Serious Violence in Lambeth

NEEDS ASSESSMENT

June 2015

Executive Summary

This report offers the key findings and recommendations from a Needs Assessment derived from evidence and research into the nature of serious violence in Lambeth incorporating a public health model. Lambeth's Health and Well-being Board and the Safer Lambeth Partnership jointly commissioned this work to assess the evidence about violence and its underlying causes in Lambeth. This is designed to be part of Lambeth's wider commissioning workstreams (providing the evidence base for the three year framework for protective and preventative services to reduce serious violence across the partnership) and will incorporating a public health approach to violence prevention, incorporating proposals from the report by Prof. Mark Bellis and based on joint work between Lambeth Community Safety and Lambeth and Southwark Public Health teams.

Lambeth has traditionally suffered high levels of violent crime in relation to the rest of London and the country. Levels of violence against the person, sexual offences and hospital admissions for violence are rated as significantly worse in Lambeth than the London or England average. In addition, Violence is a major *public health* issue causing injury, ill health and poor wellbeing to thousands of people living in Lambeth. The costs of violence to individuals, families, communities and the local economy are high, and treating the effects of violence draws heavily on local resources, including the police, social care and the NHS.

The Violence Needs Assessment (VNA) presents a picture of 'what we know' about the reality of violence in Lambeth and identifies what more we need to find out and is based on evidence and research work comprising a *Quantitative review* of relevant datasets; a *Literature survey* of published evidence about the risk factors that are known to be associated with violence; a *Service Review and Gap Analysis* of service provision and activities by relevant public services and *Qualitative Research* to examine in more detail the underlying experience and perception of violence and victimisation in Lambeth's communities.

The key conclusion of this Needs Assessment is that the public health model of violence reduction has strong applicability in Lambeth: a borough with traditionally high levels of violence and victimisation. Application of the public health model and the available evidence base, suggests an accumulation of risk factors which lead to greater predisposition towards violence in Lambeth's communities. Key risk factors in the Lambeth context include:

- Issues around early childhood and families, particularly early adverse life experiences and quality of and support for parenting.

- Issues around the influence of delinquent peer groups and social and cultural norms on the socialisation of boys and young men.

- Issues around 'socio-health' factors including the prevalence of poverty, deprivation, learning and other disabilities and poor mental health.

- Issues around the sale and consumption of alcohol (and to a lesser extent, drugs) and a lack of 'resilience' in public places such as night time economies and transport hubs.

The overall aim of 'primary' interventions needs to be to 'innoculate' communities against violence by addressing these risk factors in order to improve the social 'resistence' or resilience to violence. This leads to two key recommendations for the future:

First, that future service provision and commissioning should be focused around four priority themes:

- *Family Support and Interventions in Early Childhood* – To address key risks around the early years of the life course, particularly early adverse life experiences, families and parenting, behavioural issues, brain injury and mental health.

- *Violence Against Women and Girls* – To address key risks around victimisation of young women and girls; violence within intimate relationships and domestic settings; sexual violence in domestic and public settings.

- *Violence Involving Young Men and Boys* – To address the prevalent involvement of young men and boys, as victims and offenders, in all forms of violence in Lambeth.

- *Resilience of Public Environments* – To address key risks associated with stranger-based violence in public environments and risks that lead to declining feelings of public safety and wellbeing about the public places of the borough.

Secondly, that there is a need for *systems change* – to strengthen the public health approach to violence prevention and reduction through the many services involved and how they interact between themselves and the public. In particular,

- better detection of violence, especially in under-represented groups by the many services involved;

- timely referral, treatment and (if relevant) enforcement/mitigation;

- tackling cultural norms and improving community resilience are important;

- better evaluation of existing services to inform future service development and interventions.

Introduction

1.   Aims of this Needs Assessment

1.1   This Needs Assessment (the 'VNA') is designed to provide a new analytical foundation to the work of Lambeth's statutory Community Safety Partnership, Safer Lambeth[1], in preventing and reducing serious violence in the borough. It incorporates quantitative analysis of crime, health and other datasets, a review of literature and existing good practice, qualitative research with residents, victims and offenders and a gap analysis of existing service provision.

1.2   The VNA incorporates the *public health model* of violence prevention; incorporating proposals from the 2012 report by Prof. Mark Bellis[2] commissioned by the Department of Health and based on joint work between Lambeth Community Safety and Lambeth and Southwark Public Health teams. The VNA has been jointly commissioned by Safer Lambeth and Lambeth Health and Wellbeing Board and is intended to inform future priorities for crime reduction and public health and to provide the evidence base for a three year commissioning framework for protective and preventative services to reduce serious violence across the Partnership.

2.   Background

2.1   Lambeth has traditionally suffered high levels of violent crime in relation to the rest of London and England. Levels of violence against the person, sexual offences and hospital admissions for violence are rated[3] as significantly worse in Lambeth than the London or England average. Although violent crime has generally fallen in Lambeth, as elsewhere over the last decade[4], nevertheless there is a historic legacy and continuing concern about violence in our communities. Violence remains too high and at unacceptable levels, and Lambeth suffers more violence than our comparable neighbours.

2.2   There are three particular forms of violence, prevalent in Lambeth, that have been of particular concern:

(a)   **domestic violence:** the kind of violence that takes place in families and intimate relationships and in private, domestic environments and comprises assaults and sexual offences and usually perpetrated by men against women and girls.

(b)   **group or gang violence:** the kind of violence driven by a group dynamic, usually involving young men. Thirty years ago this might have involved violence relating to football by groups affiliated to different clubs. Today, the concern is about street gangs affiliated around post codes and/or different housing estates.

(c)   **violence between strangers:** usually in public or semi-public environments. This includes violence in or near licensed premises and related to the consumption of alcohol; robberies where violence is used or threatened; and, less often, hate crimes involving verbal and physical abuse against individuals due to their known or perceived membership of particular communities.

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[1] Consists of Lambeth Council, Metropolitan Police, London Probation Trust, NHS London and Fire Brigade.
[2] Bellis M. Hughes K, Perkins C and Bennett A. *Protecting People, Promoting Health. A public health approach to violence prevention for England*. North West Public Health Observatory - Centre for Public Health, John Moores University for the Department of Health, 2012
[3] North West Observatory, VIPER local authority area violence profiles, 2012
[4] Violence Against the Person 2002/3: 9,151; 2011/12: 7,123 = - 22% over the decade.

2.3   Despite this background, Lambeth has lacked a single, overarching strategic approach to reducing and preventing violence. Although there have been many excellent initiatives, such as the current work on Violence Against Women and Girls[5] and the work on reducing gang violence, there has been a lack of 'joining up' across interventions to create an approach that addresses the underlying, long term risk factors that are driving violence as a whole in our communities. While reactive interventions designed to support victims and manage offenders will continue to be essential, we need to achieve a better coordinated and more strategic proactive and preventative approach.

3.   Violence as a public health issue

3.1   Violence has long been recognised as a significant concern for public health because of the ill-health and suffering that it causes. Violence has sometimes been compared to a disease – a complex preventable health problem which can be understood and addressed by using some of the techniques more usually applied to disease control.[6] The World Health Organization (WHO) advocates a public health approach to tackling violence. Its first world report on violence and health published in 2002[7] called for a public health focus on the primary prevention of violence through strategies designed to reduce the risk factors for violence and to boost protective factors across the entire life-course. A public health approach also focuses on mitigation of the effects of violence through the provision of support for victims.

3.2   Violence, like many public health issues, lends itself to a life-course approach. This perspective views health as the product of risk behaviours, protective factors, and environmental agents that we encounter throughout our entire lives and that have cumulative, additive, and sometimes multiplicative impacts. A life-course approach is particularly concerned with experiences and exposures today that influence tomorrow's health.

3.3   There are a wide range of factors that influence an individual's risk of involvement in violence. The WHO has adopted a framework for grouping these risk factors and for understanding how they interact at the individual, relationship, community and societal levels (Figure 1).
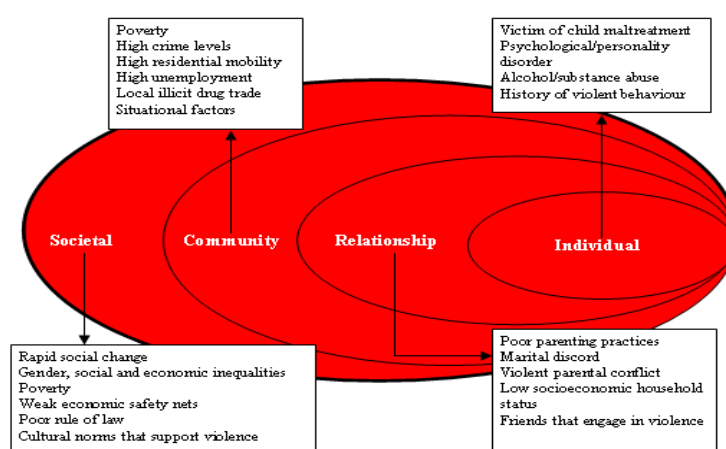

Figure 1: The "social-ecological framework": examples of risk factors for violence [Source: adapted from Dahlberg & Drug, WHO 2002]

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[5] VAWG comprises domestic violence, sexual violence, prostitution, trafficking, forced marriage, 'honour' based violence, female genital mutilation and stalking/harassment.

[6] See for example Professor Gary Slutkin: *Let's treat violence like a contagious disease?* www.ted.com Oct 2013

[7] Krug E, et al. *World Report on Violence and Health*. World Health Organization, Geneva, 2002

3.4   Public health approaches to violence prevention focus on four stages:

   (1)   **understanding** the epidemiology,

   (2)   **identifying** risk and protective factors,

   (3)   **learning** from evidence-based interventions for reducing violence, and

   (4)   **implementing** effective interventions locally.

3.5   The benefit of adopting the public health, risk based model is to broaden Lambeth's approach to violence reduction so that the traditional focus on **'acute'** interventions to tackle offending that the borough has always had is now complemented by a new focus on **'primary'** prevention. This involves charting the risk factors for violence over a **life course** – from pregnancy, to experiences in early childhood, through to adolescence and adulthood – considering the best way to reduce these risks at key points in the life cycle.

3.6   The aim of this joint work has been to produce evidence-based information and analysis which sets out the implications for strategic and commissioning intentions for all local services. Violence is a cross-cutting issue that affects the health service, the police, local authority services, probation services and the voluntary sector, among others. With the integration of public health into local government, there are considerable opportunities for sharing local intelligence on the epidemiology of violence and for public health teams to work closely with key services on effective evidence based programmes for violence prevention. The Public Health Outcomes Framework 2013 to 2016[8] includes indicators on violence reduction which present a further opportunity for local partnership working.

4.   Costs of violent crime in Lambeth, 2012/13

4.1   The total cost and impact of crime against households and individuals in 2012 in the UK is calculated to be £124 billion. This equates to an average household impact of £4,700 per year.[9] Using Home Office research[10] for costs of crime and multipliers (to translate recorded into estimated 'actual' offences), it is possible to give some indication, both of the significant under-reporting of violence and cost of violence to Lambeth's public services and communities.

4.2   Costs were calculated using the most recent Home Office Report[11] with revised multipliers and unit costs for 2010/11. 'Multipliers' are based on an assessment of 'actual' offences compared to reported offences using the survey research of the Crime Survey of England and Wales. Unit costs are adjusted for inflation using the GDP deflater (HM Treasury) where *2010 = 96.096 if 2012 = 100*. Crime data is from MPS performance statistics.

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[8] Public Health Outcomes Framework 2013 to 2016. Department of Health. 2013

[9] 'UK Peace Index 2013 : Exploring the fabric of peace in the UK from 2003 to 2012' (Institute for Economics and Peace)

[10] Home Office Research Study 217 (2000)

[11] *Revisions made to the multipliers and unit costs of crime used in the Integrated Offender Management Value for Money Toolkit* , Home Office, September 2011, Annex 1.

Table 1: Lambeth borough key violent crime types and actual costs for FY2012/13

Crime Type	Recorded Offences 2012-13	Revised Multipliers 2011	Estimated Offences 2012-13	Unit Cost (2012 prices)	Recorded crime calculation 2012/13	Estimated crime calculation 2012/13
All Violence Against the Person	6,826	n/a		£12,937	£88,308,718	n/a
Homicide (murder, manslaughter, infanticide)	5	1	5	£1,846,779	£9,233,896	£9,233,896
"Serious wounding" (Wounding & GBH)	435	1.5	653	£26,793	£11,654,954	£17,482,431
"Other wounding" (offensive weapon, assault with injury)	2,585	1.5	3,878	£10,188	£26,335,279	£39,502,919
Total sexual offences	488	13.6	6,637	£38,453	£18,765,168	£255,206,287
Common assault and Harassment	3,470	7.9	27,413	£1,821	£6,319,202	£49,921,692
Robbery – personal	2,431	4.8	11,669	£9,168	£22,287,202	£106,978,571
Robbery – commercial	191	4.8	917	£9,753	£1,862,775	£8,941,318
TOTAL OFFENCES	9,605		51,170			
TOTAL COSTS					£96,458,477	£487,267,117

4.3   The Home Office multipliers give some sense of the degree of under-reporting of violence in our communities: from almost 1:1 for the most serious violence (homicide and serious wounding), to 8:1 for low level violence (common assault) to almost 14:1 for sexual offences. Using this methodology, 9,600 recorded violent offences in 2012/13 translate into over 51,000 actual offences – one violent offence for every six people in Lambeth's population.

4.4   With the cost of violent crime in Lambeth ranging between £96 million (recorded offences) to £487 million (estimated actual offences), it is clear that investing in future violence prevention by tackling underlying risk factors as proposed in the public health model is a hugely cost effective use of public and community resources.

Methods

5. Approach

5.1 The VNA seeks to build a picture of 'what we know' about the reality of violence in Lambeth and the prevalence of underlying risk factors that may make Lambeth communities more susceptible or less resilient to violence. We employed a range of methods for the VNA. as follows:

(1) **Epidemiology**
Identifying risk factors for involvement in violence from an evidence review of the national literature, and quantifying these risk factors in the local population in order to understand who is at greatest risk and why.

(2) **Quantitative work: crime and health datasets**
Analysis of relevant service datasets, particularly crime and health data in order to understand patterns of violence within the borough and draw conclusions about victims, offenders, locations and times in relation to incidents of violence.

(3) **Qualitative work: survey and focus groups**
Qualitative research into the attitudes, perceptions, experiences and behaviour of the general population and people affected by violence. This research is based on focus groups and one to one interviews to examine in more detail the underlying experience of violence and victimisation in Lambeth's communities.

(4) **Evidence and best practice**
An evidence review into the effectiveness and cost-effectiveness of interventions for the prevention of violence. There has been a huge volume of research undertaken in the last few decades that has enhanced understanding of the causes of violence and the effectiveness of strategies to prevent violence. The Public Health Team has conducted an evidence review to summarise the main findings from this research.

(5) **Resource mapping and gap analysis**
Mapping of existing resource provision (2013/14 budgets) and major activities by Lambeth public services that are designed to react to, reduce or prevent violence. In addition to this we conducted a 'gap analysis', comparing our mapping of what we do locally, against the evidence of what works best and the identification of need from the evidence review.

Epidemiology – Who is at risk of violence?

This section reports on the national burden of violence, risk factors for involvement in violence, and the prevalence of these risk factors in Lambeth.

6.   The national burden of violence

6.1   Violence is a major cause of ill health and poor well being in England. Violent incidents and fear of violence affects many people in the population. Specific types of violence have a disproportionate effect on particular groups and communities: domestic violence, elder abuse and gang-related violence for example. As well as the physical and mental suffering caused to individuals, families and communities, violence is a major drain on health service resources and on the economy.

6.2   The burden and cost of violence are outlined in Professor Mark Bellis' report for the Department of Health in table 1.

Table 2: Annual figures on the extent and cost of violence nationally, 2011-12

Annual number of violence incidents against adults	2 million
Annual number of violence incidents against children aged 10-15 years	500,000
Annual number of emergency department attendances for violence	300,000
Annual number of emergency hospital admissions for violence[12]	35,000
Annual cost of violence to society	£29.9 billion
Annual cost of violence to health services	£2.9 billion

6.3   There are various sources of information on levels of violence, including the Crime Survey for England and Wales (CSEW), police recorded offences, and health service data. There are major differences between these data sources. The differences between the Crime Survey and police recorded offences show that many people do not report incidents of violence to the police. Some of these people will seek treatment for injuries related to violence, which is why health services are important in identifying the extent of violence and who is at risk.

6.4   In England and Wales levels of violence increased significantly in the 1990s and early 2000s. This trend seems to have been stopped and violence has been decreasing since the mid-2000s.

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[12] England. All other figures are for England and Wales. Data from the North West Public Health Observatory. Cost data calculated by the London School of Economics. From – Bellis et al. Protecting people. Promoting health. A public health approach to violence prevention for England. Department of Health 2012.

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Key facts about violence

➢ One million secondary school students in the UK have suffered severe emotional, physical, or sexual abuse, or neglect (NSPCC).

➢ There were 13,000 emergency hospital admissions for assault among 13-24 years olds in England in 2010/11.

➢ 900,000 women and 600,000 men have suffered abuse from an intimate partner in England and Wales in 2011/12 (CSEW).

➢ 400,000 women and 80,000 men were sexually assaulted in England and Wales in 2010/11 (CSEW).

➢ One in three rapes recorded by the police involves child victims under the age of 16.

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7.   Risk factors for violence

7.1   Southwark and Lambeth Public Health Team conducted an evidence review into the main risk factors for violence. The full evidence review can be found in **Appendix 1**. This review focused on recent systematic reviews, national and US reports, and the findings of the *Bellis* report.

7.2   The main risk factors for involvement in violence are:

(1)   ***Early adverse life experiences***

(2)   ***Severe behavioural problems in childhood***

(3)   ***Peer relationships and gangs***

(4)   ***Deprivation and income inequality***

(5)   ***Alcohol and drugs***

(6)   ***Cultural and social norms supportive of violence***

(7)   ***Disability***

(8)   ***Mental health disorders***

(9)   ***Brain injury***

7.3   In this section we summarise the evidence for these risk factors, and describe, as far as we are able to, the prevalence of these risk factors in the local population.

8.   Early adverse life experiences

8.1   Adverse early life experiences are a strong predictor of involvement in violence. For example, children are more at risk of being abused if the pregnancy was unplanned, the parents are young, single, socially isolated, suffer from mental health conditions or alcohol/drug abuse, or have violent relationships.[13] Domestic violence is a significant risk factor for child abuse. A family with domestic violence present is 23 times more likely to abuse their child under 5 years of age compared with a family with a child under 5 years without domestic violence.[14]

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[13] Bellis M et al. *Protecting people. Promoting health*. Department of Health 2012.
[14] Browne K and Jackson V. Community intervention to prevent child maltreatment in England: evaluating the contribution of the family nurse partnership. Journal of Public Health. Vol. 35, No.3, pp.447-452

8.2 Exposure to violence in early life makes children more likely to be involved in violence in adolescence and adulthood as victims or offenders. Neglect and abuse can affect emotionally healthy brain development and predispose individuals to aggressive and violent behaviour. Neglect and abuse can also contribute to lower self-esteem and poor social skills - both factors associated with antisocial behaviour and violence.

8.3 Looked after children – most of whom will have had very difficult early childhoods - are more likely than children who are not looked after to be victims and perpetrators of violence.[15]

> **In Lambeth**
>
> ➢ There are 330 children with child protection plans. 14% of these last more than two years).
>
> ➢ There are 550 looked after children in the borough.
>
> ➢ Domestic violence is the largest component of violent crime flagged by the police in Lambeth. A high proportion of assault attendances in the Emergency Departments of Guy's and St Thomas's Hospital and King's College Hospital are domestic violence-related.
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> ➢ The recent needs assessment for the Youth Offending Service found that at least one third of teenagers using the service had had childhood experiences that predisposed them to violence: 38% had witnessed violence, 36% had suffered a significant bereavement, and 33% had experienced abuse (YOS needs' assessment, 2013).
>
> ➢ Lambeth's teenage pregnancy rate of 33.2 per 1,000 girls aged 15-17 is higher than the London average of 25.8 and the England-wide rate of 27.7. However, there has been a 67% reduction in the rate since 2003 (2012 data, Lambeth Public Health report).

9. Behavioural problems in childhood

9.1 Severe behavioural problems in childhood can lead to a range of negative outcomes in later life, including school exclusion, school non-attendance, disrupted personal relationships, substance misuse and criminality.[16] Early aggressive behaviour and low educational achievement are risk factors for youth and adult violence.

9.2 Severe behavioural problems in children are often described as 'conduct disorder.' The prevalence of conduct disorder among children aged 5 to 10 years is estimated to be 4.9% (Office for National Statistics estimates). The condition is almost twice as common among boys (7.5%) as among girls (3.9%). The 5% of children with severe behavioural problems are four times more likely to be involved in violence by their mid-twenties than children with no behavioural problems. [17]

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[15] www.tactcare.org.uk Accessed 31 July 2013.
[16] Rosa Brown E., Khan L. & Parsonage M. A chance to change. Delivering effective parenting programmes to transform lives. Centre for Mental Health, 2012.
[17] Krug E et al. World Report on Violence and Health. World Health Organization. Geneva 2002.

9.3 Further research has found an association between behavioural problems and gang membership. One study found that nearly 40% of girls involved with gangs showed signs of behavioural problems before the age of twelve.[18]

In Lambeth

Applying national prevalence rates to the local population suggests that there are around 2,100 children with conduct disorder living in Lambeth with the breakdown by age group and gender as follow (Child and Adult Mental Health Services' Needs' Assessment 2013):

children 5-10 yrs	children 11-16 yrs	boys 5-10 yrs	boys 11-16 yrs	girls 5-10 yrs	girls 11-16 yrs
939	**1150**	**669**	**713**	**270**	**437**

The CAMHS NA suggests that very few of these children are accessing mental health services. Only 29 children in Tier 2 and 3 services had a diagnosis of conduct disorder and 33 children had a diagnosis of 'mixed disorders of conduct and emotions' in 2011/12. However, only limited conclusions can be drawn from this data as 45% of records for 2011/12 did not have a diagnosis that could be matched to an ICD code.

10. Peer relationships and gang

10.1 Peer relationships and gangs affect young people's risk of involvement in violence. Young people with delinquent friends are more likely to be involved in violence.[2] Delinquent youths fall into two types: early onset delinquents who have behavioural problems from early childhood, and late onset delinquents who adopt or mimic such behaviours in adolescence. There is a particularly strong relationship between gang membership and violence.

In Lambeth

➢ Lambeth has been identified by the Home Office as a priority borough for support in relation to gang and serious youth violence.

