trust for successful collaborations - this requires devoting sufficient time and attention to relationship building and establishing key connections with local organisations

- Decision-making by the local community in partnership with researchers; this can involve using strategic prevention planning models that use data-driven approaches to select and implement evidence-based programmes based on local need (e.g. Communities That Care or PROSPER)

- Including the perspective and participation of young people, for example by using evidence-based approaches, such as Youth Empowerment Solutions to enhance the ability of community organisations to engage youth in violence prevention activities

- Assessing the degree of readiness or capacity within organisations to effectively deliver prevention programs. This includes both of:
  (a) innovation-specific capacity (match between organisational and programmatic priorities)
  (b) general organisational capacity (resources, infrastructure, leadership)

[31] CDC website - https://www.cdc.gov/violenceprevention/youthviolence/index.html
[32] CDC Constructing ''Packages'' of Evidence-Based Programs to Prevent Youth Violence: Processes and Illustrative Examples From the CDC's Youth Violence Prevention Centers 2016
[33] CDC Community engagement in youth violence prevention: Crafting methods to context 2016
[34] CDC grand rounds: preventing youth violence 2015

- Leveraging or building work upon existing programs and capacity

- Creating a mix of programs that balance evidence of effectiveness and programs requested by community partners tailored to meet each community's specific needs

- Organising packages of interventions to target multiple ecological level using a combination of universal and high-risk components

Principles of Prioritisation

Thomas Abt (of the Center for International Development, Harvard University, USA) brings together public health and criminological approaches to propose an innovative framework for youth violence prevention. Abt's conceptual framework, outlined in his 2016 meta-review on behalf of USAID[35] and in his 2016 article 'Towards a framework for preventing community violence among youth'[36] makes a compelling argument for the principles of accumulation, concentration and co-ordination, supported by the imperatives of sound implementation and rigorous evaluation, as priorities when designing and implementing youth violence prevention programmes.

Accumulation

Abt suggests that success requires the accumulation of interventions with individually modest but collectively robust programmatic effects. He reasons that risk and protective factors for violence are cumulative by nature so a strategy that builds impact over multiple programs makes similarly good sense.

Concentration

It is well established that crime and violence generally concentrate in and around a small number of high-risk places, people, and behaviors. Abt outlines the evidence demonstrating interventions focusing on the highest risk places, people, and behaviors generate the strongest effects i.e. interventions targeting at-risk populations tend to outperform universal ones. Abt quotes the U.S. National Research Council (2013) with regard to youth at risk for violence and criminality, 'Whatever the specific mechanism, the appropriate focusing of more intense (and costly) interventions on higher risk adolescents produces a greater reduction in subsequent offending and limits the negative effects of unwarranted intensive intervention on less serious offenders.'

Co-ordination

Abt reasons that areas with high rates of one type of violence generally suffer from numerous forms of violence, necessitating a set of separate but loosely connected strategies. He argues that policymakers cannot afford to focus on only one type of violence to the exclusion of all others and suggests that community violence prevention practitioners should therefore meet regularly with

[35] USAID What Works In Reducing Community Violence 2016
[36] Abt, Thomas P - Towards a framework for preventing community violence among youth 2017

colleagues working to prevent other forms of violence, maintaining situational awareness and seizing opportunities to collaborate when possible.

On the subject of comprehensive approaches, he highlights that they can be ineffective due to the inherent implementation challenges of working with numerous participants and organisations, but on the other hand they capitalise on the strength and diversity of multiple stakeholders. He warns that '*the primary threat to the effectiveness of comprehensive interventions is implementation failure, caused by overloading limited coordination capacity',* thus, although complete comprehensiveness is unlikely to be achievable in practice, '*the best case for multi-disciplinary collaboration recognises that the capacity to coordinate is a finite resource like any other, and ought to be used judiciously.'*

Sound Implementation

Abt puts forward the view that 'strong program design plus weak implementation equals failure'. According to Lipsey (2009), "in some analyses…a well-implemented intervention of an inherently less efficacious type can outperform a more efficacious one that is poorly implemented." He makes the case that studies looking at implementation always find that it is strongly related to program effectiveness, but he cautions that "model" programs do not necessarily outperform similarly well-designed, well-implemented interventions that are generic and lack brand name recognition.

Rigorous Evaluation

Abt argues that evaluating interventions effectively means incorporating evaluation into program development from the beginning, starting with a conceptually clear theory of change. In addition to the benefits of evaluation for guiding future action, an unanticipated benefit is that *evaluation assists and drives effective implementation*.

A key component of effective programs identified in Abt's meta-review was the effective use of analysis and data; additionally, he argues that rigorous evaluation should include cost-benefit analysis.

