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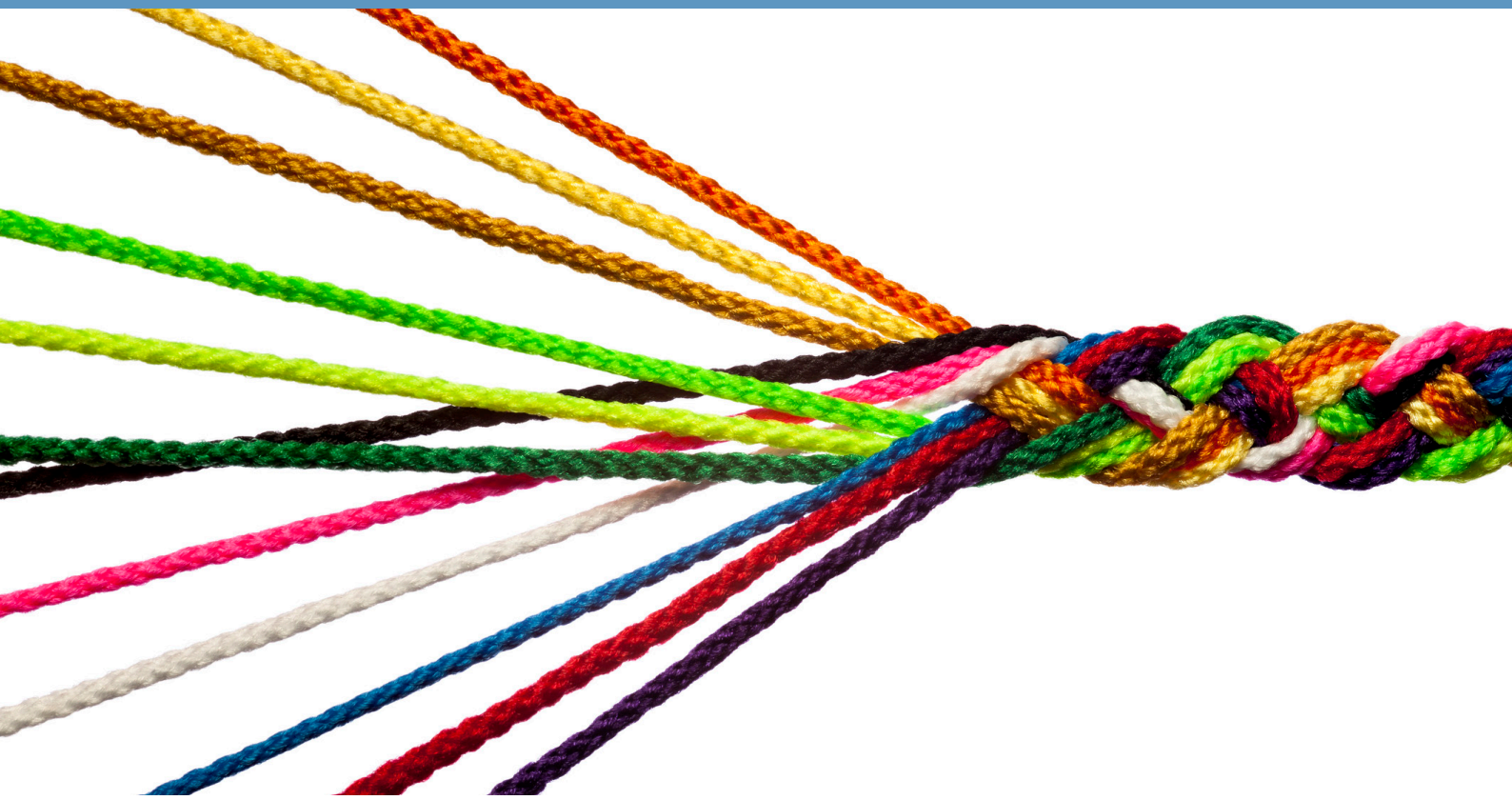
The Children's Society

Tackling Child Exploitation Support Programme



A public health approach to violence reduction

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Purpose of this briefing

Violence is a major problem for many countries around the world, including the UK. Not only can violence devastate the lives of those directly involved, but it also adversely impacts the lives of family members, friends and the wider community. Well-resourced and holistic public health approaches have the potential to generate significant and lasting reductions in violence. To do so, however, they require the buy-in and engagement of a range of organisations working together to tackle drivers of violence at societal, community, relationship and individual levels.

This briefing has a threefold purpose:

- It distils the core features of public health approaches and explains their potential for reducing violence.
- It outlines how system leaders can ensure they play their part in creating and implementing public health approaches to violence reduction.
- It explores some of the potential problems and possible solutions associated with public health approaches.

The causes of violence are deep-rooted and complex, crossing not only multiple areas of people's lives, but also the scope and remit of different organisations and professionals. For this reason, it is important that efforts to make societies safer are seen as shared and mutual endeavours. No single organisation should bear the burden of reducing violence alone; efforts to reduce violence will be more effective and enduring if every relevant organisation plays its part in tackling this pressing social problem.

This briefing outlines three main ways in which system leaders and senior managers across local government and key partner agencies can ensure their organisations are making a positive contribution to public health approaches to violence reduction:

- By facilitating and engaging in multi-agency collaboration that brings together all organisations and professionals whose remit includes (or should include) the reduction of violence.
- By adopting approaches that value and actively engage with the lived experiences of communities, families and young people, so as to ensure services are genuinely tailored to local need.
- By creating and promoting effective policies, practices and learning opportunities, underpinned by evidence and committed to ethical standards around equality, diversity and anti-racism.

Some organisations in England and Wales are increasingly using the term 'whole-systems approach' in place of 'public health approach' (see Craston et al., 2020). In this briefing we use the term 'public health approach' as it reflects a broader commitment to evidence-based policy and practice, as well as indicating cultural and organisational change in addition to systemic coordination.

Violence: Definitions, causes, scope and nature

Before exploring the principles of public health approaches – and how system leaders and senior managers can best put these principles into practice – we will first provide a brief overview of the subject of violence.

Violence, by which we mean interpersonal violence in this briefing unless stated otherwise, is a perennial problem, existing in all societies across the globe and throughout history. Violence can have serious consequences, not only for those directly involved, but for families and friends. The most harmful potential result of violence is loss of life, which in the case of children and young people is particularly devastating.

Non-fatal injuries, however, also produce serious and wide-ranging adverse effects. Survivors of violent injury can suffer from prolonged periods of trauma and heightened anxiety that reduce the likelihood of being able to live happy and fulfilling lives.

If arrested and convicted, perpetrators of violence – many of whom might already have been the victims of various forms of violence themselves – can face severe criminal justice sanctions, depending on the seriousness of the offence. The consequences of penal sanctions do not come to an immediate end when a sentence has expired: criminal records and the enduring personal and practical effects of punishment can make it difficult for people convicted of violent offences to pursue pro-social, non-violent lives.

Violence also generates significant economic costs to the National Health Service, the youth and criminal justice system, the social care system, and elsewhere. The cross-party Youth Violence Commission, for example, estimated that over the last eleven years the total economic and social cost of serious youth violence had been somewhere in the region of £11 billion (Irwin-Rogers et al., 2020b). In short, the significant human and economic costs justify serious and concentrated efforts to reduce violence and its associated harms.

Clear definitions, as much as possible, are needed in order to understand and tackle serious social problems. In the case of violence, this is not straightforward, because the precise meanings of relevant concepts are contested and there are different ways in which to conceptualise the scope and nature of the problem.