➢ Gangs in Lambeth continue to congregate along geographical divisions based around social housing estates. The main areas for gang activity continue to be within the central part of Lambeth: Coldharbour, Stockwell, Vassall and Tulse Hill wards.

➢ There are six main gangs of note that are currently active, including GAS/SIRU (Myatts Fields, Angell Town and Somerleyton estates) which has the highest Gang Related Incident Tracking Score in London.

➢ The gang situation within Lambeth is fluid and constantly changing. Senior gang members continue to live in Lambeth borough and have moved from offending locally to travelling and offending outside of London. The majority of younger gang members in Lambeth offend locally and are mainly involved in street crime, ASB and youth violence.

[Further details from Gangs Problem Profile, para.28, below.]

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[18] Khan L, Brice H, Saunders A, and Plumtree A (2013).*A need to belong. What leads girls to join gangs*. Centre for Mental Health.

11. Deprivation and income inequality

11.1 Deprivation is a strong risk factor for violence. This is thought to reflect an accumulation of risk factors for violence in more deprived areas, such as teenage parenting, single parent families, and substance abuse. Evidence for this association can be found in analyses of rates of emergency hospital admission for violence which are around five times higher for residents of the most deprived communities.

11.2 The association between income inequality and violent crime is not clear. Some research suggests that inequality is more important for predicting violence than poverty.[19] However, violent crime is falling in many countries despite increases in income inequality.[20]

In Lambeth

- Almost one third of children in the borough live in poverty. This is worse than the England average of 21% and London average of 27.8%.

- 21% of households receive means-tested benefits.

- 8.5% of young people are not in education, employment or training. These values are significantly worse than the England average (Lambeth Children & Young People Joint Strategic Needs Assessment - JSNA 2013).

- Lambeth is in the top 50 of all 326 local authorities in England on five of the six summary measures of deprivation (IMD 2010 – GLA briefing, 2011).

- Lambeth is the 9th most deprived borough in London and 29th most deprived in England which is an improvement from 2007 (NHS Information Centre for health and social care, 2010).

12. Consumption of alcohol and drugs

12.1 Consumption of alcohol and consumption of drugs are risk factors for involvement in violence as victims and perpetrators. Some 44% of all violent incidents in England and Wales are thought to be committed by individuals who are under the influence of alcohol.[21] There is a higher risk of involvement in violence for people who started drinking at a young age, drink in greater quantities, and drink frequently.[22] There are higher levels of violence in areas where there is a greater density of places selling alcohol.[23,24]

12.2 There is a strong relationship between drugs and violence. In the United States, young people aged 12 to 17 who had used an illegal drug in the past year were almost twice as likely to have engaged in violence as those who had not used an illegal drug (49.8% versus 26.6%). Victims of violence consider that the perpetrator was under the influence of drugs in a fifth of all cases of violence in England and Wales.[21]

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[19] Elgar FJ, Aitken N. Income inequality, trust and homicide in 33 countries. *European Journal of Public Health* 2010;21:241-46

[20] Where have all the burglars gone? The Economist. July 20th 2013.

[21] Chaplin R, Flatley J, Smith K. *Crime in England and Wales 2010/11*. London: Home Office, 2011.

[22] Hughes K, Bellis MA, Hughes S. *Youth violence and alcohol*. World Health Organization. Geneva 2006.

[23] Rossow I, Norstrom T. The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities. *Addiction* 2011;107:530-37.

[24] Livingston M. A longitudinal analysis of alcohol outlet density and domestic violence. *Addiction* 2011; 106:919-25.

In Lambeth

➢ Lambeth has higher rates of alcohol-specific hospital admissions (male) and higher rates of alcohol-attributable hospital admissions (male) than national and regional averages. (See para. 22.2, below for LAPE profile.)

[Note: Alcohol-specific means conditions that are wholly related to alcohol. Alcohol-attributable includes alcohol-specific conditions plus conditions that are caused by alcohol in some, but not all, cases.]

➢ Analysis of the Probation Service's caseload for JSNA 2013 (2,121 offenders) suggested 17.4% had alcohol issues and 26.8% had drug issues linked to their offending behaviour. (See para. 46.4, below, for reference.)

13. Cultural and social norms

13.1 The rules and expectations of behaviour in different cultural or social groups can contribute to violence. This includes harmful traditional practices such as female genital mutilation (FGM) and forced marriage which are sustained by group cultural norms. The possession and use of weapons (for example, extensive gun ownership) may also be a cultural norm in some communities or societies. Violence against women permeates all cultures and communities but for some communities or families, culture can be used to explain or excuse the abuse.

13.2 In some communities violence is an acceptable way of resolving conflict or a normal way to raise a child, making cycles of inter-generational violence difficult to break.[7] Victims of violence may be reluctant to report abuse if violence is commonplace or considered acceptable in their domestic and communal environment.

In Lambeth

➢ In 2004 an estimated 8.35% of pregnancies were to women with FGM compared with 6.3% for Inner London and 1.43% at a national level. From this, it has been estimated that Lambeth has the third highest percentage of women in London who have experienced FGM following Brent and Southwark.

[Prevalence was based on research by FORWARD in 2007 using proxy measures based on the demographic composition of the borough and the proportion of pregnancies to women with FGM (Women's Resource Centre 2011).]

➢ Gang and youth offenders have increasing taken to social media, for example posting videos to YouTube, and are involved in producing 'urban' music and other cultural media (eg. graffiti). The YouTube videos are frequently antagonistic towards rival gangs. This cultural activity has the potential to 'normalise' group affiliation, rivalry and violence amongst young people in the borough.

➢ There is a difference in types of violence that victims' experience. Qualitative research revealed most participants struggled to think of why domestic violence could be more of an issue in Lambeth than any other place, nor with any one community more than another. Domestic abuse and honour related crimes was not recognised to be a common occurrence in the African Carribean community however young black males were recognised to be more involved in knife and gun crime. Race, sexuality, ability and background were not thought to have a particular impact on the likelihood of becoming a victim of violence. Exploration of the 'hidden' types of sexual violence occurring and elderly abuse is needed.

14. Disability

14.1 People with disability are more vulnerable to violence because of dependence, exclusion, and other factors. In addition, they are vulnerable to neglect or abuse within institutional settings. Children and adults with mental health problems or intellectual disability are more likely to be at risk of violence. Disabled children are three times more likely to suffer physical/sexual violence than non-disabled children.[25] Similar issues of dependence and exclusion can mean that elderly people are more prone to be abused.

In Lambeth

Around 2,000 children are estimated to have some form of disability in Lambeth with the commonest disorder being communication disorders, moderate to severe learning disability, and autism. (JSNA 2013)

15. Mental health

15.1 Poor mental health is associated with violence. Children of a mother with depression are five times more likely to have conduct disorder compared to children whose mother is not depressed, and conduct disorder is a risk factor for adult violent behaviour.[26]

15.2 Mental health disorders are highly prevalent among male and female members of gangs. A recent study from the Centre for Mental Health found that more than one quarter of female gang members had a suspected diagnosable mental health problem. 30% were also identified as self-harming or at risk of suicide and 30% had sleeping or eating problems. The same research also found that the more risk factors a young person accumulates, the more likely they are to be identified as members of gangs. Young women involved in gangs were three times more likely to have health and social problems compared with average youth justice entrants.[27]

15.3 High levels of psychiatric illness have also been found among gang members. Male gang members and violent young men not in gangs were significantly more likely to have a psychiatric disorder and to access mental health services than non-violent men.[28] Adults with psychiatric disorders are at increased risk of being victims of violence.

15.4 There is a relationship between personality disorders and violence,[29] and personality disorders are often found among young violent offenders. The prevalence of personality disorders among the prison population is far higher than in the general population, particularly among young offenders.[30,31] People with psychiatric disorders are more likely to be involved in violence if they had conduct disorders as children.[32]

[25] Jones L, Bellis MA, Wood S, et al. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *Lancet* 2012;380:899-907.

[26] Melzer H, Gatward R, Corbin T et al (2003) *Persistence, onset, risk factors and outcomes of childhood mental disorders*. London: The Stationary office.

[27] Khan L, Brice H, Saunders A, and Plumtree A (2013).*A need to belong. What leads girls to join gangs*. Centre for Mental Health.

[28] Coid J, et al. Gang membership, violence and psychiatric morbidity. *Am J Psychiatry 2013;:.*10.1176/appi.ajp.2013.12091188

[29] Freestone M, Howard R, Coid JW, et al. Adult antisocial syndrome co-morbid with borderline personality disorder is associated with severe conduct disorder, substance dependence and violent antisociality. *Personality and Mental Health* 2012.doi: 10.1002/pmh.1203.

[30]Coid J, Roberts A, Yang M et al. Prevalence and correlates of personality disorder in Great Britain. *British Journal of Psychiatry*. 2006; vol. 188, (5) 423-431.

In Lambeth

➢ There are high rates of common mental illness in young people in Lambeth. Hospital admissions due to depression are showing a rise especially in ages 14 and above (CAMHS Needs' Assessment, 2013).

➢ Applying national prevalence rates to the local populations suggests that 3,537 children aged 5-16 years in Lambeth are likely to have a mental disorder. As Lambeth has higher rates of risks factors than the national average these estimates are likely to be on the low side. Previous local needs assessments were able to use an ONS model which incorporated risk factors to produce ward level estimates of prevalence of mental health disorders. This model is no longer available.

➢ Young people who use the YOS have high rates of depression, anxiety, and previous referral to mental health services. In a recent study, 60% of YOS clients reported experiencing and/or suffering from mental health problems.

➢ Using the YOS screening tools, 78% were found to have psychological problems. Parental risk factors were also very common, including witnessing violence, suffering a significant bereavement, experiencing abuse, and having a family member involved in criminal activity. (YOS Needs Assessment, 2013)

16. Brain injury

16.1 There is considerable evidence to show that traumatic brain injury (TBI) is a risk factor for violence.[33,34] Studies show that people who have ever experienced a head injury before young adulthood report more interpersonal violence than participants who have never had a head injury. This relationship is stronger when the head injury was more recent.[35,36] There is an increased risk of offending in people who have experienced traumatic brain injury. There is a very high prevalence of TBI in offenders in custody relative to the general population.

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[31] Singleton, N., Meltzer, H., Gatward, R., Coid, J., Deasy, D. (1998).*Psychiatric morbidity among prisoners in England and Wales.* TSO: London.

[32] Hodgins S, Cree A, Alderton J, et al. From conduct disorder to severe mental illness: associations with aggressive behaviour, crime and victimization. *Psychological Medicine* 2008;38:975-987.

[33] Fazel et al. Neurological disorders and violence: a systematic review and meta-analysis with a focus on epilepsy and traumatic brain injury. Neurology. October 2009, Volume 256, Issue 10, pp 1591-1602.

[34] Fazel S et al (2011). Risk of Violent Crime in Individuals with Epilepsy and Traumatic Brain Injury: A 35-Year Swedish Population Study. *PLoS Med* 8(12): e1001150. doi:10.1371/journal.pmed.1001150.

[35] Stoddard S. & Zimmerman M. (2011).Association of interpersonal violence with self-reported history of head injury. Paediatrics, 2011;127;1074 DOI: 10.1542/peds.2010-2453

[36] Leon-Carrion J. & Chacartegui Ramos F. Blows to the head during development can predispose to violent criminal behaviour: rehabilitation of consequences of head injury is a measure for crime prevention. *Brain Injury*, 2003, Vol. 17, No. 3 : Pages 207-216

17.   Emerging research

17.1   There is a growing body of research into biological and genetic factors that predispose people to commit violent acts.[37] The hypothesis is that biological and genetic factors are just as important – possibly more important - than environmental factors in causing crime. Research involving twin studies and brain imaging indicates that there is a neurological basis to violence – i.e. violent offenders have brains that are different to the rest of the population because of structural defects suffered during fetal development, birth or infancy. The causes of these defects are thought to include poor maternal nutrition and alcohol and tobacco exposure during pregnancy, and exposure to heavy metals in childhood.[37]

> ## Summary of this section
>
> ➢ People living in Lambeth experience many of the factors that put them at risk of involvement in violence as victims and/or offenders.
>
> ➢ Lambeth has a large number of children who have had disruptive, difficult and even violent childhoods, as seen by the number of looked after children and children with child protection plans..
>
> ➢ Many young people who use the YOS have had traumatic childhood experiences.
>
> ➢ The teenage pregnancy rate is high when compared to the London and England average.
>
> ➢ There are high levels of deprivation in the borough and almost one third of children are living in poverty.
>
> ➢ More people are admitted to hospital because of alcohol related illnesses than elsewhere in London and England.
>
> ➢ In addition, there are high rates of mental illness among young people in the borough, particularly among young people who use the YOS.

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[37] Raine A. The anatomy of violence. The biological roots of crime. Allen Lane 2013.

The local picture: how much violence is there in Lambeth?

This section outlines the local picture for violence. It summarises findings from Metropolitan police (reported crime), public services, and health service data, to describe the pattern of violence in the borough.

Reported violent crime in Lambeth

18.   Metropolitan Police Data sources

18.1   Crime datasets were used to create a 'Problem Profile' of violent crime in Lambeth based on the 'VOLT' typology (ie. crime pattern analysis for *Victims-Offenders-Locations-Times* of recorded offences).

18.2   The following datasets/sources were used: Metropolitan Police Service Performance Data; Metropolitan Police Crime Recording Information System (CRIS); British Transport Police data; "Delius" Probation Data; Violence Indicator Profiles for England Resource (VIPER); and Local Alcohol Profiles for England (LAPE).

18.3   All datasets and reports looked at the reporting period 01/04/2012 to 31/03/2013 with all crime mapped within the Borough of Lambeth and all partner agency data in relation to Lambeth. Offences were extracted from CRIS for the period 01/04/2012 to 31/03/2013 based on recorded date and their current classification and in line with Home Office Classifications. To identify particular offences such as Domestic Violence (DV) related incidents and gang related incidents, the flagging code on CRIS was used. However, it should be noted that the flagging system has limitations.

19.   Violent crime: volume and trends

19.1   The three main forms of violent offences in Lambeth are **violence against the person** (VAP); total **robbery**; and total **sexual offences**. VAP includes harassment, common assault, assault with injury, wounding/grievous bodily harm and murder/homicide.

19.2   In 2012/13, there were **6,827** VAP offences (68.7% of the total), **2,622** robberies (26.4%) and **490** sexual offences (4.9%) – **9,939** offences of violence in total.

19.3   **Violent crime breakdown**
A breakdown of violent crime by category is shown in figure 2. Of the 9,939 recorded violence[38] offences in Lambeth in 2012/13, the number of offences in each category was as follows:

- *1,797 (18%)   – harassment*
- *1,673 (16.83%)   – common assault;*
- *2,411 (24.26%)   – assault with injury;*
- *435 (4.38%)   – wounding/GBH*
- *332 (3.34%)   – other violence*
- *174 (1.75%)   – offensive weapon*
- *5 (0.05%)   – murder*

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[38] As publicly reported on the MPS website for performance purposes. This information cannot be compared to figures from the MPS Crime Reporting Information System as crime categories may change during the course of investigations. According to CRIS there were 6,189 offences in 2012/13 compared to an MPS total of 6,827.

- **6,827 (68.69%)**   – all **Violence Against the Person**
- 2,431 *(24.46%)*   – *personal robberies;*
- 191 *(1.92%)*   – *commercial robberies*
- **2,622 (26.38%)**   – all **Robbery**
- 170 *(1.71%)*   – *rape*
- 320 *(3.22%)*   – *other sexual*
- **490 (4.93%)**   – all **Sexual Offences**
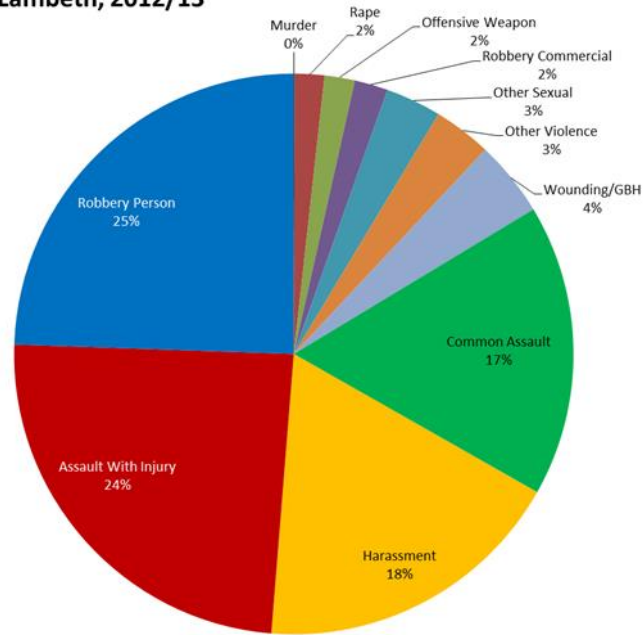
19.4   VAP has been on a falling trend since a peak in 2004/5 and reduced by 30% in the eight years to April 2013. Robbery has also been on a falling trend since 2001/2 and reduced by 60% in the ten years to April 2013. Total sexual offences have not decreased, generally fluctuating between 500 and 600 offences a year. Figure 3 shows changes in the three key components of violence in Lambeth since 2000/01.
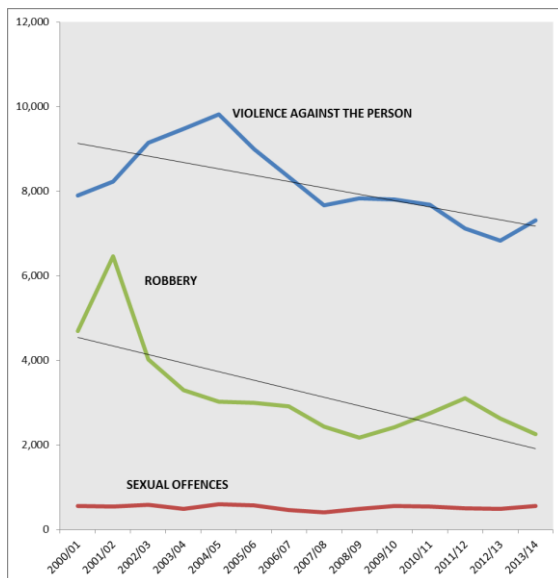

*Figure 2: Changes in components of violent crime in Lambeth, 2000-2014*

19.5   Violent crime has also fallen in other categories[39]:

- assault with injury has **decreased by 35%** since 2005.

- wounding/GBH has **decreased by 30%** since 2008.

- possession of an offensive weapon is **down by 70%** since 2002;

- serious youth violence is **down by 35%** since 2011.

- the number of homicides in the borough has also decreased from an average of 15 a year from 2000 to 2003 to an average of 8 a year from 2010-13.

19.6   **The changing picture of Violence Against the Person**
Although overall Violence Against the Person has been on a falling trend, the contribution of the offence categories within it has changed over time. The diagram shows the change in VAP and its components between 2000 and 2014.
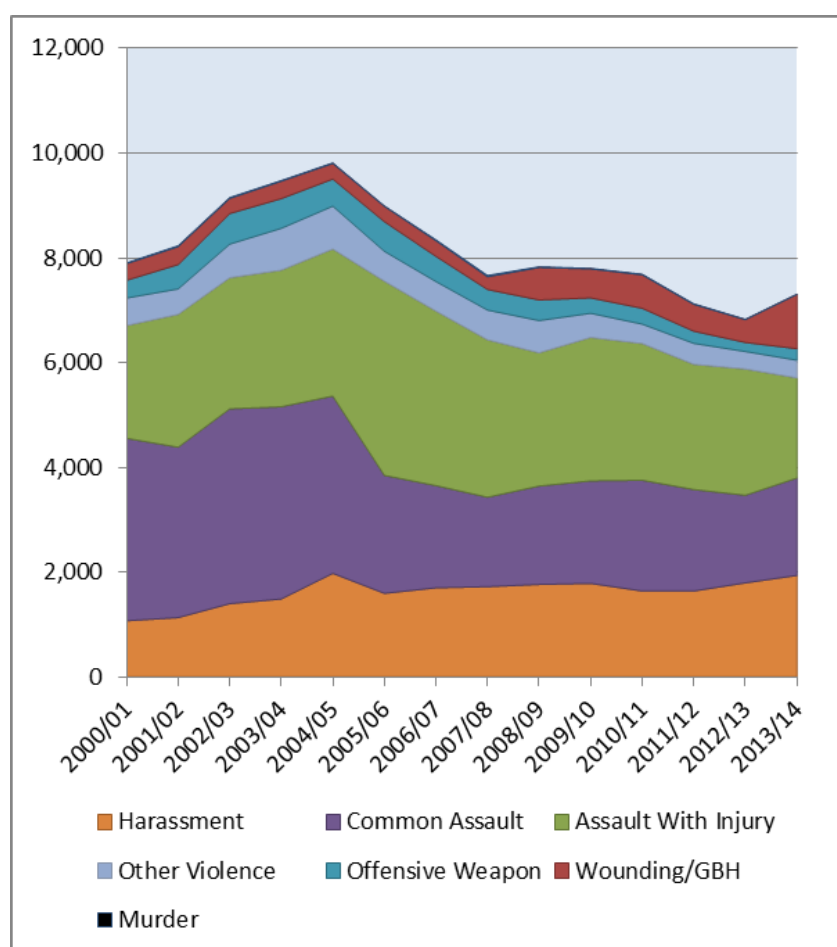
19.7   The first change is the rise in harassment. These offences have increased by 80% over the period, but more significantly, the contribution of this category to overall VAP has more than doubled from 13.6% in 2000/01 to 26.5% in 2013/14.

19.8   The second change is a shift from common assault to more serious violence (assault with injury and wounding/GBH). Common assault accounted for 44% of VAP in 2000/01, the largest category, but by 2013/14 had shrunk to 25% of total VAP. By contrast, in the same period, Assault with Injury, Wounding/GBH increased from 31% to 40% of total VAP.

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[39] 2012/13 MPS crime data.

