

Middlesex University

# Evaluation of Oasis Youth Support violence intervention at St. Thomas' hospital in London, UK.

## FINAL REPORT 2010-2016

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## 0. EXECUTIVE SUMMARY

### INTRODUCTION

This is the final report of the Oasis Youth Support (OYS) service evaluation at St. Thomas' Hospital. The service is an intervention for young people (ages 12-20) who have experienced violence and attended the Emergency Department (ED) at St Thomas' Hospital in London. The service was initially launched in 2010, funded by Guys & St. Thomas' charity as a 3 year pilot and since then has received funding for a further 3 years. The evaluation of the original term demonstrated good service implementation, and high positive impact on service users' psychological and lifestyle risk factors. This report summarises the work done over the life of the evaluation, using mixed methods to collect baseline and follow up data from young people (YP) attending, staff, and other stakeholders with further emphasis on gaining longer term follow up data. This report is delivered by the evaluation team, based at the Centre for Abuse and Trauma Studies, Middlesex University.

The report describes the development, and implementation of the intervention including changes and progress in methods and outcomes. The report includes an analysis of quantitative and qualitative outcomes for service users, including a long-term assessment of a subsample of cases. Data is presented on the last 3 years of the intervention (since the start of Term 2) and from the life course of the intervention over 6 years.

### REFERRAL AND ENGAGEMENT

One thousand and sixty young people came to the attention of the service from August 2010 to July 2016. All young people had attended the ED due to injury from violence, whether inflicted by self or other. Of the total, 79% of young people attending were eligible for the service, with approximately a third engaging. Over half of the referrals were as a result of assault (55%), with approximately a fifth (20%) as a result of self-inflicted injury due to poor emotional regulation. Most viewed themselves as victims only (48%) but a significant proportion considered themselves both victims & perpetrators (20%). There were 215 incidents listed as having involved the use of weapons, with over 140 incidents citing the use of knives or sharp objects.

Referral methods changed over the duration of the intervention with the second term seeing increasing numbers of referrals directly by clinicians encountering the young people at their index attendance for their injury (50%), some however were referred by the multidisciplinary psychosocial meeting (20%) or referred through other routes including the ED assault report (9%).

Sixty percent of those who engaged completed the intervention (18% of the total cohort). Rates of engagement were higher in the second term of operation (52% vs 32% of those eligible). There was also a higher rate of intervention completion in the second term at a rate of 27% of eligible cases (up from 21% at the first term).

### DEMOGRAPHIC AND ATTENDANCE CHARACTERISTICS

The majority of participants were male (74%) and the average age was 15.3. There were overall slightly more from Southwark (42%) than Lambeth (34%). The demographic profile of the YP

matched the areas of London they came from with high ethnic diversity and high rates of single parent households. There were high levels of statutory service engagement, either present or in the past and in particular high levels of contact with Social Services (42%). The most common attendance characteristics included: ED attendance in the afternoon 16:00-20:00; most common days were Tuesdays and Fridays, with March, May and June being the most common months of presenting at the ED. In 15% of cases there was a record of at least one prior attendance at St. Thomas' hospital due to violence (n=153).

## INTERVENTION

Length and intensity of the intervention was dependent upon initial risk categorisation of the young person by the youth worker based on issues such as repeated attendance at ED for involvement in violence; use of weapon; gang membership; being in a high crime area; being bullied; family with psychiatric disorder or criminality etc. Overall there were 41% rated as high risk, 37% moderate risk and 22% rated as low risk. The second term saw an increase in the number of high risk cases (48%) compared with the first term (39%) and a reduction in the number of medium risk cases (28% vs 51%). The number of one-to-one sessions with a youth worker was allocated based on risk categorisation. The allocation was increased by the second term of the project: high risk allocated 12-20 sessions, medium risk - 6-12 and low risk 0-3. There were a total of almost 650 face to face sessions (f2f) recorded over a 3 year duration in term 2 – the average duration was 20 weeks (approximately 5 months). High risk cases received a range of 1-35 (average 9) f2f sessions over a duration of 1-22 months within an average of 26 weeks (6.5 months). Medium risk cases received 1-18 (average 8) f2f sessions between 1-14 months with an average of 18 weeks (or 4.5 months). Low risk cases received 1-10 f2f sessions (with an average of 5) for over an average duration of 12 weeks (or 3 months) with a range of 1-9.5 months.

## ASSESSMENT

Upon joining the intervention the YP were assessed with lifestyle and symptom questionnaires. Personal characteristics and details of the violent incident leading to ED attendance were collected on all YP undertaking the intervention. Analysis looked at rates both for the total number of YP through the life of the intervention and for the subset from the latest phase. Findings for total sample show that the YP had high levels of psychological disorder (56% with at least one disorder and 42% with two or more disorders simultaneously) with conduct and hyperactive being the most prevalent. There were multiple lifestyle risks at baseline and significant correlations with psychopathology. Following intervention there was a significant reduction in both lifestyle risk and psychological disorder across multiple dimensions. A small sample of cases were available for follow up one year or more following intervention closure, and these suggested that the effects of the intervention were maintained long term.

## IMPACT AND OUTCOME

Exit questionnaires and interviews carried out with a subsample of YP after a minimum of one year further corroborated the positive effects of the intervention in the long term. YP endorsed the service and the impact it had had on various aspects of their life. Overall YP cited the relationship, as

well as the guidance offered through it, as the catalyst to change. An audit of second term of the service showed that overall there were few incidents of re-attendances at St.Thomas' (28 cases out of a total of 170 or 17%), there was a significantly smaller number of re-attendances amongst those cases who had prior attendances and received the intervention (19% vs 35%) but where there weren't prior attendances recorded, the difference were marginal. However the numbers for this analysis were very limited and thus the conclusions are tentative.

A follow up staff survey exhibited increased awareness and usage of the service; high satisfaction rates were seen to increase. Interviews with stakeholders maintained strong support for the service and a desire to expand it to more vulnerable YP.

A review of intervention methods and content showed that intervention goals being set at the outset were largely achieved by the end of the intervention (60%). Goals were primarily selected around educational targets (73%), health including anger management (55%) and social/community engagement (37%). Analysis of case contents showed key dimensions within which the work with YP was being done, including: relationships, crime, emotions, future aspirations, external activities and self-reflection.

## DISCUSSION

Overall the intervention has made many gains, both in terms of impact on its recipients and in terms of embedding itself within the hospital infrastructure and gaining permanence. The current methods of operation are evidencing greater efficacy in terms of achieving engagement, intervention completion, and research questionnaire attainment. The impact on recipient's lifestyle and psychological risk is apparent, with an indication that in a sub sample the effect is sustained over time. The service saw positive outcomes in terms of the implementation and impact on young people's lives. Analysis of service recipients over the longer term provided further evidence for the positive effect of the lasting positive impact in averting harm by violence in the local community through its hospital based violence intervention team.

The evaluation was effective in charting the positive impact and implementation, but also fed into improving assessments and procedures in the service delivery over the six year period. Its strength lay in its use of combined quantitative and qualitative method approaches, its broad scope and the longer term of follow-up possible. Limitations included relatively small numbers completing the intervention and the assessments at both time points even though these were sufficient for to show significant findings. Another limitation is the lack of a control group, but this was impossible within the service design (e.g. no waiting list). Also there was limited information on the reason for YP not engaging with the service as well as on repeat attendances which was not routinely collected by the service. Future evaluations could also cover the cost benefit of the service. In terms of the intervention, a limitation is the lack of standardisation in the service delivered, with its tailored nature meaning each young person had a different variant of the intervention in terms of the element delivered or its frequency and duration. A method to chart these elements would increase understanding of the mechanisms for bringing about change and enable replicability, comparison and continuity.

The discontinuation of the independent evaluation presents a further challenge in terms of maintaining the evidence base. Options on performing this by the service 'in-house' should be discussed.

## RECOMMENDATIONS

The overall recommendations include continuing to embed and extend the Oasis Youth Support service with efforts to create more sustained funding. Whilst creating partnership networks has been successful solidifying these and creating common goals, particularly with the neighbouring programme Redthread would be of benefit with linked evaluation outputs. Also the position of the OYS project in the allied projects nationally is important for its visibility and sustainability as one of the first hospital based violence interventions and the one with the longest term of evaluation to date.

If no external evaluation of the service is provided it is recommended that a strategy is needed to collect relevant data on an ongoing basis by the service itself. The OYS should consider in particular greater links with Redthread the neighbouring youth violence services for consistency and comparison:

- Greater cross-comparison of outcome measures with other services, particularly Redthread. Similar risk assessments should be adopted. Ensure that all staff are trained to interpret and integrate outcomes into service plan.
- Develop links and data sharing pathways to examine re-attendance rates with comparable and/or neighbouring hospitals, especially King's hospital where RedThread is based.

In terms of service implementation:

- Consider whether it is possible to administer the risk assessment to all YP who present to the ED, even those who do not take up the intervention, as this could potentially inform the working practices of violence prevention teams.
- Ensure that YWs presence onsite is matched with the pattern of typical attendance by YP, in terms of time and days. To ensure uniformity in methods and ultimately replicability, there is a need to develop the staff manual to include the identification of which methods are specifically used to address risk factors. Consider reporting to clinicians with feedback on individual cases they have referred.

In terms of wider impact it is recommended:

- The aims and objectives of the intervention are updated going forward, to ensure that these are guiding all activity undertaken.
- Identify additional key personnel to join the steering group, in line with revised aims of the service.
- Consider validation by Project Oracle at level 3 and how this can be achieved for greater visibility and credibility. An external evaluator will probably be required for achieving this goal.

- Apply with related services for funding for a UK-wide network, with the aim of coordinating the activities undertaken by the various HBVIs and supporting new emerging programmes, taking a lead from US-based colleagues in the NNHVIP.

## DISSEMINATION

The OYS service and its evaluation has been widely disseminated:

- Two peer-reviewed journal articles have been published:
  - Ilan-Clarke, Y Bunn, A, DeMarco, J, Bifulco, A, Criddle, J & Holdsworth, G (2013) Setting-up a Youth Violence Prevention Project in a London hospital Emergency Department. *Journal of public mental health*, 12 (2), pp 80-92.
  - DeMarco, J, Ilan-Clarke, Y., Bunn, A., Isaacs, T., Criddle, J., Holdsworth, G. & Bifulco, A. (2016) Improving mental health and lifestyle outcomes in a hospital Emergency Department based Youth Violence Intervention. *Journal of Public Mental Health*, 15 (3), pp. 119-133.
- Twelve reports have been compiled charting the evaluation of the intervention over 6 years 2010-2016, including focus group, staff surveys, interviews with YP, YP's outcomes, and general assessment of intervention organisational application.
- Presentations at academic and professional conferences:
  - Stockholm Criminology Symposium [2013]
  - The Howard League [2014].
  - Poster presentation at King's Health Partnership Event [2011]
  - At Evelina Grand Round [2011].
  - Presentation at a number of local interest group events including within academic settings.
- First HBVI Network event, 'Healing the Wounds of Violence' seminar day organised and funded by Middlesex University (2015).
- Contributions to press releases and funding applications by Oasis UK.
- Supporting the validation for Project Oracle at level 2 including the Theory of Change.

The University team has valued its involvement in the Oasis YV project and in showing ways in which the service has aided young people in London.

## 1. INTRODUCTION

### 1.1 BACKGROUND

The Centre for Abuse and Trauma Studies (CATS) at Middlesex University was appointed by Southwark & Lambeth Public Health team to undertake an evaluation of the Oasis Youth Support (OYS) project at St. Thomas' hospital. The original pilot phase of the project was launched in 2010 for 3 years and reported elsewhere<sup>1</sup>. The second term ran from 2013-2016. This report summarises the entire duration of the evaluation over six years (2010-2016), with particular emphasis on the work done in the second term (Figure 1).

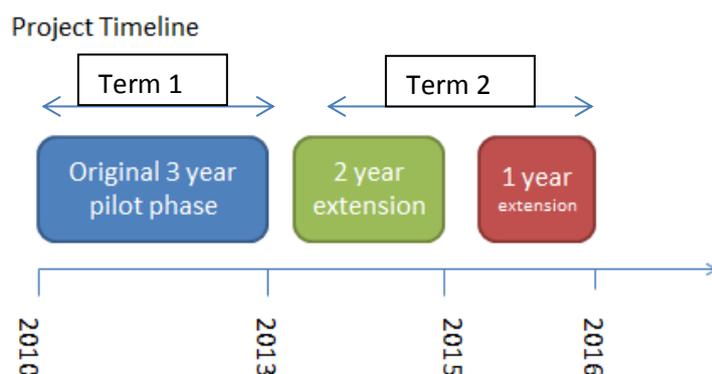


FIGURE 1: PROJECT TIMELINE

The service was originally funded by Guys & St. Thomas' charity (GSTT) as a pilot and constituted a collaboration between a hospital Emergency Department (ED), Guy's and St. Thomas' NHS Foundation Trust and public health teams of two boroughs in London, the Southwark and Lambeth Public Health Teams. A voluntary sector charity (Oasis UK) is delivering the intervention ([www.oasisuk.org](http://www.oasisuk.org)). Its aim is to deliver a public health approach to violence to young people attending emergency care. Funding for the continuation of the service since 2013 has been through various sources including Southwark Youth Offending Team, the London Met Police, MOPAC, Lambeth & Southwark Clinical Commissioning Group (Appendix 1).

The service set out to develop the capacity of the Accident and Emergency Department at St. Thomas' hospital to contribute to reducing harm to young people from violence. This is achieved through the provision of a youth work function within the hospital to support and refer young people accessing Emergency Department (ED) care. On the basis of highest needs, care pathways are determined and following a tailored youth work intervention, referrals made to existing community services. Two adjacent boroughs which St. Thomas' predominantly serves as a local hospital, were included as recipients of the service: Southwark and Lambeth.

<sup>1</sup> Ilan-Clarke, Y, De Marco, J, Bunn, A. & Bifulco (2013) Evaluation of Guy's & St. Thomas' violence intervention project: Final report. Middlesex University. The executive summary can be accessed here [http://cats-rp.org.uk/pdf%20files/Exec\\_summary\\_GST\\_final\\_report.pdf](http://cats-rp.org.uk/pdf%20files/Exec_summary_GST_final_report.pdf).

This report summarises the findings for 6 years of the service and includes details of referrals, service-uptake, service provision, wider impact and development over the extension of the service 2013-2016. In addition, the results of the research over the lifetime of the service are presented. Limitations of the service and evaluation as well as prospects for future sustainability and productivity are outlined.

## 1.2 STRUCTURE OF THIS REPORT

The report is planned in nine sections which deal with different aspects of the investigation.

Section 0: provided a brief description of the Youth Violence Intervention Programme being evaluated, the policy context and background.

Section 1 will report developments in the service and in changes occurring in relation to the service.

Section 2 will outline the evaluation design, including a description of the measures and updates.

Section 3 will examine the findings from this term and those relating to the entire intervention duration. This will include:

- An outline of referrals including uptake, attrition, and completion
- The characteristics of young people attending including a breakdown of demographic profile, reasons for attending the ED and their risk levels.
- The analysis of change in terms of psychosocial risk factors, including long term findings.

Section 4 attempts to capture some of the experience and content of the intervention through the exit questionnaire and outcomes of assessment of YWs practice.

Section 5 presents the findings from qualitative interviews with the YP carried out as part of the long term follow up, approximately 1 year or more following completion of the intervention.

Section 6 collates the follow up survey of front line staff and continues with an analysis of views of key stakeholders.

Section 7 Includes a review of intervention content, including intervention goals set and achieved and the activities undertaken with a sample of cases. In addition there is a description of the changes the intervention has undergone in the past 6 years.

Section 8 will conclude the report with a discussion of the key findings and future direction of the project and evaluation.

## 1.3 RATIONALE AND RELATED POLICY

### THE PUBLIC HEALTH APPROACH TO VIOLENCE

The rationale for hospital-based violence interventions (HBVIs) is anchored in a public health approach to violence. This approach calls for the primary prevention of violence by reducing risk factors associated with violence and enhancing protective factors<sup>2</sup>. This calls for four stages of action: 1) Define the problem 2) Identify the risk and protective factors 3) Develop and test prevention strategies and finally 4) Ensure widespread adoption and application of evidence based interventions.

The Public Health approach conceptualises violence as a disease, taking into account the risk and protective factors present throughout the life course. These can be grouped into different spheres of the human experience which include: individual, relationship, community and societal levels (Op Cit) (Figure 2).

### SOCIAL ECOLOGICAL MODEL



Figure 2: Example of a socio ecological model to violence based on the public health approach<sup>3</sup>

The use of novel settings (such as EDs) to address risk factors and the importance of providing recipients of violence with support are key elements which underpin HBVIs. Furthermore, emphasis is placed on testing and accumulating an evidence base, as such the centrality of evaluation is highlighted<sup>4</sup>.

2 Dahlberg LL, Krug EG. Violence-a global public health problem. In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World Report on Violence and Health. Geneva, Switzerland: World Health Organization; 2002:1–56.

3 Arizona Coalition to end sexual & domestic violence (2016). Page viewed on: <http://www.acesdv.org/about-sexual-domestic-violence/prevention/> (20/7/16)

4 Butchart, A., Phinney, A., Check, P., & Villaveces, A. (2004). Preventing violence: A guide to implementing the recommendations of the World Report on Violence and Health. World Health Organisation.

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## YOUNG PEOPLE AND VIOLENCE

Overall violence in England & Wales has been decreasing since the mid-nineties; however there is still a large volume of violent incidents occurring, with approximately 2 of every 100 people in the population becoming a victim of violent crime over the last year<sup>5</sup>. In England and Wales it is estimated that children between the ages of 10-15 experienced 398,000 cases of violent crime over the year 2014-2015 (Op Cit).

Recent NHS ED assault data shows that in England alone for the 12 months ending April 2015, there were 28,992 hospital admissions for assault; a reduction of 8% compared with figures for the preceding 12 months (Op Cit). Young people between the ages of 15-29 were the highest represented category amongst those who were admitted to hospitals for assault, accounting for 48% of the all cases<sup>6</sup>, at approximately 14,000<sup>7</sup>. The highest rate of hospital admissions and ED attendances were seen in young males from deprived communities<sup>8</sup>; the rates of these can be up to five times higher in the most deprived communities in comparison to the most affluent<sup>9</sup>.

It is therefore evident that young people are at a greater risk of involvement with violence whether as an offender or victim. Victims of violence are also significantly more likely to seek treatment following recurrent violent encounters<sup>10,11</sup>. Youth violence, whether it occurs directly to oneself or experienced vicariously, is related to psychological distress and subsequent offending<sup>12</sup>.

Overpopulated cities, such as London tend to experience the large majority of violence. In the last 10 years (between 2005 and 2015) 185 adolescents were murdered on the streets of London, with almost 20% of these murders occurring in the boroughs of Southwark and Lambeth in South London<sup>13</sup>.

Both Lambeth and Southwark have higher than average levels of crime and violence in London and the UK. In-depth assessments of violence in both boroughs has sought to identify the dominant

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5 Office for National Statistics (2016) Crime Survey for England and Wales: Year Ending December 2015. Statistical Bulletin prepared from data available in Crime Survey of England and Wales.

6 Health & Social care information centre (2015) Provisional monthly topic of interest: assaults. HSCIC.

7 Baker, C. (2015) Accident and Emergency Statistics, 2014-2015. Briefing paper 6964, House of Commons Library.

8 Bellis, M.A., Hughes, K., Wood, S., Wyke, S. and Perkins, C. (2011), National five-year examination of inequalities and trends in emergency hospital admission for violence across England, *Injury Prevention*, vol. 17, No. 5, pp 319-25.