Frameworks for Comprehensive Programmes

Within the global evidence-base, there are, broadly speaking, two approaches to designing comprehensive violence prevention programmes: hierarchical prevention models (based on preventative healthcare science) and frameworks composed of strategic themes (based on life-course and ecological models).

The simplest framework for discussing comprehensive prevention programmes is the hierarchical prevention model (as used in this review) usually consisting of primary, secondary and tertiary levels +/- other levels. Through this lens, a comprehensive program would attempt to cover all levels of prevention in order to provide the whole population with needs-matched support, similar to a 'proportionate universalism' approach.

Frameworks based on this traditional prevention model are advocated by both the long-established and highly successful Scotland Violence Reduction Unit, as well as the newly formed London Violence Reduction Unit.

The other approach is more thematic and often involves a blend of life-course and ecological approaches to create strategic themes wherein prevention interventions would have the highest impact. A comprehensive approach in this context would necessitate some degree of provision across all recommended themes. The WHO and CDC have both offered thematic frameworks as a basis for planning violence prevention programmes.

Scotland Violence Reduction Unit

Since the establishment of an innovative Violence Reduction Unit in Strathclyde in 2005, Scotland has been working in a cross-sectoral way to systematically apply the public health approach to violence reduction. Scotland now has the lowest levels of violence in 41 years. Their 10-year strategy[37] is divided into five strategic levels of prevention, outlined below with examples of key areas of work within each level:

1. Primary Prevention – early interventions to prevent the onset of violent behaviour, inc.:
    - Early years support
    - 'Second Step' intervention in primary schools
    - Positive masculinity and male role models
    - Alcohol minimum unit pricing

2. Secondary Prevention – early detection to halt the progression of violence, including:
    - Bystander training
    - Asset-based policing
    - Mentors in Violence Prevention (MVP programme)

3. Tertiary Prevention – rehabilitation of perpetrators and victims, including:
    - Employment and mentoring
    - Violence Brief Intervention in hospitals
    - Navigator A&E-based programme

[37] Scottish Violence Reduction Unit 10 Year Strategic Plan (publication date unknown)

4. Enforcement and Criminal Justice – innovative justice practices to reduce offending and recidivism, including:
    - Building Safer Communities
    - Evidence-led effective sentencing
    - Multi-Agency Public Protection Arrangements (MPPA)

5. Attitudinal Change – changing attitudes and behaviours towards violence at individual, community and societal levels, including:
    - Engaging with the media, including use of social media
    - Improving relationships between communities and the police
    - Promoting equality to reduce violence

London Violence Reduction Unit

The London VRU was announced by the Mayor of London in September 2018 and is currently in the process of being set up. The steering group have released some provisional materials to indicate their approach and set out their priorities. The framework that will be used by the London VRU is loosely based on the Scottish VRU's approach, with some modifications for the London context.

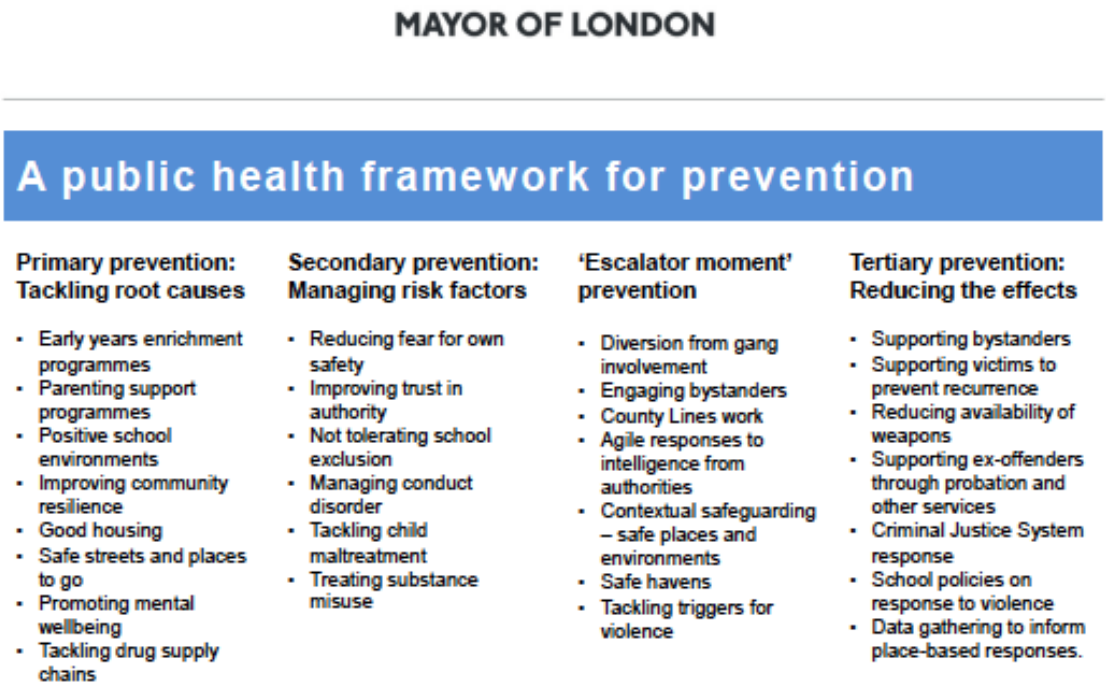


Fig. 7 London VRU action framework (from introductory slides circulated by Mayor's Office)

