Evidence Session: Public Health, Mental Health and Youth Violence

Monday 11th December 2017
11.00-13.30
Wilson Room, Portcullis House

Present:

From the Commission	***Witnesses***
Vicky Foxcroft - Chair	Karyn McCluskey, CE Community Justice Scotland[1]
Chuka Umunna	Mark Bellis, Director of Policy, Public Health Wales
Abhinay Muthoo	Matthew Shaer, West Midlands Police Superintendent
Zoe Leadley-Meade	Duncan Bew, Consultant Trauma Surgeon & Founder of Growing Against Violence
	Emer Sutherland, Emergency Medicine Consultant at Kings Hospital
	John Poyton, CE of Redthread
	Sinem Cakir, CE of MAC-UK
	Jamel Fraser, Youth Consultant at MAC-UK
	Alika Agidi Jeffs, Youth Worker changing stigma around mental health
	John Sutherland, Chief Superintendent at Scotland Yard[2]

Key themes to emerge from this session were:

- Significance of Adverse Childhood Experiences (ACEs)
- Trauma and mental health as significant factors
- Education: early Intervention and role of schools
- Education: changing public perceptions on violence
- A public health approach and the importance of a multi-agency working, including co-location
- Poverty/Inequality as an overlooked factor
- Identifying effective points of intervention
- Commitment must be long term

Specific suggestions to arise:

- Establishment of a Violence Reduction Unit, based on the Glasgow VRU
- Research to be commissioned on the relationship between relative poverty, resilience and violence.

[1] Former Director of the Scottish Violence Reduction Unit
[2] Author of "Blue: A memoir – Keeping the Peace and Falling to Pieces"

Before the session, witnesses were asked to consider the following questions:

- What is known about "what works" in terms of adopting a public health approach to violence reduction? Are the lessons learned transferable to different localities?
- What the main challenges are to adopting a public health approach – are these more to do with people and perceptions, for example, or rather resources and logistics?
- To what extent might exposure to violence at a young age be a contributing factor in mental health issues? And, conversely, to what extent might mental health issues contribute to youth violence?
- What policy developments would you like to see as a result of the Government's recent Green Paper on Mental Health Services for Children and Young People?
- How can schools play a greater role in the identification and/or prevention of ACEs and mental ill-health in children and young people and are teachers well placed to take on board this extra responsibility?

During the session, the following additional questions were asked:

Abhinay Muthoo asked what the three biggest constraints in trying to implement a joined up multi agency public health approach were and how could these be addressed.
Chuka Umunna asked whether there was any empirical evidence or research into relative poverty and inequality impacting mental health or being a driver of violence and, if not, how any potential links between relative inequality and violence could be measured.
Zoe Leadley-Meade asked what was required to get schools behind a public health model.
Chuka Umunna wanted to know how successful Pupil Referral Units were and whether they were being tasked with an almost impossible job.
Abhinay Muthoo asked whether London should establish a Violence Reduction Unit similar to the one in Glasgow.

A summary of the points that were made by witnesses (grouped by theme):

Significance of Adverse Childhood Experiences (ACEs)

Early childhood experiences had a significant impact on a person's life; these experiences might be physical, sexual or emotional abuse, neglect, or growing up with parents who had drug addictions or severe mental health problems themselves.

People who had experienced four or more ACEs were 10 times more likely to be involved in violence every year by the time they were 18, compared to a young person who hadn't experienced any ACEs.

If these experiences in early life could be addressed – and minimised - subsequent violence in a person's life could also be significantly reduced or eliminated.

As one witness said, "Witnessing violence normalises violence for young people. Stabbings, shootings become ordinary for young people, who become used to witnessing violence. Growing up like that means violence becomes easier to resort to yourself."

A "trauma-informed approach" was vital, therefore, in understanding young people and in helping professionals to see past an angry victim or an angry perpetrator etc. Research into ACEs had been helpful in removing problematic labels such as "gangs" and "offenders".

All organisations and professionals who had a statutory responsible for the safeguarding and wellbeing of young people needed to recognise the importance of ACEs and build these into the way they worked with young people and the policies they adopted. A shared understanding of ACEs would also facilitate better collaboration between organisations that worked with vulnerable young people.

Trauma and mental health as significant factors

MAC UK used a phrase "It's not what is in their heads, it's what's going on in their worlds." For young people everything around them, their streets, schools, homes, hospitals and more, could all be traumatic in different ways and full of stressful experiences, which invariably resulted in poor mental health.

When people thought of mental health issues, they usually focussed on recognisable medical symptoms. In young people, however, anti-social or violent activities were often hiding underlying factors such as anxiety and depression and so consequently their behaviour was misunderstood and they did not receive the support they really needed.