9 Department of Health (2012) *Protecting People; Promoting Health: A public health approach to violence prevention for England*.

10 Borowsky, I. W., & Ireland, M. (2004). Predictors of future fight-related injury among adolescents. *Pediatrics*, 113(3), 530-536.

11 Cunningham, R. M., Carter, P. M., Ranney, M., Zimmerman, M. A., Blow, F. C., Booth, B. M., Goldstick, J. & Walton, M. A. (2015). Violent re-injury and mortality among youth seeking emergency department care for assault-related injury: A 2-year prospective cohort study. *JAMA Pediatrics*, 169(1), 63-70.

12 Hartinger-Saunders, R. M., Rittner, B., Wiczorek, W., Nochajski, T., Rine, C. M., & Welte, J. (2011). Victimization, psychological distress and subsequent offending among youth. *Children and youth services review*, 33(11), 2375-2385.

13 Citizens Report. (2015). Mapping the Location and Victim Profile of Teenage Murders in London from 2005 to 2015. Retrieved from <http://www.citizensreportuk.org/reports/teenage-murderlondon.html>.

causes and gaps in provision to tackle violent crime (Lambeth's Serious Violence Needs Assessment, 2015<sup>14</sup>; Southwark Violent Crime Strategy 2010 to 2015<sup>15</sup>).

In Lambeth, an examination of crimes occurring under the umbrella term of Violence Against the Person (VAP) (including: harassment, common assault, assault with injury, wounding/grievous bodily harm and murder/homicide) which represented approximately 70% of violent crime in 2012/12, showed that VAP predominantly involved young people in the borough: Ages 16-25 (males) featured heavily in crimes involving serious wounding and knife crime and ages 16-20 in those involved in *gang violence* (*Lambeth Serious Violence: Needs Assessment*<sup>14</sup>, Page 24). Overall, it is found that being a single male, aged 16-24 is a key characteristic of becoming a victim of violence<sup>16</sup>.

In Southwark, a similar pattern emerged, with 41% of victims of knife crime aged 19 and under (30% under 17). 48% of gang related offending involved a victim aged 19 and under (39% for less than 17). In terms low level violence, there was a higher proportion of male victims in the age range 25-29, however females were over represented in the younger age category of 15-19 (*Southwark Violent Crime Strategy*<sup>15</sup>, page 31).

Recommendations in the Lambeth identify the need to increase effective interventions in the borough including those focusing on conduct disorder, emotional well-being and mental health care, social and life skills and alcohol misuse. There is also a recommendation to increase targeted prevention work with young people defined as high risk, and those who are on the cusp of becoming involved in gangs and serious violence, including the identification of YP not known to services. Southwark have also issued a number of recommendations in line with this, including ensuring that YP at risk of involvement with serious violent crime are offered early intervention and exit programs which facilitate breaking away from serious violence lifestyles.

The UK more generally has set out a strategy to tackle violent crime, which includes violent indicators as part of the National Public Health Outcomes Framework in the United Kingdom<sup>17,18</sup>. These are working to standardise the monitoring of violent incidents which come to the attention of hospital EDs and increase data sharing amongst agencies.

In addition, further emphasis is being put on providing greater support and ameliorating the problems occurring in marginalised and excluded youth populations to address the issues of youth violence and antisocial behaviour occurrences<sup>19, 20, 21</sup>. Methods of achieving change, and affecting

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14 Serious violence in Lambeth: Needs assessment (2015) Lambeth Community Safety,

15 Southwark violent crime strategy: 2010-2015 (2015) Safer Southwark Partnership.

16 Office for National Statistics (2013) Crime Survey for England and Wales : Focus on Violent Crime and Sexual Offences.

17 Bellis, M. A., Hughes, K., Perkins, C. and Bennett, A. (2012). Protecting People, Promoting Health: A Public Health Approach to Violence Prevention in England. Department of Health/Centre for Public Health, Liverpool John Moores University, Liverpool, UK

18 Department of Health (2013). A Public Health Outcomes Framework for England, 2013-2016. Report prepared by the Department of Health as part of Improving Outcomes and Supporting Transparency.

19 Working with Troubled Families: A Guide to the Evidence and Good Practice. (2012). Guide prepared by Department for Communities and Local Government in informing local authorities models of best practice, December 2012.

outcomes for UK youth violence, are notably varied, however skill and family based interventions are considered to have a robust effect on youth violence engagement whilst community-based methods of intervention have demonstrated promising results, with further evidence needed to substantiate this<sup>22</sup>.

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## HOSPITAL-BASED VIOLENCE INTERVENTIONS

As part of the larger drive to identify vulnerable youth and those already caught up within the cycle of violence, the UK government has set out recommendations to include youth workers (YWs) and 'specialist support' in hospital EDs<sup>23,24</sup> with the aim of intervening at the 'teachable moment'. Other bodies, such as the Centre for Social Justice, a UK think tank together with XLP, an urban charity working with London gangs<sup>25</sup>, made sweeping recommendations for EDs around the UK to include youth workers to ensure that vulnerable young people coming to the attention of EDs were offered the necessary support to address the issues affecting them as a result of their vulnerability, exploitation and involvement with gangs<sup>26</sup>.

The unique advantage of the ED as a location for service referral originates in a number of factors: Firstly, the numbers of YP presenting with injuries to the ED are high, and yet only a minority of these assaults are reported to police or other services<sup>27</sup>. Secondly, adolescents injured in the context of youth violence are more likely to experience further violence, related injury and involvement in criminal violence and therefore to come to the attention of the EDs repeatedly<sup>28</sup>. Thirdly, there is evidence to show that being a victim of violence during adolescent years significantly increases the chances of being either a victim or perpetrator of violence as an adult therefore trying to change the trajectory at that point offers obvious long term benefits<sup>29</sup>. Finally, the theory of the 'teachable moment' suggests that there are points of vulnerability which increase following traumatic incidents, which facilitate the possibility of encouraging lifestyle changes<sup>30</sup>. For these reasons the ED represents an optimal point of identifying young people (YP) at risk, to alter their risk trajectory for future victimisation.

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20 MHP Health (2013). Violence Prevention, Health Promotion: A Public Health Approach to Tackling Youth Violence. Report prepared through Catch-22 and the Dawes Unit on research conducted in London, October 2013.

21 Home Office (2015). Ending Gang and Youth Violence: Annual Report 2014/2015. London, UK: Home Office.

22 O'Connor, R.M. & Waddell (2015). What works to prevent gang involvement, youth violence & crime? A Rapid Review of Interventions Delivered in the UK and Abroad. Early Intervention Foundation: London, UK.

23 Antrobus, S. (2009). Dying to belong: an in-depth review of street gangs in Britain. Policy Report Produced by the Centre for Social Justice: London, UK.

24 Home Office (2014). Ending Gang and Youth Violence: Community Engagement. London, UK: Home Office.

25 Centre for Social Justice (March 2014) Girls and Gangs. XLP

26 It is of note that both projects existing at the time, Redthread and Oasis Youth Support were cited as leading the way in putting into practice such violence intervention.

27 Shepherd, J. (2007). Preventing Violence – Caring for Victims. Surgeon, 2 (2), 114-121.

28 Sege, R.D. & Hoffman, J.S. (2005) Training health professionals in youth violence prevention: overview of extant efforts. American Journal of Preventative Medicine, 29, 5(2).

29 Menard, S (2002) Youth Violence Research. Juvenile Justice Bulletin, Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

30 Cheng, T.L et al (2007). Characterizing the Teachable Moment: Is an emergency department visit a teachable moment for intervention among Assault Injured Youth and their Parents? Paediatric Emergency Care 23, 553-559.

A network of hospital based violence interventions (HBVIs) was formed in the United States in 2009<sup>31</sup>. Since then, the network has centralised research from its members, and overall it has demonstrated support for the cost effectiveness, utility and overall efficacy of such interventions<sup>32</sup>. An analysis of four Randomised Controlled Trials and two quasi-experimental studies all demonstrated a degree of effectiveness; whether this was a reduction in re-attendance due to violent injury or improvements in psychological problems and lifestyle risk was not immediately evident, however support for the interventions standardisation, evaluation and expansion were recommended<sup>33</sup>.

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## THE UK PICTURE: HOSPITAL-BASED VIOLENCE INTERVENTIONS

When the OYS service was first launched in 2010 there was one existing service of its kind in the UK, Redthread youth violence service at King's hospital. Since then a further four services have launched in and around the capital, including three at London Major Trauma Centres (MTCs) of St. Mary's, St. George's and Royal London, with the services delivered by Redthread, and a further service at North Middlesex hospital delivered by Oasis UK. An additional service has been launched in Glasgow and another is planned in Nottingham.

The Mayor's Office for Policing and Crime (MOPAC) has invested over £900,000 to fund or part fund the MTCs and also contributed to OYS in 2016/7. It is unclear whether the funding will continue.

However the fact that there has been substantial investment does indicate recognition of the HBVIs added value to addressing the causes of youth violence. Shortly before his departure, the London Mayor Boris Johnson said: "Knife crime in London is at its lowest in seven years, but every young Londoner hospitalised by gangs and violence is one too many, and a problem we take extremely seriously... These specialist workers, at the emergency frontline, are helping to break the cycle of reoffending, offer young people the support they need to seek a way out of violent lifestyles and making London safer for everyone<sup>34</sup>"

Research regarding such interventions in the UK is currently accruing. There are a number of independent evaluations ongoing in the UK in addition to the one reported here, including one by MOPAC and another by independent evaluators of the HBVI in St. Mary's<sup>35</sup>. St. Mary's evaluation, after one year of operation (with a further two years underway) included a baseline assessment of the work of Redthread in St. Mary's within an outcomes framework set out by intervention stakeholders. Initial findings indicate that Redthread's work is having an impact on the functioning of the hospital staff in terms of managing cases admitted for violence, and the young people

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31 National Network of Hospital-Based Violence Intervention Programmes. <http://nnhvip.org/> [Accessed 1/6/2016].

32 Juillard, C., Smith, R., Anaya, N., Garcia, A., Kahn, J. G., & Dicker, R. A. (2015). Saving lives and saving money: Hospital-based violence intervention is cost-effective. *Journal of Trauma and Acute Care Surgery*, 78(2), 252-258.

33 Purtle, J., Corbin, T.J., Rich, L.J. & Rich, J.A. (2014) Hospitals as a locus for violence intervention. In P. D. Donnelly & C. L. Ward (Eds.), *Oxford Textbook of Violence Prevention: Epidemiology, Evidence, and Policy* (105-110). Oxford, OX: Oxford University Press.

34 Mayor of London (2016) Mayor Extends services for victims of gangs and domestic violence. Mayor Of London, London assembly [viewed on [www.london.gov.uk/press-releases](http://www.london.gov.uk/press-releases) 6th march, 2016]

35 NPC Associates (2016) St Mary's Hospital Youth Violence Intervention Programme: Year 1 Evaluation Report, January 2016.

themselves, in terms of changing attitudes and engagement with violence. The MOPAC report is due to follow later this year. The current evaluation has in the past found support for the work of OYS in impacting on YP's lifestyle risk factors and indicators of psychological disorder<sup>1</sup>.

A UK network of hospital-based violence interventions (HBVIs) was launched in 2015 at an event produced last year by Middlesex University ('Healing the Wounds Of Violence'). Although still in its infancy, the network has recently held its second annual gathering at an event produced by Red thread ('The Teachable Moment', July 2016). The vision for the forthcoming year is to create opportunities for shared working and learning and an annual event to bring all the HBVIs together.

In summary, utilising the unique vantage point of hospitals as a source for intervention referrals provides an opportunity to act in line with the premises of a public health approach:

1. HBVIs enable the identification of victims of violence who reach the attention of health professionals but who may not come to the attention of other services; there is evidence for under-reporting of violent incidents to the police.
2. HBVIs enable the immediate delivery of support to victims, regardless of their complicity in their injury; this ties in with the view that those involved in violence are victims.
3. HBVIs facilitate the possibility of intervention at the 'teachable moment'; to enable reflection on the causes of violence and encourage changes which reduce risks associated with violence and adoption of protective behaviours.
4. HBVIs offer holistic methods of treating victims of violence by extending their medical treatment to their psycho-social world by working to tackle some of the existing risk factors which led to their hospital attendance and engaging them in long term support networks in their communities and local services.
5. HBVIs lend themselves to empirical investigation in order to draw out evidence-based outcomes and build on them.

## 2. THE INTERVENTION

### 2.1 OASIS YOUTH SUPPORT (OYS) SERVICE

In 2010 a pilot youth violence intervention programme was launched with the aim of applying a public health approach to violence amongst YP. The intervention seeks to address causes of violence for which young people were presenting at St. Thomas' hospital. The intervention is delivered in the form of a youth work service based within the ED. The staffing of the service has consisted of one full time Youth Support Manager (who delivers both a managerial role and works directly with service recipients) and a part time student youth worker or volunteers taking up individual cases. There is an administrator who works 20 weekly hours and supports both the intervention and the evaluation (extended from 8 weekly hours in Aug 2016). Very recently (August 2016) a second full time youth worker has been successfully recruited.

Inclusion criteria for the intervention are:

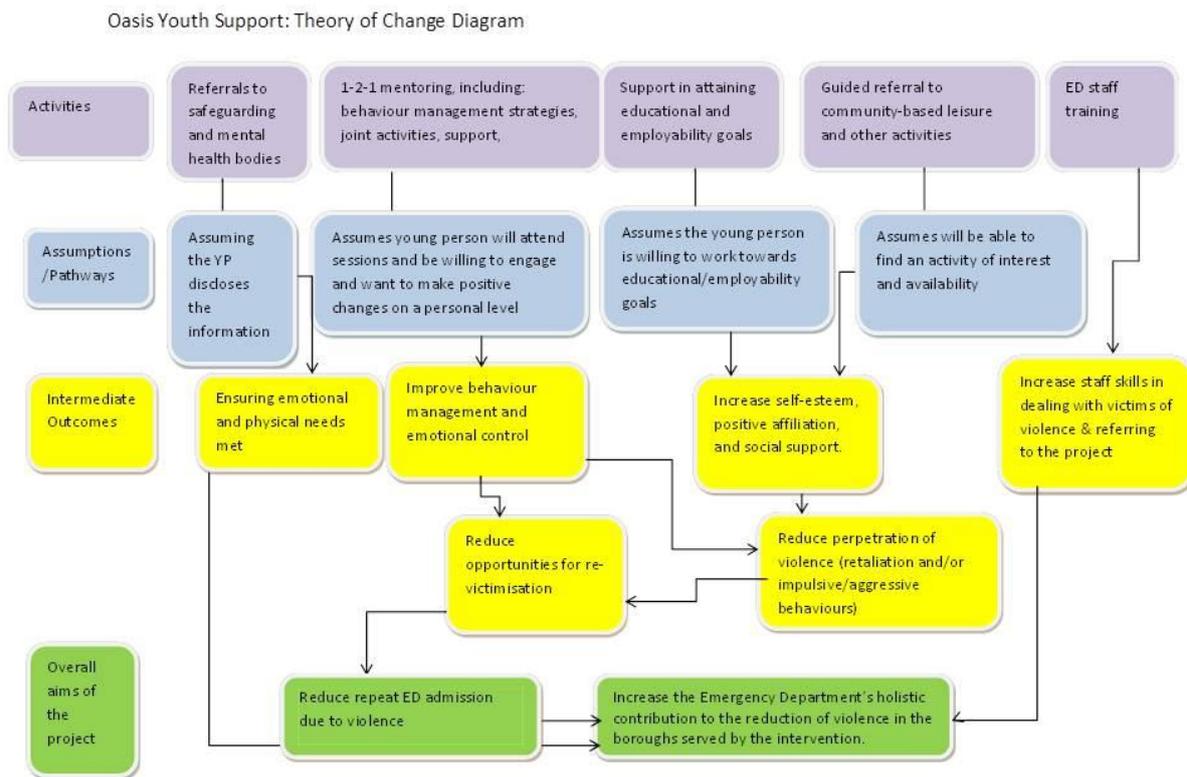
- To be aged 12-20 (extended from 12-18 in the first term)
- To be a resident in Southwark or Lambeth Boroughs
- To have attended the ED as a result of an injury caused by violence whether by peer or self.

Referral method is through direct referral by front line clinicians in the Paediatric and Adult EDs. Other referral routes include the Psychosocial meeting, a meeting of hospital professionals to discuss safeguarding cases, hand therapy unit and minor injury units. The clinicians will get the YP to sign a data sharing consent form so that they can complete the referral. Where possible the YW will meet with the YP when they are still in the ED; where this isn't possible, follow up will be carried out via telephone calls.

At the first face to face meeting, the youth worker administers a questionnaire and builds rapport with the YP. The assessment and meetings enable the completion of a risk assessment based on risk and protective factors. Risk factors included aspects such as repeat ED attendance for violence, criminality in the home, lack of school attendance etc. The degree of intervention offered is based on the level of risk assigned, with a range of one-to-one sessions offered as follows: High Risk YP receive 12-20 sessions; Medium Risk YP receive 6-12 and Low Risk YP receive 0-3 sessions. These ranges are offered as a guide, however the YW tailors the length of the service based on their experiences working with the YP.

For the majority of participants the intervention consists of mentoring, with emphasis on creating a trusting relationship, on building self-esteem, working on reducing salient emotions (fear, anger) and changing risk behaviours. Referrals are then made to their chosen activity including music, sports, arts, volunteering or work experience. Personal goals are determined at the outset with a view to attaining tangible achievements by the end of the intervention term. The intervention involves a multi-component and flexible approach tailored to each individual based on a youth work paradigm. Towards the end of the intervention the YP is offered guided referral to activities in the community, of their choice. This fulfils their need for continued support, creating a wider network of positive relationships and also aiding in building self-esteem through achievement and affiliation. The theory of change designed for the intervention can be seen here (Appendix 2).

An additional element of the service has been the piloting of a fortnightly group following the completion of YP's individual intervention. Basing this on a model practiced by US NNHVIP colleagues, OYS began piloting an evening meeting for YP who had exited the service but still wished to remain in contact. 'Next Level' offers an opportunity for service completers to retain contact with the YW, without the individual cost. Sessions revolve around personal and professional development. The Oasis theory of change is shown in the slide below, given as part of their presentation materials and the tools for engagement shown in the second figure:



## TOOLS for engagement WITH YOUNG PEOPLE



## 2.2 THE INTERVENTION - CONTENT ANALYSIS OF CASES

The youth work intervention provided by Oasis was largely tailored to individual needs. Subsequent analysis for the evaluation, of the diary sheets of ten cases in depth provides the range of assessments, mentoring, topics for discussion/direction; activities, future goal setting, reframing in terms of 'big picture' and some environmental changes made. The following lists help to capture the scope and content of the intervention.