They have also provided an indication of their view on the role of Local Authorities within the broader violence prevention system:

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

Fig. 8 London VRU outline of the role of local authorities in youth violence prevention

World Health Organisation

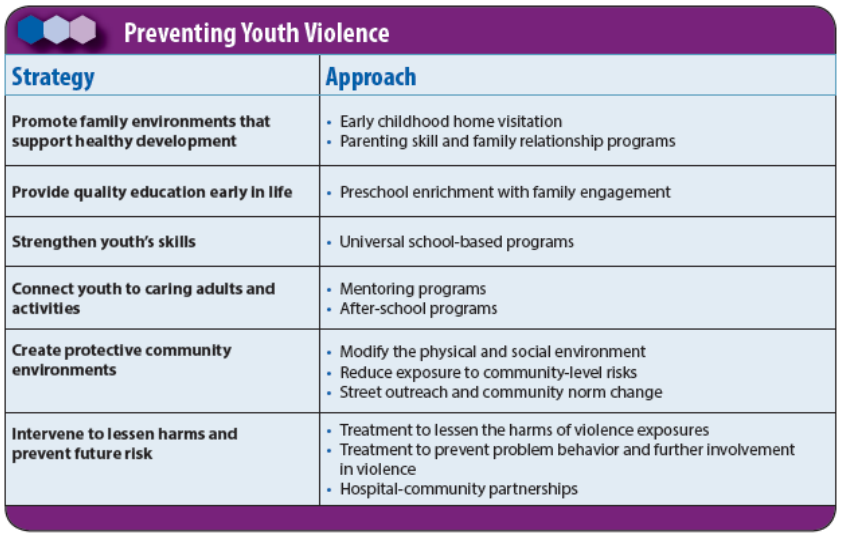
The WHO's 'Preventing Youth Violence' manual offers a relatively simple framework which maps well to broad policy areas (Fig. X), whereas the WHO's INSPIRE framework (Fig. Y) (which although it is designed for the prevention of violence against children, is highly generalisable to all types of violence prevention) is more detailed and ensures complete comprehensiveness in its approach.

Strategy	Approach	Sectors	Cross-cutting activities
Implementation and enforcement of laws	• Laws banning violent punishment of children by parents, teachers or other caregivers • Laws criminalizing sexual abuse and exploitation of children • Laws that prevent alcohol misuse • Laws limiting youth access to firearms and other weapons	Justice	
Norms and values	• Changing adherence to restrictive and harmful gender and social norms • Community mobilization programmes • Bystander interventions	Health, Education, Social Welfare	Multisectoral actions and coordination
Safe environments	• Reducing violence by addressing "hotspots" • Interrupting the spread of violence • Improving the built environment	Interior, Planning	
Parent and caregiver support	• Delivered through home visits • Delivered in groups in community settings • Delivered through comprehensive programmes	Social Welfare, Health	
Income and economic strengthening	• Cash transfers • Group saving and loans combined with gender equity training • Microfinance combined with gender norm training	Finance, Labour	
Response and support services	• Counselling and therapeutic approaches • Screening combined with interventions • Treatment programmes for juvenile offenders in the criminal justice system • Foster care interventions involving social welfare services	Health, Justice, Social Welfare	Monitoring and evaluation
Education and life skills	• Increase enrolment in pre-school, primary and secondary schools • Establish a safe and enabling school environment • Improve children's knowledge about sexual abuse and how to protect themselves against it • Life and social skills training • Adolescent intimate partner violence prevention programmes	Education	

Fig. 9 WHO Preventing Youth Violence strategic framework
Fig. 10 WHO INSPIRE (preventing violence against children) framework

US Center for Disease Control

The CDC's framework, from its 'Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors' defines the desired outcomes as its starting point but ultimately produces a similar product to the WHO.