Communities and families were influential. If a person grew up around high levels of violence, even if they didn't experience violence themselves, they could still develop a damaging fear of violence, a fear which over the years could lead to further stress, anxiety, paranoia and other problems.

Many young people were unaware of their own mental health state or where to access mental health support from. A lot of young people were suffering from PTSD – post traumatic stress disorder without understanding this.

Not enough was known about resilience. Why did some young people develop mental health problems when others didn't, even if they grew up under similar conditions? Why did some turn to crime? It would be sensible to look at the possible contributing factors within different families and communities as this might provide an insight into how resilience was built.

Not having positive role models also contributed to mental health issues. Absent fathers were a significant issue. Young people needed help to deal with these issues and to feel that they were safe and loved.

Many young people who were in prison had mental health issues but there was a lack of understanding and support in these areas. Professionals – and young people themselves – didn't always understand the reasons why a young person had a committed a crime or the underlying issues that had led them to that point.

Few black men talked openly about mental health issues - Alika Agidi Jeffs was one of the first to try and change this.

Many perpetrators of violence were suffering from mental health issues and feelings of extreme vulnerabilities could lead to violence. As one witness said, "regardless of what they might show on the exterior, they are dealing internally with a world of pain."

Trauma existed in various forms, including:

- Primary trauma – things a person was directly subjected to,
- Secondary trauma – things a person witnessed happening near them, for example a child growing up in a household where domestic violence was a regular occurrence,
- Ambient trauma – such as distressing images and stories on the news, all of which could exacerbate existing vulnerabilities.

Education: early Intervention, including role of schools

Schools could play a vital role in violence reduction as they were often the most constant and stable link in young person's life. But for schools to be effective everyone had to be involved and all staff needed to be trained so that they understood the issues properly. Parachuting in external specialists on an irregular basis was not effective. Involving schools in violence reduction would, in turn, have other benefits such as improved academic performance.

Karyn McCluskey explained that in Scotland, when they established the Violence Reduction Unit, they had focused on early years. They had worked with teachers on keeping students in schools with the aim of moving towards a zero exclusion policy. When a pupil was at risk of exclusion, they included them even more**.** This had proved to be successful.

Training for teachers was crucial so that they could understand and identify the underlying triggers of violent behaviour. Poor attendance and low performance was often the result of traumas happening elsewhere in a child's life. It was difficult for a young person to achieve at school if they were frightened or felt unsafe on their journey to and from school.

Knife arches at school could actually have a reverse effect as there was some evidence to show that they made pupils feel more unsafe and, perversely, might be more likely to make a pupil want to carry a weapon themselves.

Mark Bellis mentioned Walla Walla school in Washington State as a good example of where a school had played a central role in helping to reduce violence as part of a wider public health approach.

There needed to be excellent communication between schools and statutory agencies who were working with young people so that professionals could get a holistic understanding of what was happening in each young person's life.

Too many young people were ending up excluded and in Pupil Referral Units (PRUs) when what they really needed was dedicated support within mainstream education. Schools and parents should be supported to help ensure that pupils who are on the cusp of exclusion were able to stay in mainstream education There were some example of where PRUs had been successful but these were always when they were not been seen as a "place of no return" – if they were seen as temporary, or as a possible route back into mainstream education, they tended to be more successful.

Some specific lessons that had been learnt from Scotland included:

- Schools were a vital part of a multi-agency, public health approach to violence reduction
- Training in ACEs and how these should be dealt with was crucial for teachers
- Keeping kids in school and keeping them engaged should be a shared objective
- A lot could be learnt from schools in Finland where education focussed on team work and life skills as well as literacy and numeracy.

Alika Agidi Jeffs said he was living proof that early intervention worked. He had been referred to the NHS SLaM[3] programme where he learnt about the impact that early life experiences had had on him and his mental health. This had been life changing.

Pupils should be encouraged to talk about mental health from a young age at schools and time should be allocated for this in the curriculum.

Changing the way that history was taught on the curriculum could also have a positive impact. This should include positive aspects of black history and inspirational figures.

Education: changing public perceptions on violence

Another key element of a "public health approach" to violence reduction was the engagement of community and the wider public. Very few people, for example, understood the impact that ACEs could have on the life course of an individual. Small things - in parenting and elsewhere - could have big health impacts and so public messaging and changing perceptions about youth violence, its causes and possible solutions, was a key part of the overall picture.