Structural violence

The World Health Organization (2016, p.21) defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation'.

The definition incorporates three forms of violence:
(1) *self-directed violence*, involving self-harm and suicide
(2) *interpersonal violence*, involving familial and community violence (including youth violence)
(3) *collective violence*, involving social, political and economic forms of violence.

Notably, this definition recognises that violence occurs not only at the individual level but between groups, within families, and by governments. There is overwhelming research evidence that interpersonal violence is related to collective forms of violence such as inequality and oppression. These forms of violence have been referred to as structural violence, which has its roots in the work of Johan Galtung (1969) and has neatly been defined by Bandy X. Lee (2016, p.110) as:

> *'...the avoidable limitations society places on groups of people that constrain them from achieving the quality of life that would have otherwise been possible. These limitations could be political, economic, religious, cultural, or legal in nature and usually originate in institutions that have authority over particular subjects.'*

Violence involving young people has been of particular concern in recent years, and public health approaches to violence reduction, while often focusing on various forms of violence, in many cases centre primarily on the reduction of youth violence. This inevitably raises issues around how to define the 'youth' in 'youth violence'.

Defining youth

The World Health Organization estimates that 43 per cent of global homicides involve people aged 10-29 (WHO, 2016), and most jurisdictions have a distinct system of youth justice for children and young people. However, the definitional parameters of 'youth' are far from clear. Though most jurisdictions recognise a stage of social development between childhood and adulthood, where full maturity and criminal responsibility has not yet been reached, there is a distinct lack of international consensus.

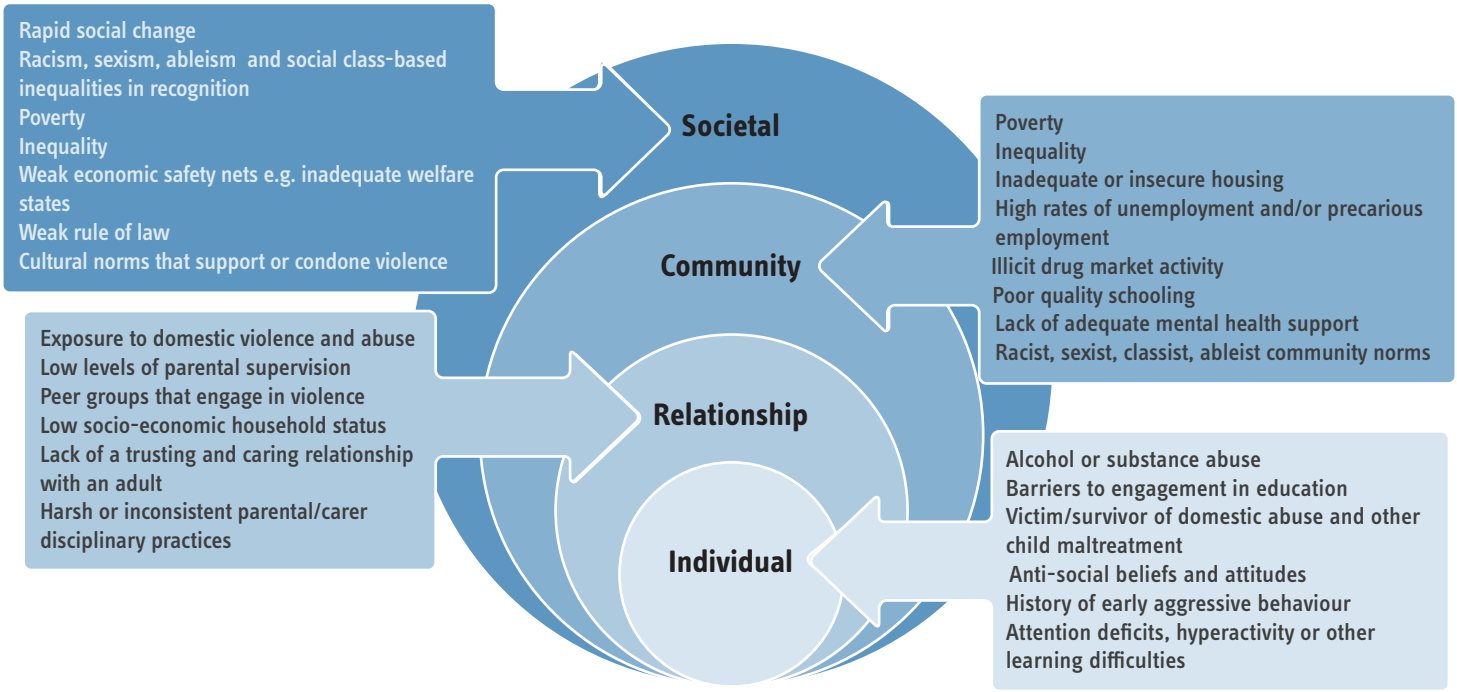
The United Nations (UN) (2018) defines youth as referring to those between 14 and 25 years of age, but stresses that this age range is flexible given that the experience of being young is likely to vary across the world. We agree that the ages of 14-25 provide a good starting point definition of youth in the context of the UK. With this in mind, it is unhelpful that so many forms of professional support for young people pivot on a strict binary definition of youth and adulthood that often holds the age of 18 as being a strict cut-off point that distinguishes between someone 'being young' (and therefore in need of appropriate levels of consideration, care and support) and being an adult.

The causes of violence

The causes of violence are complex and interrelated. The World Health Organization (2020) distinguishes between four levels, each of which contain various inter-related factors that can increase the likelihood of someone's involvement in violence, either as a victim or a perpetrator:

- Individual
- Relational
- Community
- Societal.

Figure 1: An ecological framework (adapted from World Health Organization, 2020; drawing on Irwin-Rogers et al., 2020b and Currie, 2016)



It is notable that these different levels do not operate in isolation but in dynamic relation with one another. Violence must therefore be understood as an issue that requires intervention across multiple, connecting areas. There is a need to replace 'simple, often short term, individual-level health outcomes' with 'complex, multiple, upstream, population-level actions and outcomes' (Rutter, 2017, 2602).

Gangs and youth violence

Youth violence is often considered an individual or group-based phenomenon, with 'gang membership' a frequent reference-point (Decker & Pyrooz, 2010). A body of evidence suggests that gang affiliation can be a driver of violence between young people, as well as creating obstacles to meaningful desistance from crime. Evidence suggests, moreover, that the nature, form and character of group crime is reconfiguring in the global era, reacting dynamically to social, economic and technological change (Fraser, 2017).

At the same time, however, it is increasingly clear that gangs are a social phenomenon that is frequently misunderstood. In both media and policy depictions, youth gangs are often misrepresented, resulting in the perpetuation of what can be highly racialised stereotypes (Williams & Clarke, 2016).

Not only is there evidence that gang-specific interventions have mixed success (Matjasko et al., 2012; Davies, Grossmith & Dawson, 2016), there is increasing evidence that the designation of 'gang member' is applied in ambiguous and opaque ways, resulting in a range of discriminatory consequences (Jacobs, 2009; Fraser, Armstrong & Hobbs, 2020).

An excessive focus on 'gangs' as the primary driver of violence between young people can distract attention from deeper structural drivers of violence such as inequality, oppression and exploitation.

In 2018, youth violence re-emerged as a major public and political issue in England and Wales, which saw marked increases in homicide, knife crime and hospital admissions for stab-wounds (Allen & Audickas, 2018; Office for National Statistics, 2019). While there is insufficient evidence to state with confidence what has caused the recent rise in violence, there are reasonable grounds for suspecting that drug market activity – including so-called 'county lines' activity, by which drug dealers from urban hubs (often highly vulnerable and exploited children and young people) transport drugs out to county towns in order to sell them through the use of a branded phone line – is responsible for a proportion of the increase (Morgan et al., 2020). Moreover, compelling arguments have also been made linking austerity (the significant reduction in UK Government spending) to the recent increase in knife crime (see Winchester, 2019).