Preventing Youth Violence

Strategy	Approach
Promote family environments that support healthy development	• Early childhood home visitation • Parenting skill and family relationship programs
Provide quality education early in life	• Preschool enrichment with family engagement
Strengthen youth's skills	• Universal school-based programs
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Create protective community environments	• Modify the physical and social environment • Reduce exposure to community-level risks • Street outreach and community norm change
Intervene to lessen harms and prevent future risk	• Treatment to lessen the harms of violence exposures • Treatment to prevent problem behavior and further involvement in violence • Hospital-community partnerships

Fig. 11 Strategic framework from CDC's Technical Package for Youth Violence Prevention[38]

UK Cross-Party Youth Violence Commission

The national cross-party Youth Violence Commission, set up in 2017 to collate evidence and stakeholder input on the causes of youth violence in the UK, published its interim report in July 2018.[39] Based on its findings, it sets out a series of recommendations that are structured thematically. This work can be thought of as a framework for a high-impact prevention programme and is particularly useful as it provides a UK-tailored set of strategies based on an up-to-date assessment of needs and relevant stakeholder consultation within the current UK policy context.

Fig. 12 Youth Violence Commission Interim Report recommendations

Further details on each strategic theme are outlined below:

1. Developing a PH Model

A public health approach requires whole-system, cultural and organisational change supported by sustained political backing. It recognises the impact on young people of childhood trauma and

[38] CDC A Comprehensive Technical Package for the Prevention of Youth Violence and Associated Risk Behaviors 2016

[39] Youth Violence Commission - Interim Report 2018

adverse experiences, the importance of early intervention in preventing violence later in life and the need for greater integration of services.

2. Focus on Early Years and Early Intervention

Focus on preventing or mitigating the impact of adverse childhood events with evidence-based interventions, implementing a trauma-informed approach in all services for children and young people with training for all professionals with a statutory responsibility for the safeguarding and wellbeing of young people, and the revitalisation of Early Childhood Centres.

3. Reform of Youth Services

Including:

- The establishment of a National Youth Policy Framework which makes the provision of youth work a statutory duty for both local authorities and central government.
- Overhaul of funding arrangements
- A greater role for faith groups

4. Support in Schools

A key aspect of this would be an aspiration of zero exclusions from mainstream education and a reallocation of funding from Pupil Referral Units to support in mainstream schools to help achieve this. Other key aspects would be overhauling the way careers advice is delivered in schools, more emphasis on high-quality sex and relationship classes and resilience building, better integration of support services within schools (e.g. school nurses, social workers and CAMHS workers and improving education in custody.

5. Improving Employment Opportunities

This work would take place in schools, with employment skills training, good careers advice and work experience and involvement BAME role models (and would be mirrored in custody), as well as through provision of apprenticeships.

6. Investment in community policing and a look at current drugs approach

In this area, the Commission recommends:

- Increase in community policing
- A police officer attached to every primary and secondary school in the country
- Intelligent stop and search
- Revised national approach to illegal drugs

END

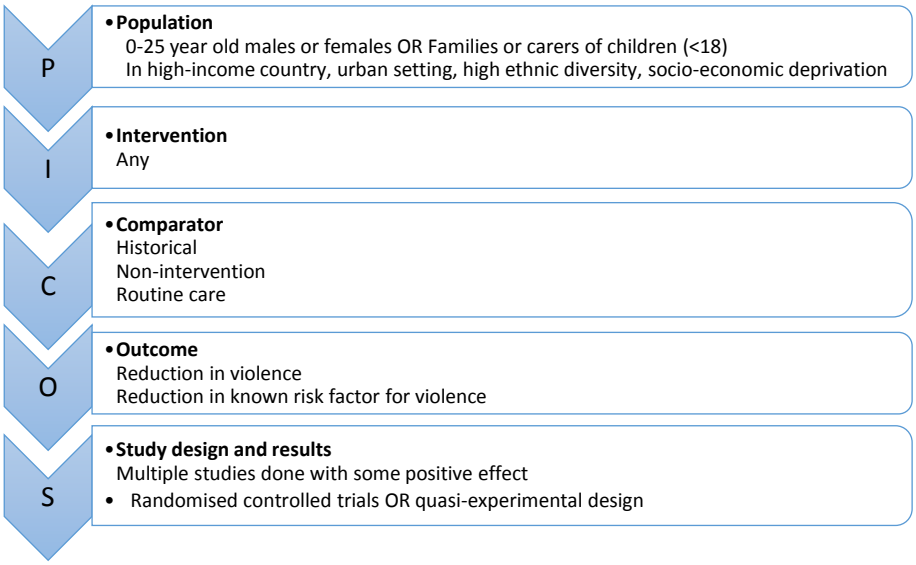
Appendix 1 – Preventing Youth Violence Sources and Search Strategy