### *Example of Questionnaires and Activities in sessions*

- Initial assessment including: WDYTQ and SDQ
- Intervention goals sheet
- Holds me back and Pushes Me Forward Card Activity
- Risk I Take Form
- Anger Breakdown Sheet
- What Keeps Me Calm Activity Sheet
- Assessing Risk Level
- Assessing Housing Situation
- Life Triggers and Anger Sheet (STOP THINK CHOOSE)
- Aspiration and Character Building Session
- Which One is Right Game

Issues talked about with mentors to effect change in thoughts and feelings:

<p><i>Talking About Emotional Difficulties &amp; psycho-physiological problems</i></p> <ul style="list-style-type: none"><li>• Losing a loved one or a peer</li><li>• Concentration problem</li><li>• Behavioural Problems</li><li>• Sleeping Problems</li><li>• Eating problems / diet</li><li>• Dyslexia</li><li>• Depression</li><li>• Problems with taking medication</li><li>• Self-harming &amp; self-injury</li><li>• Talking about the importance of being healthy</li></ul>	<p><i>Anger and Conflict Resolution</i></p> <ul style="list-style-type: none"><li>• Discussing violent and non-violent responses to situations</li><li>• Educating about having a good attitude towards people and environment</li><li>• Advantages of staying out of trouble in school</li><li>• Importance of focusing on the positives in life</li><li>• Ways of managing anger - strategies on how to control violent behaviours</li></ul>
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<p><i>Talking through relationship Problems (Family members, sex)</i></p> <ul style="list-style-type: none"> <li>• Talking about relationship boundaries and respect</li> <li>• Talking to parents about current situation of their child</li> <li>• Teaching how to support other family members</li> <li>• Acting as a link between school and home</li> <li>• Talking about puberty, hormones and sexuality</li> <li>• Increasing social interaction with peers</li> <li>• Absent parents and what this means to the child</li> <li>• Talking about importance of making close relationships positive</li> <li>• Meaning of sexual consent</li> <li>• Safe Sex</li> </ul>	<p><i>Dealing with issues around Crime, the Law, Alcohol, Drugs, Gangs and Peer Problems</i></p> <ul style="list-style-type: none"> <li>• Smoking cannabis</li> <li>• Drinking alcohol</li> <li>• Hospitalization after being attacked</li> <li>• Being arrested</li> <li>• Talking about custody / prison</li> <li>• Talking about healthy option for reducing stress other than drugs</li> <li>• Selling drugs</li> <li>• Associating with others involved in criminal behaviour</li> <li>• Reality/ consequence of criminal record/ prison</li> <li>• Postcode wars/ gang rivalry</li> <li>• Court orders/ YOS engagement</li> <li>• Getting stabbed</li> <li>• Retaliation</li> </ul>
<p><i>Big Picture and Self Reflection</i></p> <ul style="list-style-type: none"> <li>• Talking about importance of seeking and being role model</li> <li>• Increasing the sense of responsibility of actions</li> <li>• Reorganizing sense of self and increasing confidence and self-esteem</li> <li>• Talking about ways to control mood</li> </ul>	

*Activities undertaken jointly*

- Attending CAMHS appointment (for child with ADHD/Autism or other mental health problem)
- Group strategy meeting (child, Mum, teacher, social worker, YW etc.)
- Going to studio and recording song
- Listening to music
- Writing song lyrics
- Making loom bands
- Visiting galleries
- Going to cinema
- Visiting library
- Bowling
- Accompanying to ETE interviews
- End of intervention celebration (celebration meal, going to cinema or etc.)

*Goal Setting for Future and Education*

- Arranging weekly/monthly sessions

- Liaising with school about current concerns
- Referring/searching new school/college
- Seeking counselling
- Apprenticeship
- Importance of finishing school without getting excluded
- Taking responsibility for actions
- Looking for Part-Time work
- Visiting Careers Advice Services/Centres

#### *Referral to External Activities*

- Youth Theatre
- Drama groups
- Sport Academies such as athletics, football or boxing club
- Art groups
- Creative Writing classes
- Cake baking
- Archery
- Music recording studio
- Come Correct contraception scheme
- Faces in Focus counselling service
- Quit Smoking Services
- Hands up for Health (HUFH)
- Police cadets
- Sexual health clinics
- GP

#### *Environmental changes*

- Relocation
- Starting a New School

A review of diary sheets from 10 cases identified the following intervention characteristics:

- **BUILDING OF TRUST - OFFERING A SAFE SPACE TO SHARE** - Offering a non-judgemental and non- consequential (i.e. not statutory) approach. *“Everything we talk about when we meet can stay confidential”[excluding safeguarding concerns].*
- **SETTING BOUNDARIES BY DEFINING THE INTERVENTION LIMITS, TIMELINE, AND CONTACT**  
Example: *B068 said he would like to go on for two years! I explained till December would be the longest, but explained contact stays open after that.”*
- **YOUTH PERSONAL DEVELOPMENT THROUGH GAMES** - Using activities to stimulate discussion and thought about YPs risk behaviours and situations they are exposed to, thinking about their future, encouraging the use of creative outlets (e.g. writing skills/ the use of rap).  
Examples:

*"I identified grief of gran, fighting and anger as main hold backs but mum and uncle are biggest help to him." (B146)*

*"B102 expresses how music now influences a good mood and is a healthy option for chilling out rather than drugs and doing 'bad man' things."*

- **ENCOURAGING CHANGE IN KEY AREAS, SUCH AS EDUCATION** - Supporting the YP to identify and change destructive behaviours at school and work towards attainment where possible.

- **ANGER MANAGEMENT TECHNIQUES** – helping YP identify triggers to anger and providing skills on how to manage their actions in specific trigger situations.

Examples:

*B006 identified with YW triggers for anger: "feeling like he is behind on school work and when people cuss him" which prompted the YW to provide him with organisational skills for keeping on top of school work and apply STOP THINK and CHOOSE method to decide actions of situations."*

*"Which one is right? Game" played with the YW increased the understanding of the right conduct which led to B006 having no other big outbursts of anger.*

*"Encouraging B107's understanding on how to interact socially and handle adverse situations with card game linking appropriate behaviour and desired reaction instead of anger"*

- **PLANNING A FUTURE** -Making positive strides in areas which interest the YP increased their confidence and gave them something positive to focus on, building social skills and engaging positively within their community. Examples:

*"B108 Anger improved as there had been minimal violent out bursts. An application to college was made and T was very adamant to succeed and start studying. B108 expressed how life was good and had started dance class"*

*"...B004 felt pleased with himself about positive interactions he had been making with other people".*

- **LINKING IN TO LOCAL ACTIVITY**- Guided referral by accompanying YP to first activity and staying nearby until completed. Offering encouragement to attend next session. Examples:

YW: *"I took B004 to Art group at Downside Fisher Youth Club and got myself stuck in."*

*"B043 recognised getting into trouble with the police and school due to being bored and not thinking things through but at Downside Fisher Youth Club does Football and attends the gym"*

- **HARNESSING INVOLVEMENT FROM AND WITH PARENTS, WHERE POSSIBLE** - Family relationships also enabled effective youth work, as parents were involved in the mechanisms the YW used to advocate change within the YP. Family was also one of the main arenas in which YP were able to exercise control over their behaviour and potentially lead to improved relationships

Example: *“R wanted to quit smoking. Dad also said he would quit with him”*. (B146)

Change was also evidenced within the findings reflecting family relationships as the interactions between siblings improved and argumentative situations were dealt with positively *“B004 did not hit his brother although his feelings were hurt he walked away.”*

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## SUMMARY OF CONTENT ANALYSIS

This list of activities and processes identified by the case study analysis give a glimpse into the content of the service. It is evident that YWs strives to build a relationship built on trust and clear boundaries. The YW then works with the YP using various direct and indirect, didactic and experiential strategies, to tackle problem areas in YPs lives, often around social interactions with their family, peers, and school staff. YWs encourage reflection by the YP by breaking down entrenched behaviour patterns to distinct cause and effect units, thereby allowing and encouraging revision of reactive behaviours such as anger and the selection of other strategies of response.

### 3. THE EVALUATION

This section describes the evaluation from August 2010 to August 2016. It includes the broad approach and design of the evaluation and the qualitative and quantitative measures used.

#### 3.1 EVALUATION DESIGN AND STRATEGY

The service evaluation includes mixed qualitative and quantitative methods to evaluate all aspects of the intervention. This includes the project implementation, the YW's case work, data collected on the numbers of YP accessing ED services, referral procedures and risk characteristics of those entering the service. It also monitors change in the YP attending at follow-up.

Ethical permission for the project was provided by the university ethics committee. This required informed consent for the intervention by the YP involved and their parents. Verbal consent was allowed for the latter. A requirement was made for all data to be anonymised and questionnaires and interview transcripts kept securely in locked cabinets or under electronic passwords<sup>36</sup>.

#### 3.2 METHODS AND MEASURES

The following section describes the measures and methods used by the evaluation team. A mixed methods approach was applied to gain fuller understanding of the intervention and its impact on those attending. The evaluation also sought to reflect the personal experience of stakeholders. The approach was a responsive one, 'action research', which aimed to work with the service to feedback initial findings to aid with planning and reflecting for best outcomes.<sup>37</sup>

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#### QUANTITATIVE ANALYSIS – QUESTIONNAIRES

##### YOUNG PEOPLE:

The quantitative evaluation involved questionnaire administration to YP at baseline, time 1 (T1: approximately 3 months from the beginning of the intervention) Time 2 (T2: after the end of the intervention), and for a small subgroup Time 3 (T3: a year or more from the date of intervention completion). The questionnaire administration was almost entirely carried out by OYS staff. At baseline this constituted part of the assessment process and the data captured was used to define risk and tailored service provision and planning. At T1 and T2 follow-up this was usually administered by the youth worker at a special meeting arranged for follow-up purposes. For first follow up, where the case was still Live, the questionnaire assessment took place during the one-to-one sessions. T3 was administered by the research team.

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<sup>36</sup> Health Trust ethical permission was not required since the project was deemed 'audit' and this was confirmed by Chair's Action.

<sup>37</sup> Can, W & Kemmis, S. (1986) *Becoming Critical Education, Knowledge and Action Research*. Falmer Press, London

Measures referred to in this report include the ‘What do you think’ portion of the ASSET assessment and Strengths and Difficulties questionnaire. These measures are described in short below (more information can be found in previous reports):

- **ASSET ‘What do you Think’ (ASSET-WDYT)** (Youth Justice Board, 2000)<sup>38</sup> was used to assess lifestyle risk issues at T1, T2 and T3. This is a self-report subset of the ASSET. The ASSET is a structured assessment tool used nationally by the Youth Justice Board (2000) to aid with the prediction of reoffending by YP<sup>39</sup>. The full measure has been extensively investigated to identify risk and protective factors and its validity and reliability were tested in over three thousand YP from Youth Offending Teams. This section has been partially validated<sup>40</sup>. It was used as a general indicator of risk in each domain of the respondent’s lives, with higher scores on each section representing higher levels of risk and a higher overall score representing high overall risk in their lives. The subscales include: family & neighbourhood, school & work, lifestyle & area, substance use, health and thinking & behaviour. A final subscale relating to injuries was removed due to poor reliability. Example questions include - under lifestyle: ‘Live in places with a lot of crime’ or ‘Have lots of friends who get into trouble’. Under Family: ‘Stay away from home without asking’ or ‘See members of family fighting and arguing’. Under health: ‘Do things they know will be bad for their health’ or ‘Worry about something that might happen in the future’
- **The Strengths and Difficulties Questionnaire (SDQ)** (Goodman, 1999)<sup>41</sup> was used at T1, T2 and T3 to assess emotional, conduct and hyperactive disorder, peer group and prosocial problems. This questionnaire is used nationally, with reliability and validity published and reliable cut-off scores for case/borderline disorder and high level difficulties established. An overall level of difficulty is derived with each of the subscales also providing a case and borderline level of disorder. Each question asks the respondent a statement regarding social interactions or symptoms. Examples include – emotional disorder : ‘I worry a lot’ or ‘I am nervous in new situations. I easily lose confidence’; under conduct disorder: ‘I get very angry and often lose my temper’ or ‘I am often accused of lying or cheating’; under hyperactive disorder: ‘I am restless, I cannot stay still for long’ or ‘I am constantly fidgeting or squirming’.
- **Exit questionnaire (T2)** - At the closing session of the intervention YP were asked to fill out an exit questionnaire. This questionnaire included questions about what the best and worst things about being involved with OYS were and how much they agree with statements regarding the impact of the intervention.
- **Record of intervention goals (T1)** - Youth workers were asked to record the goals set in the interventions in a number of key areas, including: educational engagement and attainment, employability skills and experience, health including anger management, mental health,

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<sup>38</sup> [www.yjb.gov.uk/Publications/Resources/Downloads/Asset.pdf](http://www.yjb.gov.uk/Publications/Resources/Downloads/Asset.pdf)

<sup>39</sup> Baker, K, Jones, S, Roberts C & Merrington S (2004) ASSET: The evaluation of the validity and reliability of the Youth Justice Board’s Assessment for Young Offenders. London YJB,

<sup>40</sup> [www.yjb.gov.uk/publications/Resources/Downloads/AssetSum.pdf](http://www.yjb.gov.uk/publications/Resources/Downloads/AssetSum.pdf)

<sup>41</sup> Goodman, R. (1999). The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 40(5), 791-799.

substance use, and social goals. This record was aimed at gathering more information the content of the interventions being delivered, due to the tailored nature of these.

## STAFF SURVEY

A follow up staff survey was circulated through the staff directory and in person. Comparison of staff awareness and satisfaction with the service over 3 time points, is presented in the current report.

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## QUALITATIVE ANALYSIS

### YOUNG PEOPLE:

Qualitative interviews were carried out with a sub-sample of the YP utilising the service to explore their views and experiences (n=9). The current report will present findings from longitudinal interviews taking place a year or more after case closure which explore the long term impact on the intervention and if change was sustained over time. Data on interviews at first follow up (3 months) is presented elsewhere<sup>[1]</sup>.

### STAKEHOLDERS:

Interviews were also carried out with key stakeholders with a view to gaining their views of the OYS service, its development, current status and future directions (n=5).

### CONTENT ANALYSIS

A depth analysis YP's case files was undertaken<sup>[2]</sup>, the purpose of which was to qualitatively examine case files to gauge what activities the YWs were undertaking in order to create a more defined understanding of the content of the intervention being delivered (n=10).

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## DATA MANAGEMENT

Questionnaires were kept in paper case files locked in the intervention team office. Copies of questionnaires were retrieved monthly by the evaluation team. An electronic database was maintained by the intervention team and emailed fortnightly to the evaluation team with updates on new and closed cases. A record was kept to ensure that follow up questionnaires and interviews were followed up by the intervention team at relevant times. The database was kept confidential, encrypted by a password to protect the information with identity numbers given to cases.

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<sup>[1]</sup> Ilan-Clarke, Y., De Marco, J. Bunn, A. & Bifulco, A. (2013) Report 6: Results from interviews with YP (June 2013); Evaluation of St. Thomas' youth violence intervention. Middlesex University.

<sup>[2]</sup> This work was conducted by Ebinehita Iyere as part of her undergraduate dissertation in (BSc) Criminology and Youth Studies. A further portion was carried out by Elif Bestenigar Mert. A summary of the work done is included with permission.

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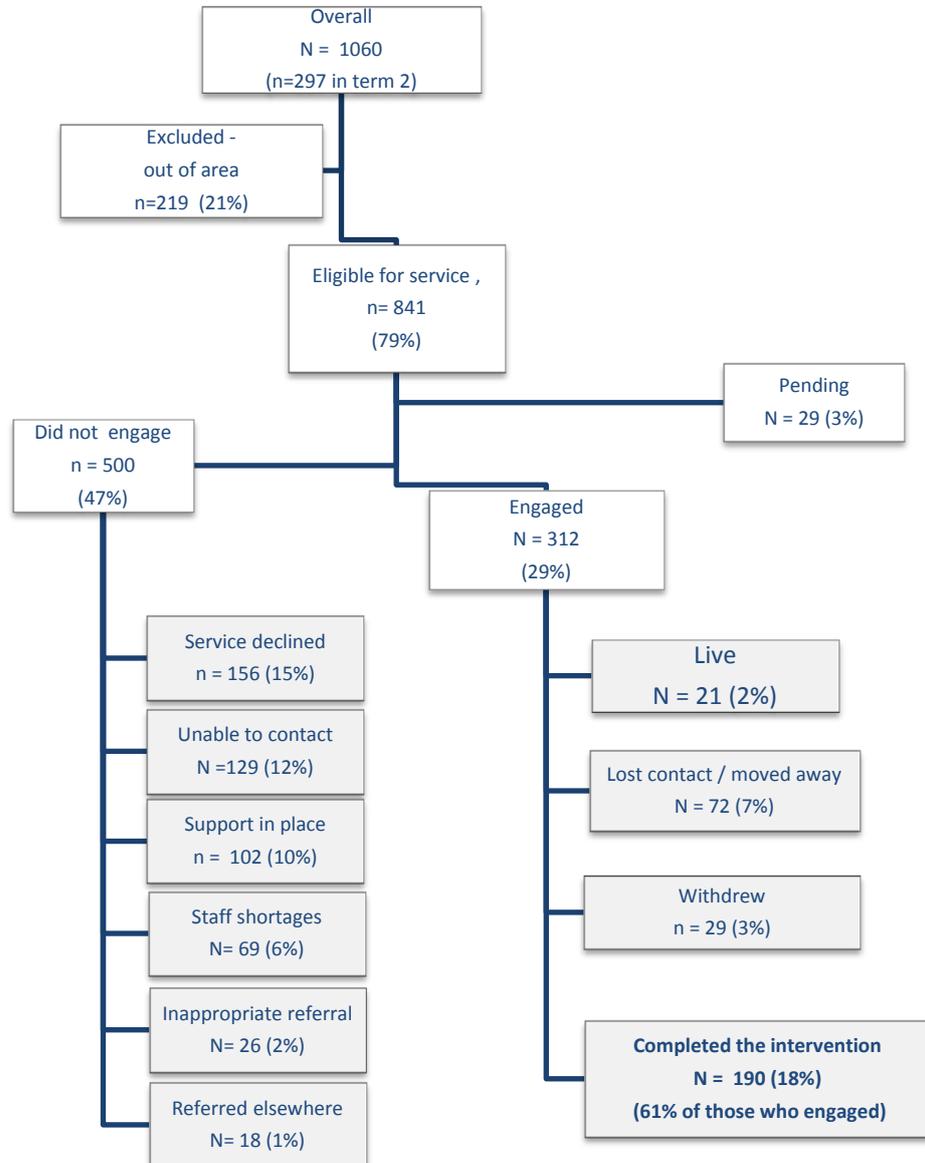
## DATA ANALYSIS

All data on the service-users and providers was collated by the evaluation team. Quantitative analysis was undertaken to examine frequencies of characteristics of those coming to the attention of the service and those completing the intervention. Statistical analysis was undertaken using the SPSS version 21 programme. Frequency and Pearson's correlations were used for risk and disorder scores, and chi-square for comparing dichotomised risk and demographic variables in relation to disorder to determine statistical significance. Investigations into significant changes between 'baseline' and 'follow-up' scores on both the ASSET and SDQ subscales and entire measures were done through 't-tests' and chi-square cross-tabulations. Statistical significance was determined by 'p' values at 0.05 or below. For the qualitative analysis, transcripts were made of interviews and these were analysed for themes.