The most accurate data on violence pertains to murder, both because it is relatively difficult to hide and because efforts to investigate and record it are greater than those associated with violence that has non-fatal consequences.

Figure 2: Victims and perpetrators of homicide by age, 2008-2018, England and Wales (Office for National Statistics, 2020c)

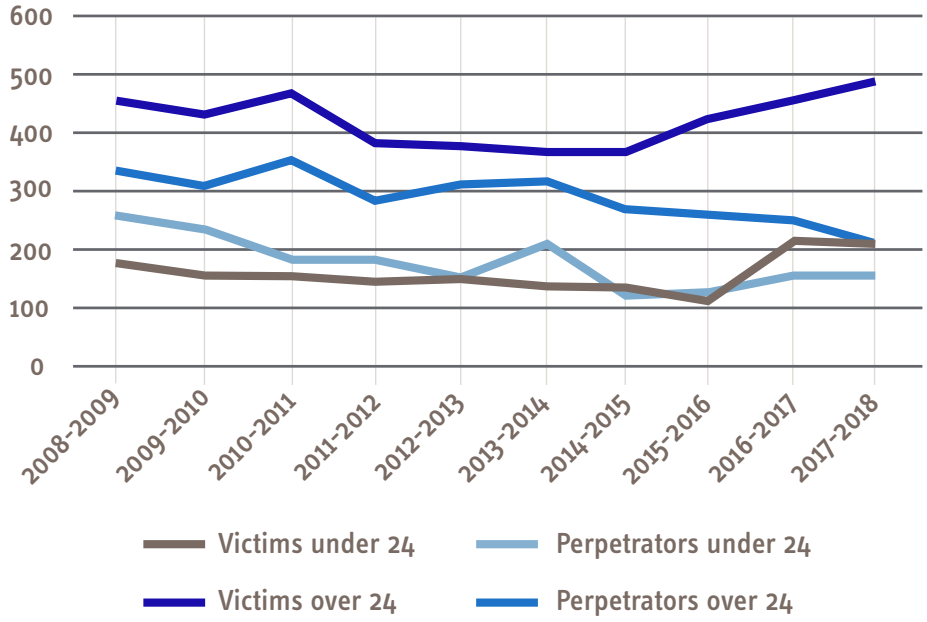


Figure 2 shows the number of people murdered and convicted of murder in England and Wales each year between 2008 and 2018. For each year during this period, there were more victims and perpetrators over the age of 24 compared to those under 24.

Looking at rates per million people, the 16-24 age bracket has consistently contained the highest homicide victim rates, indicating the vital importance of transitional safeguarding as adolescents move into adulthood (Cocker et al., 2021; Holmes & Smale, 2018). At a rate of 36 per million victims in 2018, however – even for this most at-risk age bracket – less than 0.001% of young people are the victims of murder in England and Wales.

In the UK, as elsewhere, interpersonal violence is a gendered phenomenon, with men disproportionately being perpetrators of violence compared to women. In 2018, 336 men were convicted of homicide compared to 28 women. Men are also more likely to be victims of homicide compared to women: in 2018, 484 men were murdered compared to 220 women.

Victims of certain forms of violence, however, such as domestic and sexual violence – both of which are prone to being under-reported and under-recorded – are more likely to be women than men (Office for National Statistics, 2020b). Gender differences are also notable in relation to gang association, with the Metropolitan Police Service Gang Violence Matrix in 2019/20 recording 6 females compared to 2,511 males (MPS GVM, 2020). However, girls and women are affected by violence, including gang-associated violence, and their needs may be hidden or overlooked - in part because the system response is largely focused on boys and men (Eshalomi, 2020).

Given its potential to dominate media headlines, people may be under the misleading impression that the vast majority of violence occurs between strangers (and particularly young people) outside the home. It is important to highlight, therefore, that much violence takes place within the home: based on figures from the Crime Survey for England and Wales, for example, an estimated 3,125,000 people now aged 18-75 were subject to physical domestic abuse (Office for National Statistics, 2020).

In recent years, media and politicians have highlighted the serious harm associated with, and growing prevalence of, violence involving the use of knives. In 2018-19, for example, there were 5,149 finished consultant episodes[1] where the cause was recorded as an assault with a sharp object. This figure was up from 3,888 in 2012-13 (NHS Digital, 2020). In relation to violence with injury offences more generally, the police recorded 512,743 offences in 2019-2020 (Office for National Statistics, 2020).

Overall, therefore, while murder is a relatively rare occurrence in England and Wales, violence that does not result in loss of life is far more prevalent, affecting a sizeable proportion of the country's population.

Key points

- Interpersonal violence affects people of all ages, but those aged 16-24 are disproportionately likely to be affected - both as victims and perpetrators.
- Women are far less likely to be the perpetrators of this type of violence compared to men.
- While street-level violence between young people often attracts media headlines, it is important to note that a significant amount of violence takes place in the home, involving family members or those acquainted with one another.
- Although homicide has a devastating impact on the lives of those affected, the prevalence of homicide in England and Wales is relatively low when considered in the context of the size of the country's total population. Violence resulting in physical injury, however, is a problem that affects a sizeable proportion of the population.

1 'Finished consultant episode' is an NHS term used to describe cases in which patients have spent time in the continuous care of a hospital consultant, before the discharge, transfer or death of the patient.

Origins and expansion of the public health approach

With their roots in a report by the US Department of Health and Human Services (1985) and stressing upstream prevention, public health approaches are viewed by many as holding significant potential to reduce violence (Bellis et al., 2012; Local Government Association, 2018). These approaches frame the problem of violence not as an individual pathology but as a public health epidemic, with a range of social, cultural and economic causes. As such, they extend responses to violence beyond law enforcement to health, social care, education, youth services and third sector organisations. In addition, public health approaches conceive of members of the public not as passive recipients of professional-led responses, but as active partners in problem-solving.

The World Health Organization (WHO) defines the public health approach as seeking 'to improve the health and safety of all individuals by addressing underlying risk factors', which consists of four main steps:

> To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.

> To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.

> To find out what works to prevent violence by designing, implementing and evaluating interventions.

> To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.

(WHO, 2021)

It is important to note that the four steps focus on the individual, relational and community levels rather than societal. One of the key benefits of public health approaches is their potential to shine a light on various forms of structural violence that afflict many people's lives, often disproportionately across social divisions such as gender, race and social class. To fully realise the potential of public health approaches to violence reduction, therefore, such approaches need to be understood under the expansive remit offered in this briefing.

The term 'interventions' might, for example, be interpreted broadly to include initiatives that might be taken at national and international governmental levels - for example, taxation and welfare policies designed to reduce various inequalities and tackle deep-rooted structural forms of disadvantage. In order to ascertain the multi-faceted ways in which the public health approach might operate across multiple levels, it is helpful to examine specific case studies.

Case study

What worked? Public health and violence reduction in Scotland

In 2005, Glasgow was a city with an unenviable reputation for gangs, youth violence and knife crime. The United Nations announced that Scotland had the highest rates of violence in the developed world, and the World Health Organization found Glasgow to have the highest murder rate of 21 European countries (Krug et al., 2002). In response, the then Strathclyde Police Force set up a Violence Reduction Unit (VRU) with a specific aim of reducing the epidemic levels of violent crime.