20. Comparison with other similar boroughs

20.1 Despite significant reductions in the key components of violence since 2000, because violence has also fallen in other comparable London boroughs, Lambeth retains its position at or near the bottom of the 'league table' for violence compared to its 'family'[40] of most similar London boroughs:

Table 3: Comparative violent crime table of similar boroughs, 2012-13

Rank	All Violence Against the Person	Wounding / GBH	Assault with Injury	Weapon Offences	Personal Robbery	Serious Youth Violence	All Sexual Offences
1	Barnet	Barnet	Barnet	Barnet	Greenwich	Hsmith & Fulham	Barnet
2	Wandsworth	Wandsworth	Wandsworth	Wandsworth	Barnet	Greenwich	Wandsworth
3	RBKC	H'smith & Fulham	RBKC	Greenwich	H'smith & Fulham	Brent	Waltham Forest
4	Croydon	RBKC	Brent	Haringey	Wandsworth	RKBC	Brent
5	Haringey	Croydon	Croydon	RBKC	Haringey	Barnet	Greenwich
6	Waltham Forest	Brent	Waltham Forest	Waltham Forest	RBKC	Islington	Croydon
7	Brent	Waltham Forest	Lewisham	Brent	Brent	Hackney	RBKC
8	Greenwich	Greenwich	H'smith & Fulham	Tower Hamlets	Lewisham	Haringey	Islington
9	Lewisham	Lewisham	Greenwich	Hackney	Waltham Forest	Lewisham	Haringey
10	**LAMBETH**	Hackney	Haringey	Lewisham	Hackney	Tower Hamlets	H'smith & Fulham
11	Southwark	Haringey	Tower Hamlets	Croydon	Croydon	**LAMBETH**	Southwark
12	Hackney	Tower Hamlets	Southwark	**LAMBETH**	Islington	Croydon	Lewisham
13	H'smith & Fulham	Islington	Islington	H'smith & Fulham	Tower Hamlets	Southwark	Tower Hamlets
14	Tower Hamlets	Southwark	Hackney	Islington	**LAMBETH**	*Waltham Forest*	Hackney
15	Islington	**LAMBETH**	**LAMBETH**	Southwark	Southwark	*Wandsworth*	**LAMBETH**

*Based on crime rate per 1000 population, ranked best to worst [No data available for SYV in Waltham Forest and Wandsworth]

20.2 Therefore, for comparative violence, Lambeth scores:

- **highest** – for wounding/GBH, assault with injury and sexual offences;

- **second** highest – for personal robbery;

- **third** highest – for serious youth violence;

- **fourth** highest – for weapons offences.

20.3 This picture fits with the VIPER profile provided by the North West Observatory (see para. 22, below) that suggests Lambeth is significantly worse than the London and England average for Violence Against the Person, sexual offences, hospital admissions for violence, and A&E attendances from assault.

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[40] Groupings of boroughs proposed by Home Office for comparative performance purposes.

21.   Comparison with the national picture

21.1   The Crime Survey of England and Wales provides estimates for 'actual' offences and experience of crime victimisation based on face to face interviews and self-completion questionnaires with around 35,000 individuals. As such, it is the most accurate 'baseline' we have to assess the national picture of the extent and nature of violent crime. CSEW provides a continuous time series since 1981 for violent crime, showing how these crimes more than doubled in number between 1981 and 1995 and then fell back again through to 2011/12 (2.074m – 4.176m – 2.051m)[41].

Trends in recorded violent crime and CSEW violent crime, 1981 to 2011/12
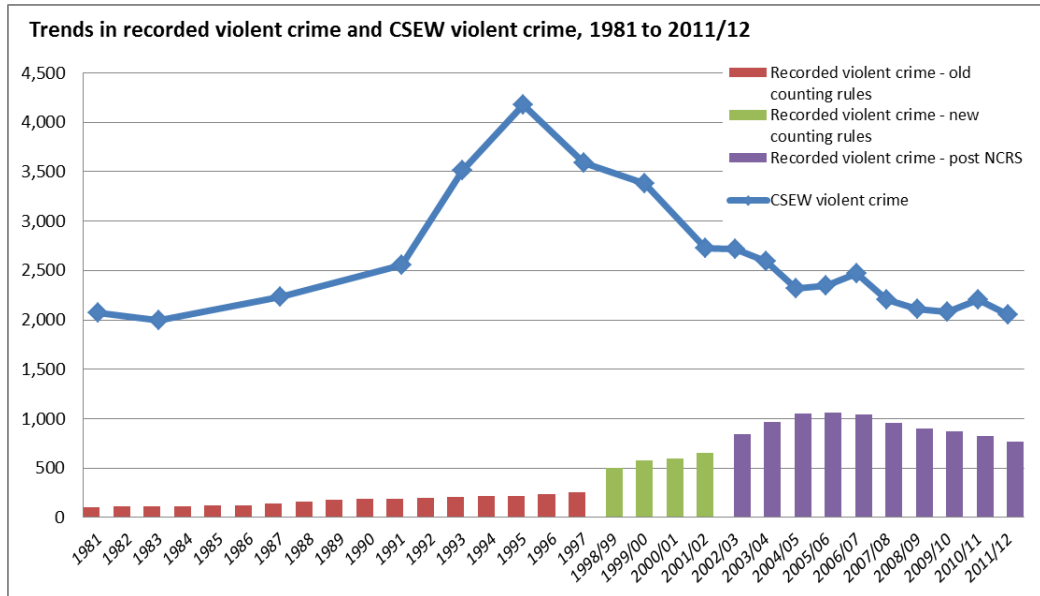
21.2   The falling trend for CSEW violent crime since 1995, and for recorded violent crime using current definitions (purple bars) since 2004/5, mirrors the same falling trend for Lambeth. Of interest is how this overall falling trend in CSEW masks differences in changes in particular categories of violence based on information about the offender. CSEW distinguishes between *'domestic'* violence (offender is an intimate partner or related), *'acquaintance'* (offender is known to victim but not otherwise related), *'stranger'* (offender is not known to victim) and *'mugging'* (offender engaged in robbery or snatch theft). Trends since 1981 for these categories are as follows:

Trends in violent crime by type of violence, 1981 to 2011/12 CSEW

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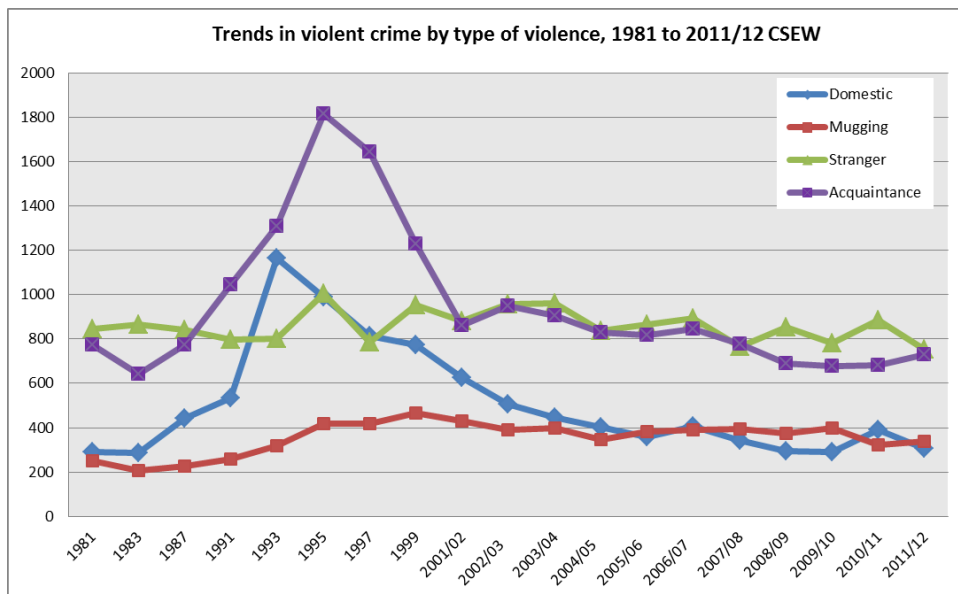
[41] *Focus on Violent Crime and Sexual Offences, 2011-12* ONS February 2013.

21.3 As can be seen, since the peak of 1995, offences characterised as 'domestic' have fallen by 69% and for 'acquaintance' by 60%, whereas 'stranger' (-25%) and mugging (-19%) have fallen far less. In 1995, 'domestic' contributed over 23% of violence and 'acquaintance' nearly 43%. But by 2011/12 this had fallen to 14.5% and 34% respectively, while mugging and stranger violence increased from 34% to 51% of total violence[42].
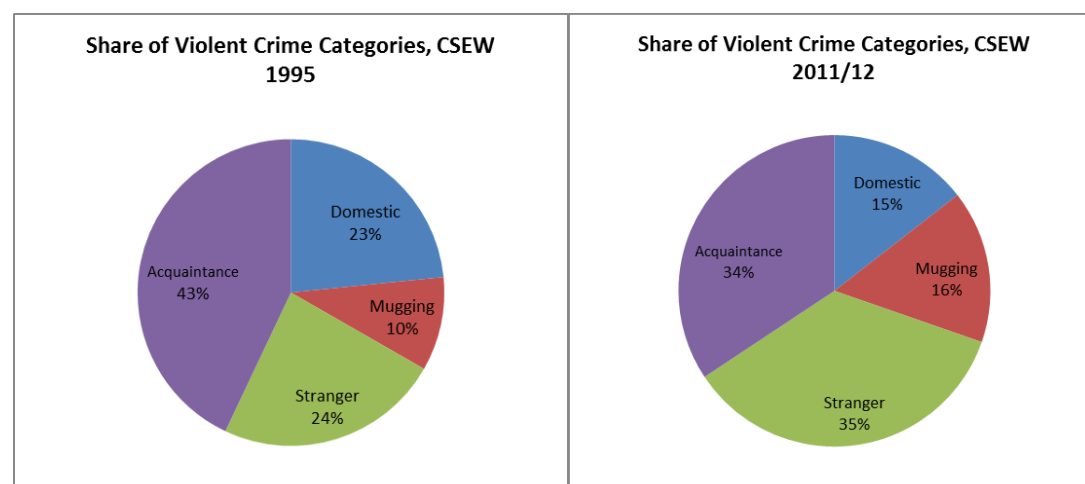
21.4 There is a similar pattern for repeat victimisation: in 1995, 68% of violent incidents were committed against repeat victims, but this had fallen to 50% by 2011/12. These changes lead ONS to conclude that reductions in repeat victimisation and violence between people who are intimately related or acquainted may explain the substantial changes seen in violence in England and Wales since the mid 1990s.

21.5 In the absence of similar survey data we cannot know whether these patterns are repeated in Lambeth though, as we noted earlier, the falling trend for reported violent crime since 2000 fits the England and Wales picture.

21.6 The breakdown of recorded violent crimes in Lambeth shows some key differences with that for recorded crime for the whole of England and Wales:

Table 4: Comparison of rates of recorded violent offences, Lambeth and England and Wales, 2012/13(offences per 1000 pop.)

	Lambeth	England & Wales
Violence Against the Person	**22.525**	10.720
Sexual Offences	**1.617**	0.955
Robbery (personal)	**8.021**	1.056
Overall violence rate (per 1000 pop)	**32.793**	12.837

21.7 Therefore, rates of VAP in Lambeth are over twice as high as the rate for England and Wales, more than one and half times as high for sexual offences and almost eight times as high for robbery. The overall violence rate in Lambeth is more than two and a half times as high as the rate in England and Wales.

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[42] ONS *op cit*, pp.9-10

21.8   In addition, we should note that, whereas personal robbery in England and Wales is 9.1% of total recorded violent crime, in Lambeth it is 24.5%. Sexual offences in England and Wales constitute 4/9% of violent crime, but in Lambeth 7.4%. These figures demonstrate the **significant disproportionality for personal robbery** and **sexual offences** in Lambeth as components of violent crime.

22.   Local Profiling by the North West Observatory

22.1   **Violence Indicator Profiles**

Violence Indicator Profiles for England Resource (VIPER) have been developed by Public Health England/Liverpool John Moores University to enable comparisons of standard violence indicators for 326 local authority areas.[43] Using figures for 2011/12, Lambeth's VIPER profile shows the borough is **significantly worse** than the England or London average in four categories as shown in table 2 below.

Table 5: Extract from Lambeth VIPER profile (LJMU 2012)

	Violence against the person offences[44]	Sexual offences[45]	Hospital admissions for violence[46]	A&E first attendances for violence[47]
Lambeth	25.0	1.79	114.02	631.62
London	19.71	1.29	71.89	408.51
England	13.60	0.96	67.68	360.07

22.2   **Local Alcohol Profiles**

Local Alcohol Profiles for England (LAPE) are also produced by Public Health England/Liverpool John Moores University.[48] The LAPE profile for Lambeth shows the borough as being 'significantly worse' than the London and England average for alcohol related recorded crimes (ranked 147 out of 151 primary care organisations); alcohol related violent crimes (ranked 142) and alcohol related sexual offences (ranked 145) as shown in table 3 below:

Table 6: Extract from Lambeth LAPE profile (LJMU 2012)

	Recorded crime attributable to alcohol[49]	Violent crimes attributable to alcohol[50]	Sexual crimes attributable to alcohol[51]
Lambeth	14.15	9.25	0.23
London	11.10	7.29	0.17
England	7.02	5.03	0.13

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[43] Violence Indicator Profiles for England. Public Health England/Liverpool John Moores University
http://www.eviper.org.uk/
[44] crude rate per 1,000 population (2011/12)
[45] crude rate per 1,000 population (2011/12)
[46] (ICD 10 codes X85-Y09). Directly age standardised rate per 100,000 population (09/10 to 11/12)
[47] crude rate per 100,000 population, (2010/11)
[48] Local Alcohol Profiles for England. Public Health England/Liverpool John Moores University
http://www.lape.org.uk/
[49] crude rate per 1,000 population (2011/12)
[50] Ibid.
[51] Ibid.

Violent Crime Patterns[52]

23.   Victims

23.1   **Gender**
Except in the context of intimate partner violence, rape , sexual violence where women are more likely to be subject to serious sustainable violence from men, the data in the table below shows a higher percentage of men are subject to serious wounding ,knife and gun crime and robbery categorised as serious violence in this study.

23.2   More women than men are victims of harassment, common assault and assault with injury for every age group from 11 to 35 years. Significantly more men than women are victims of serious wounding in every single age group. For personal robbery, 72% of victims are male, but sexual offences are overwhelmingly against women – 92% of rapes and 90% of other sexual offences. Gender breakdowns for key violent crime categories include:

Table 7: Victims of violent crime in Lambeth: gender breakdown (%)

	Female	Male
All Violence Against the Person	49	50
Harassment	55	45
Common Assault	52	48
Assault with Injury	51	48
Serious Wounding	18	82
Knife Crime	27	73
Gun Crime	26	74
Robbery (person)	28	72
Sexual Offences	91	9

23.3   We conclude that there is gender disproportionality for key categories: for women – sexual offences, harassment; for men – robbery, weapons offences, serious wounding. Serious violence for men is more likely to be assault (wounding/GBH), for women more likely to be sexual assault/rape.

23.4   **Age**
Violence Against the Person is overwhelmingly a crime type involving young adults in Lambeth: 21-35 years constitutes the peak age range for all *VAP*, *harassment*, *common assault* and *assault with injury*. 21-30 years is the peak age range for *personal robbery* and *rape* (21-25 for women). However, some types of violence demonstrate a lower age profile: key ages for *serious wounding* are 16-25 years (male); for *knife crime*, 16-25 (male); for *gang violence*, 16-20; *for other sexual offences*, 11-15 and 21-25 years.

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[52] *Violent Crime Problem Profile* Lambeth Community Safety, 2013. Based on analysis of MPS Crime Reporting Information System (CRIS) for offences reported in 2012/13.

23.5   Generally, the older you are, the less likely you are to be a victim of violent crime, an exception being *murder* where 35-59 is the peak age range (53 out of 152 between 2000 and 2011).

23.6   **Ethnicity**
There is significant disproportionality with respect to Black African Caribbean people as victims of violent crime. African, Caribbean, Black and Mixed Race British make up about 34% (male, 16% and female, 18%)[53] of Lambeth's population. However, this group (identified by IC3 flag in CRIS) are, for example:

- 39% of victims of all violence against the person;
- 69% of victims of youth most serious violence;
- 50% of victims of youth knife crime;
- 43% of victims of gun offences;
- 73% of victims of gang related violence against the person.

23.7   The position of African Caribbean women as victims of violence is of particular concern. This groups makes up approximately 35% of Lambeth's female population[54], but constitute:

- 45% of female victims of all violence against the person;
- 44% of female victims of assault with injury;
- 50% of female victims of most serious violence;
- 85% of female victims of youth most serious violence;
- 49% of female victims of gun crime;
- 67% of female victims of youth knife crime and youth gun crime.

23.8   **Violence Victim Profile from CSEW**
Analysing data from the Crime Survey of England and Wales 2011/12, ONS are able to offer a profile of key characteristics associated with being a victim of violence. They conclude that, "...age, sex and marital status had strong relationship with the chance of being a victim when the effects of many other characteristics were taken into account."[55] Being single, male and aged 16-24 are the key characteristics of victimhood.

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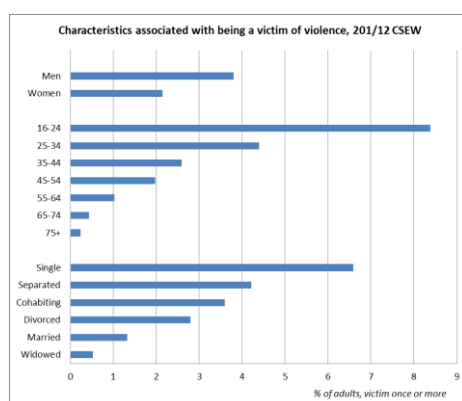
[53] Figures from Census 2011. This uses somewhat different definitions from the IC codes used by police in CRIS so there is only rough comparability.
[54] Ibid. Same health warning applies.
[55] ONS, *op cit*. pp11-12.

24. Offenders

24.1 **Gender**

Perpetrators of violent crime are overwhelmingly male: 78% of those charged for common assault, 83% for assault with injury, 87% for serious wounding, 91% for knife crimes, 97% for gun crimes, 91% for robbery, 98% for sexual offences, 100% for rape. Note how violence becomes 'more' male as it becomes more serious.

24.2 **Age**

Peak age for violent offending is generally in the 26-30 range – this is the case for VAP and its key components – *harassment, common assault, assault with injury*. However, there are some significant exceptions:

(a) *all VAP* – peak age range for *African-Caribbean* suspects is 16-20;

(b) *serious wounding* – peak age range is 16-20;

(c) *knife crime* – peak age range is 14-25; of those charged, a third were 15 to 17 years old;

(d) *gun crime* – peak age range is 16-20; of those charged, 41% were 16-20 years old;

(e) *robbery* – peak age range of suspects is 15-25; of those charged, the peak age is 13 to 17.

(f) *other sexual offences* – the only offence category that has older age groups (41-45 and 51-55) strongly represented among suspects.

24.3 The disproportionate involvement of the younger age groups in more 'serious' violence – wounding, weapons, robbery – is of particular concern.

24.4 **Ethnicity**

There is similar disproportionality with respect to African, Caribbean, Black and Mixed Race people as offenders as for victims. Individuals from these groups were identified as:

- 52% of suspects for all violence against the person;
- 52% of suspects for assault with injury and 49% of those charged;
- 47% of suspects for serious wounding and 55% of those charged;
- 56% of suspects for youth most serious violence and 72% of those charged;
- 74% of suspects for knife crime and 75% of those charged;
- 73% of suspects for gun offences and 87% of those charged;
- 67% of suspects for personal robbery and 80% of those charged.

25. Locations

25.1 There are a small number of significant 'hotspots' for violence in Lambeth, particularly in relation to public or semi-public, stranger-based violence, eg. robbery. Key hotspots appear to be transport hubs and/or night time economies where there is a concentration of licensed premises. For example, for **serious wounding** offences, key areas were Southbank (30 offences), Brixton Road (24 offences), Clapham High Street (17) and Vauxhall (13). With offences concentrated in the night hours and in the vicinity of licensed or fast food premises (eg 10 of 17 offences in Clapham; 12 of 24 in Brixton Road) serious wounding generally appears to be a night-time economy related issue.

25.2   This night-time economy pattern is repeated for ***personal robbery***: 131 in Clapham High Street, 65 between 00.00 and 05.00, and 21 of those near licensed premises; 254 in Brixton and Stockwell, 131 between 21.00 and 05.00, and 41 near licensed or fast food premises.

25.3   For ***sexual offences***, 22 of 109 rape offences were in Brixton or Stockwell and 14 in Streatham. 10 'other' sexual offences were in Clapham; 6 of these involved strangers and 7 offences were near licensed premises.

25.4   An analysis of most serious violence using 2009/10 CRIS data[56] showed an interesting difference in 'hotspot' locations between males, females and youth (under 19) victims:
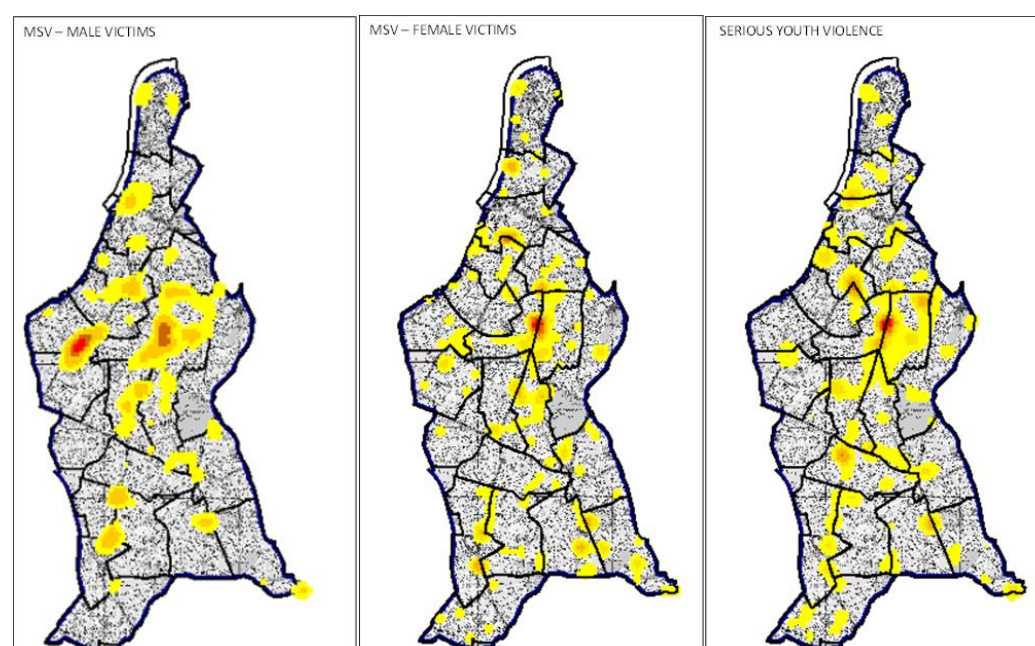
25.5   The male profile is more strongly linked to night time economy areas in Brixton, Clapham and Vauxhall, while the female profile highlights the transport hub in Brixton, but also residential areas in Streatham and Norwood, pointing towards domestic locations. Hotspots for Serious Youth Violence (most serious violence and weapons offences where the victim is 19yrs and under) point very strongly towards transport hubs – Brixton, Stockwell, Waterloo, Vauxhall, Streatham High Road.