Young people often felt unfairly judge and labelled - "Perhaps if I wasn't labelled as being in a gang or growing up on murder mile, I would view myself and my community differently". These labels were problematic and could influence how young people perceived themselves and their prospects. If a young person was repeatedly told they'd end up in prison, it could become a self-fulfilling prophecy. This was a cycle that needed to be broken. Professionals needed to work alongside young people and their communities to begin approaching the problems is different ways.

[3] https://slam-iapt.nhs.uk/

As one witness explained, in communities with high levels of violence: each block - communities within communities - had its own way of dealing with the violence. In these communities, it was survival of the fittest and dog-eat-dog world with little or no consideration for neighbours. This had to change but that change could not happen without the communities involved themselves.

Community and the third sector should be involved in a multi-agency approach (see below), indeed it was crucial to have community support and buy-in. Statutory agencies should not develop and implement policies without speaking to communities and service users.

Jamel Fraser highlighted the need for more positive role models, especially for young black men. There were notable expectations in some areas, such as in music or sport, but these industries were not accessible to the majority of people so for many young people there was a lack of role models in careers they could aspire too. Professionals and communities should work together to change this.

A public health approach and the importance of a multi-agency working, including co-location

Youth violence could not be solved by the criminal justice system in isolation. It was also a huge public health issue with complex underlying causes that should be considered and addressed by a full range of authorities working strategically together under a shared framework.

As John Poyton explained, although police were often first through the door in dealing with youth violence issues, we cannot "arrest our way out of this problem". Other services, in particular health-related ones, need to be at the centre of any policy approach.

Mark Bellis said it was estimated that violence cost the national health system about £3 billion per year and wider society a further £30 billion per year. In this respect, therefore, it could be compared to other epidemics (such as obesity) in terms of the pressure it was putting on a range of services. A public health approach to violence reduction had to be multi-agency and getting the health services involved was critical.

The criminal justice system was continually dealing with mental health conditions. In South Wales, for instance, about 90% of the work undertaken by police was not related to criminal justice and a large proportion related to mental health issues, many of which included a risk of violence.

People – professionals included – should think differently and challenge previous approaches. Mark Shear said that the lightbulb moment for him in the West Midlands was when he brought people from a public health background on board who challenged current thinking within the police force.

A multi-agency approach needed to include co-location. Having people from different organisations physically working together made a dramatic differences and many of the "clunky" issues around information sharing fell away. That said, multi-agency working was not easy and some of the key hurdles were:

- data-sharing; this remained one of the biggest constraints and more work was required in this area.

- Leadership; this was a central factor in the success – or otherwise – of joint working. Building partnerships could be tough and it was often easier for agencies to remain single, working to to their own objectives
- politics and culture change; people had to be ready to adopt a different path and work together, regardless of their political or ideological views.

In short, implementing a public health approach that worked effectively was extremely complex and required sociological change. To give one example, in Scotland, when colleagues from the VRU approached staff in A&E departments, they talked about violence but in the context of health, highlighting, for example, the way in which violence reduction and a public health approach would also reduce the numbers of victims coming through A&E.

Duncan Bew, Emer Sunderland and John Poyton all spoke about lessons they had learnt from working youth violence issues within health and, in particular A&E, settings. These included:

- co-location had been key; youth workers who were embedded in the hospital working alongside clinical professionals had been extremely successful and were viewed as trusted colleagues in trauma response situations
- youth workers in hospitals were able to reach and engage with young people in ways they couldn't do elsewhere (see below)
- evaluation of interventions was important in understanding what works –outcomes should include a wide range of indicators including mental health and school attendance.
- for a public health approach to be sustainable, collaboration also need to happen at central government level and this had not yet happened; at the Westminster level there was little or no cross-departmental understanding, support of funding for this work which meant that is remained too easy for officials to pass responsibility for outcomes from their silo to another.
- it was encouraging to see police and criminal justice commissioners beginning to get on board with a public health model, but this now needed to be backed up with revised funding models.

Identifying effective points of intervention

The idea of "hard to reach" young people was outdated. The problem lay more with services that were hard to access. A public health model could ensure that services were easy for young people to access. One way to ensure this was for practitioners to proactively identify different and effective points of intervention.

These "teachable moments" often arose post an event, when an individual had already been assaulted, arrested or convicted. Work carried out at Kings Hospital by youth workers and organisations such as Redthread meant that young people were approached at moments when they were most likely to respond to offers of support. Conversations between the youth workers and young people in hospital needed to be honest, open and focussed on the young individual and their needs. Evaluation from the Kings' violence prevention strategy showed that 44% of the young people they were working with were not otherwise engaged with any statutory services, despite the fact 33% of them had been referred to one service or another. And of those who were in contact with a statutory organisation only 23 % were actively engaging.