## 4. RESULTS: QUANTITATIVE ANALYSIS

### 4.1 TOTAL OYS FIGURES 2010-2016

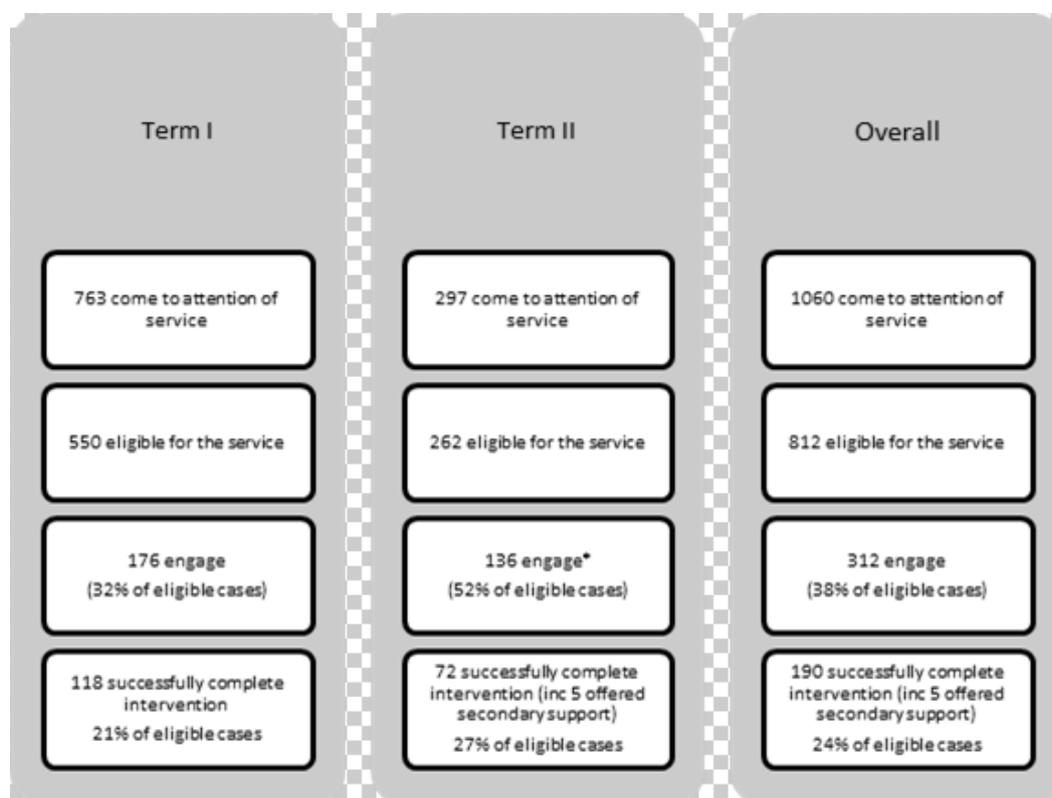
FIGURE 3: REFERRAL AND ENGAGEMENT PATHWAY JULY 2010 - JUNE 2016



Referral and pathways data suggest that overall, across both terms, almost a third of those who came to the attention of the service were eligible for the intervention; of those eligible 24% (almost 20% of the entire sample) completed the intervention.

Comparison of service uptake between Term 1 (2010-2013) and term 2 (2013-2016) shows that while there were more cases identified in the first term (predominantly through the Symphony record system) the rate of engagement was higher in the second term in comparison to the first term (52% vs 32%). Completion rates overall were also higher in the second term (27% compared to 21%), thus increased use of the service as it matured [Figure 4]. Overall figures for the total period are also shown (Figure 4, column 3). See section 7.2 Evolution of the intervention, to see how staff structure and referral methods have impacted on service delivery over time.

FIGURE 4 – REFERRAL AND ENGAGEMENT FIGURES



## 4.2 CHARACTERISTICS OF THE SAMPLE AND ED ATTENDANCE

Characteristics of the sample are presented below. Information is presented on the whole sample referred since July 2010; where there was evidence for differences between Term 1 and Term 2, this is highlighted in the relevant section.

### OVERALL

Total numbers of participants referred to the service was 1060. Of these 50 cases were currently *live* or *pending*; the remainder completed were 1010.

## AGE

The age range for the YP considered eligible was 9 – 24 years (mean age = 15.13). The mean age did not differ between females and males. Of the YP who engaged with the service the age range was 11-24 (mean age 15.1). The overall mean age has slightly increased over the last year, previously it was 14.8 years.

## GENDER

Most of the young people referred were males (n=788, 74%). The Females were only 26% of the total sample (n = 272). Ratios were identical between Term 1 and Term 2.

## BOROUGH OF RESIDENCE

Of the 1060 cases coming to the attention of the service since the start of the intervention, 445 cases were from Southwark (42%), 361 from Lambeth (34%). 249 cases were referred from other boroughs (including all 'Out of area' cases not eligible for the intervention) (23%).

## ETHNICITY

White ethnicities, British, Irish, and White Other made up 41% of the sample (n=439). Black ethnicities, including British, African, Caribbean and mixed Black and other, made up a further 33% of the sample (n=350). Sixty two cases regarded themselves as mixed ethnicity (6%); a small proportion of Asian ethnicities was represented (1%); 75 people categorised themselves as 'Other' (7%); finally, the ethnicity was unknown in 119 cases (6%).

## FAMILY COMPOSITION

Of the 467 cases for whom this information was available, the most common form of family arrangement was living with a single parent, predominantly mother (n=221, 45%); living with both parents was reported in 35% of the cases (n=171); living with a parent & step parent was noted in 26 cases (5%). Other family and non-family arrangements were reported in 51 cases (10%). Living in care occurred in 4% of cases (22).

## REFERRAL METHOD

Throughout the lifetime of the service, overall Symphony was the largest source of referrals (n=306, 29%) used in the first term of the service. The next most common referral routes were as follows: 22% referred from the Paediatric ED (n=228); 11% through the PSM meeting (n=115 %); 6% referred through Adult ED (n=67). Urgent Care Centres (UCCs at Guy's and St. Thomas') referred a further 3% (n=34). Other routes included 2% from other sources (25 cases) and 2% where route was not recorded (n=24). Finally, referrals through the ED assault report came to 3% (n=28).

Reviewing the second term identifies that referral routes differed from the first term: there were no referrals through the Symphony records system<sup>42</sup>. Instead, referrals were predominantly received either directly through clinicians or the psychosocial team or at the last part of the second term, made via the 'assault data' (data collected by A&E receptionists to record attendances due to violence). The differences seen in Term 2 compared to Term 1 identify that the proportion of

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<sup>42</sup> Symphony referrals were discontinued in 2013 as it was not an efficient method of referral, taking up many administrator and staff hours with smaller uptake of the service in comparison to the direct referrals.

referrals from Adult ED tripled from 3% to 14%; referrals from Paeds doubled from 16% to 35%; referrals from PSM almost tripled from 7% to 20% [Table 1].

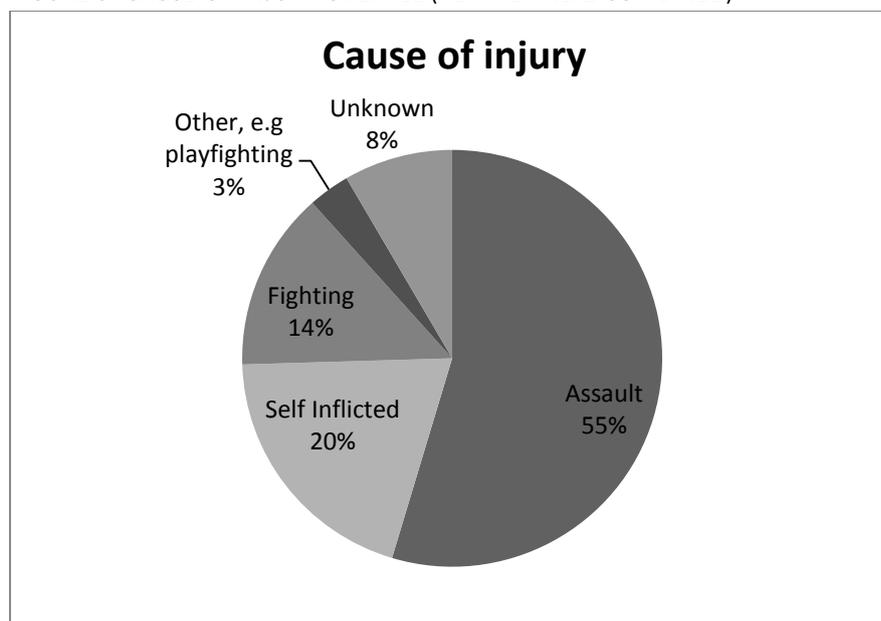
TABLE 1 REFERRAL METHODS

Source of referral	Term 1 N=532	Term 2 N=295	Overall N=827
<b>Symphony</b>	40% (306)	-	37% (306)
<b>Paeds ED</b>	16% (124)	35% (104)	28% (228)
<b>PSM</b>	7% (56)	20% (59)	14% (115)
<b>Adult ED</b>	3% (25)	14% (42)	8% (67)
<b>UCC or MIU</b>	1% (9)	8% (25)	4% (34)
<b>ED assault report</b>	-	9% (28)	3% (28)
<b>Other</b>	1% (9)	5% (16)	3% (25)
<b>Not recorded</b>	.5% (3)	7% (21)	3% (24)

### CAUSE OF INJURY

The dominant cause of injury reported was assault, occurring in 55% (579) cases, with 59% (449) of cases reported as assault in the first term and 44% (130) in the second term. Self-inflicted injuries<sup>43</sup>, usually the result of anger or frustration (eg putting a fist through a window or punching a wall), the next largest cause of injury occurred in 20% in both terms (n=211). Fighting was cited as the cause of injury for 13% in Term 1 and 15% in Term 2 (n=147). Finally, other causes, predominantly play fighting, was reported in 12% in Term 2, 0% in Term (n=134 cases). The cause of injury was unknown in 8% and 10% of cases respectively in Term 1 and 2 (n=89 cases) [Figure 5].

FIGURE 5: CAUSE OF INJURY OVERALL (TERM 1 AND 2 COMBINED)



<sup>43</sup> Note that self-injury was differentiated from self-harm as indicated by suicide attempt which would be referred directly to CAMHS.

## ROLE OF YP IN INJURY

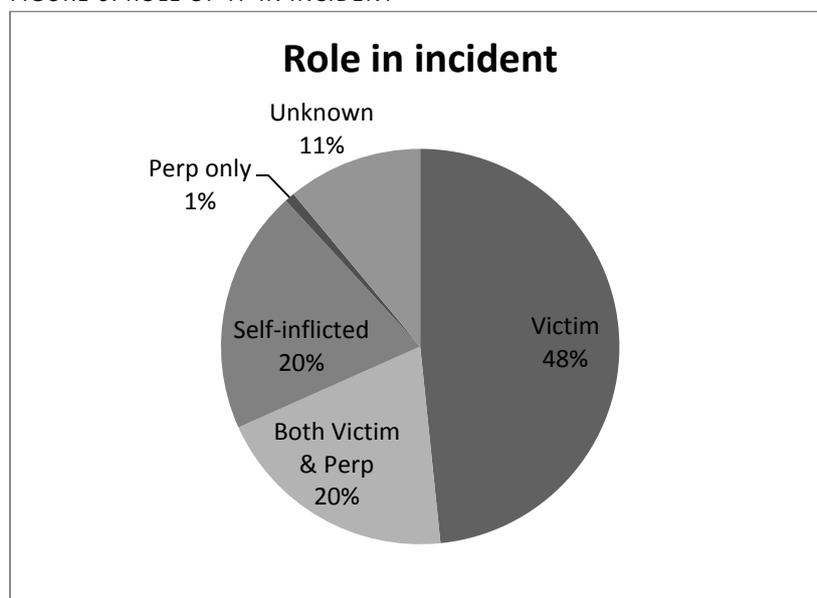
Of the total cohort, YP reported themselves as the victim of the event that led to their injury in 451 cases (51% in Term 1 and 20% in Term 2). Self-inflicted injuries were the second largest cause in 194 cases (19% and 15%). They regarded themselves as both victim and perpetrator in 157 cases (16% and 12% in Term 1 and 2 respectively). There were 8 cases who reported being the perpetrator of the event that led to their injury (1% in both terms). Finally, Other, or Unknown causes were noted in 249 cases (13% in Term 1 and 51% in Term 2). The large percentage of unknown cases in Term 2 is attributable to the fact that 50 cases were pending or live so data not yet entered [Table 2].

TABLE 2: ROLE OF YP IN INDEX INCIDENT - COMPARISON TERM 1 AND TERM 2

Victim or perp	Term 1 N= 764	Term 2 N=295	Overall N=1059
<b>Perpetrator =8</b>	1% (4)	1%(4)	.7% (8)
<b>Victim = 451</b>	51% (391)	20% (60)	43% (451)
<b>Both = 157</b>	16% (121)	12% (36)	15% (157)
<b>Self-inflicted =194</b>	19% (149)	15% (45)	18% (194)
<b>Unknown =199</b>	6% (49)	51% (150)	19% (199)
<b>Other =50</b>	7% (50)	-	5% (50)

Of the cohort who engaged (n=246): 119 of were victim (48%); 49 of cases were regarded as being both victim & perpetrator (20%); in 49 cases the injury was self-inflicted (20%); 2 cases reported as to be perpetrators only (0.8%); and other roles/not recorded occurred in 27 cases (11% ) [Figure 6].

FIGURE 6: ROLE OF YP IN INCIDENT

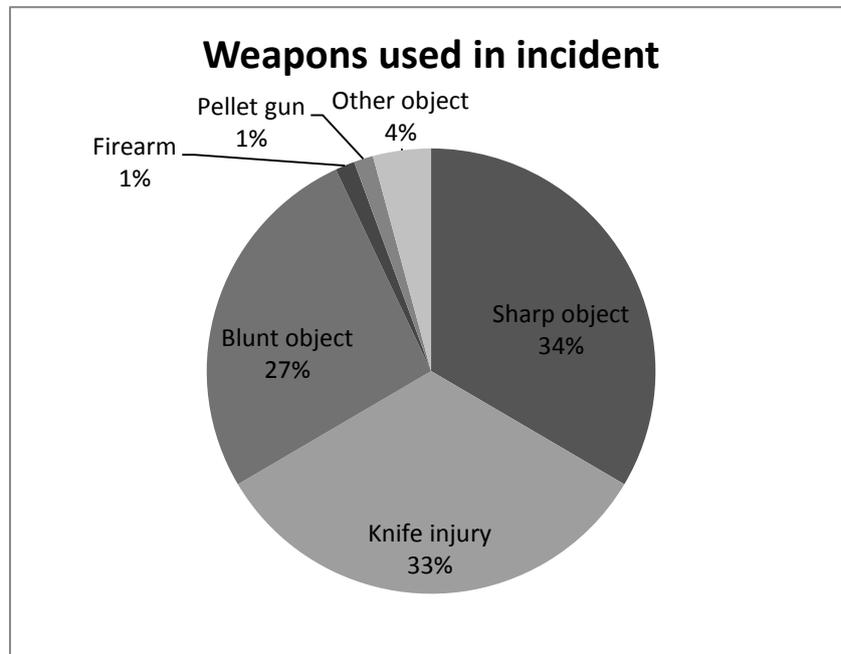


## WEAPONS USED

Use of a weapon was reported in 215 cases. The use of a sharp object (including a bottle, broken glass) was recorded in 34% (n=72). Knife injuries occurred in 33% (n=71), including 2 uses of a machete. The use of a blunt object was recorded in 27% of cases (n=57). In 4% (n=9) other

objects/weapons were used, such as chemical products used in the attack. Finally, there were 3 reported cases of pellet gun use and 3 cases of handgun use, together 2% [Figure 7].

FIGURE 7: WEAPONS REPORTEDLY USED IN INCIDENTS THAT LED TO ED ATTENDANCE



### GANG INVOLVMENT

Gang-related events were reported definitively in 54 cases. The remainder were either noted as non-gang related n=163, or missing information. This is unlikely to be an accurate figure as voluntary disclosure, particularly amongst the high risk cases and those who failed to engage, was improbable.

### RISK ASSESSMENT

Risk assessments were undertaken for those who engaged in the intervention. [In 74 cases this information was not available because the risk assessment was not completed by the time the YP discontinued their involvement with the service].

Overall, of those for whom the risk assessment was completed at baseline (n= 214) 41% were rated as High risk (n=87); 37% rated as Medium risk (n=79) and 22% rated as Low risk (n=48). Cases were more likely to be low or high risk in term 2, whereas term 1 had a larger proportion of medium risk cases.

### STATUTORY SERVICE INVOLVEMENT

Of the 291 cases who engaged, the following information was available regarding service involvement:

- Child and Adolescent Mental Health Service (CAMHS): 13% of YP who engaged reported current or prior use of CAMHS (19 had current service use, 18 had prior service use, overall 37 cases).
- Social Services (SS): 42% of YP who engaged had current or prior use of SS, 47 cases with current service involvement and 75 with prior involvement.
- Youth Offending Teams (YOT): This information was only recorded from Term 2. Of 90 engaged cases, 29% reported current or prior engagement with YOT (12 current and 14 prior YOT involvement)
- In 34 cases, there was current or prior reported use of both CAMHS and SS (12%) and in 11 cases there was reported use of all three services (4%) (data available only for term 2 cases).

#### NUMBER OF FACE TO FACE SESSIONS

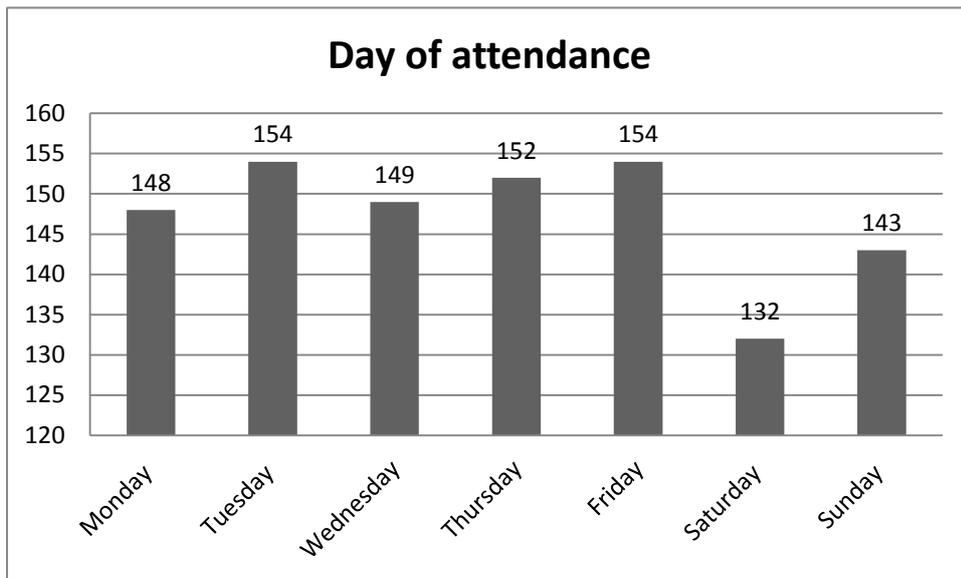
The number of face to face sessions was recorded only from Term 2. In total, since July 2013 YWs met face to face (f2f) with young people 645 times (with an average of 215 per year). There was a range of between 1- 35 f2f sessions with an average of 9. When viewed in terms of risk levels, High risk cases received a range of 1-35 (average 11) f2f sessions over a duration range of 1-88 weeks (22 months) with an average of 26 weeks (6.5 months). Medium risk cases had received 1-18 (average 8) f2f sessions on a range of 1-56 weeks (14 months) with an average of 18 weeks (or 4.5 months). Low risk cases received 1-10 f2f sessions (average 5) over an average of 12 weeks (or 3 months) within a range of 1-38 weeks (9.5 months). In some cases there were additional face to face sessions following intervention closure, but these are not recorded here; these included 'catch up' sessions or sessions aimed at completing the research questionnaires.