Profile of key violent crime types for Lambeth

26.   Violence Against Women and Girls

26.1   In the Violence Problem Profile[57] 1,522, or 25% of all VAP offences in 2012/13 were flagged by CRIS as being '**domestic violence**' (ie. the victim was believed to be intimately related to the perpetrator by the recording officer) and this rises to a third of assaults with injury. When broken down by offence category, domestic violence is a factor in a high proportion of 'lower level' violence such as harassment (17%) and common assault (30%), but also in more serious offences such as rape (27%). However, it tends to feature less for Most Serious Violence (13%) and weapons offences (7% for knife), and not at all for robbery.

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[56] *MSV Problem Profile*, Lambeth MPS analysts, 2010. An obvious health warning attaches to this data as it is five years old, though these maps 'fit' with the Violence VOLT undertaken in 2013.
[57] Lambeth Community Safety 2013, *op cit*. p.13

26.2 The gender breakdown for domestic violence VAP is 80:20, female/male, so domestic violence is overwhelmingly a crime against women and girls. The peak age range for victims is 21 to 30 years old and, strikingly, 43% of victims are of African-Caribbean ethnicity (despite constituting 18% of Lambeth's population.) As might be expected, locations are quite spread across the borough, but with hotspots in the vicinity of Brixton Road and Streatham High Road, and the key times for these offences tends to be the early hours of the morning and weekends.

26.3 For **sexual offences**, there were 106 rape offences recorded in 2012/13 and 234 other sexual offences. The gender breakdown is about 90:10, so these offences are even more disproportionately against women and girls than domestic violence. 21-25 is the peak age range for victims, though for other sexual offences 20% of victims were aged from 11-15 years.

26.4 For **rape**, 27% were flagged as domestic and, of victims, 26% knew the perpetrator as a partner or ex-partner and 29% as a friend or acquaintance. This suggests about 45% of rape may be perpetrated by strangers, unknown to the victim. Key locations are SW2, SW9 and SW16 postcodes and peak times are 11pm to 1am Fridays and Saturdays, pointing to linkage with socialising and night time economies.

27. Serious Youth Violence

27.1 This is a specific category, based on the number of offences where the victim of most serious violence and/or of offences involving knives or guns was aged 19 or under. In 2012/13 there were 314 such offences on CRIS – 27% MSV, 7% gun crimes, and 65% knife crimes.

27.2 The majority of offences in the serious youth violence category are serious wounding. Most victims of serious youth violence are male, African Caribbean, and aged between 17 and 19 years old which coincides with the peak age for victims of knife crime. Perpetrators tend to have a similar profile. Serious youth violence occurs on estates near town centres. Weapons are also a prominent feature in serious youth violence (50% of offences). In knife offences - the victim tends to be male, Afro Caribbean and between the ages of 25 and 30 years old. However, 31% of total knife crime offences had a victim who was aged 19 or under.

27.3 Analysis of the 'top 10' offences of the YOS client group shows a strong representation of violent offences: robbery, 1st (9.8%); assault by beating, 4th (5.3%); 'having an article with blade or point in a public place' 6th (3.9%); common assault, 7th (3.6%). These offences constituted over 22% of the offences in the client group.

28. Gang violence

28.1 Although only a small minority of VAP offences were flagged by the police as gang-related in 2012/13 (83 offences), gang-related violence makes up 28% of overall serious youth violence and 22% of youth gun crime. 10% of youth knife crime is flagged as gang related. A later analysis[58] looked at 103 gang flagged offences between October 2012 and September 2013. The key offence categories were Serious Wounding (21%), Offensive Weapon (13%) and drug related (21%). A knife was used in 33% of offences and a firearm in 11%.

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[58] *Gangs Problem Profile*, Lambeth Community Safety Apr 2014.

28.2 The victim and offender profiles are strikingly similar for gang related violence: male (victims 76%, offenders 95%); ages 16 to 20 (peak age of those accused of gang violence is 16 years); African-Caribbean (victims 76%, offenders 73%).

28.3 The key locations for gang violence are Tulse Hill and Brixton Road with the top ward for gang flagged offences being Coldharbour.

28.4 Additional information on gang offenders is available from the **Gangs Connect Matrix** maintained by the Metropolitan Police. This is an intelligence-based, risk assessment tool consisting of the most significant gang members in the Borough. Currently, there are 248 individuals listed on the Lambeth Matrix: 100% are males, the age range is 14 to 53 with an average age of 21 and 91% are of African-Caribbean ethnicity, with 80 being held in custody. Of interest is that, whereas the peak age for offenders identified in the Violence Problem Profile is about 16 years, 86% of the individuals on the Gangs Matrix are aged over 18, implying that higher risk gang members have a higher age profile.

29. Personal robbery

29.1 Personal robbery is the largest category at 24% of total violent crime in 2012/13. This is three times the national average of 8% of total violence in England and Wales in the same period. With personal robbery rates running at nearly 8 times the average for England and Wales[59], and with only Southwark having higher rates in our group of most similar London Boroughs, this crime category is of particular concern in Lambeth.

29.2 We have three analyses to build a profile of personal robbery in Lambeth:

   (a) the Violent Crime Problem Profile with an analysis of 2,272 offences across the borough in 2012/13;

   (b) an analysis of 133 personal robbery offences in Clapham Town Centre between December 2011 and December 2013;

   (c) an analysis of 174 offences in the vicinity of Stockwell Tube Station between 2/9/13 and 13/10/13 (during a 6 week anti-robbery initiative).

29.3 The key characteristics are strikingly similar in all three cases:

   (a) The majority of offences in this category involve theft of *mobile phones* – 61% in the Violent Crime Problem Profile and 70% in Clapham. 62% of robberies in Clapham and 54% in Stockwell were specifically of *iPhones*. The next most common category is robbery of purse, wallet or money – 33% of offences in the Violent Crime Problem Profile.

   (b) In a significant proportion of cases a *weapon* is involved – 18% involved a knife in the Violent Crime Problem Profile and in Stockwell and 8% in Clapham, though in the latter 39% of offences involved the use of physical violence.

   (c) Personal robbery is a very *male* crime – 72% of victims and 95% of suspects in the Violent Crime Problem Profile; 69% of victims and 91% of suspects in Stockwell and 73% of victims in Clapham.

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[59] Para 21.6, above.

(d) It has a *lower age profile* than for other types of violence – peak ages are 21-25 for all victims in the Violent Crime Problem Profile, but there is also a peak for males between 11-15 years. Suspects were generally in the 15-25 range, but for those charged with robbery, the peak ages fall to 13-17 years. In Clapham, although 56% of victims were 20-29, almost one in five (18%) were aged 10 to 19 years. In Stockwell, although 26-30 was the peak age range for all victims, for males there are also strong peaks in the 10-15 and 16-20 age ranges. Most suspects in Stockwell were in the 16-20 age range.

(e) The key *hotspots* tend to be transport hubs and night time economy areas with Clapham High Street, Vauxhall, Stockwell and Brixton Road all featuring strongly.

30. Hate Crime

30.1 This constitutes a range of violent crime types the distinguishing character of which is that these are offences that are perceived by the victim, or any other person, to be motivated by prejudice or hate based on the victim's perceived membership of a social group or community of identity. The key categories for which data is kept include race, homophobic, faith and disability hate offences. In recent years, more data has been collected for the specific issue of Islamophobic hate crime.

Hate Crime Offences in Lambeth, by category, 2008-14
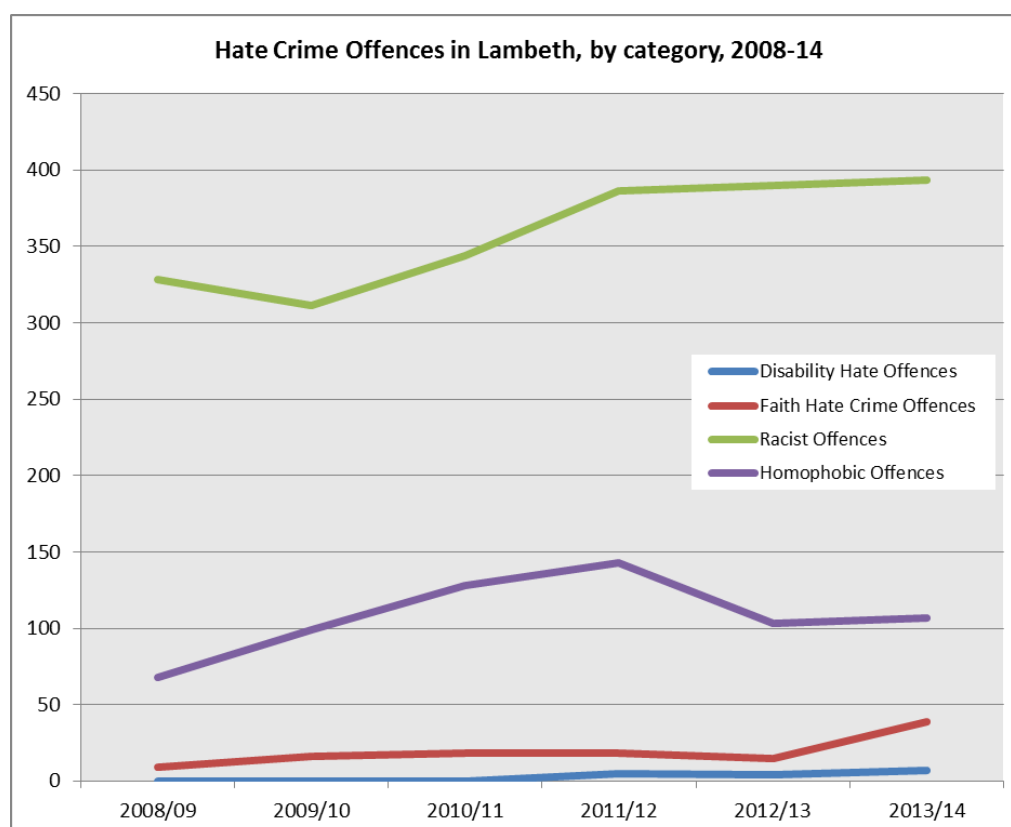
30.2 MPS performance statistic collected by the borough's Community Safety Unit suggest a rising trend from 2008 to 2012, followed by some reduction, particularly for homophobic, though a continued upward trend for racist hate crime.

30.3 Some caution attaches to these figures as hate crime is traditionally very under-reported and increases in recorded figures can actually reflect the success of measures to encourage greater reporting. The negligible reporting of disability hate crime, for example, in no way reflects how prevalent this form of hate crime may be.

30.4   An analysis[60] of 618 hate crime flagged offences on CRIS between October 2012 and September 2013 suggests that:

(a)   **Victims**:

- *Homophobic*: 250 offences, 22% of which were harassment, 55% of victims were male and 48% were 21-35 peaking at 26-30. 58% of male victims were white European, but 49% of female victims were African Caribbean.

- *Racist and religious*: 333 offences, 56% being harassment. 56% of victims are male and key age range is 26-30. Ethnicity: African Caribbean 38%; White European 26%; Asian 20%.

- *Islamophobic*: 28 offences, 14 of which were harassment. 78% of victims were female and key ages were 21-30 and 36-40. 11 victims were African-Caribbean and 11 Asian.

- *Disability*: 3 offences – 2 VAP, 1 criminal damage. Victims are 2 female and 1 male. There are serious problems of under-reporting with this hate crime category.

- *Transgender*: 4 offences, all VAP. Victims were 2 male and 2 female. Both females White European. There are serious problems of under-reporting with this hate crime category.

(b)   **Offenders**:

- *Homophobic*: 77% male, 22% 16-20 and 55% African Caribbean. (Note that White European suspects tend to be older at 26-30.) About 30% of suspects were known (as partners, ex-partners or acquaintances) to the victim.

- *Racist and Religious*: 72% male, key ages 26-35, 44% of suspects are White European and 34% African Caribbean.

- *Islamophobic*: 77% male, 27% in 26-30 and 51-60 age groups. 45% of suspects are White European. 73% of suspects not known to victim (or not disclosed).

(c)   **Locations**:

- *Homophobic*: key locations tend to be in vicinity of licensed premises eg. in Clapham. Key wards are Clapham Town, Ferndale, Coldharbour and Vassall.

- *Racist and Religious*: 40% of offences occurred at home address of the victim. Note that 5 victims were working as TfL bus drivers at the time of the incident so location would count as their 'workplace'.

- *Islamophobic*: very distributed in a large range of public environments across the borough. Some in the vicinity of Brixton Mosque.

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[60] *Hate Crime Problem Profile*, Lambeth Community Safety Apr 2014.

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Summary of this section

➤ Violent crime has fallen significantly in Lambeth over the last 15 years, but remains stubbornly high compared to other, similar boroughs. Rates of violence are much higher in Lambeth than compared to the England and Wales average.

➤ Women and girls (particularly African-Caribbean women) suffer disproportionate violence victimisation, particularly in domestic settings and at the hands of partners and ex-partners.

➤ Young men and boys are disproportionately affected by more serious violence, robbery and violence involving weapons. African Caribbean young men and boys are the single most effected group.

➤ Lambeth has a very serious problem with personal Robbery, which is the largest single component of violence, runs at eight times the national average and for which only Southwark has a worse record in our group of most similar London boroughs.

➤ Night time economy areas and transport hubs are the key locations for most of the 'public' and 'stranger' based violence in the borough. The early hours of the weekend are the key times.

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Overview of violence from other data sets

31. Data sources and methods

31.1 In preparation for the VNA, the Community Safety and Public Health teams attempted to obtain information from a range of statutory services on violence affecting different population groups. Information was obtained in the following areas: Safeguarding activity, the Gaia Centre[61] annual referral and outcomes report, and the School Health Education Unit survey

31.2 Safeguarding data was for the period 2012/13 unless stated. Gaia Centre data was for the year 15/01/2012 to 15/01/2013. The results of the School Health Education Unit survey were for 2012.

32. Child and Elder abuse

32.1 **Safeguarding data: Overview**
The total number of child abuse offences in 2012/13 has reduced from the previous year. However, Lambeth remains in the top five London boroughs for the number of physical, sexual and neglect forms of child abuse recorded in the borough.

32.2 Lambeth saw an increase in the number of alerts and referrals for adult abuse in 2012/13 compared to the previous year. Across London, Lambeth has the highest number of referrals and second highest number of alerts for adult abuse.

32.3 Although Lambeth has higher numbers of child abuse offences and adult abuse referrals than other boroughs, the overall number of reported cases is very low compared with other types of violence occurring in the borough.

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[61] The Gaia Centre provides confidential, non-judgmental and independent support for anyone experiencing gender violence in the London borough of Lambeth. The Centre supports women and girls aged 14+ and their children, and men aged 16+.

32.4   **Child safeguarding data**

Data in relation to children's safeguarding comes from a number of different sources and tells a number of different stories about the extent of child maltreatment in Lambeth. Children's Social Care receives referrals in relation to children who are in need of protection or at risk of significant harm under the Children's Act 1989. Local Authorities undertake assessments of the needs of individual children to determine what services to provide and action to take. Lambeth generally receives a higher number of referrals to Children's Social Care for child abuse referral rate compared to equivalent boroughs, because it has traditionally operated lower thresholds for receiving referrals. A referral is defined as a request for Services to be provided by children's social care. This is either in respect of a case of a child not previously known to the local authority; or where a case was previously open but is now closed. A decision regarding what action to take, must be made within one working day (24hrs) of receiving a referral.

32.5   **Children's assessment data**

In 2012/13 there were 4,252 referrals to children's social care. The rate of referrals reduced slightly by 0.4% from 2011/12 (from 4272 to 4252). 79.5% of referrals went to initial assessment, down from 87.5% the previous year, though still higher than many of Lambeth's statistical neighbours. The top three referrers to children's Social Care continued to be the Police, Schools and Health (Hospitals) in 2012/13. 299 Lambeth children were on a child protection plan as of March 2013 and 358 as at March 2014. Although there were no child deaths in Lambeth as a result of abuse or neglect in 2011/12, there was one child death in both 2012/13 and 2013/14 which met the threshold for a Serious Case Review (the first SCR published in May 2014 and the second currently underway and expected to be published in late September 2014).

32.6   Data in relation to child abuse offences is held by the Police.   In 2012/13 the Police recorded 214 **physical** child abuse offenses, a reduction of 15.6% from 2011/12. Of these 81% were familial offences. Lambeth has the fifth highest number of physical child abuse offences in London.

32.7   In 2012/13 there were 103 recorded **sexual** child abuse offenses, a reduction of 11.2% from 2011/12. Of these 60% were familial offences. Lambeth has the second highest number of sexual child abuse offences in London.

32.8   In 2012/13 there were 110 recorded **neglect** child abuse offenses, a reduction of 13% from 2011/12. All were familial offences. Lambeth has the fifth highest number of neglect child abuse offences in London.

32.9   Only 22 % of Police recorded child abuse offences resulted in charges during 2012/13, illustrating the difficulty of bringing adult offenders against children before the courts.

32.10   **Adult safeguarding data**

The definition of an adult at risk is a person who;

- is or may be in need of community care services by reason of age, mental and or other disability age or illness, and

- may be unable to take care of him/herself or protect him/ herself against significant harm.

32.11 There were 1,611 **safeguarding alerts** recorded and 988 **referrals** reported in 2012/13. This is an average of 138 alerts recorded per month. There was an increase of 19% in safeguarding alerts compared to the previous year. The most common source of referral was social care staff (29%), followed by health staff (26%).

32.12 Referrals were most likely to involve individuals with a **physical disability** and this group accounted for 62% of all referrals. The majority of referrals for clients with physical disabilities were for older adults (aged 65 and over), while for all other client types the largest proportion of individuals were in the younger age group (aged 18-64).

32.13 **Types of abuse:** vulnerable adults may be subjected to more than one type of alleged abuse. Physical abuse accounts for 28% of abuse reported. This is followed by neglect, accounting for 26% of abuse reported. 19% of the instances reported were related to emotional or psychological abuse and 18% for financial abuse. Sexual abuse accounted for 4% of abuse reported.

32.14 **Age, gender and ethnicity:** the majority of sexual (90%), physical (65%) and discriminatory (65%) abuse allegations involve adults in the 18-64 age group. For neglect and institutional abuse, the majority of referrals (between 64% and 74%) involve adults aged 65 and over. Women are more likely than men to be the alleged victims of all categories of abuse except for financial abuse. The majority of safeguarding referrals in 2012/13 involved adults who were White (59%) and Black/ Black British (29%).

32.15 **Location of abuse:** home was the most common location for alleged abuse (42% of cases) followed by residential care settings (25%). When abuse was alleged in a care home or hospital setting, the majority of cases involved adults aged 65 and over. With referrals involving allegations of abuse in the victim's own home, 63% concerned adults aged 65 and over and 37% concerned adults in the 18-64 age group.

32.16 **Relationship of abuser to abused:** 33% of perpetrators of alleged abuse were social care staff. 23% were family members. 8% of alleged abusers were other vulnerable adults and 7% were neighbours/friends.

32.17 **Comparison with other boroughs:** Lambeth has a higher number of alerts and referrals per 100,000 people than comparator boroughs. Lambeth has the highest number of referrals and the second highest number of alerts as shown below:
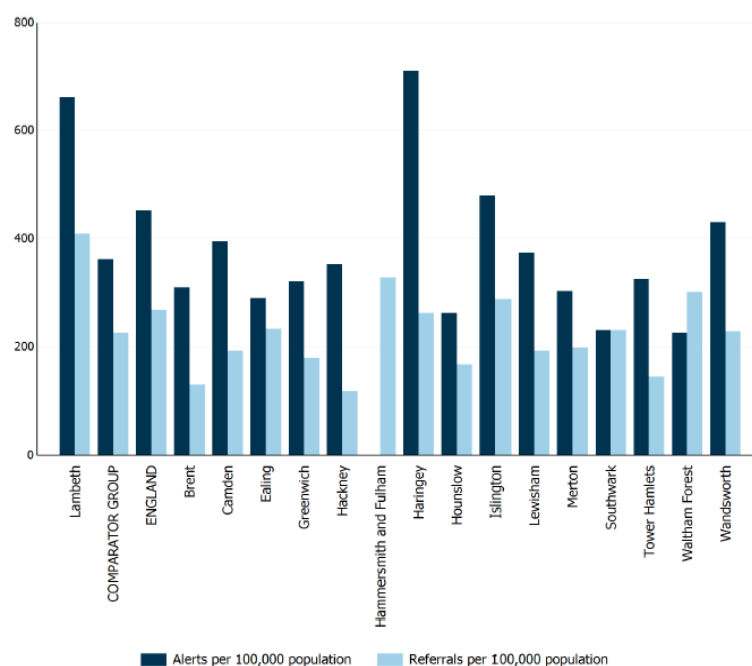
Number of alerts and referrals for Lambeth compared to England and comparator London boroughs, 2011-12

33. Schools data

33.1 We do not have reliable information on levels of violence in schools. However, we have some information from a health survey of school pupils[62].This work was commissioned by Lambeth Healthy Schools on behalf of the then Lambeth Primary Care Trust and Lambeth Council's Children and Young People's Service as a way of collecting information about young people's lifestyles. Some of the questions relate to crime, bullying and violence.

33.2 The survey covered primary and secondary school pupils aged 8 to 15 in Lambeth during the summer term 2012. Pupils in Years 4 and 6 in the primary schools and Years 8 and 10 in the secondary schools anonymously completed the questionnaire. A total of 2276 pupils took part in 26 schools. Completed questionnaires were then returned for analysis to the School Health Education Unit, an independent research unit based in Exeter. This survey was also undertaken in 2004, 2006, 2008 and 2010. Tables 4 and 5 show the results from 2012 for primary and secondary school pupils:

Table 8: Results for primary school children Years 4 and 6 (ages 8 to 11)

Crime	34% of Year 6 boys and 34% of Year 6 girls were worried about crime.
Bullying	33% of pupils overall reported that they felt afraid to go to school because of bullying, at least sometimes.
	8% of pupils overall said they felt afraid to go to school because of bullying 'very often'.
	5% of pupils reported that they thought others might fear going to school because of them.
Violence	41% reported being pushed or hit for no reason. The majority of pupils reported that these incidents took place at school.