The VRU adapted violence reduction policies from Cincinatti and Boston, initially focusing on enforcement but developing into a broader public health agenda involving interventions at individual, relationship, community and societal levels.

Since 2006/7, police recorded crime statistics have shown that non-sexual violent crime in Scotland has decreased by 48% (Scottish Government, 2016, 2018a). This includes a 38% fall in murder and 43% fall in attempted murder and serious assault. The reality of a major drop in violence is confirmed through data published from other sources, including hospital admissions and victimisation surveys which show similar levels of reduction (Scottish Government, 2018b).

Historically, violence in Scotland has been strongly associated with the use of bladed weapons (Soothill et al., 2000), but recorded crime figures since the mid-2000s reveal a 65% decline in weapon-related incidents. Research confirms that the reduction in both fatal and non-fatal violence in Scotland is primarily a drop in weapon-related incidents involving young men in public spaces (Skott & McVie, 2019; Skott, 2019). It appears, therefore, that Scotland has witnessed a real and significant change in the problem of youth violence, especially in the West of Scotland (Fraser et al., 2010).

There is, however, a lack of clear understanding of 'what worked' in the Scottish context. While specific interventions show evidence of moderate success (Williams et al., 2014), robust evaluations are scarce and a range of other factors might have been involved (McVie et al., 2018). The VRU tailored the principles of public health to the Scottish context. This involved connection with the Scottish 'Kilbrandon' ethos in youth justice (McAra, 2008) and making available a range of social and emotional supports to individuals affected by violence.

At the same time, however, these changes were made against a backdrop of decreasing punitivism, investment in early years and education, and a large number of small-scale initiatives at local and public sector level. The Scottish VRU was also notably responsible for a dedicated media and communications strategy - drawing on storytelling, oratory and publicity to change the conversation on violence - that mirrored a shift in Scottish political rhetoric toward a more compassionate era of justice (McAra & McVie, 2013). Rather than a set of clear-cut interventions, the Scottish approach has been characterised as a 'whole-system, cultural and organisational change' (Youth Violence Commission, 2018) involving a number of charismatic opinion-leaders.

One important lesson, therefore, is that public health approaches are not a single policy or silver bullet, but require systemic change and investment of leaders across areas of education, early years, health (including mental health), the community and social care, as well as police and the courts.

Recent initiatives and policy development in England and Wales

In recent years – and based at least in part on the perceived success of public health approaches to violence reduction in Scotland – the idea of developing similar approaches in England and Wales has garnered some political support (see House of Commons, 2018). Outward enthusiasm, however, has not yet been matched by adequate system-level strategic policy change of the kind that could fully realise the potential of such approaches. In addition, it has been noted that, in many ways, Glasgow is a very different city to others in England - both in terms of the nature and levels of violence as well as its demographic make-up (see McVie et al., 2018).

Notable recent initiatives in England and Wales associated with the public health approach to violence reduction include:

- A proposed new *Serious Violence Bill* containing a **legal duty for public sector bodies to work together to prevent and reduce serious violence** (see Home Office, 2019).
- The establishment of a £200 million Youth Endowment Fund, whose purpose it is to fund programmes and build up the evidence base for effective early interventions (primarily targeting those 10-14 years of age), to steer children away from crime and violence.
- The establishment of a **regional network of 18 Violence Reduction Units** across England and Wales, with the purpose of each specialist team being to bring together different organisations - including police, local government, health, community leaders and other key partners to prevent violence by understanding its root causes.
- The **publication of various forms of guidance on the scope and nature of public health approaches** to violence reduction, including that from Public Health England (2019), the cross-party Youth Violence Commission (2020), and the World Health Organization (2020).

Taking one example of recently published guidance on public health approaches to violence reduction, Public Health England (2019, p.21-53) advocated a place-based, multi-agency approach, distilling six core features:

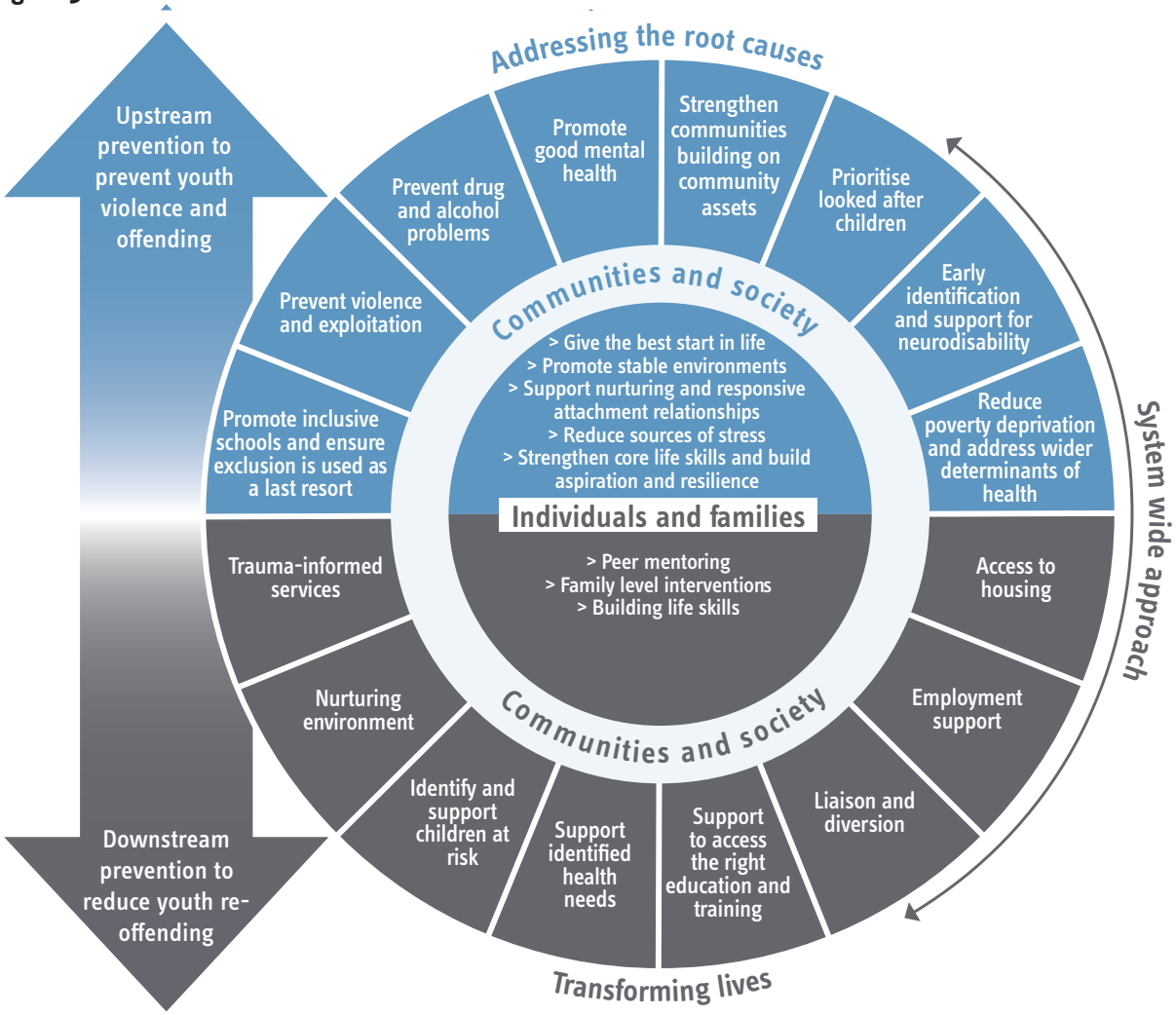
- Focused on a defined population, often with a health risk in common.
- With, and for, communities.
- Not constrained by organisational or professional boundaries.
- Focused on generating long-term as well as short-term solutions.
- Based on data and intelligence to identify the burden on the population, including any inequalities.
- Rooted in evidence of effectiveness to tackle the problem.