Type	Source	Resources Used	+	-	Applicability
National / international accredited bodies' - reports and guidance	NICE [UK public body for health and social care related guidance]	CG110 NG76 PH50 PH28 NG26 NG87 CG158 CG77 NG64 PH40	Offers guidance on preventing and optimising many risk factors. Evidence-based and cost-appraised recommendations Some recommendations are tailored to different populations (age, gender, ethnicity)	Offers no direct guidance on violence prevention Long lag-time between emerging evidence and guidance Recommendations are not tailored to regions	Highly applicable. Aim to follow all relevant guidelines as fully as possible.
	WHO [UN agency for global health and healthcare]	Violence and Health 2002 Global Status Report on Violence Prevention 2014 Preventing Youth Violence 2015 INSPIRE 2016	Generates evidence as well as offering evidence-based guidance	Offers globally applicable policy guidance, much of which is targeted to middle- and low-income countries	Guidance pertaining to high-income countries will usually be relevant though some may not be applicable to the legal, health and social care context of UK
	PHE [UK governmental agency for public health]	A Public Health Approach to Violence Prevention 2012 Mental health needs of gang affiliated youth 2018	Generates evidence and guidance relevant to the UK Highly relevant guidance for local authorities	Violence prevention guidance now slightly out of date	Highly applicable. National-level evidence will be less useful than that specifically relating to London.
	CDC [USA governmental agency for public health]	Technical Package for Preventing Youth Violence 2015	Generates high-quality evidence and guidelines Offers some economic evaluation	Guidance is produced for the USA and therefore based within a policy context that is quite different to the UK Economic evaluation only relevant within USA context	Moderately relevant as from culturally comparable, high-income country. Evidence pertaining to inner-city, ethnically diverse contexts may be especially relevant to Lambeth. Guidance relating to health and social care systems, legislation and government policy will not be applicable.
	Commonwealth Health Hub [Commonwealth Secretariat initiative for health resources]	Preventing Violence Report 2018	Comprehensive approach to violence - all forms of violence considered, and all levels of prevention addressed	May not necessarily update guidance in the long-term Lots of guidance generalised for all Commonwealth countries	Reliable and evidence pertaining to high-income Commonwealth countries may be relevant. Only guidance specific to the UK will be applicable due to the strong health system and population differences between the UK and other high-income Commonwealth countries.
National or regional democratic bodies	UK National Government	Ending Gang and Youth Violence Programme Report 2015 Serious Violence Strategy 2017	Highly tailored to the UK setting Takes whole systems-approach Considers societal actions including legislation	Lag-time between evidence and guidance Not reliably rigorous in approach to evidence; inherently party-political	Policy recommendations are applicable as they relate to the UK, however guidance tailored towards London will be more useful. Evidence used may now be out of date. Useful for becoming aware of policy and practice innovations in other parts of the UK.
	Greater London Authority (GLA)	Knife Crime strategy 2017 Youth Violence Commission interim report 2018 London VRU provisional reports	Highly tailored to London Targeted towards policy-makers	Not reliably academically rigorous YVC and London VRU guidance is provisional and currently in development	Highly relevant for Lambeth in terms of aligning local policy with regional policy as well as offering evidence and epidemiological analysis that is highly applicable to Lambeth.
Evidence Clearinghouses	Early Intervention Foundation (EIF) [UK resource for evidence on early interventions]	EIF Report EIF Guidebook - whole database	Regularly updated Specifies if interventions tested in UK Clear appraisal of evidence quality	Does not cover full prevention spectrum - little information at the contextual and tertiary prevention levels	Highly useful and applicable in terms of providing a menu of interventions and guidance on principles of success but need to use other sources to understand how to select interventions to create a complementary and comprehensive package.

			Detailed discussion of included studies Economic evaluation relevant to UK setting Guidance on key principles of successful interventions		
	Youth Justice Board [UK resource for evidence relating to crime and justice]	Youth Justice Resource Hub whole database	Looks at evidence as well as offering implementation and policy guidance Disseminates best practice guidance across the UK		Mostly applicable though may not all pertain to local authority functions.
	CDC STRYVE	STRYVE Strategy Selector	Covers violence and risk factors and all prevention levels Able to stratify results by demographics, types of prevention and outcome of interest	USA-focused Unclear how up-to-date Not easily stratified by level of evidence	Useful in terms of stratifying interventions based on settings where they have been applied (urban, rural etc.) and also by ethnicity of study populations.
	Prevent Violence [LJMU and WHO partnership for violence prevention resources]	Database covering studies from UK and Europe appraised as high quality	Global evidence base, stratifies evidence by region Up-to-date Quality appraisal of single studies	No collation of study results by intervention No implementation guidance	Not very useful for local policy-making as only single study information with no way of understanding the size and quality of evidence base by intervention type
	Crime Solutions [Run by US National Office of Justice - resources for preventing and reducing crime]	Database covering intervention types with evidence of effectiveness from multiple studies	Regularly updated Spans full prevention spectrum Stratifies evidence by specific interventions or by intervention themes Information on study designs and settings	No implementation guidance Cannot stratify evidence by country	Moderately applicable where the intervention or theme has been tested in multiple contexts including in urban, ethnically diverse settings
Evidence databases	NIHR DARE Cochrane	Whole database	Highly up to date High quality studies only	Individual studies only	Highly useful for updating older guidelines and reports, subject to generalisability of study population
	NHS HDAS Trip SSRI	Whole databases	Highly up to date	Individual studies Variable quality	Moderately useful for updating older material, subject to quality appraisal and generalisability of study population