YWs also communicated with YPs family members, professionals working with them (including school or statutory services, multi-professional and safeguarding meetings), the activities to which they were being referred into and various other people involved in their care within the hospital and beyond. The number of phone calls and texts is not included in the total above. In addition, YWs also expended resources on trying to contact YP who ultimately did not take up the service, 'non-contactables', and those who had exited the service but remained in contact, as well as young people who had agreed to the service not attending prearranged meetings and last minute cancellations (consistent behaviour with a 'hard to reach' cohort).

#### ED ATTENDANCE CHARACTERISTICS (FOR PEER VIOLENCE)

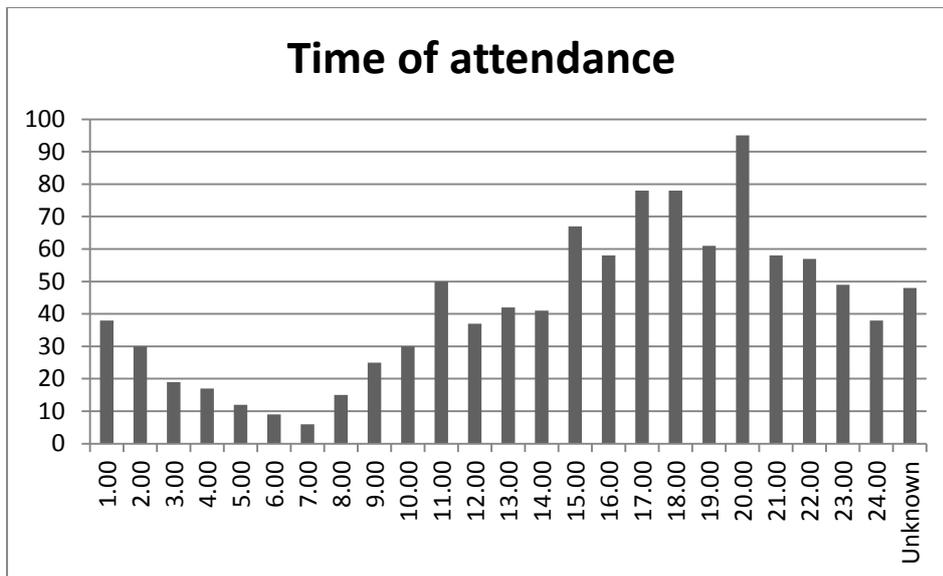
Inspection of days most frequently attended showed little difference between week days, with Saturday and Sunday being less frequent. Tuesday and Friday were shown to be the most common days of attendance [Figure 8].

FIGURE 8: ATTENDANCE BY DAY (2010-2016)



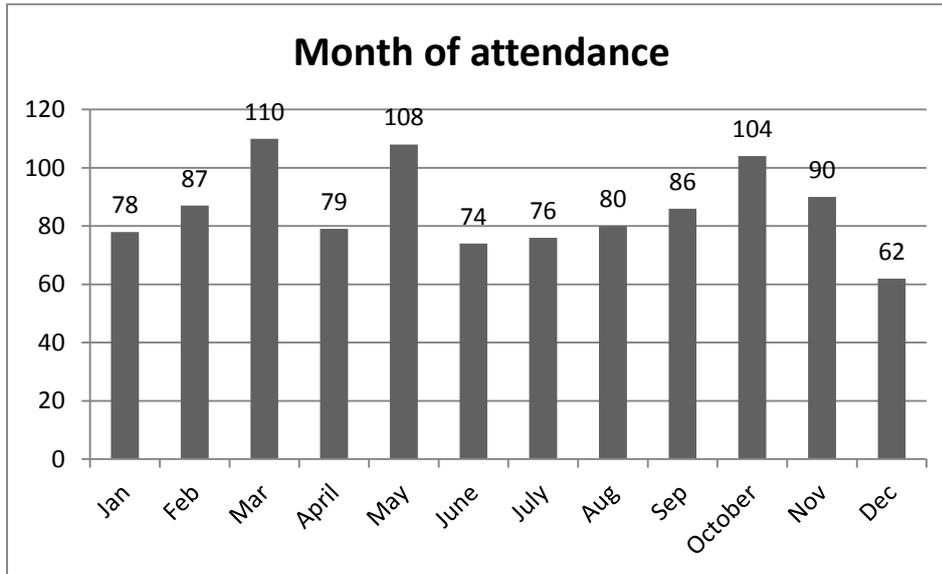
Analysis of the attendance times reveals that the most common time for a YP to attend the ED for a violence-related incident was 20.00-21.00. The next most common time of attendance was evening time between 17:00 and 19:00 [Figure 9].

FIGURE 9: ATTENDANCE BY TIME PRESENTING TO ED



When viewing the rate of attendances by month, overall March, May and October appear to be the months with the most attendances due to violence; December, June and July have the lowest ED attendance [Figure 10].

FIGURE 10: ATTENDANCE BY MONTH PRESENTING TO ED



### PREVIOUS ED ATTENDANCES

Previous ED attendances at St. Thomas' hospital were recorded for 1012 of the cases (5% missing information n=48). In most cases, there was no prior attendance recorded (n=859, 81%). In 153 cases (15%) there was a record of at least one prior attendance, ranging 1-5 and more.

When including only those cases who had engaged, prior ED attendance due to violence was almost double the average – at 27% (40/176).

### RE-ATTENDANCE RATES FROM TERM 2

An audit of the service, conducted by the service administrator in July 2015, included in this report with their permission, found the following information regarding re-attendance rates amongst YP referred to the service July 2013 - June 16 (Term 2 cases only):

One hundred and seventy YP were included in the analysis. There was rate of re-attendance of 17% following the index incident (n = 28). These ranged from 1-5+ re-attendances, with a mean of 2.4. Of the total 170 cases, 80 YP received the intervention: of these, 85% had no re-attendance (n=68); 15% re-attended (n=12). 90 YP did not undergo the intervention, of these 82% (n=74) had no record of re- attendance and 17% of cases re-attended (n=16).

Of the YP who had a record of prior attendances at St. Thomas' ED (25% of the sample of 170, n=43), re-attendance was recorded in 19% of YP who received the intervention (5/26) vs 35% of those who did not (6/17). Amongst YP without any prior attendances (n=126), there was a re-attendance rate of 13% in those who received the intervention (7/54) vs 14% (10/72) of those who did not take up the service.

Put together, the re-attendance rates of those who met with a youth worker were marginally different to those who did not take up the service: 15% (12/80) vs 18% (16/90) respectively. However when taking into account multiple attendances occurring before the index attendances,

the engagement with the YW was associated with a significantly smaller re-attendance rate (19% vs 35%)

It is however difficult to reach any definite conclusion regarding these figures as they represent very small numbers and do not include attendances at other hospitals.

#### 4.3 ANALYSIS OF QUESTIONNAIRE ASSESSMENTS, BASELINE AND 1<sup>ST</sup> FOLLOW UP

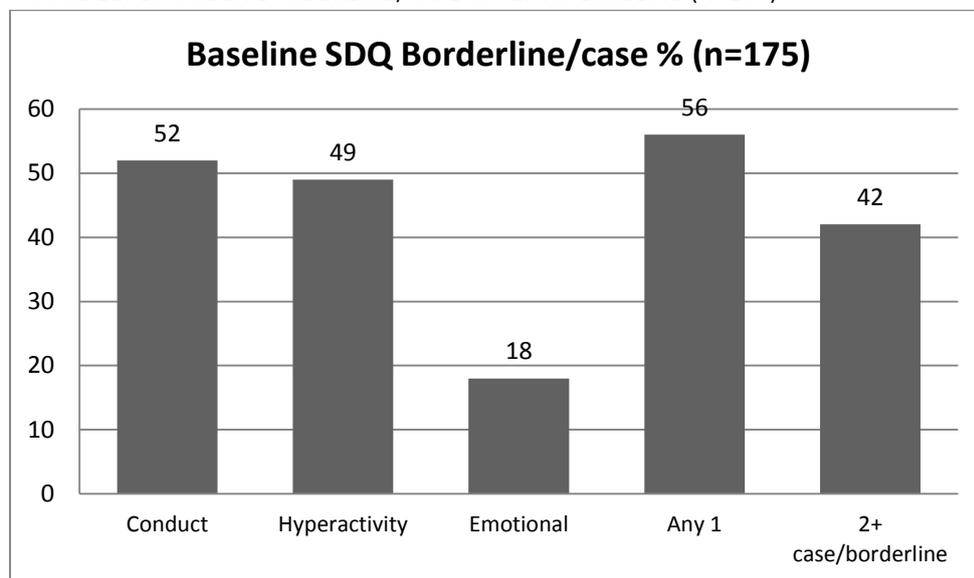
The following analysis relates to the entire sample of YP who completed the intervention from July 2010 to June 2016. [This analysis amalgamates both Term 1 and Term 2 YP to provide sufficient numbers for a statistical analysis of intervention outcome for the overall project].

Baseline assessments were available for 150 SDQ and 175 WDYT questionnaires (n=145 completed both measures). The follow-up analysis was conducted for 83 cases with completed WDYT and SDQs who had completed questionnaires at baseline and at approximately 3 months (T2). In addition there were 25 completed questionnaires for all time points for YP followed-up at 12 months after the end of their intervention (T3).

##### DISORDER AND PEER ISSUES AT BASELINE (SDQ)

The baseline sample was assessed for disorder (at case or borderline case level) using the SDQ, showing that disorder remains common, with as many as 56% having at least one disorder at entry into the intervention and 42% having two or more disorders simultaneously. The most common disorders were Conduct disorder (52%) and Hyperactive disorder (49%). Emotional disorder continued to have lower rates 18% [Figure 11].

FIGURE 11: DISORDER BORDERLINE/CASE RATES AT BASELINE (N=175)



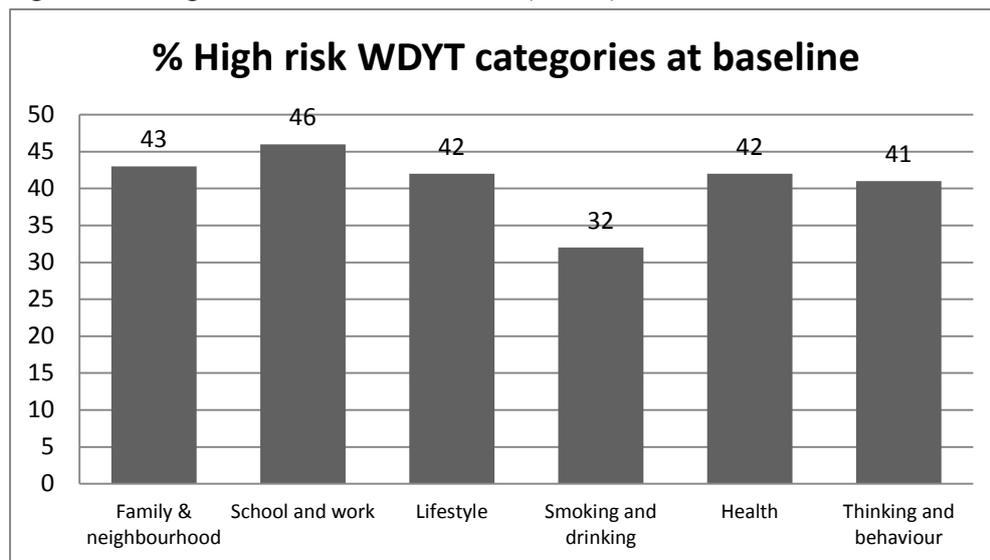
SDQ also measures difficulties with peers in terms of peer problems and problems with prosocial behaviour. When 'abnormal' or borderline peer problems were examined, 23% of the baseline sample had high levels of such difficulties, and 17% had prosocial problems such as lack of empathy or nurturance.

The rates of disorder at baseline were the same for the total sample and the subset used in the follow-up comparisons.

### LIFESTYLE RISK AT BASELINE (WDYT)

Given the lack of any published cut-offs points for the WDYT questionnaire scores, these were calculated as the mean point for the whole baseline sample. Thus the rates of high risk ranged from 46% (school/work) to 32% (drinking/smoking). Rates did not differ significantly from the first term [Figure 12].

Figure 12: % high risk on WDYT at baseline (n=175)



There were significant correlations between the SDQ and WDYT subscales, as can be seen below in Table 3. There were consistently high correlations between the lifestyle health scores and the SDQ symptom scores which were not at all surprising, but lends weight to the measures to show the overlap. Family and neighbourhood characteristics related most to emotional symptoms and conduct problems. School aspects related equally to all three disorders, lifestyle related most to conduct and hyperactive disorder. Smoking and drinking related most to conduct disorder problems.

TABLE 3: CORRELATIONS BETWEEN THE SDQ AND WDYT SUBSCALES N=145

Lifestyle scales:	Emotional symptom Score	Conduct disorder Score	Hyperactivity score
Family and Neighbourhood 'Score'	.40**	.35**	.16*
School and work overall 'score'	.39**	.44**	.39**
Lifestyle and area overall 'score'	.25**	.42**	.41**
Smoking, drinking and drugs overall 'score'	.15	.33**	.23**
Health overall 'score'	.60**	.49**	.33**

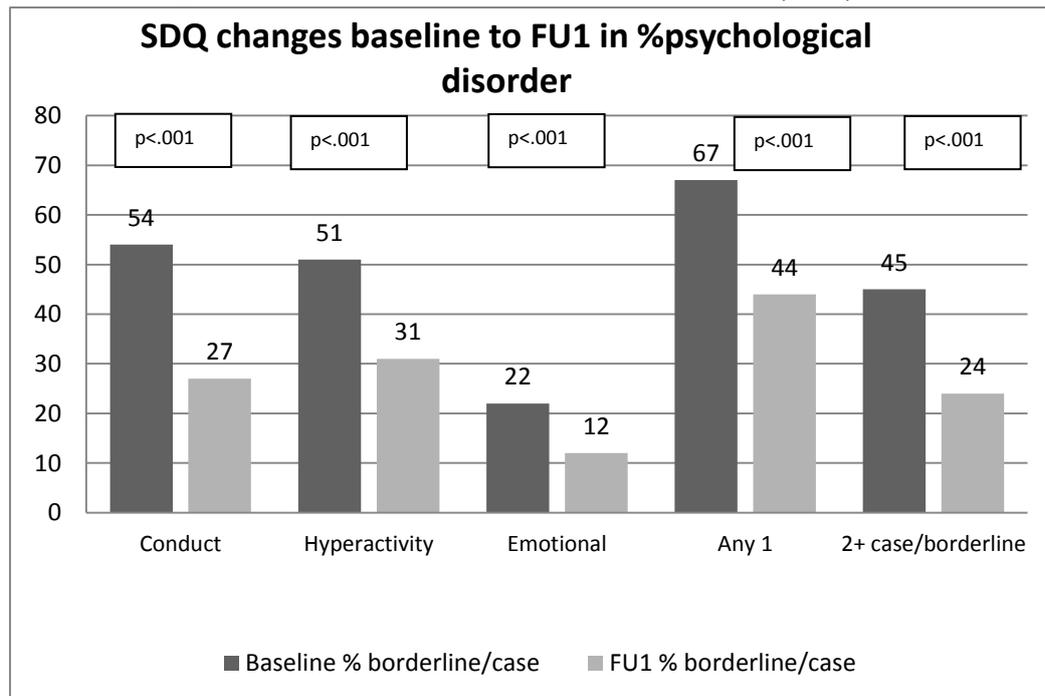
\* P<.05 \*\* p<.001

#### 4.4 IMPACT AT FOLLOW-UP (CHANGE IN RISK AND DISORDER)

The dichotomised scores on the SDQ and the WDYT self-report questionnaire scores at baseline and follow-up were examined for change using the subset of 83 cases. A subsample of 25 who completed questionnaires at time 2 (12 months after completing the service) were also examined in the following analysis.

All disorders showed significant reductions in rates after the intervention[Figure 13].

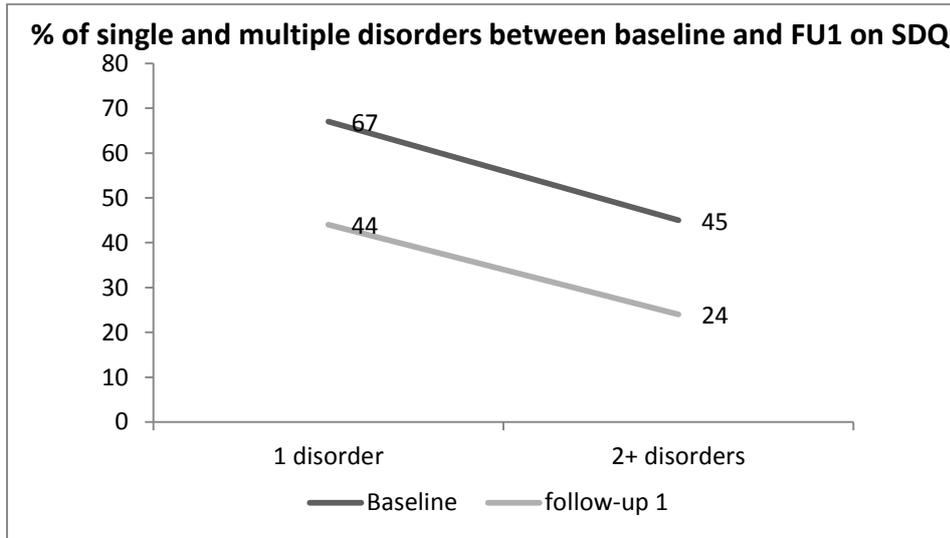
FIGURE 13: SDQ SYMPTOMS: CHANGE IN DISORDER BASELINE TO FU1 (N=83)



Both Conduct and Hyperactive disorder rates were almost halved with Conduct reducing from 54% (44/83) to 27% (22/82) and Hyperactivity going from 51% (42/83) to 31% (25/82). Even Emotional disorder, which was fairly uncommon in the sample, showed significant reduction from 22% (18/83) to 12% (10/82). All changes were statistically significant (p<.001).

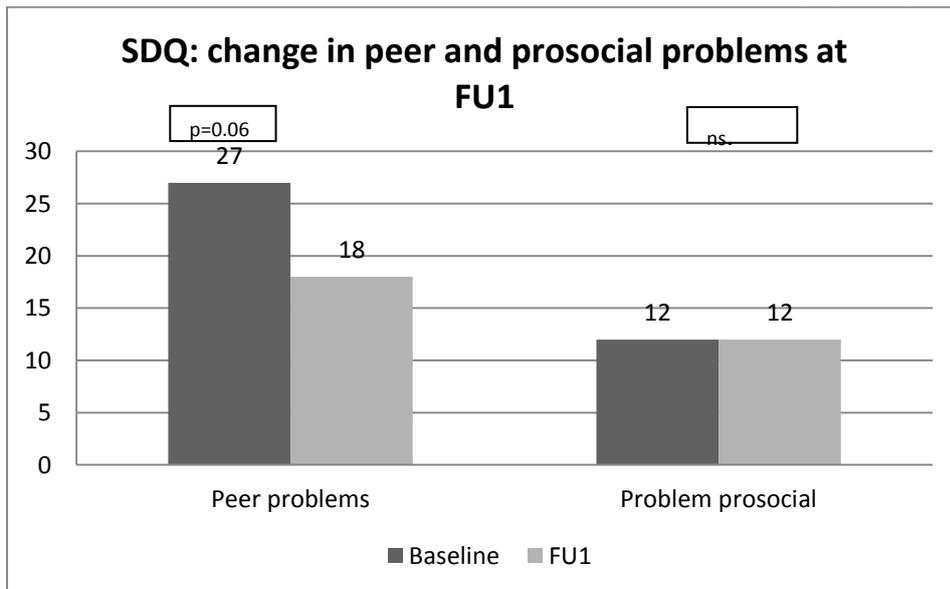
Figure 14 below shows the percentage of those with one or more simultaneously held disorders between baseline and first follow up in the sub sample of 83. This evidences a significant drop. Having any one disorder reduced from 67% (54/81) to 44% (56/82) at FU1. The number of YP with two disorders or more, went from 45% (37/83) to 24% (19/81).