In addition, Public Health England promoted five principles to operationalise these features of a public health approach, which they referred to as **the '5 Cs':**

- **Collaboration** – a collaborative whole-systems approach brings together partners from a broad range of functions who have the shared goal of tackling and preventing violence.
- **Co-production** – the multi-agency perspectives of all partners should inform the approach and workstreams undertaken locally to prevent and tackle violence.
- **Cooperation** in data and intelligence sharing – partners should create a Common Recognised Information Picture (CRIP) to overcome barriers to effective data and information sharing, and mobilise effective preventative and operational interventions.
- **Counter-narrative** – partnerships should help to promote positive narratives and aspirations, underpinned by the mobilisation of community assets. For example, long-term opportunities for employment.
- **Community consensus approach** – efforts to reduce violence should be with, and for, local communities, and empower these communities to actively participate and get involved in tackling issues that affect them collectively.

Public Health England has also outlined a public health approach to reducing youth offending and violence in what it called the 'Collaborative approaches to preventing offending and re-offending by children' (CAPRICORN) framework.

Figure 3: PHE's CAPRICORN framework



This framework is intended to support those involved in the prevention of youth violence and other forms of offending by focusing attention on both primary (upstream) and secondary (downstream) causes. The core features, principles and framework provided by Public Health England all help to convey how a holistic public health approach to violence reduction differs from a narrower enforcement and suppression response to violence. Some of the main benefits of public health approaches to violence reduction include:

- The significant potential they hold in including young people and communities as partners and co-designers of effective solutions to violence.
- Their broad scope, which requires the collaboration of a range of relevant professionals and organisations with a stake in reducing violence in people's lives.
- Their potential to move past a simplistic and reductionist understanding of violence focused on individuals and families, towards a more expansive and deeper understanding of community and societal drivers of violence.

Key points

- The core feature of public health approaches to violence reduction is that responses should be evidence-led, rather than driven by ideology or dogma.
- Being evidence-led means collecting and generating the best possible evidence on the nature and scope of the problem, and rigorously evaluating the effectiveness of any responses designed to reduce violence.
- While whole system, multi-agency collaboration should not be conflated – nor viewed as in conflict - with the term 'public health approach', such collaboration has come to be seen as an important component that facilitates the development of effective public health approaches.

Implementing an effective public health approach: Putting principles into practice

While many of the principles associated with public health approaches to reducing youth violence are sensible and straightforward, they can be difficult to apply in practice. This section provides system leaders and senior managers with advice and guidance on how to operationalise key principles.

Whole system, multi-agency collaboration

Public health approaches are more expansive in their scope than whole system, multi-agency collaboration. Such collaboration, however, plays an important role in creating the conditions through which public health approaches are likely to be effective. To reiterate, the core feature of public health approaches is that they are driven by evidence, both about the nature and scope of the problem and the potential effectiveness of any responses.

A lack of whole system, multi-agency collaboration makes it more difficult to collect or generate evidence on violence, and therefore makes it more difficult to understand the scope and nature of the problem. It also reduces capacity to effectively implement and evaluate interventions. Essentially, this is because the term multi-agency collaboration, at its core, refers to different agencies cooperating and working together to achieved shared goals.

For the adult and children's social care sector in particular, multi-agency collaboration in relation to violence is important because:

- violence is a reason for referrals to social care services
- violence can interfere with service delivery
- violence disproportionately affects social care sector clients and their families
- preventing violence would support progress towards other positive outcomes for clients
- coordinating with other sectors to prevent violence would expand the social care sector's capacity to assist vulnerable individuals, families and communities.

(WHO, 2020, p.11)

As is well-established, however, multi-agency collaboration is easier said than done. It is one thing for organisations and professionals to express their buy-in to multi-agency collaboration in principle, and another for this to translate into genuine collaboration in practice.

Many barriers or challenges to effective collaboration are likely to exist, including:

- Organisations having different visions, priorities, agendas and status in terms of safeguarding arrangements.
- Problems being understood and framed through different language, terminology and definitions.
- Competition over owning or receiving the credit for reductions in violence.
- Competition for scarce resources, compounded by short-term and narrowly defined funding streams.
- High levels of stress and anxiety amongst staff – particularly in relation to work with vulnerable populations that involves an ongoing risk of serious harm – that can drive cultures of distrust and defensiveness.
- Legal and ethical issues around sharing data to understand the problem and evidence success and an over-reliance on decontextualised, partial data that can distort the perceived nature of social problems.

Guidance and advice from organisations, such as the Violence Prevention Alliance (2020) and Public Health England (2019), can be helpful in addressing some of these barriers and challenges. The WHO 'collaboration multiplier tool to prevent interpersonal violence', for example, provides a list of potential differences across sectors and indicates a number of opportunities to overcome challenges.

Challenges to multi-agency collaboration and opportunities for overcoming them

	Differences across sectors	Opportunities to overcome challenges
Shared vision and understanding	Sectors have different definitions and understandings of key terms. A lack of common language can hinder communication, understanding, and the ability to see the benefits of working together.	Developing a shared language for sectors to communicate with each other.
	Organisations representing different sectors have different missions, values and mandates. They also may utilise different work styles, management styles and modes of operation, and abide by different administrative boundaries, laws and regulations, and budgets. All these dimensions contribute to varying comfort levels and expectations for processes and outcomes, potential partners, timelines, strategies and solutions.	Bridging differences across sectors.
	Representatives from any one sector may hold assumptions or stereotypes about any other sector. This can result in misunderstanding across sectors, a lack of confidence in what others can contribute, reservations about the motives of others, and barriers to open engagement.	Supporting trust-building and overcoming preconceived notions about other sectors.
Partnership buy-in	The different interests of multiple sectors make it challenging to meet the needs of everyone.	Finding a common agenda to advance collectively
	One or more sectors may have a real or perceived need for some degree of credit in preventing violence, thus creating tension.	Sharing credit and expanding ownership for shared solutions.
	The nature of accountability for outcomes drives participation in two ways: 1) For sectors that are held most accountable for violence prevention outcomes, these participants will want to maintain a high level of control. 2) For sectors who have little or no accountability related to violence prevention, it is much more challenging to keep them engaged.	Balancing the engagement of sectors with different levels of accountability.
Shared measurement	Establishing a common set of measures to monitor performance, track progress toward goals, and learn what is or is not working takes effort. Sectors typically have their own data sets, systems, technological equipment and software, and their jurisdictional and outcome metrics differ from each other.	Measuring the problem and progress with data from multiple sectors.
	Different sectors are bound by differing legal regulations and ethical considerations. Often, data is confidential or a particular partner may consider its data proprietary and feel uncomfortable sharing it.	Overcoming confidentiality barriers and proprietary information.

(Adapted from Violence Prevention Alliance, 2020, 4-5)

The problem of violence is not one that respects organisational boundaries. Instead, the causes of, and solutions to, violence are likely to cross the scope and remit of many different organisations, and involve communities too. For this reason, a key consideration for improving the consistency and coherence of support to families and young people is the nature of commissioned services.