Table 2. Evidence sources and appraisal

Search Strategy for Evidence Clearinghouses and Databases



Appendix 2 – Relevant Guidance from NICE

Risk Factor	NICE Document	Relating to	Recommendations	
ACEs **Teenage Conception** **Childhood Abuse** **Parental drug use** **Family violence/ abuse**	**CG110** **Pregnancy & Complex Social factors Sep 2010**	Pregnant women with substance misuse or domestic abuse	Multi-agency working to jointly develop care plans (healthcare, social care, police and third-sector agencies) Co-locate services where possible Ensure good sign-posting to services provided by other agencies	
	NG76 **Child Abuse & Neglect Oct 2017**	Vulnerable mothers (low level of education or income, <18yo)	**Parenting programme based on planned activities training model**	
		Mothers taking part in methadone maintenance	**'Parents Under Pressure' programme**	
		Parents/carers with substance misuse	**Parenting programme**	Including content helping to address substance misuse in context of parenting
		Parents at risk of abusing or neglecting their child	**Parenting programmes e.g. 'Pathways Triple P'**	
			Home visiting programmes e.g. 'Healthy Families' model	In addition to DoH's Healthy Child Programme
		Parents who have abused or neglected their child <5yo OR Foster carers of abused/neglected child <5yo	**Attachment-based intervention e.g. 'Attachment and Biobehavioural Catch-Up'**	Deliver intervention in the parent or carer's home, provide at least 10 sessions.
		Parents who have abused or neglected their child <5yo or child exposed to domestic violence	**Child-parent psychotherapy**	Ensure it is based on the Cicchetti and Toth model, consists of weekly sessions (lasting 45–60 minutes) over 1 year, is delivered in the parents' home by a therapist trained in the intervention and involves directly observing the child and the parent–child interaction.
		Parent/carer who have abused or neglected child <12yo	**Comprehensive parenting intervention e.g. SafeCare**	Should be delivered by a professional trained in the intervention and comprise weekly home visits for at least 6 months.
		Foster carers of abused/neglected	**Group-based parent training intervention e.g. KEEP**	Provide group sessions over at least 16 weeks with groups of 8 to 10 foster

		children 5-12yo who are showing problematic behaviours		carers, including video, role play and homework practice.
		Parents/carers who have abused or neglected child 10-17yo	**Multi-systemic therapy for child abused and neglect (MST-CAN)**	This should last 4 to 6 months, involve the whole family, be delivered in the home or in another convenient location, include a round-the-clock on-call service to support families to manage crises.
		Foster carers for abused or neglected children 10-17yo	**Trauma-informed group parenting intervention**	Should last for at least 4 day-long sessions.
		Children (<18yo) who have been sexually abused	**Group or individual trauma-focused cognitive behavioural therapy**	12 to 16 sessions (more if needed)
			Therapeutic programme e.g. 'Letting the Future In'	
		Girls who have been sexually abused	**Group or individual psychoanalytic therapy**	
	PH50 **Domestic Violence & Abuse Feb 2014**	Children and young people exposed to domestic violence	JSNA and comprehensive service mapping against Home Office-endorsed Local strategic multi-agency partnership with representatives of frontline practitioners and service users. An integrated commissioning strategy to meet the health and social care needs of victims including CYP and address perpetrators behaviour and health needs. Monitor and evaluate strategy for effectiveness with qualitative and quantitative data. Commission integrated care pathways including clear referral pathways to local services that can support children and young people affected by domestic violence and abuse. Provision of specialist domestic violence and abuse services for CYP that address the emotional, psychological and physical harms, provide a personalised and co-ordinated package of care and support and provide interventions to strengthen the relationship between the child or young person and their non-abusive parent or carer. Interventions should be timely and should continue over a long enough period to achieve lasting effects (recognising that long-term interventions are more effective.	