FIGURE 14: NO' OF SDQ DISORDERS HELD SIMULTANEOUSLY: CHANGE FROM BASELINE TO FU1



At first follow up the SDQ also evidenced changes in peer problems, with rates of disorder reducing from 27% to 18% ( $p < .006$ ), whereas there were no changes within the prosocial scale (Figure 15 below).

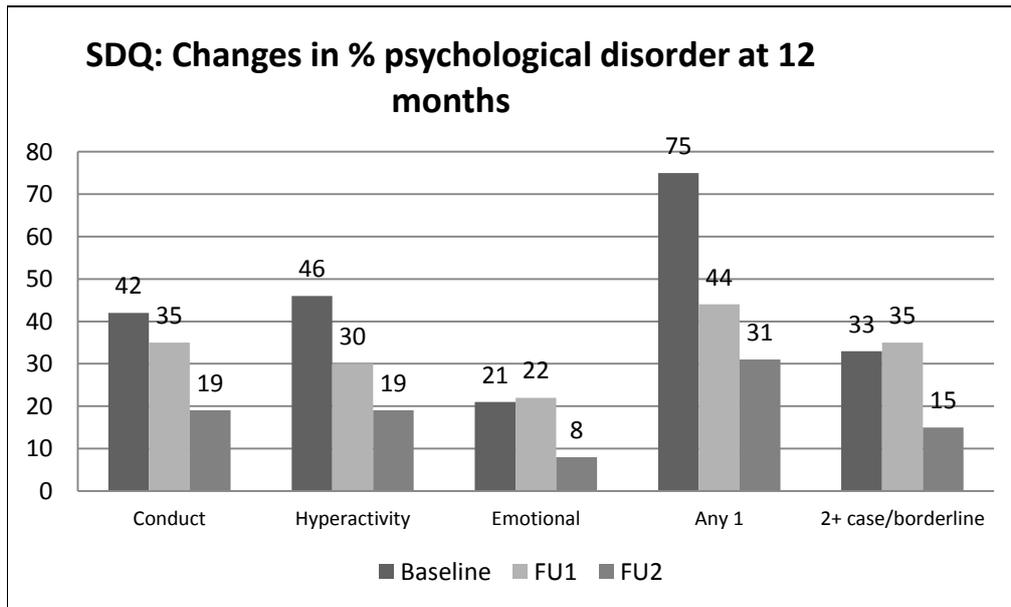
FIGURE 15: PEER AND PROSOCIAL PROBLEMS - CHANGE AT FOLLOW UP (T2, N=84)



### SDQ FOLLOW UP AT 12 MONTHS (T3)

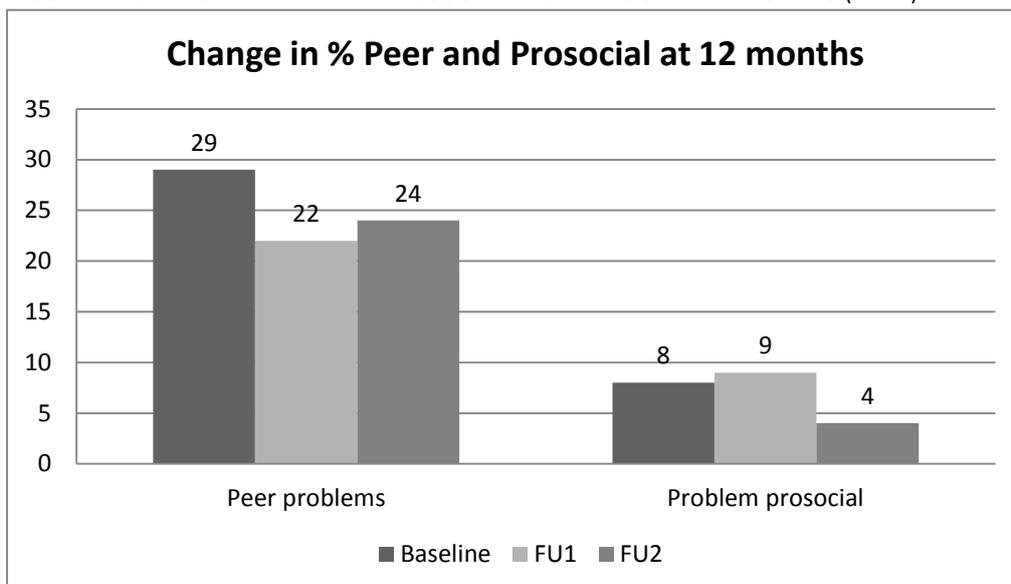
A subsample of 26 YP in the sample were examined approximately 12 months following the intervention to look for stability of positive change. It was apparent that positive change was maintained over time and even reduced (Figure 15). Whilst numbers are too small for statistical analyses, it can be seen that conduct problems went down from baseline 42% to 19%; Hyperactivity from baseline 46% to 19%; Emotional problems from baelines 21% to 8%. Having at least one disorder was halved (reduced from 75% to 31%) and the same for having 2 or more disorders simultaneously (33% to 15%). [See Figure 16 below].

FIGURE 16: WDYT: CHANGE IN PSYCHOLOGICAL DISORDER OVER 12 MONTHS FOLLOW UP (N=25)



Peer and Prosocial problems, when examined over 12 months, were little changes, albeit with a slight trend in reduction. These numbers were too low to examine statistically [Figure 17].

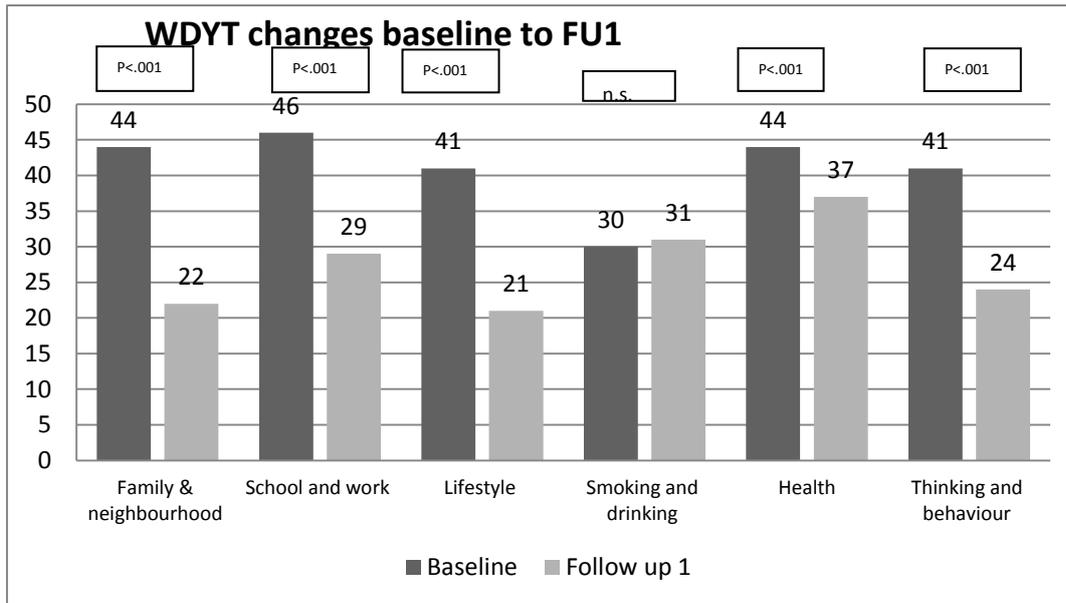
FIGURE 17: CHANGE IN PEER AND PROSOCIAL PROBLEMS OVER 12 MONTHS (N=24)



### CHANGES IN LIFESTYLE RISK

The WDYT lifestyle risks were examined and evidenced similar significant reductions when the same cut-offs applied at T1 were utilised at T2. Family and neighbourhood risks were reduced by half (44% to 22%). School/work domain went from 46% risk to 29%. Lifestyle risks also reduced by half (41% to 21%) and Health (including mental health) evidenced a reduction from 44% to 37%. Thinking & Behaviour scale (violence and impulsive behaviour) went from 41% to 24%. All these changes were statistically significant at  $p < .001$ . The only risk domain which didn't change significantly was smoking/drinking/drugs which remained stable after the intervention. See figure 18.

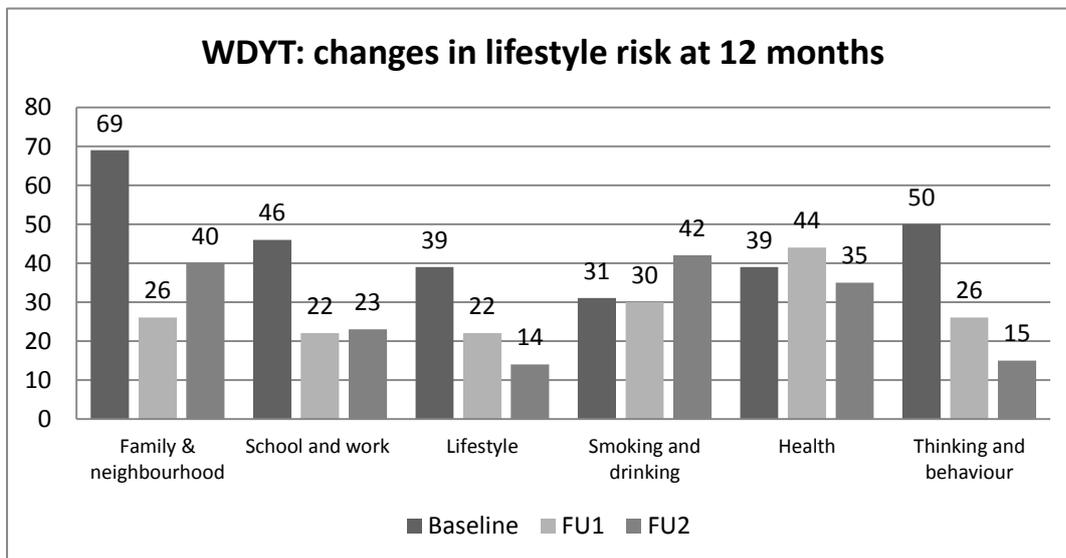
FIGURE 18: CHANGE ON WDYT FROM BASELINE TO FOLLOW UP 1 (N=84)



#### WDYT FOLLOW UP AT 12 MONTHS

When the sub sample seen over 12 months was examined (n= 25), there is evidence that positive change is maintained. This did not apply to smoking/drinking and health which was stable and then rose somewhat (Figure 19).

FIGURE 4: CHANGE IN LIFESTYLE RISK OVER 12 MONTHS (N=25)



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## SUMMARY OF QUANTITATIVE FINDINGS

The analysis shows significant levels of change in both risk and disorder following the intervention. This had been evident in earlier analyses with lower numbers, but has been sustained with larger numbers involved in the intervention and there is a trend for long term effects as evident from inspection of the 12 months follow up data. A smaller number of data points in the second follow up preclude definitive statistical analyses; however the trends indicated by the data do show a positive impact of the intervention.

Overall the intervention is associated with positive outcomes that appear to be retained over time, at least in a subsample of YP. Changes are seen in indicators of psychological disorder (both behavioural and emotional), including a significant change in levels of conduct and hyperactive disorders and a reduction in the total number of disorders held simultaneously indicating reduced comorbidity and intensity of symptoms. Lifestyle risks improve across most domains, with changes made in terms of relationships with family, educational, risks in area/lifestyle and impulsive and aggressive behaviour.

## 5. YOUNG PEOPLE’S EXPERIENCE AND VIEWS OF THE SERVICE

### 5.1 EXIT SATISFACTION QUESTIONNAIRE

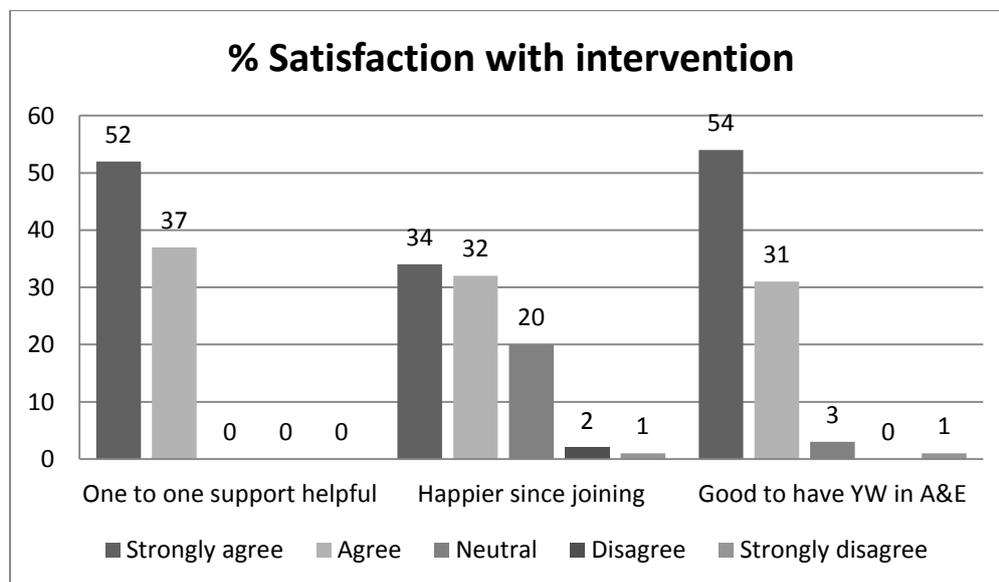
The following section describes the results of the Exit questionnaire completed by YP at the end of their intervention to evaluate their satisfaction with the service. Eighty nine YP completed the exit questionnaire.

In the first section, YP were asked to identify the best things about the intervention. *Support* was rated most highly (39%), *activities* were next best valued (22%), *mentoring* closely followed (19%), *networking*, *friendship* and *opportunity* also noteworthy.

When asked what the service could do to improve, respondents primarily replied that there was “nothing” to change (49%), that they should expand (10%), extend sessions (2%), be more visible in the hospital and relate more to youth (1% each). 37% left this section blank.

As to their experience, all of the respondents surveyed agreed (42%) or Strongly agreed (58%) that the One-to-One sessions were helpful. 74% felt much happier since joining, whilst 22% were neutral and 3% disagreed. Almost all (96%, n=70) respondents agreed it was a good idea to have a Youth Worker in a hospital, with 2% neutral and 1% disagreeing with this statement (Figure 20).

FIGURE 20: EXIT QUESTIONNAIRE SATISFACTION WITH SERVICE (N=89)



Finally, when asked if they thought it likely that they will return to the ED, 64% of respondents (n=56) thought that this was unlikely, whereas 25% neither agreed nor disagreed (18) and 11% thought that it was likely they will return (10 cases).

When Term 1 and Term 2 responses were examined separately, the only differences seen were when asked about likelihood of returning to A&E, Term 1 cases thought they were more likely to return (14% vs 6%).

## SUMMARY:

Overall there was evidence that YP highly valued the relationship elements of the intervention as well as the activities within which they engaged through it. They felt the intervention had improved their wellbeing and all agreed that it had been helpful. There was nonetheless some degree, albeit not very pervasive, of uncertainty around their likelihood of returning to the ED.

## 5.2 INTERVIEWS WITH SERVICE USERS – LONGER TERM FOLLOW UP

Interviews with 10 service users at first follow up were presented elsewhere<sup>44</sup> and initial findings from long term interviews were presented in a previous report<sup>45</sup>. Therefore, the current report will present only a selective sample of data collected from nine YP who were interviewed at second FU. The full details of their interviews can be sought from the authors.

Quotes have been extracted from typed transcriptions of the interviews and coded with their unique study identifier. Details about the YP can be viewed in Table 6 below:

TABLE 6: DESCRIPTION OF T2 INTERVIEWEES

ID	Age	Gender	Length of time since intervention	Reason for index attendance	Activities currently engaged in
A029	16	Female	27 months	Self-inflicted	Hair and beauty college
A057	20	Female	18 months	Assault	Became a mother and completed a youth work course.
A189	17	Male	12 months	Self-inflicted	About to re-start college through Princes Trust; Applied for motor mechanics course
A257	20	Male	24 months	Injury during fight	Studying architecture; Gym
A343	19	Male	12 months	Assault	Prince's Trust – security course, voluntary work at hospital, applying job health care assistant
A425	19	Male	12 months	Assault	Bin loader (just started)
B044	15	Male	12 months	Assault	School
B055	14	Male	16 months	Self-inflicted	School
B069	16	Male	12 months	Self-inflicted	School

<sup>44</sup> Report 10: Evaluation of Guy's & St. Thomas' violence intervention project: Final report. Middlesex University (Oct 2013).

<sup>45</sup> Report 12: Evaluation of Guy's & St. Thomas' violence intervention extension: 2013-2015 (Oct 2015)

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## THEMES EMERGING FROM THE INTERVIEWS

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### HAD THE YP BEEN INVOLVED IN FIGHTING OR RETURNED TO THE ED AS A VICTIM OF VIOLENCE?

Interviewees were asked in detail about any experiences involving fighting or visiting the A&E over in the time since the intervention had finished. Almost all the YP said that they had not been involved in any violence or “trouble” since the intervention ended and had not been to the A&E. One of those interviewees talked about how he was happy with the new direction his life was taking since staying out of trouble.

*“Two years now, I’ve been out of trouble. And that’s really good...” Q: Do you think that you’re going to carry on in this direction? “Most definitely. I like the way that I’m going and I’m hoping to get somewhere in the future”. (A343)*

Another interviewee said that he had been back to A&E a few times when he started the intervention but identified that his tendencies to violence had reduced over time as he was shown by the YW other alternatives to using violence:

*“I can see where I go, I see what I need to do, I can be there for the family more instead of going out fighting because that was a regular weekend or a regular day. I go out, have a fight, eat, sleep, eat get back out and have a fag and go back out. That was me but now, I get up, have a fag, get dressed, go out, have fun...spend some time with my girlfriend, I’m done”. (A189)*

In contrast to those who had been to A&E due to violence/fighting four of interviewees had been to A&E for self-harm, all of whom had not gone back. One of them described that when she was angry she would hit whatever was nearest to her and would end up breaking her knuckles. Due to help with managing her anger she had not been back to A&E and did not see this happening in the future.

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### PERCEIVED CHANGE IN THE YP AS A RESULT OF THE INTERVENTION

All nine of the YP interviewed felt they had changed a great deal as a result of the intervention and said they had sustained the positive change over time. Whilst the changes described varied with each YP and their particular circumstances, similarities emerged across the interviews.

#### EMOTIONALLY CALMER

Most YP felt they were generally calmer and had started to notice and control how they reacted to events or altercations or how they responded in potentially dangerous situations. For instance one young man described an incident where he and his cousin were attacked in a shop in an attempted stabbing. Instead of getting involved in a full-blown fight, he kicked the knife out of the assailant’s hand and then proceeded to run away. He explained that prior to the intervention he would have stayed and retaliated.