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[62] Lambeth SHEU 2012

Table 9: Results for secondary school children Years 8 and 10 (ages 12 to 15

Safety	26% of pupils rated the safety of their area, when going out after dark, as 'poor' or 'very poor'. 7% said this about going out during the day.
Bullying	18% of pupils reported a fear of going to school at least sometimes because of bullying. 4% thought others may fear going to school because of them. 21% said they didn't know.
Violence	13% of pupils said that they had been the victim of violence or aggression in the area where they lived in the past 12 months.
Weapons	12% of pupils reported that they were 'fairly sure' or 'certain' that they or their friends carried weapons or other things for protection when going out. These weapons were thought to have blades.

34. Gaia Centre: summary of referrals and outcomes

34.1 The Gaia Centre provides confidential, non-judgmental and independent support for anyone experiencing gender violence in the London borough of Lambeth. Services support women and girls aged 13+ and their children, and men aged 16+. From 15 January 2012 to 15 January 2013 the Gaia Centre received a total of 1469 new referrals for victims of gender based violence – 1409 referrals were female, and 60 were male.

34.2 Of the female referrals, 28% were aged 20-29 years, 30% aged 30-39, and 18% aged 40-49. Ethnicity was not recorded for 26% of female clients. The largest ethnic group were White British (16%), followed by Black or Black British African (13%) and Black or Black British Caribbean (12%). 58% of female referrals had one or more child.

34.3 The largest percentage of female referrals to the Gaia Centre came from victims self-referring (25%). 15% of referrals came from the police and 12% from social services. Roughly 36% of referrals to the Gaia experienced more than one form of violence against women and girls.

Summary of this section

➢ The total number of child abuse offences in 2012/13 has reduced from the previous year. However, Lambeth remains in the top five London boroughs for the number of physical, sexual and neglect forms of child abuse recorded in the borough.

➢ There was an increase in the number of alerts and referrals for adult abuse in 2012/13 compared to the previous year. Across London, Lambeth has the highest number of referrals and second highest number of alerts for adult abuse.

➢ Although Lambeth has higher numbers of child abuse offences and adult abuse referrals than other boroughs, the overall number of reported cases is very low compared with other types of violence occurring in the borough.

➢ The Gaia Centre saw 1469 new clients last year: the majority of female victims were White British, Black African and Black Caribbean. Almost one third of female victims were aged 30-39.

➢ Many primary and secondary school children in Lambeth are concerned about their safety and worry about crime. In one survey 41% of primary school children and 13% of secondary school children had recently experienced violence inside or outside school.

Overview of violence from health service datasets

35. Data sources and methods

35.1 We looked at a range of health datasets covering general practice and hospital care. Tables 6 and 7 provide information on the health service datasets that were reviewed by the public health team and other datasets that were considered but could not be obtained. Presented below the tables are the main findings from each health service area.

Table 10: Information on health service datasets utilized for the needs' assessment

Type of information	Content
Assault A&E report by Debbie Baker Oates and Julian Pepper (Community Safety)	Report containing analysis of the Accident & Emergency (A&E) attendances data for 'assaults' received from King's College Hospital and Guy's and St Thomas' (GSTT) Hospital. Contains summary of analysed data including: • 2009-10 to 2011-12 trends (by month, day, time) • By ethnicity, age, incident location, cause • Map of home postcodes of patients
King's and GSTT A&E database of attendances due to assault	Source: Hospital trusts collection data provided to Lambeth Community Safety Raw data used for analysis as above for time period April 2009 to June 2013.
LAS – ambulance data	Source: Liverpool John Moore's University (LJMU) Contains number of assault related calls from 2010-11 to 2012-13 by age, gender, year, month, week, time, location of call out and % knife or gun related.
HES data	Source: Liverpool John Moore's Univ. Contains number of emergency admissions due to assault injuries for the duration 2009-10 to 2011-12 at King's and GSTT. ICD codes X85 to Y09 (Assault) appearing in all diagnostic fields for emergency admissions. Data included by month, age, ethnicity, and gender. Mapped DSRs and crude rates by LSOA of patient postcode.
Alcohol related / specific hospital admission rate + mortality rate + alcohol related crime rate	LAPE profiles – obtained from http://www.lape.org.uk/LAProfile.aspx?reg=h
National A&E dataset	Source: Liverpool John Moore's Univ. Contains number of assault related attendances from 2009-10 to 2011-12 by year, month, day, hour, age, sex, ethnicity, deprivation quintile, and crude rates by LSOA of patient postcode.
Domestic violence data	Source: Public Health Team Information obtained and analysed from: IRIS programme, REACH in GSTT, MOZAIC in GSTT, and antenatal data in King's.
Alcohol work in Lambeth	Source: Public Health Team. Work conducted in 2011/12 to support the development of local policy included mapping issues related to night-time economy. Maps done on LAS callouts.
Oasis Youth Support project at GSTT	Source: Lifespan Research Group, Middlesex University Evaluation of the Oasis Youth Support project

Table 11: Health service datasets that could not be accessed for the needs' assessment

Mortality rate due to assaults and injuries	Not analysed because of capacity issues in Public Health Team.
SLAM data (Mental health)	Public Health Team held discussion with South London and Maudsley NHS Trust about whether any data suitable – outcome was that patient level data did not contain necessary information.
Sexual Assault Referral Centre data	Data requested by LJMU but not ready in time for this analysis
TARN data (Trauma Audit and Research Network)	Data requested by LJMU and by Public Health team. Data received from GSTT but incomplete and coding issues so not used.
Primary Care data	No codes for violence available in ht v23 of QOF readcodes.

36.   The value of health service data

36.1   The public health team co-ordinated the collation and analysis of health care data to inform the development of this needs' assessment. This was considered an integral part of a public health approach to violence prevention. The aim was to see if health care data could improve understanding of the profile of violence in the borough by telling a different story about people who are injured through violent incidents. Health settings are particularly important because many people injured through violence will seek medical treatment but will not report what has happened to them to the police. Studies suggest that only 23% of people attending hospital because of violent assault report such incidents to the police[63].

36.2   Although a range of data sources exist in healthcare settings, the public health team encountered some difficulty in terms of access, quality, consistency and comparability of data. The public health team were helped by researchers at Liverpool John Moore's Centre for Violence Prevention who kindly shared analyses of local data that they had conducted for the national research project on A&E data sharing.

37.   London Ambulance data

37.1   Analysis of London Ambulance Service (LAS) data for the three year period 2010-11 to 2012-13 shows high numbers of ambulance call outs for people injured through violence. London Ambulance records consist of data collected by paramedics or other ambulance staff who record retrospectively if they believe an assault or other type of incident has taken place. Data is also collected on whether a weapon was used, and if the incident was alcohol/drug related.

37.2   There was a 20% reduction in calls related to violence from 2010-11 to 2012-13 as shown in figure 3. This supports the finding from recorded crime data that violence is declining in the borough. However, the LAS reduction may reflect a real decline in violence or a coding issue.

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[63] Department of Health. Information sharing to tackle violence. Guidance for Community Safety Partnerships on engaging with the NHS. September 2012.
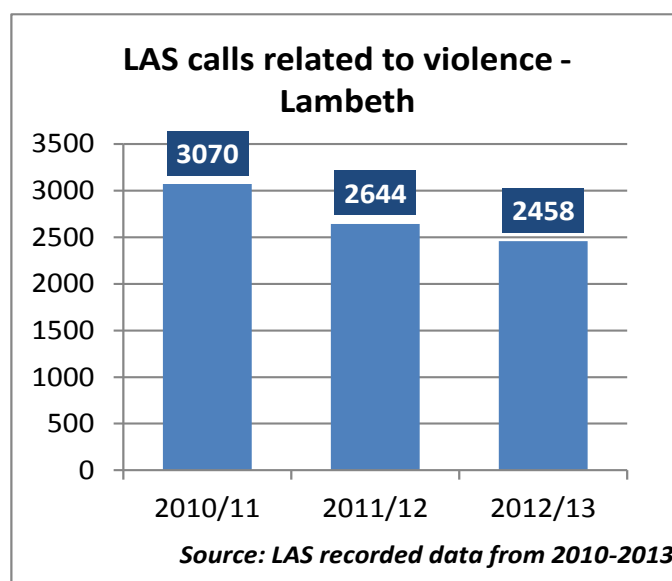
Figure 3: LAS calls related to violence 2010-11 to 2012-13

37.3 There were 2,458 call outs for injuries related to violence in 2012-13. It is difficult to relate this to recorded crime data. However, it is worth noting that the LAS total for violence in 2012-13 is close to the total for assault with injury (2,414) recorded by the police.

37.4 **Victims:** Over the three year period from 2010-11 to 2012-13, **almost two thirds of call outs for violence were for men** (63%). The main age categories were as follows: 10 to 19 years (13%), 20 to 29 years (31%), 30 to 39 years (24%) and 40 to 49 years (17%). Figure 4 shows total and crude age specific rates for LAS violence calls. The age specific crude rate shows that a high proportion of call outs are for 10 to 19 year olds – 35 per 1,000 residents. **This is consistent with MPS data which shows that younger adults are more affected by violent crime than older adults**. MPS data also shows that nearly 16% of victims of the most serious violence (serious wounding, GBH etc.) and 28% of victims of knife crime are male and aged under 19 years.
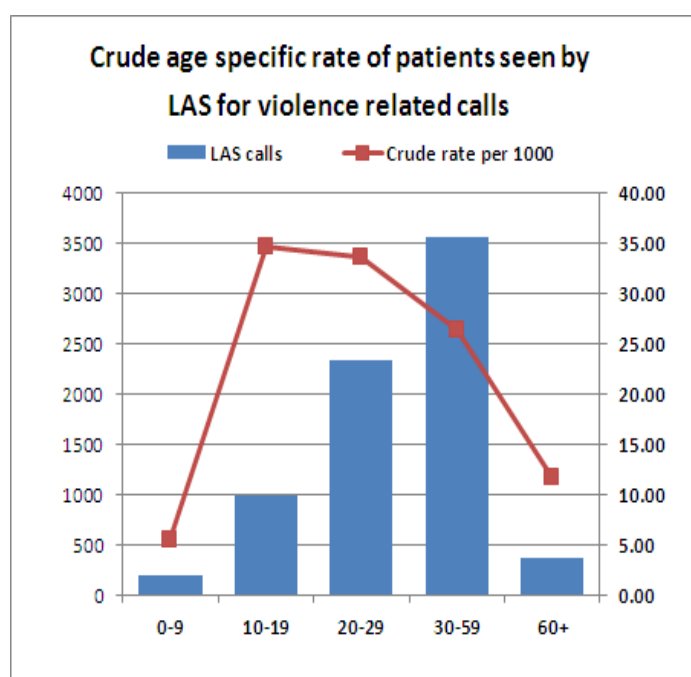

Figure 4: Total and crude age specific rates for LAS violence related calls 2010/11 to 2012/1

37.5   **Locations:** Over the three year period the highest number of call outs were in Coldharbour ward, followed by Bishop's, Oval, Clapham Town, Prince's and St. Leonard's.

37.6   **Weapons:** 8.6% of LAS calls were knife or gun-related over the same period (Lambeth borough). (Interestingly, this compares to about 8.5% for gun and knife offences compared to total VAP/robbery/sex offences in the Violence Problem Profile.)

38.   Hospital admission data

38.1   Emergency hospital admissions due to violence slightly increased by 5% from 295 in 2009-10 to 309 in 2011/12. Data for 2012/13 was not published in time for this analysis. Note that there are limitations with this dataset as the numbers are small and there are inconsistencies in coding. This dataset cannot be compared to recorded crime data as it is for Lambeth residents rather than Lambeth incidents.

38.2   Over the three year period 2009-10 to 2011-12, **83% of admissions were for males**, and 17% for females. Since emergency hospital admissions are for patients with serious injuries, this reflects the finding from recorded crime data that men are more likely to be the victims of serious violence than women.

38.3   Most admissions were for the 20-29 age group followed by the 30-39 age group. However the crude rate shows **a high proportion of admissions in the 10-19 age group**, followed by the 20-29 age group. Figure 5 shows total and crude age specific rates for hospital admissions due to violence.
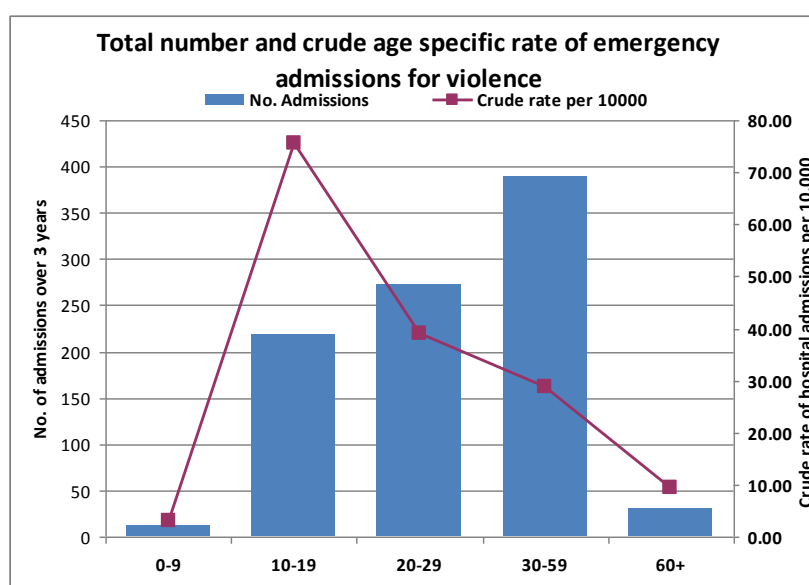

Figure 5: Total and crude age specific rates of hospital admissions due to violence 2009-10 to 2011-12

38.4   Of the total hospital admissions, the highest proportion were for 'White' and 'other White' individuals, followed by 'Any other black', 'Black Caribbean' and 'Black African.' However, ethnicity was not recorded in almost one third (32%) of patients.

39. A&E attendances: young people and violence (OASIS Youth Support at St Thomas' hospital)

39.1 753 young people aged 12 to 18 attending A&E at St Thomas' hospital because of violence-related injuries were referred to OASIS Youth Support over the three year period from 2009-10 to 2011-12.

39.2 70% were Southwark or Lambeth residents. 75% were male and 25% female. The average age was 15 years. The main ethnic groups were White (42%), Black (33%), and Mixed (25%). 16% of young people referred to OASIS had attended A&E previously with a violence-related injury. On this occasion 52% presented following an alleged assault; 12% had been involved in a fight; 8% had been stabbed; and 25% had self-inflicted injuries. 12% of young people reported gang involvement

40. A&E assault attendances (St Thomas' and King's hospitals)

40.1 Data was analysed for the three year period 2009-10 to 2011-12. The majority of people attending A&E at St Thomas' and King's because of violence-related injuries over this period had been attacked on **streets** (St Thomas) or **a public place** (Kings) – 45% and 54% respectively. However, 31% (Kings) and 15% (St Thomas') of incidents occurred at **home** – the assumption is that many of these cases will involve domestic violence and the dataset should be investigated further to see if there is a cross-match with gender (male-public / female-home). Note that only 5.4% of attendances at St Thomas' specifically cited 'bar/pub/club' as the location.

40.2 The highest number of attendances were for men aged 20-29 years over the three year period. The main assault type was body part. Where a weapon was used, the main ones were bottle, glass, blunt object and knife.

41. Domestic violence data

41.1 High levels of reported domestic violence in Lambeth are a concern. However, the true extent of domestic violence in the borough is not known as many incidents are not reported to the police. The public health team contacted local health services to ask if they could provide public health with anonymised monitoring data from clients/patients that would improve understanding of the prevalence of and risk factors for domestic violence in the local population. The results of the analysis of domestic violence in healthcare settings were summarised in a report which can be found in Appendix 7.

41.2 In primary care, information was obtained from Lambeth Community Safety for the IRIS (Identification and Referral to Improve Safety) programme. This is a general practice-based domestic violence and abuse (DVA) training, support and referral programme. The programme provides training and education to practice staff, promotes care pathways, and provides an enhanced referral pathway to specialist domestic violence services. It is aimed at women who are experiencing DVA from a current partner, ex-partner or family member. IRIS also provides information and signposting for male victims and for perpetrators. 27 out of 52 GP practices in Lambeth participate in the Lambeth programme. Table 8 provides summary information for IRIS for 2012-13.

Table 12: Summary information for IRIS programme 2012-13:

Number of new referrals	94
Clients successfully engaged into support	57
Number of repeat IRIS cases	6
Number of IRIS cases heard at Lambeth MARAC	13

41.3   In 2012-13, 61% of victims referred were successfully engaged into support. The main reason that clients could not be engaged was failure to respond after three contact attempts. Other reasons included clients declining the service and clients already engaged in another domestic violence service.

41.4   All clients referred through IRIS 2012-13 were female. The highest number of referrals were in the 31 to 40 age range, with White British and Black British being the main ethnic groups. There were 59 children associated with the 94 women who were seen in 2012-13.

41.5   In secondary care, information was obtained from the REACH service manager/IDVA. REACH is an IDVA scheme based in the Accident and Emergency Department of St Thomas' hospital in Waterloo. The project began accepting referrals in 2007 and has helped more than 1,000 victims of domestic abuse since that time. A full-time IDVA – sometimes supported by a social work student on placement - provides advocacy and support services to male and female victims of domestic abuse.

41.6   The majority of REACH's clients come through A&E after seeking treatment for injuries arising from domestic violence. REACH also sees patients who disclose domestic abuse in other hospital departments as well as hospital staff who are experiencing domestic violence and abuse.

41.7   REACH received 177 referrals in 2012-13. 156 of the referrals (88%) were female and 21 (12%) were male. Half of the male referrals turned out to be perpetrators. 172 referrals were via St Thomas' A&E; the remaining 5 were staff from GSTT.

41.8   The age range for female referrals for 2012-13 was between 17 – 85 years with the average age 36. The main ethnic groups were White British (55) and Black British (110). However, ethnicity was not recorded in 50% of referrals.

41.9   REACH also report the following information for 2012-13:

- 89% of REACH clients were injured during the latest incident of domestic abuse.

- over a third of injuries involved the use of a weapon.

- 60% of perpetrators threatened to kill REACH clients or children.

- 10% of clients' children had been physically harmed by the perpetrator.

- 6% of clients had been or were in a forced marriage.

- 36% of referrals in 2012-13 resulted in a police report.

41.10 Information was also sought from the antenatal services at King's and St Thomas' hospitals. Midwives in both hospitals carry out routine screening for domestic violence ("routine enquiry") for all women at booking, if the women are alone at their appointment. The hospital also puts in the booking letter a confidential time for

mothers to be seen alone, and women are given information for relationship problems and a DV helpline number. Women disclosing abuse to their midwife are referred to local services. At King's hospital, 2.7% of women who were asked about abuse disclosed that they were in an abusive relationship (1 Jan 2013 to 30 Sept 2013).

41.11 Information from IRIS and from REACH on the main ethnic groups referred (White British and Black British) and the main age group referred (31 to 40 years) indicates that female victims of DV seen in healthcare settings have a similar demographic profile to clients supported by the Gaia Centre. It would be helpful to analyse further the recorded crime data where DV is flagged (25% of VAP) to see if there is a correlation with the demographic profile of women reporting abuse to the police.

Summary of this section

➢ Anonymised data on violence from the health service can add value to reported crime data because many people treated by the health service do not report what has happened to them to the police.

➢ Health data shows us that the number of London Ambulance Service calls related to violence has declined over the last three years.

➢ The majority of LAS violence call outs are for men aged 20 to 29 years.

➢ A high proportion of call outs are for teenage boys aged 10 to 19.

➢ There has been a slight rise in emergency hospital admissions for injuries related to violence. However, the numbers are small and it is difficult to draw conclusions from the data.

➢ The majority of hospital admissions are male in the 20 to 29 age group. A high number of admissions are for teenage boys.

➢ Many victims of violence who seek treatment in A&E were assaulted in the home. Domestic violence advocacy services situated in health settings in Lambeth support high number of female victims, and many of these women do not report the incident to the police.

Key themes and issues emerging from the data

42.   Is violence becoming more serious?

42.1 Reported violence is decreasing in Lambeth. However, there are indications that violence in the borough is becoming more serious. Common assault accounted for 44% of all Violence Against the Person in 2000/01, but only 24% by 2012/13. By contrast the contribution of assault with injury during the same period increased from 27% to 35% of VAP. Although VAP fell by over 30% in the eight years to April 2013, there appears to have been a shift in its composition towards violence involving bodily harm. Is this a real shift or a definitional issue between 'common' and assault with injury?

42.2 A related issue is the willingness of offenders to carry and use weapons – has this got worse? Actually, offensive weapons offences are down over 60% since the peak of 2003/4, but our finding (para 24.2, above) that knife and gun offenders tend to be younger than for other violent crimes (16-20 compared to 25-30) is of concern.

43. **Does more violence take place between people who know one another or between strangers?**

43.1 As reported in para. 21.3, above, ONS analysis of CSEW data for 2011/12 suggested a breakdown of violence categories depending on the relationship between offender and victim. This suggested a 49:51 split in incidents of violence between people who know each other and between strangers:

Table 13: CSEW 2011/12 breakdown for violence categories by type off offender

offence **category**	*percentage*
Domestic	**15%**
Acquaintance	**34%**
Stranger	**35%**
Mugging[64]	**16%**

43.2 In the absence of a large sample survey, it is not possible to replicate this breakdown for Lambeth. However, our analysis of CRIS reports for 2012/13 does give some idea of how many victims reporting offences claimed to know the perpetrator as a partner, relative or acquaintance:

Table 14: violent offences in Lambeth 2012/13: victims who knew the perpetrator

offence	*Number **of** victims*	*Number who knew*	*% who knew*
VAP	**5831**	**3382**	**58%**
Rape	**106**	**58**	**55%**
Other Sexual	**234**	**77**	**33%**
Robbery Person	**2272**	**227**	**10%**
TOTAL	**8443**	**3745**	**44%**

43.3 Therefore, 44% of total violence victims claim to know the perpetrator, which suggests Lambeth may be slightly below the national average. This may be a consequence of robbery rates being much higher than the national average (see para 21.6, above) in Lambeth and robbery being predominantly a crime between strangers.