The dominant approach has been for different sectors – health, local authorities, police, schools, and so on – to commission specialist private or third sector services in isolation from one another (see Dickinson et al., 2013). If the problem of violence is one with complex causes that cross multiple life domains, this approach contains serious limitations. There is an important opportunity, therefore, to enable commissioned services to operate in a more proactive manner, focusing on upstream intervention activities and across organisational boundaries.

According to a recent paper by Catch22, a public health approach to violence reduction should involve organisations pooling their resources to joint-commission primary prevention services that have the potential to deliver significant, long-term benefits (see Jones & De Zoete, 2018). Consistent with a public health approach to violence reduction, commissioning of specialist services should be guided by the best available evidence on 'what works'. In this regard, the ongoing work of the Youth Endowment Fund (2020) – a ten-year initiative with the primary goal of identifying and scaling-up effective interventions for preventing violence – should be useful in informing the selection of appropriate interventions.

It should be noted, however, that evidence around effectiveness should not be limited to the findings of a small number of Randomised Controlled Trials (or quasi-experimental evaluations of specific interventions) but, instead, should include all types of evidence, quantitative and qualitative, that helps to determine what is likely to work, for whom, in what ways, and under what circumstances.

In addition to pursuing whole-system, multi-agency collaboration, it is also important to think in terms of **place-based approaches**, which also require a shift away from organisational silo working. Defining the precise 'place' in place-based approaches is not always straightforward, as different organisations are likely to have different perspectives as to what constitutes appropriate and useful boundaries for the purpose of reducing violence.

The key consideration is that, however the place is defined, it must be meaningful to local partners and members of the community. This is likely to result in different place-based approaches across the UK, covering significantly greater or smaller geographic areas.

Place-based approaches cannot materialise without the active support and engagement of a range of local system leaders - that is, those responsible for shaping or managing the policies, practices, processes and people involved in a particular system. Indeed, a key ingredient of effective multi-agency collaboration is 'generous leadership'. This involves system leaders:

- being open to new ideas
- showing curiosity and patience
- displaying a drive to build strong alliances with individuals, groups and communities who can achieve shared objectives together
- starting with the bigger picture, rather than focusing on what an individual organisation can do on its own
- trusting colleagues, and being generous with, and open to, feedback
- being rooted in place and seeing themselves as part of an ecosystem and wider movement.

(Big Lottery Fund, 2018, 5)

While social care system leaders are well placed to play an important role in the creation and implementation of place-based approaches, it should be noted that one of the key functions of the recently established regional Violence Reduction Units is to bring together a full spectrum of organisations and professionals whose work centres on, or relates to, violence reduction. For colleagues working in an area which has a regional VRU[2], therefore, this unit should be well placed and willing to play a leading role in bringing different organisations onto the same page by helping to surmount many of the differences and challenges referred to above.

2 There are currently 18 regional Violence Reduction Units operating in: London, the West Midlands, Greater Manchester, Merseyside, West Yorkshire, South Yorkshire, Northumbria, Thames Valley, Lancashire, Essex, Avon and Somerset, Kent, Nottinghamshire, Leicestershire, Bedfordshire, Sussex, Hampshire and South Wales.

Case study
The Essex Data programme

The Essex Data (ED) programme was designed to facilitate multi-agency collaboration, bringing together partners from adult and children's social care, education, police, health, and voluntary and community service organisations. The programme linked data from each local-level partner to harness their collective knowledge, create new data dashboards, and improve the efficiency and quality of targeted interventions in areas as diverse as school readiness, preventing domestic abuse, and tackling gang activity and violence.

Each participating organisation helped to scope the requirements platform and signed up to an information-sharing protocol that facilitated the sharing of pseudonymised data. Combined with additional data collection, ED helped to identify local communities that could benefit from early intervention approaches and, among other things, led to the recommissioning of domestic abuse services, informed Ofsted and HMI strategic assessments, and helped to develop additional funding bids for further partnership work (for more information, see Future of Essex, 2019).

Case study
Nottingham City and Nottinghamshire Violence Reduction Units (NNVRU)

From its inception, Nottingham City and Nottinghamshire Violence Reduction Unit's (NNVRU) strategy was guided by a Theory of Change approach that coupled evidence and public health intelligence with the lived experience of those experiencing violence. By taking this approach, NNVRU did not restrict its focus to what was easily measured, or where evidence was strongest, choosing instead to work on soft system drivers of change such as fostering collaboration and mutual trust with partners and local communities. Outcomes such as 'feeling safe' are held in equal regard with a 'reduction in violent offences', in recognition that reported crime is only a proportion of actual crime.

The umbrella Theory of Change is evolving, becoming increasingly sophisticated and is used to guide strategy and commissioning. Topic specific Theories of Change are also being developed to pursue, among other things, the aspiration to become a trauma-aware Nottingham and Nottinghamshire. In this case, the discussion of the Theory of Change approach across the partnership is leading to the commissioning of systemwide eLearning informed by local topic expertise and a whole city and county strategy.

Engaging communities, families and young people

Bringing together multiple sectors is an important part of creating the conditions in which public health approaches are likely to succeed in preventing and reducing violence. Alongside whole system, multi-agency collaboration – and equally, if not more, important – is organisational commitment to actively engaging and collaborating with communities, families and young people as partners in the identification and implementation of solutions to social problems such as violence. This is particularly the case within the context of social care and social work, because of its commitment to empowering people to achieve positive change, as well as its focus on ethical practice and individual rights that are important in curbing excessive intervention.

As discussed earlier in this resource, the causes of violence are complex and, at least to some extent, are liable to shift over time. Without the active engagement of communities, families and young people themselves, it is much harder for organisations to design and deliver effective support and interventions. To this end, the mantra of 'working with, not doing to' holds significant value (see Kay, 2015).

The underpinning principle is that services, at their core, are always about quality of relationships. High quality relationships depend on respect, care and trust, and these are fostered by working *with* people, rather than doing things *to* or *for* them.

There is no 'magic bullet' or single mechanism or approach through which engagement is best fostered and maintained. Engaging with communities, families and young people is an ongoing process that takes time, patience, adequate resources, and an authentic and genuine commitment. While young people most at risk of becoming victims or perpetrators of violence might be some of the most challenging for professionals to consult and co-design services with, considerable effort should be made to remove any barriers to engagement as they are also by far the most beneficial group to involve.

Guidance provided by the Home Office (2014, p.3) suggests that organisations adopt the following basic principles when designing an effective community engagement process:

- **Clearly scoped** – the emphasis should be on action, framing the issues in a way that is conducive to finding solutions. Why are we engaging? What are we trying to achieve? What is on the table? And, equally important, what is not?
- **Connected to decision-making** – the process is meant to achieve an outcome, otherwise there is a risk that those involved could become frustrated.
- **Inclusive** – all people should have access to the information they need to participate.
- **Involve deliberation** – people should be given the chance to think things through and weigh up alternatives.
- **Build relationships** – getting to know people and providing opportunities for everyone to appreciate each other's viewpoints and perspectives.
- **Influential** – people will disengage if there is no evidence that their input influences the outcomes.
- **Provide feedback** – people should be informed of how their contribution has made a difference.
- **Build trust** – a good community engagement strategy will result in people having trust and confidence in one another.

In addition to these basic principles, specifically in the context of community engagement and violence reduction, it is important that any engagement challenges rather than reinforces the notion that violence is normal or inevitable, and seeks to draw on a full range of stakeholders – including, but not limited to, the voluntary and community sector, local businesses, faith groups and members of the public.

If efforts to engage and work with communities, families and young people are perceived as superficial box-ticking exercises, this can further erode the ability of organisations to connect with those they most need to reach. Conversely, effective engagement and genuine co-production of services should not be thought of as a zero-sum game, but as something that can generate additional value (Williams, 2020).