A young person who was recovering from penetrative injuries in hospital had been through an extremely traumatic experience. Youth workers located within the hospital were able to meet the pain and distress of that environment with their advocacy and support. Evaluation showed that 80% of young people approached whilst in hospital actively engaged with the programme but that engagement levels dropped 55% if the initial contact was not made until after the young people had left hospital. Part of the reason for this, was that the young person would already have put back on the invisible mask/bravado they had to wear to navigate their day to day lives.

As John Poyton said "For me, it comes down to the teachable moment and the reachable moment – a very short window when a young person is in hospital. Suddenly aware of their own vulnerability, often for the first time. They have had to create this bravado or mask while they are at home or on the streets, and have often grown up with incredible adversity during their childhood."

A&Es were incredibly important places in every community where people knew they could turn up if they find themselves in crisis. Redthread's intervention work could be replicated in hospitals across the UK but this was about system change in the NHS.

As Simen Cakir explained, seeking help is often perceived as a weakness. There is a need for more safe, accessible and therapeutic spaces for young people where they can address their own vulnerabilities.

"Teachable moments" weren't only possible in emergency settings. They could also be identified earlier in a young person's life, helping to prevent violence. Growing Against Violence (GAV), for example, delivered sessions to teachers and parents. In their experience, it was particularly important to focus on the transition between primary and secondary education. (Also links to education and role of schools above).

Poverty/Inequality as an overlooked factor

There was anecdotal evidence of relationships between poverty, inequality and violence, and poverty, inequality and mental health. These factors were not widely understood, recognised or taken into account in policy development. More research was required into the motivations behind violence in relation to visibility of relative poverty and social deprivation. It would also be helpful to understand why equally impoverished boroughs had different violence levels and to what extent this difference was down to the communities and families.

Relative poverty was a particular issue in cities where the rich and poor lived side by side but technology and were social media were making these differences even starker. The "shame of deprivation" could impact on young people's mental health and wellbeing. And the shame of poverty at school, for example, could have a violent impact on a young person.

Poverty might mean that someone who did have the same clothes or technology as their peers became a target for bullying, which could impact negatively on their mental health. Poverty might also lead a young person to crime in order to acquire the same things as their peers.

Pupils in school could be brutally mean poverty was an easy target. Parents, teachers and professionals all needed to work together to help build resilience in children from a very young age. This was crucial in maintaining good mental health and wellbeing.

Alika Agidi Jeffs summarised powerfully how relative poverty had affected his own metal health, "I've gone through mental health issues in the past. One of the things that accelerated my downward spirals was looking around my estate and realising it is normal for me to see blood stains, condoms, crime on my estate. But right across my road, there are beautiful houses with gardens and driveways. That visible, vast difference in inequality really played with my head. Is this really life, is this what we settle for? Feeling unable to do anything about poverty messes with your head."

Commitment must be long term

Implementing a public health approach to violence reduction required commitment to a long-term plan of at least 10 to 15 years. There were no short term solutions.

Statutory services and youth workers had to be able to build long-term relationships with young people based on trust and understanding between individuals. All the witnesses agreed that those young people who had managed to turn their lives around would have a story with a trusting relationships at its heart. Relationships needed to be nurturing and committed for the duration. Young people were crying out for one adult to stick around long enough to make a difference in their lives but too often they got bounced back and forth between different service providers.

Unfortunately the current situation for most young people was far from this. Finding cuts often meant that relationships between service providers/youth workers and young people were regularly disrupted or severed, in itself giving young people the sense that nobody really cared. Similarly in schools, a consistent policy was required, something much more sustained than just drop in sessions.

It was difficult to get politicians to focus on and support sustainable and long-term solutions. They operated in world in which short-term fixes were the norm, in which news outlets, social media and popular culture were all thriving off immediate results and soundbites. Politicians were also very conscious of electoral cycles which in themselves could encourage short termism and a tendency to announce headline grabbing policies such a more stop-and-search even if the evidence base was not clear.

Vulnerable young people like Billy Smith are bounced between different services and individuals; the state is perpetuating this inconsistent adult involvement in his life. What young people like Billy are crying out for is just one adult who will stick around for as long as it takes to make a difference in his life.

A public health model had to retain a focus on stopping people getting to the stage of committing violence, rather than responding to it. This wasn't just a job for a few specialists, everyone had to get on board. It required visionary leadership supported by a political and social movement. It was difficult but not impossible to achieve. There was a growing body of evidence on what worked. If

successful, there were huge benefits to be gained - in education, in long term health problems, in the criminal justice system as well as in the safety, wellbeing and prospects of all our young people.