43.4 There is a disparity between men and women who claimed to know the suspect, for example 46% of female victims of common assault claimed to know the offender, compared to only 12% of men. Fewer male victims claim to know the suspect for all violent crime-types (eg. 20% for harassment, 12% for common assault, and 43% for assault with injury, compared to 80%, 46% and 77% for women). This points again to the significant disproportionality in women and girls' experience of violence from family members and intimate partners.
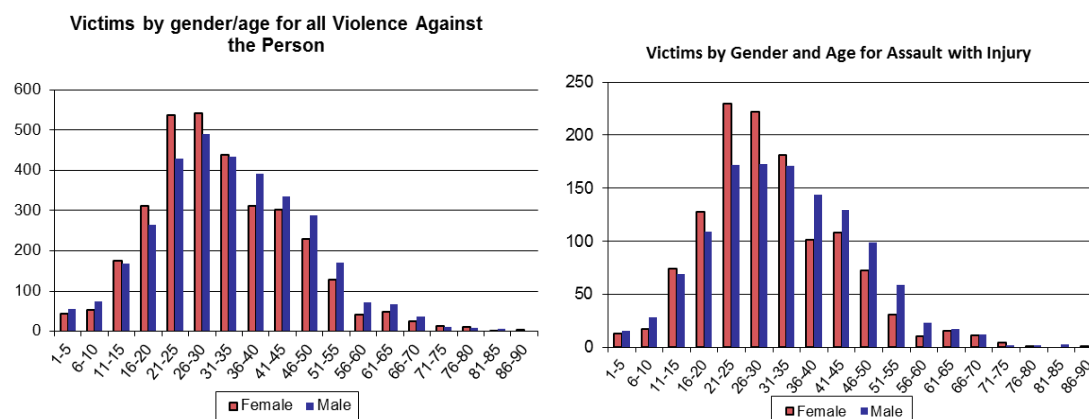
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[64] Personal robbery and snatch theft. All figures from ONS 2013 *op cit*. p.9

## 44.   Is there a gender imbalance in the nature of violence in Lambeth?

44.1   The experience of violence differs between men and women. Broadly, women experience violence as victims, at the lower levels, and more likely in domestic settings. Men experience violence as victims and perpetrators, at the higher levels, and more likely in 'public' settings.

Diagram: male and female victims of VAP and Assault with Injury, all ages, 2012/13

Victims by gender/age for all Violence Against the Person

Victims by Gender and Age for Assault with Injury

44.2   The diagrams above show how (in 2012/13) for all VAP and assault with injury, women and girls were the majority of victims in every age group from 11 to 35 years (though men for the older age groups). This gives a clue as to how prevalent lower level violence has become in the lives of young women in Lambeth.

Diagram: male and female victims of Serious Wounding and Robbery, all ages, 2012/13

Victims by gender/age for Serious Wounding

Victims of robbery by age and gender
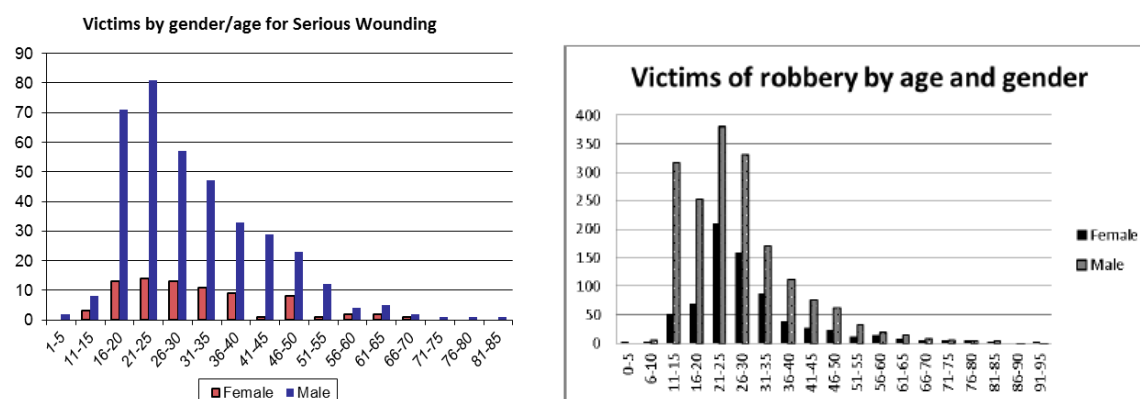
44.3   The diagrams above show that men are the predominant victims for serious wounding and personal robbery with peak ages of 21-25, though note spikes at 16-20 for wounding and 11-15 for robbery.

44.4   Table 7 (para 23.1, above) shows the gender breakdown for all categories of violent crime and leads to our conclusion that violence victimisation becomes more 'male' as it becomes more serious. Adding-in the finding (para 24.;1) that violence perpetrators are overwhelmingly male (75-90% in all violence categories) and generally in the 16-30 age range (and at the lower end for weapons and robbery), we conclude that **there is a very serious issue of *involvement* in violence – as victims and perpetrators – for boys and young men in Lambeth**.

44.5   The gender imbalance also works across ethnic and race lines: African Caribbean women are significantly disproportionately affected as victims of violence and African Caribbean boys and men as victims and offenders.

45.   Why are there so many robbery incidents in Lambeth?

45.1   Personal robbery features as only 8% of recorded violent crimes in England and Wales (2012/13). In Lambeth it is 24% - the single largest category of violence offences. Commercial robberies add an extra 2% of violent offences in Lambeth (compared to only 1% in England and Wales). 72% of victims of robbery are male; peak ages are 11-30 years; and the 'hotspots' for this offence clearly cluster around transport hubs and night time economies. Only Southwark amongst most similar London Boroughs has a higher robbery rate.

45.2   Understanding why Lambeth is so much higher than England and Wales, or most London Boroughs is a pressing priority, not least because this violence type seems to affect young age ranges, as victims and perpetrators, than other violence types.

46.   What proportion of violence is alcohol related?

46.1   The LAPE profile for Lambeth[65] shows the borough as being 'significantly worse' than the London and England average for alcohol related recorded crimes. The Violent Crime Problem profile shows that the majority of VAP offences occur in the early hours of the morning and peak at weekends. In addition, location hotspots for key violence crime types all point to areas characterised as night time economies with concentrations of licensed premises, particularly Clapham High Street, Brixton Road, Vauxhall and, to a lesser extent, South Bank and Waterloo areas. These findings are supported by mapping alcohol-related call outs for London Ambulance Service which strongly highlight Clapham, Brixton, Vauxhall, as well as areas around Streatham High Rd.

46.2   Lambeth currently has 1,230 licensed premises and concentrations of premises and patterns of alcohol consumption are seen as key drivers for other crime types including anti-social behaviour, street drinking and personal theft[66].

46.3   However, it is likely that MPS recorded crimes underestimate the contribution of alcohol to violent offending: only 4% of VAP, 4% of DV VAP, 4% of assault with injury, 9% of serious wounding and 26% of rape and 10% of other sexual offences had an alcohol flag on CRIS for 2012/13[67]. The VAWG problem profile cited earlier[68] suggested that in 6% of DV assaults leading to injury the suspect and/or victim had been drinking. But in only 4 out of 33 rape offences was an alcohol flag attached.

46.4   We do know, from looking at offenders, that problematic alcohol use is an issue for a high proportion. For example, analysis of robbery offenders on probation in 2012/13 (241 offenders) suggested that 24% had alcohol problems/issues. Analysis of the full probation service caseload in 2013 (2,121 offenders), suggested 17.4% had 'alcohol issues linked to their offending.'[69]

46.5   An analysis[70] of 635 alcohol flagged offences on CRIS between February 2013 and January 2014 suggested that the key alcohol-related offences are VAP (34% of the total), theft and handling (26%), robbery (11%), sexual offences (7%) and that offences mainly occur between 11pm and 1am with peak days of Saturday and Sunday.

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[65] See table 3, above.
[66] *Safer Lambeth Partnership, Strategic Assessment* pp32-33. Lambeth Community Safety 2014.
[67] Lambeth Community Safety 2013 *op cit*.
[68] Lambeth Community Safety Apr 2014, *op cit*.
[69] *Offender Information for the JSNA in Lambeth* London Probation Trust 2013.
[70] *Alcohol Related Crimes and Incidents in Lambeth.* Lambeth Community Safety Mar 2014.

46.6   The same analysis looked at 3,864 alcohol related ambulance call outs in the period with the highest locations, by ward, being Bishops (17%), Oval (9%), Coldharbour (8%) and Clapham Town (8%). 70% of these ambulance call outs were for males in a key age range of 21 to 30 years.

46.7   We conclude that the true extent of alcohol-related violence in Lambeth is not known and further work to ascertain its influence should be a priority.

Qualitative Review: victim and offender experiences in Lambeth

Qualitative work plays an important role in a needs assessment by adding an insight into the attitudes, experiences and behaviour of people affected by violence. It can also help to build up the picture of prevalence in the borough by giving people the opportunity to discuss violence which has not been reported to statutory agencies and hence is not counted in recorded crime or other service activity statistics.

47. Survey work

47.1 The quantitative analysis, above, of crime, health and other datasets can only take us so far in understanding the prevalence and nature of violence in Lambeth. This work needs to be augmented by qualitative research that 'drills down' into peoples' experiences as victims and perpetrators of violence.

47.2 There is some evidence from existing surveys which give an indication of people's experiences of violence in Lambeth. Findings from the **Lambeth Residents' Survey** (April/May 2013) show that crime is the top concern for adults in Lambeth, with two in five (38%) citing this as a problem. However, the numbers of adults who worry about this is falling and is at the lowest level recorded. One in five (21%) young people aged 11-19 years state that they worry about crime – the same level as six months previously.[71]

47.3 As an introductory assessment, the Community Safety Team conducted a **one-off survey** of people attending the Lambeth Country show in August 2013:

   (a) 120 people filled in the survey with more than three quarters (78%) never having experienced any violence.

   (b) Of those who had experienced violence, nearly one quarter (23%) had experienced violence one year ago.

   (c) 29% said that the violence was without injury, and 53% said it involved robbery.

   (d) In 69% of cases the perpetrator was not known to the victim.

   (e) Two thirds of respondents (67%) were quite or very concerned about violence, with gang violence, robbery and youth violence being the key concerns.

   (f) Women were twice as likely as men to be a victim and the largest age group to experience violent crime was between 46-55 years.

47.4 However, it should be noted that this was a small survey of 120 people and was a self-selecting group not necessarily representative of the wider population.

47.5 The findings from the **School Health Information Unit's survey** of young people's are reported para 33, above.

47.6 The Metropolitan Police Service (MPS) **User Satisfaction Survey**[72] showed that Lambeth ranked bottom for overall satisfaction among victims of violent crime compared to other boroughs. In 2012-13 63% of victims were satisfied with the overall service they received from the police, a 10% reduction from the previous year.

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[71] Lambeth Council Residents' Survey April/May 2013
[72] USS MPS Quarterly Report, Lambeth, Quarter 4 v1, April 2013

47.7   The MPS also conduct a **Public Attitude Survey**[73] quarterly. Key findings from the 2013 survey for Lambeth are:

(a)   65% of respondents in Lambeth thought the police were tackling gun crime well in the last financial year, compared to the overall 70% level for the MPS.

(b)   66% believed that the MPS supported victims and witnesses well, a 4% reduction from the previous financial year and less than the total level for the MPS which is 69%.

(c)   60% of respondents agreed that police treated everyone fairly in Lambeth, a 9% reduction from the previous year and less than the MPS total of 69%.

(d)   35% of respondents were worried about crime in Lambeth, a 2% reduction from the previous financial year and slightly higher than the MPS level of 34%.

47.8   The findings above suggest that more needs to be done in relation to public confidence and customer satisfaction with the police. Public attitudes towards the police may be a reason why many crimes in the borough are unreported.

48.   Qualitative work: focus groups and interviews

48.1   Anecdotal information gathered from professionals, commissioners and providers as part of a gap analysis on violence prevention is available in the appendix.

48.2   The Community Safety and Public Health teams commissioned original new qualitative research about Lambeth residents' experience of violence as part of this Needs Assessment. The aim is to broaden the evidence base for development of future commissioning intentions for the violence prevention strategy.

48.3   Limitations of the research include the small selection of people particularly relating to Brixton and Clapham for focus groups geared more towards young people (gang and youth violence).

48.4   Other views from groups across the borough known to be affected by violence were not available for interview. This includes older people, children and adults with disability, LGBT and adult mental health service users.

48.5   The research, conducted in May and June 2014 was undertaken with a selection of Lambeth residents aged 20-50yrs (including parents) and consisted of focus groups and interviews as follows:

(1)   1 discussion group with male residents of Lambeth

(2)   2 discussion groups with female residents of Lambeth (one African-Caribbean women only group)

(3)   interviews with 5 ex gang members engaged with the Gang Violence Reduction Unit;

(4)   interviews with 3 young men engaged with the Youth Offending Service;

(5)   interviews with 5 people identified and recruited by Lambeth Victim Support;

(6)   6 interviews with a range of 'front-line' practitioners from health, policing and business, engaged with the public in interventions and service provision.

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[73] The MPS interviewed 12800 people living in London to understand their views on crime at borough and MPS level: PAS MPS Quarterly Report, Lambeth, Quarter 4 v1, April 2013.

49. Key findings from qualitative research

49.1 Residents living in Lambeth remarked that positive changes had been made over recent years. There is a notable difference in how residents facing social and economic challenges benefit from the improvements to town centres. The overall view from a mixed group of residents stated how town centre areas known as hubs for violence were not perceived to be as bad due to better security measures and visible policing.

49.2 African- Caribbean women however expressed concern about living in gang affected areas, anti-social behaviour on the streets, drug use, poor housing and environmental conditions. The most noticeable issue being the street presence of people with mental health, alcohol and substance misuse issues in need of care but seem to not be receiving it.

49.3 A number of key players involved in local gangs have been imprisoned or moved on. This, combined with a higher presence of policing in certain areas has resulted in a decline in gang activity. Increasing inequality rather than poverty is seen to be driving community divisions. Joining a gang becomes a seen as viable option to gain income and acceptance.

49.4 Gang related crime and youth violence is thought to be driven particularly if people perceive a lack of opportunity and have little aspiration to improve their own lives. Schools were mentioned as places to identify early gang involvement.

49.5 Social media is a driving violent crime into certain geographical areas and activity becomes more discreet.

49.6 Participants did not define any one particular group to be more at risk of violence than any other. Race, sexuality, ability and background etc. are not thought to have a particular impact on the likelihood of becoming a victim of violence.

49.7 Early intervention was noted as key to preventing violent behaviour later in life; support for parents is vital and outreach services across settings for those at risk of violence. These services along with CAMHS however are considered too stretched to meet current demand.

49.8 Participants suggested charities and businesses could contribute to reducing violence. One participant described an organisation in a neighbouring borough set up by local businesses to improve study and work opportunities for local young people as having a positive impact.

49.9 Recognising signs and symptoms of gang involvement are important to help families struggling to cope with the detrimental impact of gang culture.

49.10 The benefits of peer support, acceptance and security within gang membership is quashed by fear and peer pressure. Gang members are immediately vulnerable to exploitation and violence which is seen as a justifiable reason to carry a weapon for self-defence.

49.11 Restorative justice is important in offering a counterview for offenders to realise the consequence of actions and make an alternative choice. Integrated offender management enables support to be offered to effectively reduce reoffending. A short reparative YOS sentence offers a key turning point.

49.12 Mentoring of younger potential offenders by people like themselves who have credible, relevant experiences to share is thought to be extremely valuable in demonstrating how to take personal responsibility for actions.

49.13 From the perspectives of professionals; an ex-policeman, ambulance manager and club owner, there have in fact been successes in reducing certain kinds of violence in Lambeth through multiagency working,, in recent years owing to factors including regeneration of the area, improvements to security, more high profile but sympathetic policing, better communications between stakeholders and agencies and campaigns to reduce violence experienced by the workforce.

49.14 It would be useful to conduct a wider piece of research focusing on the challenge posed by housing estates in tackling youth and gang violence and its impact on mental health and wellbeing and gain further insight from service commissioners.

49.15 Further research on elements within communities enabling young people to feel confident in their own abilities to identify opportunities and realise their potential e.g. mentors, education, employment and social opportunities and life skills.

49.16 More detailed knowledge of how social media plays a part in driving violent crime into certain geographical areas would be helpful. It is easier for groups to organise and contact each other more effectively and discreetly and beyond geographical boundaries.

49.17 The full research report from the qualitative work can be found in the Appendix.

Summary of this section

➢ Crime is the top concern for adults in Lambeth with two out of five people citing this as a problem.

➢ However, the number of people who worry about this is falling and is at its lowest level. One in five young people aged 11-19 years state that they worry about crime.

➢ The number of victims of violent crime who are satisfied with the Metropolitan Police has fallen – in a recent survey, one third of victims said that they are not satisfied with the service they received from the police in Lambeth.

Evidence and best practice review. Which interventions work?

In this section we summarise the findings of an evidence review conducted by the Public Health Team. The team searched for evidence of effectiveness and cost-effectiveness for interventions aimed at primary prevention of violence (prevention of first episodes of violence). Secondary prevention (prevention of repeat episodes) and the role of health services were also considered. Criminal justice interventions and strategies to mitigate societal risk factors such as poverty and unemployment were not included in the search.

The full evidence review – including information on methods and findings – is published as a companion volume to this Needs Assessment.[74]

Best practice interventions

50. Early Childhood

50.1 There is considerable evidence that interventions which encourage **safe, nurturing and stable** relationships between parents and children, and improve child mental health and behaviour, are effective for the prevention of violence. Effective interventions are:

(1) **Home visiting programmes** that provide intensive and long term early years support for vulnerable parents. Outcomes include improved parenting skills, improved maternal mental health, fewer childhood behaviour problems, and reduced child neglect/abuse.[75] The Family Nurse Partnership (FNP) programme has been positively evaluated. However, new evidence suggests that targeting FNP Programmes towards families with a history of domestic violence would protect a great number of children, and be more cost-effective.[14]

(2) **Recognition and management for children with conduct disorders** - the links between early conduct problems and subsequent criminal behaviour are well-established. One review found that the largest impact on crime reduction could be achieved by the implementation of evidence-based programmes to reduce the prevalence and severity of conduct problems in childhood. This review found that the best interventions can lead to a 50% reduction in offending; the most effective programmes are those aimed at early-intervention or pre-school; and the costs of these programmes are relatively low.[76] NICE guidance on recognition and management of children and young people with conduct disorders should be followed.[77]

(3) **Universal risk assessments for parenting** - the Department for Education and the Wave Trust recommend an assessment of maternal mental health during pregnancy, universal assessment of parent-infant bonding at 3 to 4 months, and clearly identified care pathways involving pre-natal home visits for those women identified as being at risk.[78]

[74] *Serious Violence in Lambeth, Qualitative Research Report*; Lambeth Community Safety 2015.

[75] Selph SS, Bougatsos C, Blazina I, Nelson HD. Behavioral interventions and counseling to prevent child abuse and neglect: a systematic review to update the US Preventive Services Task Force Recommendation. *Ann Intern Med.* 2013;158(3):179-190.

[76]The chance of a lifetime. Preventing early conduct problems and reducing crime. Sainsbury Centre for Mental Health. 2009.

[77] NICE clinical guideline no. 158. Antisocial behaviour and conduct disorders in children and young people: recognition, intervention and management

[78]Conception to age 2 – the age of opportunity. Framework for local area service commissioners. Wave Trust and Department for Education. 2012.

(4) **Parenting programmes** – including programmes targeted at parents of children with behavioural problems. There is evidence from an economic analysis that parenting interventions for five year old children with conduct disorders in England can generate cost savings of £9,288 per child over 25 years.[79] The implementation of parenting programmes is key to their effectiveness and this is an area that has sometimes been overlooked by commissioners. A recent report from the Centre for Mental Health found that improvements in outcomes from well-implemented programmes can be two to three times bigger than outcomes from poorly implemented ones. Particular attention needs to be paid to increasing enrolment and reducing drop out. Programmes which are poorly implemented can make children's behaviour worse.[80]

(5) The Center for the Prevention and Study of Violence at the US Centers for Disease Control has found that the most effective early childhood programmes have many different elements and are designed to tackle the family's and children's relationship to school, the neighbourhood, and the community – not only how the family functions as a unit.[81]

51. Developing social and life skills in children and young people

51.1 There is evidence that programmes that aim to nurture social and life skills in children are effective for prevention of violence and at-risk behaviours particularly when targeted at troubled children and children with deprived backgrounds. Effective interventions are:

(1) **Pre-school programmes** – that help develop children's social, emotional and cognitive skills. Pre-school programmes targeted at children with early signs of behavioural problems are particularly important.[76]

(2) **Primary school programmes** - school based programmes which emphasise the importance of social skills can lead to reduced aggression, hyperactivity and disruptive behaviour. An economic analysis found that these programmes could achieve cost savings of £10,000 per child after ten years.[79] One example is the PATHS programme in primary schools. The evidence is not strong for educational or skills-based programmes targeted at older children and young adults, such as programmes on dating and relationship violence.[82]

(3) **Bullying prevention programmes -** school-based programmes that aim to reinforce social norms and enforce school rules are also effective.

52. Working with high risk young people

52.1 There is some evidence for interventions aimed at **high risk youths and gangs**, including young offenders:

(1) **Assessment of health and wellbeing of young offenders** - should be built into local protocols so that young people who are emotionally or socially vulnerable and/or have mental health issues can be identified and helped.

[79] Knapp M, McDaid D, Pasonage E. Mental health promotion and mental illness prevention: the economic case. London: Department of Health, 2011.

[80] Scott S, Carby A. and Rendu A, 2008.*Impact of Therapists' Skill on Effectiveness of Parenting Groups for Child Antisocial Behavior.*Available at: http://www.incredibleyears.com/library/items/therapists-skill_08.pdf

[81] Elliott D. (1998). Prevention Programs That Work For Youth: Violence Prevention. Center for the Study and Prevention of Violence. US Centers for Disease Control and Prevention.

[82] Fellmeth GLT, Heffernan C, Nurse J, Habibula S, Sethi D. Educational and skills-based interventions for preventing relationship and dating violence in adolescents and young adults (Review). *Cochrane Database of Systematic Reviews* 2013, Issue 6. Art. No.: CD004534.

(2) **Family therapies** – there is evidence in favour of family therapies, particularly Multisystemic Therapy (MST), an intensive intervention for high risk 11-17 year olds and their families.[83] Intensive family interventions can be effective in reducing domestic violence and child protection issues.

(3) **Mental well being** - there is much interest in grass-roots programmes that aim to address mental health problems in high risk young people. One such example is Mac-UK's Integrate© model which brings mental health services to the street. The Mac-UK model is currently being evaluated.