			Commissioning and evaluation of tailored interventions for people who perpetrate domestic violence and abuse that primarily aim to increase the safety of the perpetrator's partner and children and link perpetrator services with victim services for ongoing risk assessments of the perpetrator with safety planning and support for victims. Work in partnership with voluntary and community agencies to develop training and referral pathways for domestic violence and abuse.
Disrupted family life **ACEs**	**PH28** **Looked-after children and young people Oct 2010 (updated May 2015)**	Looked-after children and young people	Jointly commission services dedicated to promoting the mental health and emotional wellbeing of children and young people who are looked after or are moving to independent living. These services should be structured as integrated teams (virtually or, ideally, co-located). Ensure that the commissioned team has the capacity and expertise to work sensitively with looked-after children and young people on the impact of discrimination, racism, bullying and isolation on self-esteem and personal identity. Evidence indicates that developing a positive personal identity and a sense of personal history is associated with high self-esteem and emotional wellbeing. Life-story work, as an ongoing activity, can help children and young people understand their family history and life outside of care. Support placements with family and friends as a choice of equal status to adoption, foster care and residential care for looked-after children and young people. Directors of Public Health should produce a local diversity profile covering the looked-after children and young people. Use this when commissioning services and to develop and train the workforce to meet existing and anticipated needs. Ensure all teacher training programmes have a core training module that looks at the needs of looked-after children and young people and includes an understanding of: the impact of stable care and education, the impact of loss, separation and trauma on child development, attachment and cognitive functioning, the value of engaging in activities outside the school curriculum and in the community.
		Looked-after black and minority ethnic children and young people	Understand the complexity of racism for looked-after black and minority ethnic children and young people, including those of multiple heritage, and its impact on their ability to enhance their life chances and lead settled lives.

			Create links with community support groups to reduce isolation and provide continuity of cultural experience to reinforce a stronger sense of identity.	
	NG26 **Children's Attachment**	Children in care, adopted from care or at high risk of going into care	Help arrange kinship placements, if safe and in the best interest of the child or young person. Schools and other education providers should ensure that all staff who may come into contact with children and young people with attachment difficulties receive appropriate training on attachment difficulties Develop and provide training courses for teachers of all levels on attachment difficulties, the consequences of maltreatment, including trauma and how to support these children.	
		Parents of children <5yo on edge of care with attachment difficulties	**Video feedback programme**	Delivered in the parental home by a trained health or social care worker who has experience of working with children and young people. Also suitable for foster carers of children in care.
			Parental sensitivity and behaviour training	Consists of a single session with the parents followed by at least 5 (and up to 15) weekly or fortnightly parent–child sessions (lasting 60 minutes) over a 6-month period, is delivered by a trained health or social care professional Also suitable for foster carers of children in care.
			Home visiting programme	To improve parenting skills delivered by an appropriately-trained lay home visitor or a healthcare professional such as a nurse.
		Parents who have maltreated or at risk of maltreating their child	**Parent-child psychotherapy**	To improve attachment difficulties, ensuring that safeguarding concerns are addressed.
		Parents of >5yo with attachment difficulties	**Parental sensitivity and behaviour training**	
		Children and young people who have been maltreated and show signs of trauma / PTSD	**Trauma-focused CBT**	

		Foster carers / guardians / adoptive parents of primary school-age children with attachment difficulties	**Intensive training and support**	Commencing before the placement and for 9–12 months after.
		Primary school-age children with attachment difficulties in care or adopted	**Group therapeutic play sessions**	Commencing before the placement and for 9–12 months after.
		Foster carers / guardians / adoptive parents of post-primary school-age children with attachment difficulties and the children	**Group-based training and education programme**	To maintain stability in the home and help transition to a new school environment, to improve social skills and maintain positive peer relationships.
		Residential carers of children with attachment difficulties	**Parental sensitivity and behaviour training**	Adapted for professional carers in residential settings.
ADHD **Conduct Disorder** **Antisocial Behaviour**	**NG87** **Attention deficit hyperactivity disorder March 2018**	People with ADHD	Be aware that people in the following groups may have increased prevalence of ADHD compared with the general population: people known to the Youth Justice System or Adult Criminal Justice System As part of the diagnostic process, include an assessment of the person's needs, coexisting conditions, social, familial and educational or occupational circumstances and physical health. For children and young people, there should also be an assessment of their parents' or carers' mental health.	
	CG158 **Conduct Disorder, Anti-social/ Aggressive Behaviour March 2013 (updated April 2017)**	Children at risk of developing conduct disorders	Individual risk factors include low school achievement and impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education. Assess for the presence or risk of physical, sexual and emotional abuse in line with local protocols, and include comprehensive assessment of the child or young person's parents or carers, which should cover: - Positive and negative aspects of parenting, inc. coercive discipline; the - Parent–child relationship; - Relationships within family, including domestic violence; - Parental mental health and substance misuse (inc. during pregnancy) - Parental criminal behaviour	