Listening and responding to the voices of people who use or access services will help to redress traditional power imbalances and fundamentally reconfigure the way in which these services are designed and delivered. Adhering to the principles outlined above will help to ensure that efforts at engagement and co-production are sincere, substantive, and well-received.

Case study
The London Violence Reduction Unit

From its inception, the London Violence Reduction Unit (LVRU) made engagement with communities and young people a key strategic priority. As part of its youth-led engagement strategy, it created a Young People's Action Group for people aged between 15 and 21. The Action Group involves regular meetings and training sessions, enables young people to share their views with decision-makers around programmes, interventions and campaigns, invites its members to attend key events and support community visits, and facilitates the sharing of information with other young people about LVRU projects and opportunities.

Moreover, young people on the Action Group are paid the London Living Wage, have their travel and food expenses covered, and gain access to a range of work, events and opportunities that develop important life skills and experiences.

In addition, early on in its work, the LVRU established a formal 'approach to community involvement', which explicitly outlined its understanding of who is included in the term 'community' and provided a set of principles illustrating how it intended for its work to be informed by voices from the community. Furthermore, the LVRU has held a number of community meetings and established a serious incident toolkit, designed in collaboration with community safety partnerships across London (for more information, see Greater London Authority, 2020).

Organisational policies, practices and learning training

Multi-agency collaboration and engaging with communities, families and young people are important outward-facing components of creating and implementing effective public health approaches to violence reduction. In addition to these outward-facing components, it is also important that system leaders look inwards to the policies, practices and learning opportunities internal to their organisations, which have the potential to ensure frontline professionals are able to play their part in public health approaches to violence reduction. This can include:

- Creating policy statements outlining what a public health approach to violence reduction means in the context of a particular organisation. These statements should be carefully co-designed with people using services and well communicated both internally and externally. This will help to ensure that professionals working directly with people, such as those working in the social care sector, understand the scope and significance of public health approaches and appreciate the important role they have to play within them.

- System leaders encouraging working practices that enable all professionals to play their role in the creation and implementation of public health approaches to violence reduction. For example, system leaders should facilitate ways of working that provide frontline social care workers with ample opportunities to share their knowledge and expertise with professionals working in other organisations - for instance, around the impact of trauma at the individual, family and community level (see Taggart, 2018). System leaders should role-model a learning culture and seek to protect and enhance learning opportunities for their staff wherever possible.

- Sufficient learning opportunities – including formal training, group supervision, case clinics, shadowing, coaching, and so on – concerning both the causes of, and responses to, violence should be provided to all professionals working with vulnerable children, young people and adults. System leaders should ensure space is made for their organisation to accommodate and embed new learning (Green, 2014).

  It is important that any formal training is of high quality – meaning it is informed by the latest research and evidence, sensitive to local context, presented in an engaging manner, and evaluated – and delivered with sufficient regularity that key ideas and principles are firmly embedded in professionals' direct practice.

Policies, practices and learning opportunities should all be informed by the latest research and evidence around the probable causes and most effective responses to violence. Such evidence should be drawn from diverse sources, including the practical wisdom that stems from people's lived experiences. In this regard, it is particularly worth noting that recent research has highlighted the key role played by structural inequalities based on gender, race and social class in driving violence and in understanding what is most needed in order to tackle it (see Gunter, 2017; Harland & McCready, 2015).

For example, recognising how disproportionate rates of poverty, police stop and search, and school exclusions, affect the lives of young black boys in particular, is an important step in developing a comprehensive understanding of the causes of violence among this group of young people - as well as helping to identify consequent reforms to policy and practice that have the potential to reduce these inequalities (Irwin-Rogers et al., 2020a).

Similarly, it is important for organisations to recognise the significant and often overlooked impact of violence on girls and young women, whose complex experiences of violence are often stereotyped or misunderstood (see Young et al, 2007; Irwin-Rogers et al., 2020b). Support for girls and young women, too often sorely lacking in recent years, must be a priority.

Key points

- Multi-agency collaboration, meaningful engagement with communities, families and young people, and establishing effective internal policies, practices and enabling an ongoing learning culture, are all central steps in improving understanding and responding to violence.
- Multi-agency collaboration can play a key role in creating the conditions through which public health approaches to violence reduction can be developed and implemented. To support such collaboration, guidance can be drawn from toolkits (see, for example, WHO, 2020) and recent case studies exhibiting best practice (for example Future of Essex, 2019).
- Engagement with communities, families and young people constitutes an important part of public health approaches, as it enables services to be informed by the best available evidence, and tailored to local need. To facilitate effective engagement, basic principles can be followed (see, for example, Home Office, 2014) and lessons learned from case studies (for example, Greater London Authority, 2020).

Potential problems and possible solutions

Losing sight of the macro-level causes of violence

Public health approaches recognise that multiple causes of violence can be located at the societal, community, relationship and individual level (Public Health England, 2019; World Health Organization, 2020; Irwin-Rogers et al., 2020b). Too often, however, despite explicit acknowledgement of societal level drivers of violence such as inequality, poverty, structural racism, inadequate social welfare nets, and so on, the focus of public health approaches seems to fall almost exclusively on addressing community, relationship and individual level risk factors. This can mean that efforts to reduce violence are often limited, with the spotlight focusing on the practice of professionals and the attitudes and behaviours of individuals involved in violence, to the neglect of actions that can and should be taken by people in positions of significant power.

Those working in the social care sector cannot by themselves solve deep-rooted, structural issues around endemic poverty and inequality, or offer a solution to structural racism or problematic gender norms. Nor can they compensate for inadequately resourced social welfare systems – all significant distal drivers of interpersonal violence (Currie, 2016; Irwin-Rogers et al., 2020b).

This is not to say that those working in the social care sector (or in health, policing, education, youth services, etc) are powerless to make any headway into some of these issues. It is important, for example, that policies and practice are informed by evidence around the scope and nature of gender, race and social class inequalities and power imbalances, which impact on the lives of those whom the social care sector supports (see Firmin et al., 2019). Crucially, however, societal levels of poverty and inequality, structural racism and the quality of social welfare systems are all issues for which central government has a leading responsibility to address.

All agencies whose scope includes the reduction of violence should, in collaboration with one another and through a collective voice, communicate to central government the responsibilities and opportunities it has for tackling the societal drivers of violence. In other words, responsibility for reducing violence cannot be a one-way street - central government must not abrogate its responsibility for creating safer societies and communities by delegating the task of violence reduction to regional and local level actors.

Instead, central government must ensure that agencies operating at a regional and local level receive sufficient support, funding and resources to fulfil their roles effectively, and enact national policies and legislation designed to reduce poverty, inequality and systemic racism. If we are to achieve significant and long-term reduction in violence, action at all levels – societal, community, relationship and individual – is vital.

Causing unintended harm

In medical science the term 'iatrogenesis' refers to a secondary harm caused by primary treatment. In the social sciences, this idea has been applied to interventions that cause unintended harms or which unintentionally worsen precisely the problem they are aiming to solve (Bowling, 2017). Public health approaches to violence reduction are liable to increase the scope and range of possible interventions in people's lives, resulting in increased levels of system contact.

It's been argued, for example, that efforts at curbing gang crime in the United States have created a coupling of criminal justice and community institutions which lead to situations of 'hypercriminalisation' and a 'youth control complex', which doesn't replace but instead expands punitive control over young people's lives (Rios, 2011, xiv). A similar situation appears to be unfolding in the United Kingdom (see Hallsworth, 2013; Williams, 2018; Williams & Clarke, 2018). Similarly, there is a need to acknowledge that both the criminal justice system and the social care system can, in and of themselves, create and exacerbate harm and trauma.