(4) **Hospital based programmes** - for young people attending A&E who are injured through violence have shown positive results. These programmes involve brief psychological interventions, referrals to specialist services, mentoring, and youth services.[84] A reduction in hospital attendances and admissions for violence has been seen in areas where there are good arrangements between acute trusts, crime reduction partnerships and the police for sharing anonymised data on ED attendances for assault.[85]

(5) **School-based initiatives** - evidence is emerging from the US in favour of school-based diversion initiatives that target young people with mental health outside the youth justice system. Aiming to build capacity and skills among teachers and school staff to recognise and manage behavioural health crises in schools instead of contacting the police, outcomes include fewer suspensions and expulsions and lower rates of re-offending.[86] A survey of primary and secondary schools found that two thirds of schools had mental health provision for all pupils, but largely reactive rather than preventive with very limited teacher training.[87] This is particularly important because schools will often be parents' first port of call for help with child mental health issues. The child mental health survey in England found that 75% of parents who were concerned about their child's mental health had first sought help from a teacher, compared to 25% who had approached a GP.[88]

(6) **Gang-focused strategies** – there is little formal research on effective ways to prevent gang involvement, and only limited evidence of effectiveness.[89] The favoured approach, developed in the US and now being adopted in the UK, is that of the *Comprehensive Gang Model* featuring targeted and group-based social interventions offering support and help, enhanced enforcement against the group as well as individuals, provision of social opportunities for at risk youth and community mobilisation involving agencies and citizens.[90] This model was a

[83] Butler S, Baruch G, Hickey N, et al. A randomized controlled trial of multisystemic therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child and Adolescent Psychiatry* 2011;50:1220-1235.

[84] Bifulco A, et al. *Evaluation of the youth service prevention project at Guy's and St Thomas' hospital London. Report 5 – interim report*. Lifespan Research Group. Centre for Abuse and Trauma Studies. Kingston University. October 2012.

[85] Florence C, Shepherd J, Brennan I, et al. Effectiveness of anonymised information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis. *BMJ* 2011; 342:d3313.

[86] School-Based Diversion. Strategic Innovations from the Mental Health/Juvenile Justice Action Network. Prepared by the National Center for Mental Health/Juvenile Justice. September 2012.

[87] Vostanis P, Humphrey N, Fitzgerald N, Deighton J and Wolpert M. How do schools promote emotional well-being among their pupils? Findings from a national scoping survey of mental health provision in English schools. *Child and Adolescent Mental Health.* Volume 18. Issue 3, pages 151–157, September 2013

[88] Green, H., McGinnity, A., Meltzer, H., Ford, T., & Goodman, R. (2005). *Mental health of children and young people in great Britain 2004*.Cardiff: ONS.

[89] Elliott D. (1998). Prevention Programs That Work For Youth: Violence Prevention. Center for the Study and Prevention of Violence. US Centers for Disease Control and Prevention.

[90] *Little Village Gang Violence Reduction Project (Chicago)*, Sperzel I & Grossman S (1998)

key point of reference in the development of *Operation Ceasefire*, developed in the City of Boston in the 1990s. This model is described as a "focused deterrence strategy, harnessing a multitude of difference agencies plus resources from within the community…"[91] and a modified version has been adopted in the UK in Glasgow and Manchester.

53. Reducing the availability and harmful use of alcohol

53.1 There is evidence in favour of some interventions which aim to prevent alcohol-related aggression and violence. These include:

(1) **Reducing the density of alcohol outlets** - the evidence shows that the more alcohol outlets there are, the higher the levels of violence and alcohol consumption.[92]

(2) **Controlling alcohol sales times** - the evidence for the effectiveness of controlling and restricting the times that alcohol can be sold is mixed. However, there is no evidence that the Licensing Act 2003 which extended licensing hours in England and Wales was associated with an increase in violence.[2]

(3) **Controlling the price of alcohol** - there is extensive evidence to show that making alcohol more expensive reduces alcohol consumption and violence.[93]

(4) **Managing drinking environments** - one fifth of all violence occurs in or around drinking venues. Effective interventions to tackle this include targeted enforcement, training for bar and door staff, street lighting, and CCTV.[2]

(5) **Help for problem drinkers** - interventions targeted at problem drinkers – for example screening and brief interventions in A&E – can be effective.

54. Environmental design

54.1 There is much interest in how the design and use of the built environment can reduce fear and incidence of violence. Research has considered how crime can be "designed out" of the built environment, building on principles such as defensible space, CPTED (Crime Prevention Through Environmental Design), situational crime prevention and broken windows theory.[94] Several studies in the US have found a strong association between violent crime and vacant properties and abandoned land.[95] Other research has shown how green space can help to improve cognitive function, self-discipline, reduce aggression and reduced crime.[96]

55. Changing social and cultural norms that support violence

55.1 There is a lack of good evidence for interventions that challenge social and cultural values and aim to make violence less acceptable. This includes the use of mass media for delivering violence prevention messages, for example the Dignity in Care campaign; legislation and policy to raise awareness and make violent behaviour an

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[91] *How to Stop Young Men Shooting Each Other*, Presentation to the MPA, Kennedy D. 2007

[92] National Institute of Health and Clinical Excellence. *NICE public health guidance 24: alcohol-use disorders: preventing harmful drinking*. London: National Institute of Health and Clinical Excellence, 2010.

[93] Markowitz S, Grossman M. Alcohol regulation and domestic violence towards children. *Contemporary Economic Policy* 1998; 16:309-20.

[94] Mair JS, Mair M. Violence prevention and control through environmental modifications. *Annu. Rev. Public Health* 2003;24:209-25

[95] Branas CC, Rubin D, Guo W. Vacant Properties and Violence in Neighbourhoods. *ISRN Public Health.* 2013; 2012:246142

[96] Commission for Architecture and the Built Environment. Community Green: Using local spaces to tackle inequality and improve health. 2010.

offence, for example the Female Genital Mutilation Act 2003; and social norms education programmes aimed at children and young people, for example PSHE in schools on sex and relationship education.

56. Identification, care and support for victims

56.1 The evidence is mixed for programmes that focus on **identification, care and support for victims**.

(1) **Identification and screening tools** - there is evidence that screening tools can help detect violence in patients although not enough evidence to show that identification leads to referral to services and to reductions in violence. There is evidence in favour of screening women who use antenatal services[97] and possibly for women who visit orthopaedic fracture clinics for intimate partner violence.[98] Training for health professionals in awareness of violence and referral procedures – for example through the IRIS project – is effective.[99]

(2) **Advocacy programmes** – the evidence for the effectiveness of advocacy programes in reducing intimate partner violence is mixed. A systematic review of controlled studies found that advocacy was likely to be an effective intervention and support for women victims of domestic violence.[100] A recent Cochrane review concluded that there was insufficient evidence to assess the effectiveness of interventions which aim to reduce domestic violence during pregnancy.[101] There are high rates of domestic violence among women who present to A&E, and A&E based advocacy projects to support these patients are important.

(3) **Multi-agency risk assessment conferences (MARACS)** – in most areas there is evidence that these help reduce re-victimisation and improve the safety of victims.[102]

57. Brain injury and violent behaviour

57.1 Research shows a strong link between **traumatic brain injury (TBI) and violent behaviour**. There is a very high prevalence of TBI in offenders in custody. Good practice interventions include[103]:

(1) **Violence risk assessments** for people who have experienced a traumatic brain injury, particularly for those in higher risk groups such as offenders and people who are engaged in alcohol or substance misuse.

(2) **A single comprehensive health screening tool for young offenders** which includes assessment of neurodisability.

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[97] Taft A, O'Doherty L, Hegarty K, Ramsay J, Davidson L, Feder G. Screening women for intimate partner violence in healthcare settings (Review). *Cochrane Database of Systematic Reviews* 2013, Issue 4. Art. No.: CD007007.

[98] Praise investigators. Prevalence of abuse and intimate partner violence surgical evaluation (PRAISE) in orthopaedic fracture clinics: a multinational prevalence study. Published online in The Lancet June 12, 2013 http://dx.doi.org/10.1016/ S0140-6736(13)61205-2

[99] Feder G et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *The Lancet*. Published Online October 13, 2011.DOI:10.1016/S0140-6736(11)61179-

[100] Feder G, Ramsay J, Dunne D, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment* 2009;13(16)

[101] Jahanfar S, Janssen PA, Howard LM, Dowswell T. Interventions for preventing or reducing domestic violence against pregnant women. *Cochrane Database of Systematic Reviews* 2013, Issue 2. Art. No.: CD009414

[102] Steel N, Blakeborough L, Nicholas S. Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). London: Home Office, 2011.

[103] Hughes N, Williams H, et al. (2012). Nobody made the connection: the presence of neurodisability in young people who offend. Office of the Children's Commissioner

(3) **Tools and training** for agencies and services involved with young people so that there is early identification and referral for neurodisability.

(4) **Access to specialist services and local diversion and liaison services** for young offenders with neurodevelopmental disorders.

Summary of this section

- ➢ Effective interventions exist to mitigate violence across the lifecourse.

- ➢ Achieving good outcomes requires implementation of interventions at scale and over time in a broad range of settings

- ➢ Local interventions will need to be developed and evaluated (with communities) where there is limited evidence such as tackling cultural and social norms

Gap analysis: how are resources currently used to prevent violence?

A gap analysis was carried out by Lambeth and Southwark public health team which included views from professionals and service providers. In some cases information is not available or was not supplied therefore it is not possible to provide a complete picture.

The section provides an overview of how activities and interventions are currently allocated to prevent and reduce violence and to identify two sorts of 'gaps' in our work – gaps in service provision due to inadequate resources and gaps in our knowledge and information so that we cannot know if our current provision is effective or if we fully 'understand' where resources need to be allocated.

Service and Resource Gaps

Using the eight themes of the public health model of violence reduction, and adopting the examples of good practice from the literature survey and *Bellis*, we mapped the following patterns, and gaps, in service provision. The mapping tool is available on request.

58. Theme 1: Early childhood

58.1 *Pattern* of current provision:

(a) Parenting programmes are offered and meet NICE guidance e.g. the Incredible years programme (conduct disorders) and Triple-P. The Incredible years programme is provided twice a year (previously offered termly).

(b) Strengthening families, Strengthening Communities and other family intervention programmes support families (including Troubled Families) follow NICE guidance on anti-social behaviour. Many services can refer children with conduct disorders to be identified - referrals are made to CAMHS which carries out the assessment.

(c) Maternal mental health is included as part of maternal assessment at time of booking with midwifery services. NICE Guidance for antenatal screening is used; mothers at risk for mental health problems are firstly referred to their GP, those with serious mental health issues are referred to MAPPIM (SLAM) at St Thomas' hospital. All high need first time mothers receive an antenatal home visit (health visitor). Vulnerable young parents are picked up by Bessemer Midwives (KCH) or Teenphase (St Thomas's) or referred onto Family Nurse Partnership (<19yrs). FNP is known to be effective.

(d) Parents referred to MASH are assessed by MAT to receive early intervention.

58.2 *Gaps* in provision:

(a) Conduct disorder interventions are needed for secondary school age children. Unmet need exists for conduct disorder in Lambeth. Current primary school programmes are monitored however it is not known how effective they are.

(b) Demand for emotional wellbeing and mental health services has increased over the last few years and resources have reduced. Coverage to meet need has been modelled (crudely) as about 20%.

(c) There is a need for more mental health outreach work to support CYP at risk of involvement in anti-social behaviour and during times of transition and bereavement.

(d) A clear pathway for maternal mental health is needed and a need for further follow up to measure antenatal mental health. High level needs are addressed but it is not clear what the outcomes are for those with lower/moderate needs. Such needs could be met by services including midwifery, GP's and mental health providers

(e) Vulnerable mothers who are at risk of poor parenting may present late to services (>20wks gestation) and are not able to access intensive support offered by the Family nurse Partnership. Universal home visiting antenatal coverage is needed.

(f) There are not enough parenting programmes to cover eligible population nor support for families when children have low- moderate level mental health issues

(g) Evaluation of programmes is needed. Outcomes for programmes are not yet known. Programmes require more sharing of information to create case histories for early identification and to prioritise need.

59. Theme 2: Developing social and life skills in children and adolescents

59.1 *Pattern* of current provision:

(a) Programmes for pre-school children are offered through children centres. Two programmes which specifically focus on social and life skills are available across the borough:

- Families and Schools Together (FAST) is currently being delivered in three Lambeth primary schools (a programme for children to build better relationships and narrow the gap in achievement) and

- Promoting Alternative Thinking Strategies (PATHS) in one primary school.

(b) Programmes supporting PSHE are embedded in primary schools e.g. Social and Emotional Aspects of Learning (SEAL), Circle Time. Some schools are commissioning their own emotional wellbeing and mental health provision and monitoring it themselves. The Health and Wellbeing programme (Lambeth Healthy Schools) commissions emotional health &wellbeing, substance misuse, and sex & relationships programmes, and captures more information through its audits.

(c) SEAL resources are embedded and activities are used alongside circle-time this is embedded practice in primary schools but proves difficult in Secondary schools when PSHE is not timetabled

(d) Healthy Minds programme worked with 45 schools over 10 years (offered to all primary schools, capacity prevented 100% delivery) and funding has been reduced.

(e) A borough-wide Anti-bullying policy is integrated in all Lambeth schools.

59.2 *Gaps* in provision:

(a) Provision and knowledge of what is delivered in all schools across the borough is not consistent.

(b) FAST and PATHS has limited coverage. It is not known yet known how effective these programmes are in Lambeth.

(c) There is limited funding for work in secondary schools and an overview of what is commissioned by schools themselves is not available.

(d) It is not known how sustainable these programmes are as although demand is high and not being met, provision is being reduced. There are no academic enrichment programmes for at risk children (funding withdrawn for Gifted and Talented March 2011)

(e) Funding for the Healthy Minds programme has been reduced. This also limits the opportunity for pupils to be trained by teachers as programme school inspectors and closes a route into volunteering for young people.

(f) Implementation of the Bullying Policy differs by school; there is variable support for primary school age children experiencing bullying and on the fringes of gang culture.

60. **Theme 3: High risk youth and gangs (family therapies, intensive family interventions, mental health provision, gang reduction/exit)**

60.1 *Pattern* of current provision:

(a) Multi-systemic therapies (MST) are an evidenced based family therapy commissioned through Troubled Families (funded up to 2020). Of the allocation of 14 families, 6 cases are with YOS.

(b) MST is well supervised the quality of the implementation is good, there can be duplication of work in which case Troubled Family Support workers liaise with YOS. There are no drop outs from the programme, there are sufficient resources to work with parents, volunteers are able to be brought in when required to support the work.

(c) Schools are increasingly bringing in their own counselling services. One primary school is known to be commissioning CAMHS support.

(d) YOS provide parental support (half-term parenting officer), CAMHS is a co-located service. A programme exists with 12+yrs at risk of gang involvement.

(e) Growing Against Gangs and violence have worked in 37 primary schools resulting in 77 disclosures of gang involvement since Sept 2013.

(f) Two youth worker projects are available at A&E: Redthread and Oasis at St Thomas'. Disclosures by women to Redthread A&E female youth workers has increased. Many of these young women are high risk with complex needs. Both programmes are working with high risk young people attending A&E seeking care for injuries caused through violence. Only Oasis has been independently evaluated.

(g) The ASSET form is a standard assessment for young offenders which screens for mental health and wellbeing.

(h) A Gang Violence Reduction Unit has been established in Community Safety co-funded by MOPAC and Council. The team manages GMAP multi-agency risk assessment and management of key gang members identified on the MPS Gangs Connect Matrix and commissions support interventions from third party providers (eg. St Giles Trust) to work with compliant gang members on exit from gang lifestyles.

(i) GVRU are also seeking to mobilise community assets: 'call-ons' with gang members, parents' group, and 'moral voice' – impactful suasion with gang members delivered by credible community leaders and volunteers.

60.2 *Gaps* in provision:

(a) Analytical capacity is required to improve/track eligible families across services.

(b) It is not fully known what level of supervision and coaching is given to fully deliver programmes or how other programmes are monitored and assured. MST and family intervention programmes need to be evaluated.

(c) YOS parenting interventions and gang reduction interventions need to be evaluated.

(d) There are a high number of referrals for mental health services from these above programmes however there are challenges in meeting the demand. Street-based mental health outreach (MAC-UK is not commissioned in Lambeth) is needed to support young people who will not access co-located services

(e) More interventions required for the early identification of children (<10's in particular) at the edge of gangs (e.g Growing Against Gangs coverage and addressing specific needs e.g. girls could be extended further).

(f) There is no all encompassing preventative service that works across the age spectrum for children on the cusp of criminality and gang involvement:

- Children <12 yrs disclosing gang involvement;

- CYP bullied into gang involvement in/out of school;

- Children and young people not already known to existing services identified as medium risk.

(g) There has been a lack of support provision and interventions for gang affected young adults (18-25), outside of the criminal justice system, at least until the Gang Violence Reduction team began to commission services in 2013. Provision for over 18s remains an area of concern.

61. Theme 4: Alcohol related violence (licensing policies, Night-Time Economy, targeted interventions for alcohol misusers)

61.1 *Pattern* of current provision:

(a) A new Licensing Policy exists to control density and saturation overseen by the SLP and Licensing Sub-Committee. Also includes work with off-licenses to restrict sale of super-strength alcohol and single cans, and, one-strike for under-age sales.

(b) New powers include EMRO and late night levy and a borough DPPO/Controlled Drinking Zone exists.

(c) Night time economy 'hub' in Clapham to support safer socialising of people using licensed premises in the area has been very successful.

(d) Health impact assessments are done via an alcohol licensing applications screening pilot (includes representation if indicated) and any ad-hoc requests

(e) Alcohol related violence is recorded at A&E, this contributes to police crime reports

(f) Evidence based (NICE) screening tools exist for drinkers in primary care and some settings e.g. CQUINS for medical admissions. Care pathways are in place for alcohol misusers including early intervention and psychosocial interventions

(g) KHP has an approx £2mn alcohol mitigation strategy (Charity funded) including A&E and medical admissions screening.

61.2 *Gaps* in provision:

(a) A licensing team of five officers and a manager will struggle to proactively apply the new Licensing Policy or do more than administer licensing applications and react to the worst problem premises with license reviews.

(b) There no powers over minimum pricing for alcohol – what can we do to influence Government policy (for example by working with other London Boroughs and NHS practitioners)?

(c) Need to develop further interventions to encourage self-regulated and well managed drinking environments that support responsible drinking and are resilient to violence and aggression.

(d) Licensing screening pilot needs further funding to be mainstreamed and could be extended to e.g. sex venues (alcohol and recreational drugs) and fast food outlets e.g. linked to the NTEs.

(e) Information: street level data, where last drink was taken etc is needed alongside health data. A&E and ambulance data is not detailed enough e.g. to pinpoint location

(f) Some frontline settings in the NICE guidance (alcohol) need to screening routinely e.g. Sexual health, community heath workforce

(g) KHP Alcohol Strategy – need to develop links with wider community work including A&E e.g. information sharing for licensing purposes

62. Theme 5: Community and partnership interventions (A&E information sharing, Public environment/design, Housing quality and conditions, Partnership outcomes)

62.1 *Pattern* of current provision:

(a) Hospital admission data and ambulance data are used to identify violence / injuries etc that needed hospitalisation or ambulance call outs

(b) KCH and St Thomas' emergency departments collect and share data on assault attendances in A&E with Lambeth and Southwark. Public health receives data as monthly returns and analyse outputs to develop a method of creating an independent dataset. Useful demographic data, descriptive analysis, weapon used, location of crime etc can support the understanding of population at risk as well as trends. Crime, health and social care data inform the strategic planning of violence reduction measures. Outputs are overseen by the Lambeth and Southwark safeguarding group.   Arrangements are good enough to inform crime reports, profiles are shared on type of crime and hotspot areas.

(c) Housing quality standards are met by 45% of Lambeth Living. A programme is underway for the remainder to meet standards by 2017 which includes refurbishment of kitchens and bathrooms to enable better quality standard of living.

(d) Census 2011 shows level of overcrowding (15.3%) is higher than statistical neighbour (13.2%), inner London (13.6%) and London average (11.3%)

(e) There is statutory regulation about the right of housing and sharing for private accommodation and need for landlords to be licensed

(f) A specialist housing team manages homelessness prevention reconnecting families excluded by family members including young people threatened with homelessness e.g. care leavers, vulnerable young people in need of temporary accommodation (180).

(g) The JSNA and Annual Public Health reports have highlighted violence as a public health concern requiring local action.

(h) MPS employ a Crime Prevention Design Advisor (CPDA) to review major planning applications and advise on opportunities for 'designing out' crime in public environments.

62.2 *Gaps* in provision:

(a) There are limitations on how key services are enabled to share information and use local intelligence and link to tangible actions to mitigate violence.

(b) Identification of high risk individuals not already known to social services or criminal justice system is not happening.

(c) It is not fully known what level of overcrowding exists in private rental accommodation and its impact on violence.

(d) Other Homeless Young people (<20yrs) arriving at local day centres are signposted to 'Alone in London' a north London based charity. Temporary hostel places are only allocated to rough sleepers by outreach teams and priority is given to single women with children and families. There is a need to address the majority of single homeless people who are a low priority for housing (mainly males aged 40+yrs) the majority arriving with mental health and alcohol issues

(e) There is no single partnership outcomes framework for reducing violence in Lambeth

(f) Previously, two CPDAs were allocated by MPS to work in Community Safety alongside council officers. The CPDA resource has now been centralised and only one officer is available to work across three south London boroughs.

63. Theme 6: Changing social and cultural norms (Media campaigns, social norms programmes, Policy/regulation, Community mobilisation)

63.1 *Pattern* of current provision:

(a) There is normalisation of DV and sexual violence connected to the role of women in gang culture. Levels of domestic violence are under reported – measures are counted by referrals to IDVA.

(b) As part of VAWG provision, posters and leaflets aimed at perpetrators of violence against women and girls are disseminated across the borough including NTE and at peak times e.g. '*Know the difference campaign*' during Summer/December when high rates of sexual violence occur. Teenage violence (home office), prostitution campaign to focus on reducing demand.

(c) A standard assessment tool is used across agencies and a multi-agency action plan effectively makes use of ASBO powers and housing injunctions. The Sanctuary Scheme provides target hardening of properties once the perpetrator has left to enable victims to stay in their own home.

(d) VAWG and other training is provided by Lambeth council for professionals working in Lambeth is available. It has been delivered to health workers including health visitors, school nurses, GPs and schools.

(e) A gender based violence programme (TENDER) is only offered to secondary schools. Issues relating to hate crime and extremism may be covered within the PSHE curriculum in schools as part of the promotion of 'British values'[104] and within the new statutory duties[105] for schools under the Prevent programme.

(f) A borough-wide Anti-bullying policy is integrated in all Lambeth schools

63.2 *Gaps* in provision:

(a) It is not known what proportion of DV disclosures made to GPs and hospital A&E staff result in a referral to victim support.