			Classroom-based emotional learning and problem-solving programmes	Programmes should consist of up to 30 classroom-based sessions over the course of 1 school year) for children aged typically between 3 and 7 years in schools where classroom populations have a high proportion of children identified to be at risk of developing oppositional defiant disorder or conduct disorder as a result of any of the following factors: • low socioeconomic status • low school achievement • child abuse or parental conflict • separated or divorced parents • parental mental health or substance misuse problems • parental contact with the criminal justice system.
		Parents/carers of children 3-11yo who have been diagnosed with OR are at high-risk of conduct disorder OR are in contact with CJS for antisocial behaviour	**Group or individual parent/foster carer/guardian) training programme**	
		Children 9-14yo who have been diagnosed with OR are at high-risk of conduct disorder OR are in contact with CJS for antisocial behaviour	**Group social and cognitive problem-solving programmes**	
		Children 11-17 with conduct disorder	**Multimodal interventions e.g. Multi-systemic Therapy**	
	CG77 **Antisocial personality disorder Jan 2009 (updated March 2013)**	People with antisocial personality disorder, including those with substance misuse problems in community and	**Group-based cognitive and behavioural interventions**	To address problems such as impulsivity, interpersonal difficulties and antisocial behaviour

		mental health services		
		People with antisocial personality disorder with a history of offending behaviour who are in community and institutional care	**Group-based cognitive and behavioural interventions e.g. 'Reasoning and Rehabilitation'**	Programmes focused on reducing offending and other antisocial behaviour
		Young offenders (<18yo) with a history of offending behaviour who are in institutional care	**Group-based cognitive and behavioural interventions**	Programmes focused on reducing offending and other antisocial behaviour
Substance Misuse	**NG64** **Drug Misuse Prevention**	Children and young people assessed as vulnerable to drug misuse	**Skills training**	To include: • conflict resolution • refusal • identifying and managing stress • making decisions • coping with criticism • dealing with feelings of exclusion
Social and Emotional Needs	**PH40** **General Social & Emotional Wellbeing: Early Years**	Vulnerable parents in the perinatal period	**Series of intensive home visits**	Delivered by an appropriately trained nurse to parents in need of additional support. Visits should follow a set curriculum of specified goals in relation to: • maternal sensitivity • mother–child relationship • speech, language and communication skills parenting skills and practice. They should also include developing the father–child relationship as part of an approach that involves the whole family. This includes getting the father involved in any curriculum activities.

		Vulnerable children <5	Health and wellbeing boards should ensure the social and emotional wellbeing of vulnerable children features in the 'Health and wellbeing strategy'. The resulting plan should include outcomes to ensure healthy child development and 'readiness for school' and to prevent mental health and behavioural problems. Directors of public health, directors of children's services and commissioners of maternity care should ensure the social and emotional wellbeing of under-5s is assessed as part of the joint strategic needs assessment. This includes vulnerable children and their families. Population-based models (such as PREview, a set of planning tools published by the Child and Maternity Health Observatory) should be considered as a way of determining need and ensuring resources and services are effectively distributed. Health and wellbeing boards should ensure arrangements are in place for integrated commissioning of universal and targeted services for children aged under 5. The aim is to ensure: • Vulnerable children at risk of developing (or who are already showing signs of) social and emotional and behavioural problems are identified as early as possible by universal children and family services • Targeted, evidence-based and structured interventions are available to help vulnerable children and their families – these should be monitored against outcomes • Children and families with multiple needs have access to specialist services, including child safeguarding and mental health services. Health and early years providers should put systems in place to deliver integrated universal and targeted services that support vulnerable children's social and emotional wellbeing. This should include systems for sharing information and for multidisciplinary training and development, processes to systematically involve parents and families in reviewing services and suggesting how they can be improved, and systematic and persistent efforts to encourage vulnerable parents to use early years services, including outreach methods. They should work with community and voluntary organisations to help vulnerable parents who may find it difficult to use health and early years services. The difficulties may be due to their social circumstances, language, culture or lifestyle. Early intervention can provide a good return on investment (Knapp et al. 2011). The cost of not intervening to ensure (or improve) the social and emotional wellbeing of children and their families are significant, for both them and wider society (Aked et al. 2009). For example, by the age of 28, the cumulative costs for public services are much higher when supporting someone with a conduct disorder, compared to providing services for someone with no such problems (Scott et al. 2001).

The following documents were not included as they are currently being updated: PH12 - Social and emotional wellbeing in primary education, March 2008; PH20 - Social and emotional wellbeing in secondary education, September 2009; PH7 - Alcohol: school-based interventions, November 2007

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