It is crucial, therefore, that the fundamental rights of children and adults – to privacy, to non-discrimination, to access their personal records, and so on – are held as paramount. Agencies should be cautious of generating any unintended harm by riding roughshod over these rights using blanket justifications of some purportedly higher consideration or purpose (such as the reduction of violence).

Unintended harm can also be generated through an inadequate or overly narrow conception of the problem of violence. In the UK, for example, some critics have urged caution in relation to multi-agency interventions premised on the 'gang' label. Cottrell-Boyce (2013, p.196), for example, discussing the proposed 'wraparound' approach embedded in the Home Office Ending Gang and Youth Violence programme – involving mental health, psychology, community-based intervention and family support (Wood & Alleyne, 2010) – notes the lack of definitional clarity, divergent meanings between organisations, and potential for stereotype and misunderstanding:

The key problem here is that a more holistic approach to tackling violent youth crime – which is to be welcomed – is confused by a focus on the contested and muddled concept of the gang. Focusing on gangs could result in practitioners failing to appreciate the myriad problems which vulnerable young people face.

To avoid this potential pitfall, Weaver (2015, 247) proposed a model that is premised not on treating gang members as individuals in need of 'intervention', but on social relations that emphasise 'supportive, reflexive, relational networks premised on reciprocity, or mutual helping and obligations'. This approach moves beyond both criminal justice and third sector responses to embrace what Weaver terms the 'fourth sector' of family, friends and faith.

Paying insufficient attention to local context

There are problems in assuming that the public health approach that appeared to be successful in Glasgow will achieve similar levels of success in other places. Cities such as London, Birmingham and Manchester are different to Glasgow in many ways, not only in terms of the drivers of violence but also the nature of the landscape in relation to social care, education, housing, policing, and also in terms of demographics. In Glasgow, for example, despite evidence of growing sophistication, youth gangs remain predominantly white, working-class, street-based groups of teenagers, affiliated with specific territories, engaging in territorial violence (Fraser, 2015). In London, on the other hand, the landscape of gangs is more ethnically diverse, territorially fragmented, and connected to organised drugs markets (Densley, 2013; Gunther, 2016; Hobbs, 2013; Irwin-Rogers, 2019).

There are also differences of type and magnitude in terms of the inequalities experienced by different racialised groups. Osidipe and Palmer (2020) argue that, before public health approaches are adopted across local authorities in England and Wales, contextual issues need to be considered - including 'target population size, ethnicity, evidence and other practical considerations that accompany public policy implementation'.

Osidipe and Palmer raise particular concerns around the potential failure to acknowledge the impact of systemic racism on young black males, arguing that we must seek to develop an empathetic understanding of people's lives and the challenges they face in order to develop trust – the bedrock of quality relationships and a prerequisite of meaningful engagement.

Policy transfer from Glasgow to London has failed in the past. The so-called 'CIRV' (Community Initiative to Reduce Violence) model to gang intervention was transferred to London but in the process was changed radically, with a failure to recognise the nature of the problem, or the multi-agency work that underpinned it (Densley & Jones, 2016). These findings suggest that policies must be premised on a strong form of 'analytical localism' (Ratcliffe, 2016). In this regard, the emphasis on place-based approaches highlighted previously is crucial in avoiding the problems associated with simplistic policy transfer from other times and places.

Challenges of evidencing success

One of the most significant obstacles in measuring the efficacy of the public health approach is a lack of understanding of the processes through which policies travel, the mechanisms that underpin successful policy transfer, and the difficulties of researching how and if policies travel (see Jones et al., 2019). Somewhat ironically given the centrality of evidence to public health approaches, evaluations to generate evidence about the effectiveness of public health approaches themselves are inherently challenging.

Despite increased attention around public health approaches to violence reduction (Welsh et al., 2014; Williams & Donnelly, 2014) evaluative work has indicated evidence of mixed success (Maxson & Klein, 2006; Hodgkinson et al., 2009; Matjasko et al., 2012; Davies et al., 2016). This is due in part to the complex and multi-faceted nature of violence. Controlled interventions and randomised trials are seldom possible in the context of public health approaches to reducing violence (Braga et al., 2001). It should be noted, however, that rigorous attempts are now being made to evaluate the impact of public health approaches to violence reduction, including a major evaluative initiative focusing on the work of regional Violence Reduction Units (see Home Office, 2020).

While evidence plays a crucial role in informing the development and implementation of public health approaches to violence reduction, this should not be solely equated with the findings of randomised controlled trials concerning isolated interventions. Instead, 'evidence' should be interpreted broadly to include both quantitative and qualitative data, both of which can play an important role in advancing our understanding of what is likely to work, for whom, in what ways, and under which circumstances.

Summary table of possible problems and potential solutions

Possible problems	Potential solutions
Losing sight of the macro-level drivers of violence.	Regional and local level actors should join together to communicate, with a collective voice, the responsibility and opportunities that central government has to tackling drivers of violence - especially at a societal level.
Causing unintended harm.	Ensure the problem is conceptualised accurately and appropriately – which necessitates meaningful, ongoing, inclusive engagement with communities – and ensure that individual rights are protected through co-produced solutions. Social work professionals and other advocacy agencies have a key role to play in this regard.
Paying insufficient attention to local context.	Adopt place-based approaches, co-designed with communities, which are sensitive to local variations in drivers of violence and inequalities based on gender, ethnicity and social class.
Challenges of evidencing success.	Wherever possible, help to support and facilitate rigorous evaluations of interventions designed to reduce violence and its drivers.

Conclusion: Realising the potential of a public health approach to reducing violence

This briefing has been produced to support local system leaders and senior managers, particularly those working in children's and adults' services, to play their role in creating and implementing public health approaches to reducing violence. It suggests that there is significant potential in reducing violence through the adoption of public health approaches.

The core feature of public health approaches is that they centre on careful efforts to collect and evaluate data to better understand the nature of a particular social problem and how to address it, rather than basing policy and practice on ideology or dogma. As such, public health approaches encourage ways of working that will often challenge systems to adapt and improve, based on the best available evidence.

There are three main things system leaders can do to create the conditions in which public health approaches are liable to thrive:

- Help to facilitate and engage in multi-agency collaboration that brings together all organisations and professionals whose remit and concern includes the reduction of violence. To this end, guidance can be drawn from relevant toolkits (see, for example, WHO, 2020) or from case studies that exhibit best practice in this area (see, for example, Future of Essex, 2019).

- Engage with communities, families and young people to ensure services are informed by the best available evidence and tailored to local needs. To facilitate this, basic principles of effective engagement can be followed (see, for example, Home Office, 2014) and lessons can be learned from relevant case studies (see, for example, Greater London Authority, 2020).

- Pursue inward-facing initiatives that centre on the establishment of appropriate and effective policies, practices and learning, underpinned by the best available evidence, as well as a culture of curiosity and continuous improvement, to facilitate and advance public health approaches to violence reduction.

By doing these things, system leaders can play a crucial role in the reduction of violence. It is also vitally important, however, that responsibility for reducing violence does not solely rest on organisations working at a regional, local, or hyper-local level. While efforts to reduce violence at these levels are indispensable, they are better suited to tackling community, relationship and individual, rather than societal, level drivers of violence. It is important, therefore, that system leaders come together and speak with a collective voice to highlight the societal level drivers of violence – such as poverty, inequality and systemic racism – which central government must accept its role and responsibility in addressing.

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