Another interviewee described how coming to see the YW helped him to manage his emotions more effectively so that he could concentrate at school:

*Q: Do you think working with [YW] has made a difference for your future? “He already has actually...emotionally. Before I met hi, it used to have big impact on my schoolwork I used to*

*stop working and just breakdown and just feel upset and not work the whole day but now I can put my problems to the side and just get on with everything and finish everything (A343)".*

## COMMUNICATION SKILLS AND SOCIAL CONFIDENCE

As well as feeling generally calmer, five of the young people interviewed also felt an improvement in their social confidence and communication skills. Some interviewees felt this was due to a change in the way they thought about others and how this influenced their ability to be less judgemental:

**Q: What kind of changes would you say have happened?** *My behaviour is better now, I can be more social, I can speak to people that I wouldn't normally speak to, like I would judge other people beforehand but now I'm more open to people rather than just looking at what they look like, .. (A057)*

This ability to think differently about people also affected how the YP reacted in the situation so instead of getting angry when they didn't get what they wanted they were able to use social skills to change their behaviour:

*"... It helped me understand my confidence a bit more to talk to other people and negotiate with other people about certain things instead of just getting upset and having a go at someone". (A189)*

Other interviewees mentioned that they felt they were able to trust others more easily and felt less shy in different situations such as finding suitable employment.

Three of the young people also mentioned that interactions with their family members had changed for the better since the intervention due to their changes in behaviour and attitude. In one case the interviewee described how she never got on with her mum before and how that had changed and been a source of support for her. In other cases the family were proud of the change in the YP which encouraged them to keep up the positive changes they had made:

*"Most definitely, yeah I think my family's got more proud of me that I'm doing all these types of different things. And they been supporting me and my mum's been proud of me". (A343)*

## PERCEPTION OF THE FUTURE AND SELF

In addition to improving confidence and relationships a number of interviewees seemed to have experienced a sustained change in how they perceived their future and what they would be able to accomplish. Some of the interviewees talked about their inability to see beyond their current set of circumstances and how the intervention had helped to see that there were many more options available other than violence:

*"...like, basically he (YW) tried to show me how there's so much more to do than just being a bad person or something like that... he really changed my life around". (A343)*

A common thread running through all the perceived changes was the change in the YPs thought processes around themselves, their ability to interact with others and their future. Many of them were able to identify this change in their attitudes and thought patterns and how it affected them:

**Q: Right so you've found that you're better at managing the way you..... ?** *"Feel and everything. Now I'm changing my way of thinking. If I look at someone and I think is this person going to be alright or is it going to be one of them ones where I'm just gonna walk out. And now I give him a chance and..... So it's helped me out in quite a few ways". (A029)*

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## PERCEIVED CAUSES OF CHANGE IN YP

### IMPORTANCE OF ONE-TO-ONE RELATIONSHIP AND YW QUALITIES

Interviewees were asked what they most valued about the intervention retrospectively. Many felt that one of the most important factors of the intervention was the nature in which the YW provided a space for one-to-one non-judgemental support, an opportunity to talk through problems and be listened to and understood in a confidential environment:

*"Yeah it's like an outlet for me or escape from all the emotions that I had inside too..... I just wanted to have someone to hear me..... It was more or less an emotional side of things and when I spoke to YW, I just...opening up to him and just telling him the private side of things. You know, he didn't judge me or anything.....". (A257)*

Other qualities of the YW and the sessions which interviewees highlighted were the reciprocal trust they felt with the YW. One interviewee described that because she felt she could trust the YW this helped her to open up to her. Two interviewees felt that the YW at OASIS was able to respect them for who they were and not talk down to them, something they had not experienced in other services. This was of interest as one of these was the YP who had been seen by three different OASIS YWs and she described it as a quality of the service as a whole:

**Q: About Oasis, what was different about Oasis?** *"They talk to you, as in like with CAMHS they'll ask questions as in like they just want to get information out of you. It's like with Oasis, they talk to you properly. And if you don't understand something then they will rephrase what they are trying to say. And it's like they treat people nicer than other places". (A029)*

### PRACTICAL ADVICE AND REFERRALS TO ACTIVITIES OF INTEREST

Apart from the importance of the relationship with the YW many interviewees felt that the advice given by the YW was a catalyst to their change. The advice which they found helpful was in the management of difficult behaviours and emotions and more practical advice on keeping themselves busy through work experience, voluntary work etc.

In particular two of the interviewees identified how the YW would give them advice on how to break down their specific issue into smaller goals to make it more manageable. For example one interviewee who had been getting into trouble because of drinking described how the YW had helped him to manage the amount of alcohol he was having by pacing himself and sipping the drink. Another interviewee who had difficulties in social confidence described how the YW would help him to work his way from less to more difficult situations:

**Q: So did [YW] give you some new tips on how to improve..?** *"[YW] said to work on it, go to like small places and build your way up to where you want to be..... Basically if you do that at minimum level, will start building your confidence right up which is quite good". (A189)*

Advice on finding alternative activities to keep them busy was extremely valuable for some and less so for others. Two interviewees had taken up different activities due to working with the YW. One was doing a security course as part of the Prince's Trust and was doing voluntary work in a hospital. The other YP had got involved in many out of school activities. With some of the other interviewees the YW had encouraged them in their areas of interest for careers or hobbies. The YW had introduced YPs to activities/opportunities that matched their aspirations and interests during the intervention and these experiences often led to further developments over time. What interviewees also found useful was that the YWs would go with them to visit different places and give them practical hands-on help. One interviewee described this below and also summed up what the intervention had done for him:

*"Basically he took me to ... really big hospital in London. .... And he took me there to see the ... firemen and the helicopter, ... paramedics. It was really fun, I really enjoyed it". Q: So do you think you would have gotten involved with any of these things, had you not met YW?..... "nah, I don't think so, if... if I'd never met him, then I don't think I'll be here today or done any of these things". Q: what do you think you would be doing now? "The way I was going, I would be in prison". (A343)*

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## SERVICE IMPROVEMENT SUGGESTIONS

When asked about potential improvements to the intervention, all interviewees were very happy with the service that they had received and the gains they had made. One interviewee felt that he would have liked the relationship to have been more peer based than professional although such a role could compromise the therapeutic benefit of the relationship.

Other suggestions for improvements included more opportunities for volunteering or work experience and a trip or reward for as goals are achieved:

*"I'd say at the end of it, once a certain amount of people have reached their goals like even if it's just a trip out or even to a theme park. As long as someone shows their appreciation and what they've done, it'll make people think, wow, if I can achieve this, I can achieve anything, it boosts up their confidence even more by getting a little something out of it". (A343)*

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## SUMMARY

Nine YP were interviewed at after a minimum of 12 months post intervention, all of whom had benefitted greatly from the sessions with the YW. All YPs spoke about sustained **change** as a result of the intervention and six YP were still in contact with the YW which seemed to play an important part in their ongoing change.

All interviewees felt their involvement with violence/self harm had decreased significantly. All reported feeling calmer and noticed/controlled how they reacted to events or altercations. Interviewees generally felt their communication skills and social confidence had improved helping them amongst other things to be less judgemental with others, less shy and more able to trust others. Family relationships were also reportedly improved.

Many interviewees felt they had experienced a sustained change in how they viewed their future and their ability to change things and have an impact in their own lives; a common thread running through the above changes was the alteration in the YPs thought processes in how they approached different situations

YP perceived the opportunity to receive one-to-one non-judgemental support; the opportunity to talk through problems and the nature in which the YW tried to understand them; the respect accorded by the YW and the confidential nature of the service as the key causes of change. They also valued the practical advice given for emotional aspects of problem e.g. how to break problem down into smaller components. In addition the support given for work experience, voluntary work, after school clubs etc. or along their desired career path including taking YP to different places was all considered beneficial.

#### YPS RECOMMENDATIONS FOR A HOSPITAL BASED INTERVENTION

Based on the content of the interviews, below is a list of the factors which appeared to be helpful in the interventions and which could be used to help plan future HBVIs. These recommendations need to be taken with caution however due to the small number of interviews this is based on:

- The need for a confidential, non-judgemental environment where the YP can feel safe to express their feelings and be listened to
- Respect for the YP regardless of their history
- Practical advice on how to manage their individual problem – anger management, self harm, drinking advice, communication etc. and breaking the problems down into smaller more manageable goals
- Linking the YP up to positive activities they can engage in through work experience, voluntary work or leisure activities in line with the interests of the YP
- Taking the YP to activities of interest
- Need for ongoing contact once intervention has ceased

## 6. STAFF VIEWS

### 6.1 STAFF SURVEY

This chapter investigates the views of staff in the Emergency Department (ED) in St. Thomas' hospital about the service over the duration of the project. The report describes a survey conducted with ED staff clinicians over three time points over the duration of the project: Baseline March 2011, first follow up March 2013 and final data collected in December 2015.

#### THE AIM

The aim was to gauge the changes in awareness, use of and satisfaction with the Oasis Youth Support (OYS) Service, between the baseline evaluation at 10 months and final term of the evaluation more than four years later in the 6<sup>th</sup> year of the intervention's existence.

#### THE SAMPLE & PROCEDURE

An online survey was sent out by email to doctors and nurses in the Paediatric and Adult Accident and Emergency (A&E) at St. Thomas'. A hard copy of the questionnaire was also distributed in the staff lounge.

#### THE QUESTIONNAIRE

The questionnaire consisted of questions assessing awareness of the service and the referral criteria for the service; it also asked about staff's perspective about the need for a service which tackles youth violence and their experience of it, if any. The referral criteria were given at the end of the survey as a reminder.

Completions figures were as follows:

Baseline Feb/Mar 2011	1 <sup>st</sup> Follow up (T1) Feb/Mar 2013	2 <sup>nd</sup> Follow up (T2) Feb/Mar 2016
64	54	63

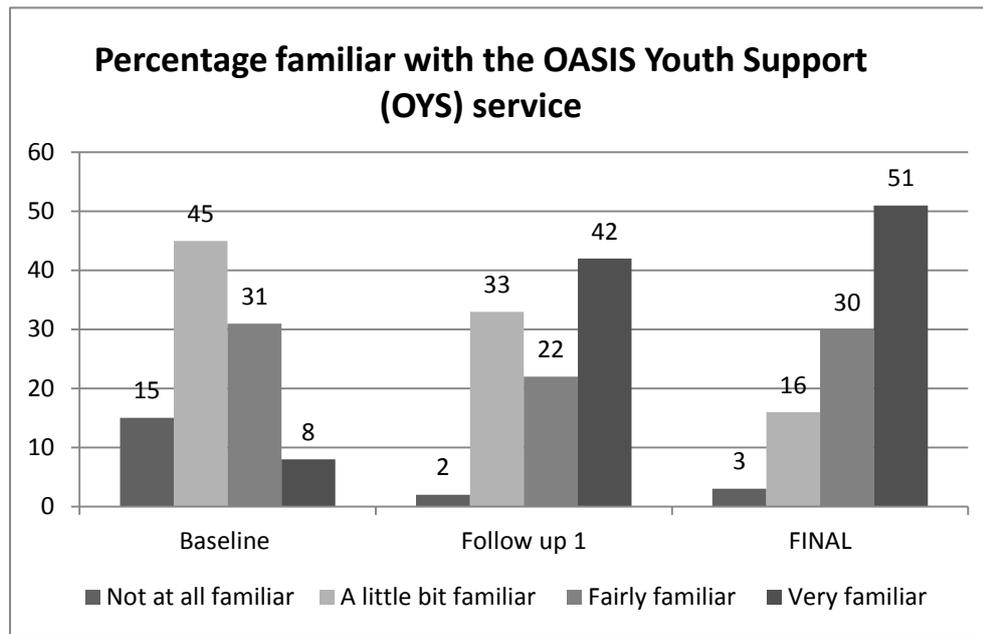
\*Due to the open nature of the survey targeting, it is not possible ascertain the response ratio.

#### RESULTS:

##### **Question 1: 'I am familiar with the OYS Service' (Figure 21)**

Rates of familiarity with the service doubled over time, growing from 39% at baseline (31% 'fairly' and 8% 'very familiar') to 81% at T2 (30% 'fairly' and 51% 'very familiar'). The corresponding rates of unfamiliarity reduced from 60% at baseline to 19% at T2 ('not at all' and 'a little bit' familiar scores combined). A Chi Square test of independence was carried out to compare the results between baseline and final follow up (T2). This showed a significant difference between these two time points in terms of familiarity with the service,  $X^2(3) = 53.13, p < .001$ .

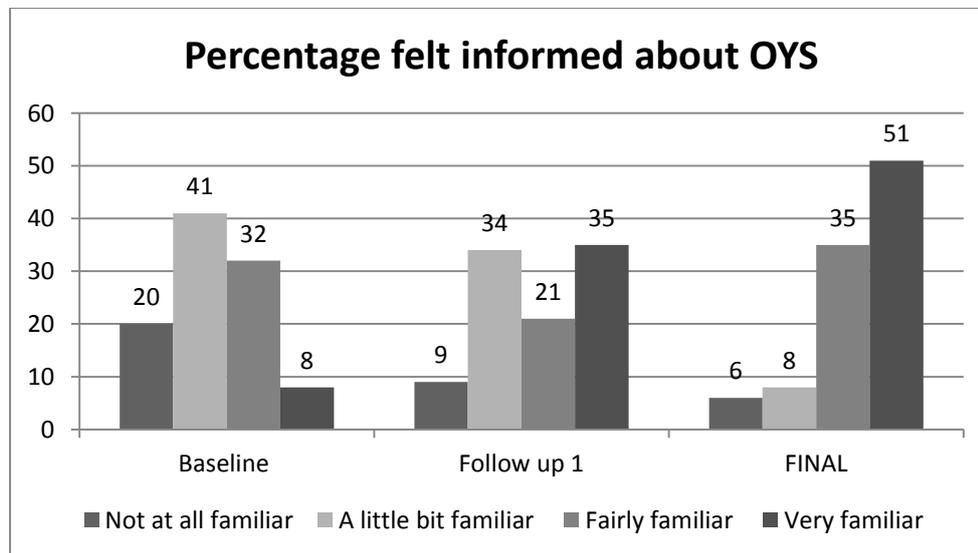
FIGURE 5: % FAMILIAR WITH OYS SERVICE



**Question 2: 'I am informed about the type of provision being offered by the OYS Service (Figure 22)**

Familiarity with the type of provision offered by OYS increased over time, with those who were either 'fairly' or 'very familiar' with the offer growing from a total of 40% (32% 'fairly' and 8% 'very familiar') to over double the rates at 86% (35% 'fairly' and 51% 'very familiar'). This was a statistically significant change ( $\chi^2(3) = 61.23, p < 0.001$ ).

FIGURE 22: PERCENTAGE INFORMED ABOUT TYPE OF PROVISION OFFERED BY OYS

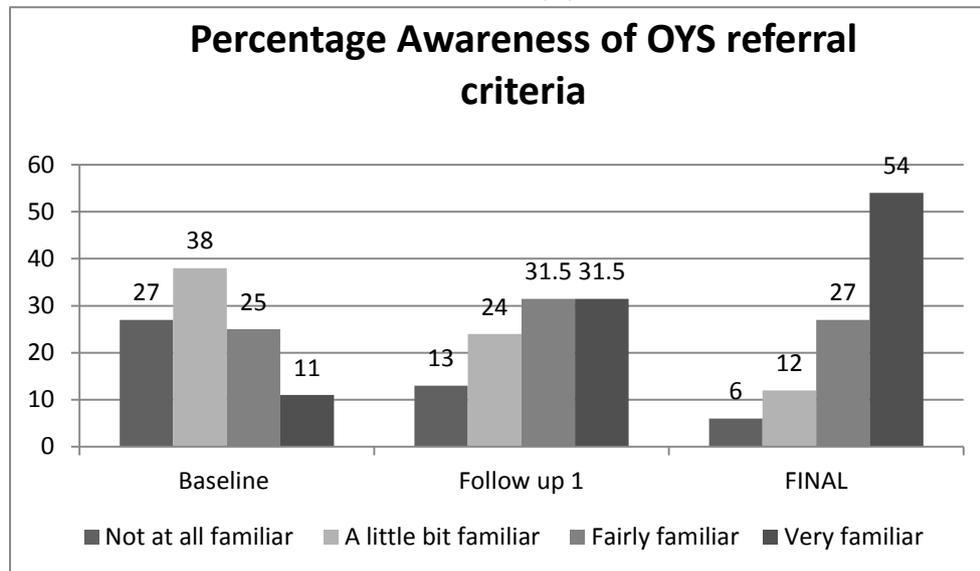


**Question 3: 'I am aware of the criteria for referring a young person to the Oasis Youth Support Service' (Figure 23)**

Knowledge of the referral criteria increased over time, with those who reported being either 'fairly familiar' or 'very familiar' growing from a total of 36% at baseline (25% 'fairly' and 11% 'very familiar')

to a total of 81% at final follow up (T2) (27% 'fairly' and 54% 'very familiar'). This was statistically significant ( $\chi^2(3) = 55.39, p < .001$ ).

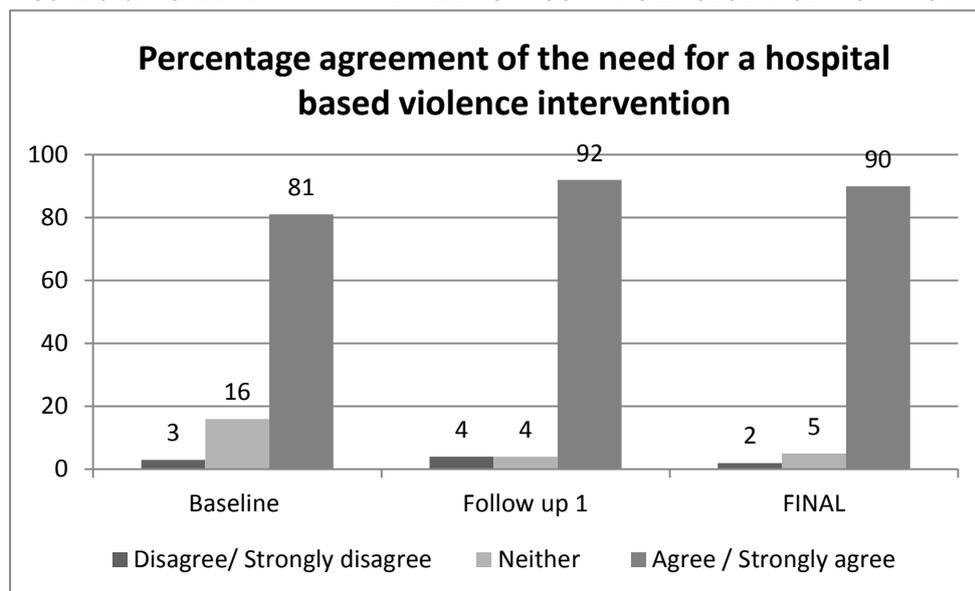
FIGURE 23: AWARENESS OF REFERRAL CRITERIA (%)



**Question 24: 'I believe there is a need for a service which offers an intervention for youth violence within St. Thomas' (Figure 4)**

Beliefs that a youth violence intervention within the hospital ED was needed, were high at both time points, with a significant increase in positive endorsement at T2 ( $\chi^2(2) = 6.3, p = .04$ ).