(b) Not all media campaigns and strategies adhere to national social marketing centre guidance. More disclosures and self- referrals have been made to victim support since a VAWG Domestic violence communications campaign

(c) It is not known how effective TENDER is in challenging gender norms and violence against women and girls. It has limited coverage in one year

(d) There is a need for an overall PSHE programme for Lambeth schools on challenging social norms linked to other forms of hate crime e.g. race, religion, sexuality or interventions to challenge violent extremism

64. Theme 7: Identification, care and support for victims (identification, reporting and criminal justice interventions)

64.1 *Pattern* of current provision:

(a) The Gaia Centre is the central resource for Lambeth's VAWG service and provides key services for victims, such as risk assessment, safety planning, advice, legal support etc. There are other services provided by community and voluntary groups such as Victim Support, Mosaic, Asha etc.

(b) Gaia and National DV Helpline provide referral through to refuge provision. In Lambeth there are 52 refuge spaces provided by Solace Womens Aid and Refuge.

(c) The DV MARAC, chaired by MPS CSU Inspector, provides multi-agency risk assessment and support for high risk DV victims.

(d) Standard assessment tools are used by health professionals. All midwives routinely screen for DV and abuse including maternal mental health at booking and follow up any previous history with GP and social care. Referral is made to GP to arrange support or further assessment. There are clear pathways for those identified using these tools. Training is given to encourage reporting which supports local campaigns aimed at perpetrators.

(e) IRIS is a GP practice-based programme (about 50% coverage), 100 referrals made through identification. IRIS worker cascades training to GPs who are able to make assessment based on clinical codes which are linked to DV.

(f) DV screening happens routinely in hospital settings; for example, REACH and MOZAIC at St Thomas'. KCH make referrals to the Gaia centre (community).

(g) Beth Centre provides interventions and support for female offenders or women at risk of offending.

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[104] Includes 'democracy', 'rule of law', 'individual liberty', 'mutual respect and tolerance'.
[105] s.26 Counter-Terrorism and Security Act 2015.

(h) A Community/ASB MARAC has been established to provide multi-agency risk assessment and support for vulnerable victims of repeat anti-social behaviour, harassment and hate crime.

(i) The Hate Crime Action Plan, VAWG Strategy, Lambeth Living tenancy agreements and licensing/regulatory policies all include approaches to proactive use of powers. A multi-agency action plan has effectively used new powers to share information and prevent a perpetrator of DV from re-entering the borough (Operation Dauntless).

(j) Outreach and advocacy from Victim Support is important, particularly for the most vulnerable victims already involved with social services and the police. Domestic violence advocacy is a good opportunity to work with victims and identify perpetrators.

(k) The majority of referrals to VS come from the police (96%). Other referrals are from agencies including social services and self-referrals. Most other-agency or self-referrals are for young people, as a result of work carried out by the vulnerable youth project which offers training for professionals to identify DV and unhealthy relationships, bullying and healthy relationships in some schools.

(l) All support is offered regardless of whether crime is reported or unreported. Some victims may be referred for criminal damage and disclose that the crime is DV related, this would not be captured on police reports.

64.2 *Gaps* in provision:

(a) DV disclosure at A&E and GPs is under-reported. There is no DV Advocacy service based at KCH and follow up of referrals made to Gaia Centre is not known.

(b) Under-reporting of DV should be addressed – health data does not routinely identify violence in the data fields requested unlike other services e.g. police crime data (DV measured by referrals to IDVA).

(c) Children and YP need opportunities to disclose their experience of violence e.g. through schools, primary care and other services.

(d) Consistent safeguarding training in school is needed.

(e) There is no multi-agency or partnership programme to address and manage offending behaviour by perpetrators of domestic violence.

(f) There is still a need for ongoing services for victims even after relocation out of the borough, the support links are not always in place.

(g) There is an intelligence gap relating to how female gang members are exploited and tracking high risk vulnerable people who move in and out of the borough.

(h) There is not enough known about support for vulnerable adults with physical disabilities and those with learning disabilities who are at risk of hate crime.

(i) Further information about dementia friendly training to support identification of adults who may be experiencing violence and raising awareness of support for older adults who may be reluctant to report abuse at hands of family members/carers.

65.   Theme 8: Managing offenders (multi-agency risk assessments, prolific/repeat offenders, brain injury, substance misuse)

65.1   *Pattern* of current provision:

(a)   MAPPA, Gangs Connect Matrix, GMAP, YOS, probation and CAMHS are all involved in risk assessment panels to determine level of risk of harm posed to the individual themselves and the public. Crimes are segregated with nothing in place to review risk factors for other types of crime.

(b)   Co-located services enable information sharing however there are points when it is difficult to assess needs due to transition between custody and probation and transfer from children to adult services.

(c)   Integrated offender management and YOS identify repeat and prolific offenders. YOS provides preventative and responsive services for 12+years to reduce level of robbery and programmes within the gang violence reduction unit are provided e.g. The Beth Centre is commissioned to reduce female offending, support custodial and community sentences and deliver substance misuse group work.

(d)   Services are evaluated as part of overall CAMHS service, they are effective in reducing the overall risk of vulnerable young people in terms of safeguarding and measures that might prevent young person from going in to prison but not necessarily having an impact on the disability/ disorder.

(e)   AUDIT (validated by NICE) is used for assessing alcohol disorders and IBA for alcohol in police custody is happening.

(f)   There are clear cut mental disorders that are seen in YOS which require more measures to prevent the young person from going into prison e.g. addressing family issues, substance misuse, skills and ability to seek medical help.

(g)   Unidentified pre-existing conditions may be related to the offending behaviour including predisposition to further injuries this may only be revealed at medical disposal (at later stages of sentencing).

65.2   *Gaps* in provision:

(a)   There is a need for 'joined-up' identification and management of prolific and repeat violent offenders with better ability to 'read across' risk assessment systems such as MAPPA, GMAP, MARAC and share a 'big picture' view about the most violent offenders in Lambeth.

(b)   Identification and management of DV offenders (particularly repeat offenders) needs to be a priority.

(c)   Information sharing and risk assessment arrangements are not clearly defined across systems.

(d)   YOS Integrated case management panel considers unmet need for educational support and previous experience of neglect and abuse.

(e)   Some offenders with mental health concerns have supporting unmet needs that require a range of services e.g. family support, communication/education skills.

(f)   Routine violence risk assessments for people who have suffered a head injury do not happen and not all agencies have adequate screening tools for the identification of neurodisability.

(g)   Further information on mental health of adult offenders, their substance misuse issues and possible previous brain injury needs to be ascertained.

Knowledge and information gaps

66. **Key gaps in our knowledge include:**

66.1 For MPS and Crime Data

(a) Most categories of recorded violent offences appear to be falling over the last 5 to 10 years. Are these trends supported by other forms of evidence for Lambeth, such as the British Crime Survey?

(b) Are falls in recorded violence, particularly low to mid- level violence, due to methodological issues regarding recording or due to genuine underlying reductions in offending?

(c) Are women more affected by violence than men between the ages of 11 and 30? Is the opposite true for the more serious types of violence?

(d) Why has assault with injury taken over from common assault as the largest component of Violence Against the Person? Is violence becoming more serious?

(e) Is there a difference in the pattern of victimisation for 'low level' violence compared to 'more serious' violence?

(f) Can we analyse the recorded crime data where DV is flagged (25% of VAP) to find out more about the demographic profile of women experiencing domestic violence?

(g) Further work is required to understand more about why robbery in Lambeth is so much higher than elsewhere (only Southwark is worse).

(h) How can we capture better where violence is alcohol-related? (Only 4% of VAP is recorded by the police as alcohol related)

66.2 From health and other services

(a) What proportion of A&E assault attendances that occur in the home involve domestic violence? Further analysis of A&E assault datasets is needed.

(b) Additional analysis of health and A&E data to develop the picture about prevalence of alcohol related violence in Lambeth requires events before last known drink, where that drink was consumed and where the injury occurred.

(c) How can we overcome some of the difficulties with access, quality and consistency of health data?

(d) How can we routinely incorporate information from health care and other services into violence prevention work (compared to a one-off trawl for a needs' assessment)? Examples include ensuring timely follow up of referrals to specialists from primary care (perinatal mental health), children with head injuries presenting at A&E, alcohol related injuries and hospital admission within 30days for serious injury. Further, shared reporting between schools and victim support on unreported incidents of intimidation and threats of violence.

(e) Road safety data would be useful to include around transport hubs, licensed premises and the NTE (including businesses with no late license to sell alcohol)

66.3 From qualitative work

(a) What more do we need to know about the experiences of victims and offenders?

(b) Interviews are needed to specifically investigate the culture of serious violent crime occurring across the borough and its association with other crime e.g. robbery, sexual violence, hate crime and the impact from anti-social behaviour.

(c) The breadth of this needs assessment has identified other areas for in-depth work. Groups of people at greater risk from health inequality and more vulnerable to exploitation: Elders abuse, older people, children and adults with physical disability, faith groups etc.

66.4 From evidence for effective interventions

(a) What local evidence do we have for good practice/effectiveness? Programmes that are working well but not formally/academically evaluated? There is much potential to learn from existing good practice initiatives to inform future development, the below are some of these:

- Gang violence reduction unit

- Redthread A&E youth work

- Victim Support vulnerable youth project

- Violence Against women AIM campaign

- Early intervention parenting support in YOS

- IRIS- GP domestic violence identification scheme

(b) How can we bring together the national evidence base with local information sources to develop evidence-informed decision-making for violence prevention in Lambeth? An approach could include recognising key timepoints across the life course to show that when vulnerability increases violence becomes more evident in an individual's life putting their health at risk.

66.5 From the Gap Analysis process

(a) Limitations: this gap analysis has compiled responses from many stakeholders in Lambeth, however whilst most were available some responses were not elicited. However by triangulating comments, it is hoped that missing information has been minimised.

(b) In some cases, where an effective intervention is offered in Lambeth, evaluation reports of services were not supplied or not available to assess the quality of their implementation.

(c) There is a disconnection across the piece in how vulnerable people not quite eligible for early intervention support or known to services are put at increased risk of violence e.g. young carers, specific cultural groups.

Summary of this section

Overarching themes:

➢ Scale/coverage: programmes need to tackle the underlying eligible populations' unmet needs should resources permit (e.g. parenting and mental health)

➢ Performance management: a framework across the lifecourse would allow an overview of actions to address violence

➢ Evaluation: routine evaluation of initiatives should be an integral part of work to identify what works in Lambeth and how best to improve

➢ Equalities: violence affects different population groups in different ways and so close attention to the equalities dimensions (age, sex, ethnicity, socioeconomic status, sexuality etc) is essential to both understand trends and assess effectiveness and impact

➢ Information exchange: better use of data from across the partnership leading to violence mitigation actions

Specific themes:

➢ Early childhood: better identification and coverage of conduct disorders, parenting interventions and access to CAMHS

➢ Social and life skills: partnership working with schools to ensure programmes are in place and are effective e.g. Healthy Minds and anti-bullying

➢ High risk youth and gangs: prevention service across all ages for children on the cusp of gang involvement, and capacity in CAMHS to meet need

➢ Alcohol-related violence: resources needed to implement the new Licensing Policy, expanded alcohol screening and brief advice in health and related care settings

➢ Community and partnership interventions: strategic framework for the partnership needed with outcomes across the lifecourse, better intelligence/information sharing and identification of high risk individuals not known to services

➢ Social and cultural norms: work to extend beyond VAWG/DV to address other risk groups and include best practice/evaluation

➢ Identification, care and support of victims: under-reporting of victims to be tackled (e.g. DV in health settings) and develop a perpetrators programme

➢ Managing violent offenders: resources to better target perpetrators needed via multiagency teams, routine head injury assessments and referral for care/mental health services required.

Conclusions and Recommendations

67.   Key conclusions of the Needs Assessment

67.1   The public health model of violence reduction has strong applicability in Lambeth: a borough with traditionally high levels of violence and victimisation. Application of the public health model and the available evidence base, suggests an accumulation of risk factors which lead to greater predisposition towards violence in Lambeth's communities.

67.2   Key risk factors in the Lambeth context include:

(a)   Issues around early childhood and families, particularly early adverse life experiences and quality of and support for parenting.

(b)   Issues around the influence of delinquent peer groups and social and cultural norms on the socialisation of boys and young men.

(c)   Issues around '*socio-health*' factors including the prevalence of poverty, deprivation, learning and other disabilities and poor mental health.

(d)   Issues around the sale and consumption of alcohol (and to a lesser extent, drugs) and a lack of 'resilience' in public places such as night time economies and transport hubs.

67.3   The aim of strategic commissioning needs to be to strengthen or 'inoculate' communities against violence by addressing these risk factors in order to improve the social 'resistance' or resilience to violence.

67.4   The crime and health data offer a mixed picture: while there has been a very significant reduction in violence in our communities over the last 15 years, levels of violence remain far higher than the national and London average. And this violence touches the lives of young people in particular – women are a majority of victims of violent assault between the ages of 11 and 35; boys and young men are disproportionately affected by serious violence, weapons and robbery between the ages of 11 and 30.

67.5   The gap analysis confirms there is extensive resourcing of interventions covering many of the key risk factors and efforts are being made in the current period of retrenchment to protect sensitive areas of funding (such as early years provision). The lifecourse approach to mitigating violence means that many different services are involved some of which are whole population (e.g. health services and schools) and others more targeted (e.g. at-risk youth) with the following gaps identified:

(a)   The coverage of existing effective interventions needs scaling up to address need - this includes parenting skills, conduct disorder, access to emotional wellbeing and mental health care, social and life skills programmes in schools and similar settings, and alcohol misuse identification, advice and care

(b)   Targeted prevention work with high-risk youth and gangs and those at the cusp including the identification of high-risk individuals not known to services

(c)   Ensuring that community and partnership work is used to its full extent like the Licensing Policy and strategic sharing of information to achieve mitigating actions

(d)   Addressing the under-reporting of victims in a variety of settings (e.g. primary care) and the lack of a perpetrator programme (DV)

67.6   There is a visible need for more outreach services for mental health and substance misuse with a strong concern for the negative impact that budget cuts have on the availability of services for vulnerable young people and adults. Further exploration of the potential for community and school based interventions for violence prevention is needed.

68.   Recommendations for future research and analysis

68.1   Depending on the availability of resources, we recommend that further quantitative and qualitative research be undertaken into the following areas:

(a)   *Survey of Residents* – the ability to replicate the CSEW analysis reported in para. 21, above would be invaluable in order to 'baseline' our knowledge of violence in Lambeth. Face to face interviews and self-completion surveys with about 5-600 residents should enable definitive answers about the true extent of violence victimisation, what kinds of violence, which communities and locations are most affected and at greater risk.

(b)   *Research into offenders' life-course* – currently we only have a basic understanding of offender characteristics; age, gender, race etc. – and very little understanding about the interplay of key risk factors across the life-course (i.e. as predicted in our public health model). A retrospective cohort analysis backed by further qualitative research could be very helpful here.

(c)   *Routine screening-* for undetected learning difficulties, unresolved behaviour issues as a result of a previous head injury, substance misuse, and mental health.

(d)   *Further work on the crime data* – particularly around the issue of 'is violence becoming more serious' ie. a shift toward assaults causing bodily harm. We also need to understand more about perception of violence and weapons use, particularly cultural norms that may 'normalise' the carrying and use of weapons.

(e)   *Further work to increase awareness of abusive relationships and exploitation:-* older people, LGBT, disabled adults and young people, faith leaders, adult mental health service users, carers.

(f)   *Further work on health data* – the prevalence and role of alcohol in violence is not well enough understood and further research around this issue should be a priority. There is not enough information known on adult mental health needs.

(g)   *Research project on Robbery* – this phenomenon (why so high in Lambeth?) is not well understood and the evidence base is very patchy. We need to go beyond traditional problem profiling of the issue (victim/offender/location/time) to understand the motivations of young people and peer groups and how this type of violence may have become embedded in the cultural and social norms and whether there is a problem of particular vulnerable locations in the borough.

(h)   *Community assets and resources* – we have sought to map patterns of public service provision and activity in this Needs Assessment. A parallel mapping exercise needs to be undertaken for those resources that exist in Lambeth's community, voluntary and third sectors. This will be particularly important to inform future coproduction and cooperative working in support of violence prevention.

69. Recommendations for cooperative commissioning and future interventions

69.1 The evidence-base described in this Needs Assessment leads us to propose **four priority themes** as the focus for future cooperative commissioning of services and interventions to prevent and reduce violence in Lambeth. Following the public health model, we distinguish between *acute* interventions (ie. those required in reaction to urgent and/or emergency experiences of violence) and *primary*[106] interventions (ie. longer term proactive and preventative measures to address underlying causes). The themes build-on existing and current provision and aim to cover gaps and priority risks identified by the evidence.

THEME 1: Family Support and Interventions in Early Childhood

69.2 **Aim:**
To address key risks around the early years of the life course, particularly early adverse life experiences, families and parenting, behavioural issues, brain injury and mental health.

69.3 *Primary interventions* around life course issues from pregnancy through to eight years, aligned with interventions and methodology of the CYP Prevention and Early Intervention Strategy (includes the LEAP initiative).

   (a) Develop role of 'antenatal and parent champions' for vulnerable first time parents and young fathers

   (b) Evaluate support around positive behaviour management for parents/carers.

   (c) Develop PSHE curriculum support in schools to increase confidence and self-esteem, incorporate anti-bullying, healthy relationships and accident prevention (head injuries)

   (d) Increase the coverage of parenting support interventions across the borough for children with conduct disorder and the management of behavioural problems associated with neurodisability.

69.4 *Acute interventions* around Troubled Families, family intervention, Multi-Agency Teams etc.

   (a) Improve early identification of children and young people with speech and language issues through children centres, schools, health services and YOS.

   (b) Increase early intervention IAPT to address conduct disorder and ASB for older age children (11yrs+) not eligible for MST.

   (c) Extend reach of health advocacy and victim support for robbery, gang reduction and bullying in schools, IDVA in hospitals and youth projects.

   (d) Increase level of mental health outreach work within communities to support those affected by serious violence

   (e) Increase availability of evaluated family based interventions e.g. for a child or young person with substance misuse, learning difficulties, problem behaviours.

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[106] Defined in health terms as, "…*essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination.*" (WHO & UNICEF, 1978)

THEME 2: Violence Against Women and Girls

69.5 **Aim**:
      To address key risks around victimisation of young women and girls; violence within intimate relationships and domestic settings; sexual violence in domestic and public settings.

69.6 *Primary interventions* around role of gender, cultural and social norms; use of alcohol and drugs; wellbeing and mental health including social and lifeskills.

   (a)   Extend reach of VAWG communication strategy to young men to reduce sexual exploitation of female gang members and intimate partner violence

   (b)   Improve reporting of FGM across health, education and police services.

   (c)   Promote self referral to IAPT for victims of violence, robbery, assault.

   (d)   Diversionary activities for young girls on the cusp of gang involvement

69.7 *Acute interventions* around multi-agency identification, risk assessment and support for victims (MARAC, Gaia, IDVAs.) Services to support women and children and improve safety in domestic spaces. Improved reporting, detection and prosecution of offences (criminal justice).

THEME 3: Violence Involving Young Men and Boys

69.8 **Aim**:
      To address the prevalent involvement of young men and boys, as victims and offenders, in all forms of violence in Lambeth.

69.9 *Primary interventions* around peer groups, cultural and social norms, use of alcohol and drugs, personality disorder/mental health and PTSD.

   (a)   Devise a social marketing campaign with GAGV to promote attitudes and behaviours which prevent bullying and deter gang involvement in primary schools.

   (b)   Widen range of screening and follow up for head injury to include children and young men aged 13-21yrs presenting at A&E.

   (c)   Diversionary youth activities for young boys on the cusp of gang involvement

69.10 *Acute interventions* around gang violence reduction and intervention; targeted interventions for prolific robbers and repeat DV offenders. Interventions around carrying and use of weapons.

   (a)   Improve reporting and arrest rate for homicide, sexual violence offences, robbery.

   (b)   Develop a programme for perpetrators of intimate partner violence in association with MARAC, MASE, MAPPA and YOS integrated risk management panel.

THEME 4: Resilience of Public Environments

69.11 **Aim**:

To address key risks associated with stranger-based violence in public environments and risks that lead to declining feelings of public safety and wellbeing about the public places of the borough.

69.12 _Primary interventions_ around design/redesign of public space; resilience of transport hubs; development of licensee forums and effective self-regulation in night time economies; saturation and early morning restrictions on alcohol sales and proactive licensing activity. Review of other public premises: fast food, betting shops, payday loans etc.

(a) Develop business investment opportunities with NTE for NEET to help reduce social exclusion on estates.

(b) Health impact assessments of neighbourhood regeneration, NTE, town centre improvements (Purple Flag) could reveal further information on effective use of current powers to provide safer and more secure environments in deprived areas

(c) Involve community health and design out crime officers as key partners of Safer Lambeth to help identify measures and indicators for violence prevention and review strategies e.g. designing out crime, housing tenancy policy, licensing and planning.

69.13 _Acute interventions_ around regulatory effectiveness of public space and management of licensed premises. Identification and closure of 'problem' premises. Anti-robbery initiatives at transport hubs.

(a) Monitor alerts on hot spot areas for robbery, street violence and alcohol related crime throughout the year.

(b) Extend measures for controlled drinking zones to include open spaces in residential areas in and around transport hubs.

(c) Offer staff training for health and social care to increase identification and reporting of alcohol related offences to police and health care workers.

(d) Arrange 'Call in' events for ex- gang offenders across the borough

(e) Ensure enforcement of businesses which repeatedly fail to adequately use measures to prevent underage drinking and deter drug use within and outside premises.

The need for systems change

69.14 A key finding of this work is that there is need to strengthen the public health approach to violence prevention and reduction through the many services involved and how they interact between themselves and the public. In particular, we recommend further work that includes:

(a) Develop social marketing campaigns as part of an overall strategy to build community resilience and challenge cultural norms. This could be informed by the successful work by VAWG and expand to include victims and perpetrators

(b) Proactively look for hidden violence in particular in under-represented groups such as LGBT, young people, the elderly and the disabled. This would involve working with, for instance, safeguarding leads, YOS and health professionals across different settings.

(c)   Earlier recognition and treatment reduces likelihood of interpersonal violence in later years. Improve screening and referral for severe head injury in YOS, IOM and probation, type of injury and date of occurrence and treatment. The community and voluntary sector is crucial here and includes Hidden Voices, Victim Support

(d)   Improve the evaluation of early intervention services for impact on violence to inform future work

(e)   Strengthen surveillance and intelligence by improving violence data collection and tracking violence related work across Safer Lambeth Partnership network so as to inform effective mitigation/enforcement action. This could also include developing referral processes.