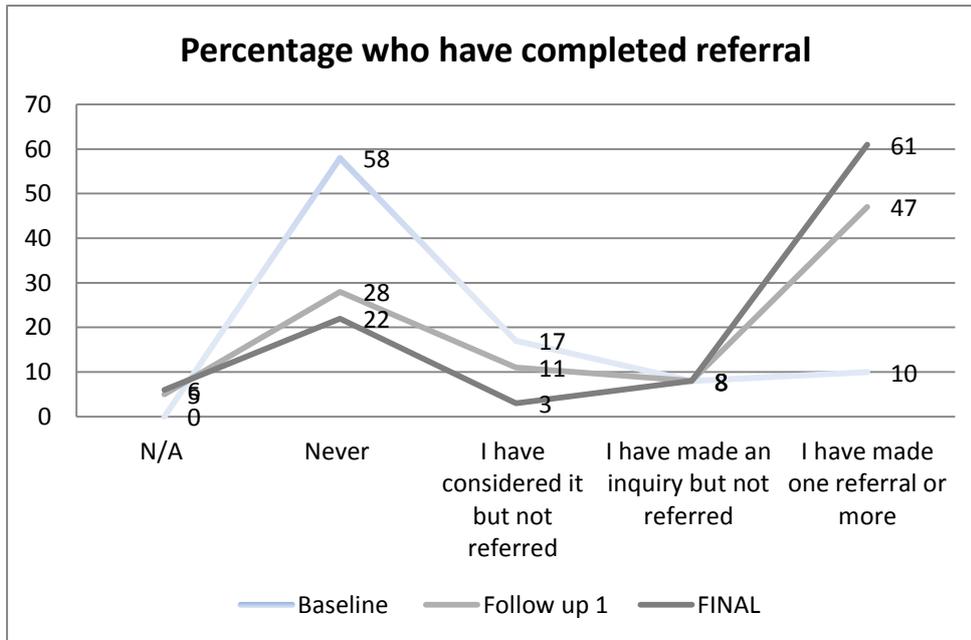
FIGURE 6: % AGREEMENT WITH THE NEED FOR YOUTH VIOLENCE SERVICE IN ST. THOMAS' HOSPITAL



**Question 5: 'I have in the past referred/considered referring a patient to the OYS Service' (Figure 25)**

Rates of those who had never completed a referral were reduced between baseline (58% never referred) and T2 (22%). Rates of those who had referred to the service increased from a total of 10% at baseline to 61% at final follow up, a significant increase ( $\chi^2(3) = 62.63, p < .0001$ ).

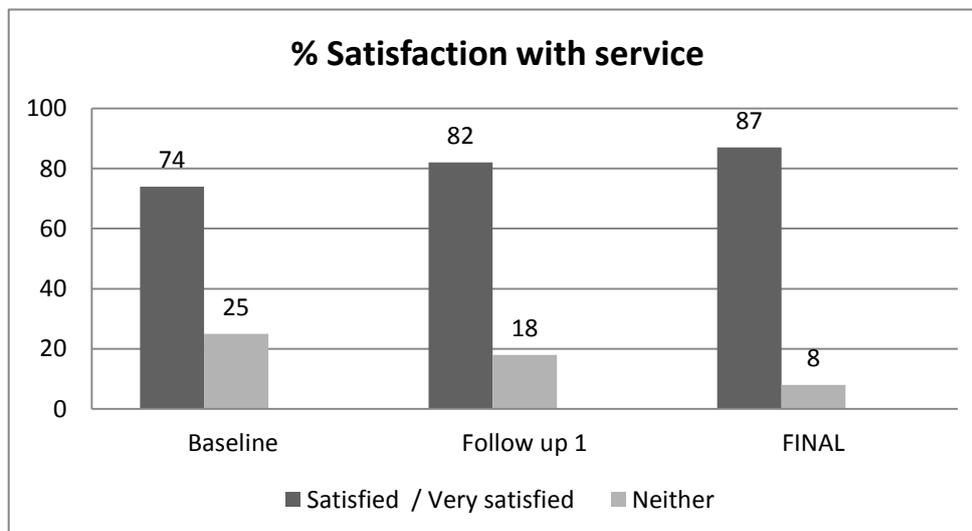
FIGURE 7: USAGE OF THE OYS SERVICE



**Question 6: 'If you have referred patients to OYS, have you been satisfied with their response / service?' (Figure 26)**

Satisfaction rates with the service were high throughout with those reporting to be either 'satisfied' or 'very satisfied' above 74% at baseline and 87% at T2.

FIGURE 8: % SATISFACTION WITH THE SERVICE AMONGST STAFF USED SERVICE\*



\*Rates of those who had used the service had gone up from baseline to follow up T1 and T2.

Percentage of those reporting to be 'neutral' over their experience of the service was reduced from 25% to 8%. None of the respondents reported to be dissatisfied with the service. When comparing the baseline and final follow up results, using a Chi Square test, a significant change in service satisfaction was observed:  $\chi^2(1)=9.72$ ,  $p=.002$

#### **Question 7: Further comments about the service.**

The following comments were given in a free text box in the staff questionnaire:

##### **Comments relating to the level of service:**

- *An excellent service - all the staff do a great Job*
- *Very visible easily approachable. Not yet met a person, but have seen them in the department seeing patients. Very prompt when in department to see patients.*
- *Tom is very helpful and approachable*
- *The guys are awesome keep up the good work!*
- *The Oasis team I find very approachable. They are always willing to give feedback about specific patients which I have referred to them.*
- *Impressive commitment to keeping the profile of the service high - turn up to handovers/ meetings/ regular email reminders*
- *It is a sad reflection upon society that we need teams like Oasis however they are needed. Tom and his team are always very approachable and enthusiastic. There have been cases that i would have liked to refer and I feel would have benefitted but the person has not consented and indeed are disparaging about the idea if only they would give them a go!!!*
- *Very approachable and informative. An excellent resource to have.*
- *Good contact and communication with oasis youth worker, notifies staff when he's on call in the evening. Valuable service.*
- *Very impressed with the speed and continuity of each case.*
- *An invaluable service for the young people who attend our department*
- *The staff are fantastic. Very visible. Keep all of A&E updated and engaged.*

##### **Suggestions:**

- *The service should be available to other patients/clients who attend the hospital for regular follow up and not just available for those who attend the emergency department as other young people would greatly benefit from it and they do not have access to a similar service within the hospital.*
- *Extend to all secondary school children, not just over 12yrs.*

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#### **CONCLUSIONS:**

A substantial increase in awareness and familiarity with the service, its purpose and referral criteria, was evident over the existence of the service. The changes were found to be sufficiently large to yield statistically significant results across the board. Satisfaction with the service increased over time, although was rated high at all time points. Usage rates increased significantly so that more staff had completed one or more referrals. Comments about the service were very positive and indicated the service was considered valuable and could benefit more people if extended. The embedding of the service so that staff recognition and usage increased required time in order to take effect. These results suggest considerable ownership of the service by ED clinical staff.

## 6.2 STAKEHOLDERS AND CLINICIANS' VIEWS OF THE OASIS YOUTH SUPPORT SERVICE

Interviews were carried out with stakeholders and clinicians involved with the OYS service in order to gain their opinions on the service being delivered and its future trajectory (n=5). Their views explored the impact of the service, its integration into the Emergency department (ED), the steering group and long term funding issues. The following is a summary of the interviews and suggestions for the future.

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### THE SERVICE AND ITS INTEGRATION INTO THE HOSPITAL

#### INCLUSION CRITERIA AND REMIT OF YW

All of those interviewed were very positive about the work of OYS and its impact on YP. Clinical staff felt that when the YW is onsite or nearby it is easier to encourage YP to meet the YW and to establish the connection to the service. Given that many YP present to the ED after school, later on in the evenings and at weekends, there are times when the YW is not on site.

The age range for those included in the service was expanded to 20 enabling some of those presenting to Adult ED to access the service. Suggestions were made about extending the inclusion criteria to all secondary age children (i.e. those younger than 12) and to the older age range (up to 24) and also including any YP who attend due to any risk behaviour from YP and those with alcohol/substance misuse.

The interviewees made the following recommendations:

- Ensuring the YW is on site at times when YP are more likely to present. Encouraging more onsite presence.
- Reassessment of the inclusion criteria in terms of age and other behaviours, ensuring capacity to undertake any further work.

#### INTEGRATION OF OASIS/YW INTO THE ED

OYS has a good presence within A&E and their work is respected by all – staff know who the YW is, what the service is about, and how and when to refer. The YW speaks to all new staff at inductions and has made links with other agencies when networking is required. Knowledge of the service and the ability to refer to OYS enable staff to give a more holistic approach to YP rather than just giving the requisite physical care. A barrier to uptake could be when ED is particularly busy and staff have less time to explain the service. Generally, staff welcome feedback from the YW regarding the YP who come through the service.

There is a general consensus that the referrals/service is better integrated into Paediatric ED than Adult ED services. This is probably due to the extra safeguarding measures which would naturally be done within a paediatric department. All cases in paediatrics are reviewed and anything that is missed during initial contact is subsequently followed up. Also once YP are over 16 they no longer need a consenting adult, who are more likely to encourage the YP to take up the referral. However

it would not be possible to change the way the adult department works unless there was a member of staff available to review notes of all presenting YP.

#### Ways forward:

- More feedback to staff to keep them motivated to refer and to hear how the YP do as a result of the referral. This could perhaps be done at an existing staff meeting with the YW attending every few months to update staff on uptake of service or perhaps a system of feeding back to clinicians about their referrals.

#### IMPACT OF SERVICE ON YP COMING TO A&E

The success of the service is viewed as being more within individual stories of change in YP than knowledge of the actual impact the service has on YP re-accessing ED due to violence/aggression more generally. Part of the challenge is not knowing whether YP reattend at EDs in other hospitals and not being able to put a cost on prevention i.e. changing someone's life versus alternative life paths. Those interviewed felt that the service was generally cost effective although due to lack of a control group it has not been possible to quantify this.

#### Recommendations:

- Presenting outcome data from the present service evaluation to the staff.
- Working to form links and a data sharing pathway between St. Thomas' and other local hospitals (especially King's which is the nearest major trauma centre) to enable assessment of re-attendances in the Lambeth and Southwark boroughs.

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### STEERING GROUP AND FUNDING ISSUES

#### STEERING GROUP

The steering group was set up to fulfil a number of functions – to help establish the service and deal with teething issues, to raise funds and to network. The steering group has also maintained ownership of the service and has made good links in networking with other agencies e.g. police, Mayor's office etc. As the service is well established now within both A&E departments the meetings focus less on clinical issues and more on the ability to raise funds to enable the continuity of the service. As the remit has changed there is less of a need for all clinical staff to be present.

#### Recommendations:

- To rethink the remit and aims of the steering group and, subsequently, a reconstitution of its members in line with this.
- To continue with multi-agency work, networking and fundraising.

#### FUNDING AND WIDER SYSTEMIC ISSUES

Within the general context, funding for youth programmes has been cut which makes securing ongoing resources more difficult. Funding has been secured year on year but has not been mainstreamed which has made it a challenge to keep the service running. Annual reports from the YW team have been an important tool to help secure further funding. Funding has recently been

secured to continue and expand the service with a female YW through MOPAC, and Lambeth and Southwark CCGs. There may be a need for empirical evidence through ongoing evaluation to help secure future funding.

Working with other hospital based violence interventions (e.g. North Mid and others) to build up a network may lead to more fundraising opportunities and better sustainability of the services. This could also initiate a regional forum focusing on preventative support for YP (e.g. through schools) and a broader approach to fundraising.

Wider systemic issues include a lack of multi-agency data sharing leading to a fragmented picture of the YP in attendance. More joined up multi-agency work locally would further enable YP access to community services. Additional barriers include lack of community structures, need for longer term monitoring and finance being primed for acute care over preventative work.

### **Recommendations:**

Finding ways to secure funding and in particular for a continual funding including:

- Continuation of annual reports from YW.
- Putting in a proposal to the hospital (or CCG) for funding.
- Raising awareness of the service through the Health & Wellbeing board, Southwark and Lambeth councils, local politicians, counsellors etc. and finding local opportunities to present findings.
- Ongoing data collection and analysis to show impact of service.
- Continued networking with other hospitals to build up a regional YW service and explore funding potential.

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## SUMMARY OF STAKEHOLDER INTERVIEWS

Overall there is strong support for the work being carried out by the service to date. The main concerns expressed are around the resourcing of the service, rather than any question of its quality or impact. The only caveat to this is the opaque nature of recording of actual cost in terms of reattendance at St. Thomas' or other hospitals. There is a desire to expand the programme overall in order to be able to offer it to more vulnerable young people.

## 7. INTERVENTION CONTENT & CHANGE OVER TIME

The following section includes the data collected to understand more about the actual content of the intervention being delivered by OYS YWs. First, there is a review of the goals that were set out by YW at the outset of the intervention and rates of achievement. Second there is a presentation of the depth case study analysis. Finally, this section reviews the development of the service over time and what changes have occurred.

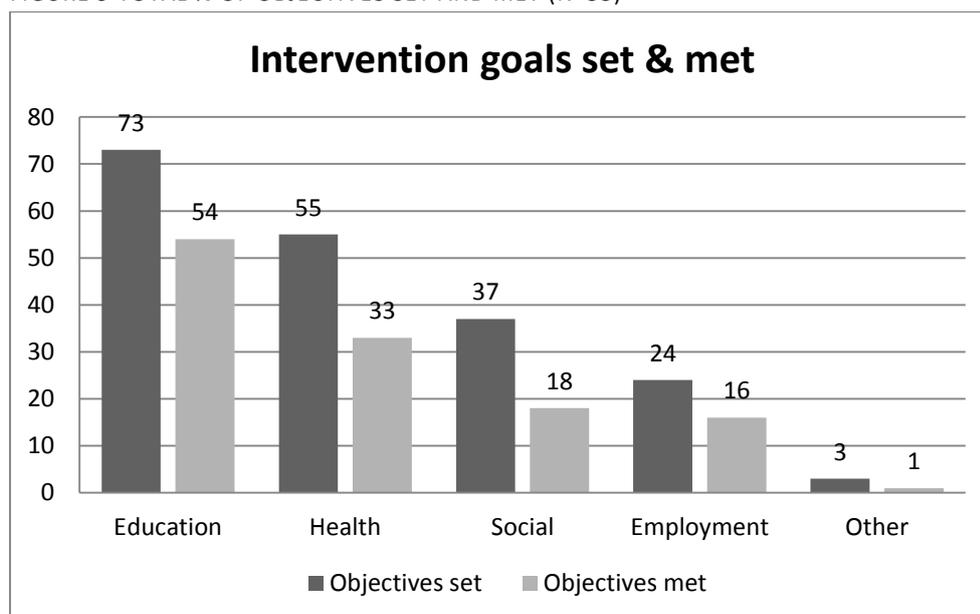
### 7.1 INTERVENTION GOALS

Recording of intervention goals was put in place in Term 2. The assessment detailed the selected goals and identified when these had been reached.

Fifty three respondents completed the *Intervention Goals* assessment. In total, 189 goals were set, an average of 3.7 per person, range of 1-7. Almost 60% (58.1) of goals set were met (n=110).

Education, including educational engagement, attainment, and other educational goals was found to be the most frequently set category, with a total of 73 goals set, of which 74% were met (n=54) (Figure 27).

FIGURE 9 TOTAL % OF OBJECTIVES SET AND MET (N=53)



Health, including anger management, changing substance use behaviours, engaging with mental/health professionals and other health, was the second most frequently ascribed category with 55 goals set, and 60% of these met (n=33). The sub-category of 'Adopting Anger Management techniques' was targeted 29 times, of which 22 were met (76%). 'Social' was the third most ascribed category set, including engaging a community/extracurricular activity, obtaining housing or doing voluntary activities. In total 37 goals were set in the Social category; 49% of these were met (n=18). 'Employment' was the least set category, presumably due to the age range, with 24 goals set; of those, 16 were reportedly met (67%). This included improving employability skills and prospects or

getting a job/work experience.

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#### SUMMARY:

Educational and health goals were the most frequently set goals, followed by social and employability objectives. Approximately 62% of goals were met, by the time intervention was closed, however it is acknowledged that some goals may require further time to achieve than is possible within the duration of the intervention. It is clear that the intervention team is taking steps to make changes which are central to young people's lives. Setting achievable goals is an important part of the tailoring of the intervention content.

### 7.2 EVOLUTION OF THE INTERVENTION OVER 6 YEARS

The OYS service launched in 2010 has developed in leaps and bounds since its inception. This section describes some of the key developments to the service in its 6 year lifespan, including changes in structure and methods over the years.

- Change in inclusion criteria: at the outset the age limits were set to 12-17 years old. In 2013 the age range rose to 19 and then to 20. The vision is for the service soon to be able to treat anyone up to the age of 24, however current staffing resources do not allow for such an expansion (current plans are to trial the extended age range in January 2017). Eventually, the target of the intervention is to be able to include any Southwark or Lambeth resident (and beyond) who is affected by any issues relating to well-being in relation to violence, drug abuse, gangs or exploitation.
- In terms of referral methods, the pilot which ran from 2010-2013 included referrals through patient records. It became apparent over time (and due to resourcing issues) that identifying potential service users through the patient record system was not cost or time-effective. Resources were being expended on the identification and the contact attempts but ultimately there was a much higher rate of those who declined the service or were uncontactable. Thus from the second term of operation, the intervention sourced its referrals directly from practitioners who were coming in contact with the vulnerable YP.
- The duration of sessions has also changed over time, with the initial number of sessions per person set out at: Low risk – no direct work; Medium risk: 1-3 sessions; High risk: 4-12. It became evident that this did not provide sufficient time to build a relationship and generate change. Ultimately this led to changing the session infrastructure in term 2, to: Low risk YP receiving 1-3 sessions, Medium risk receiving 6-12 and high risk receiving 12-20. There has also previously been an attempt at group session in 2013, which had very limited uptake; this is now being trialled again.
- In recent months staff have begun recording cases in which they have delivered 'secondary support' – in these cases there have been 3 or less f2f sessions, significant input has been made (which may include some f2f work and referrals to additional services) although not enough to be regarded as a full intervention.
- Other changes include the physical location of the OYS office: a number of moves have occurred due to the rebuilding of the hospital ED: at the outset the OYS office was based

just outside the ED, with easy access to the adult & paediatric department. During 2014 the office was relocated temporarily to an external building which was not adjacent to the ED. However in August 2016, the team have been moved to the space which sits right on top of the ED, housing the other auxiliary personnel including the ED admin & management team and other services such as REACH (Domestic violence).

- Staffing of the service has also changed: In the initial pilot scheme there was one full time worker, a part time administrator and the rest of the cover was provided by student volunteers from Oasis UK and the hospital. When moving into the second term the service had secured the full time worker and a part time student worker. Since August 2016 the service was able to fund two full time youth workers and a part time administrator. This has not only increased capacity but provided a more consistent staffing structure as administration and student hours have fluctuated in the past, as well as student supervision taken greater management time and input.
- The Steering group regularly attended by stakeholders from within the hospital and in other agencies, such as police, local councils. In the recent year there has been a decline in the number of represented agencies attending the meetings of the steering group. This is thought to be due to the many post axing occurring in the local council in recent years. With the advent of a new term of service, and hopefully with more staff being recruited in local agencies, it is hoped that new members will be identified.
- In terms of YP's characteristics, these have remained much the same over time: with a split between Southwark and Lambeth (although fewer from Lambeth in the first year of service); mean age of approximately 14.9; majority of males (70% in 2010; 74% in 2016); most attending due to assault (50% in 2010; %55 in 2016) with approximately one quarter attending due to self-inflicted injury (25% in 2013; 20% in 2016).
- Over time the intervention team has built up its way of working, both in terms of streamlining its methods of contact, increasing research completion, using key assessments and solidifying contacts within the various agencies with whom they come in contact with, including a comprehensive list of personnel in schools, pupil referral units, after school and summer activities and workplace partners.

## 8. DISCUSSION

Over the duration of the evaluation 2010-2016 the Oasis Youth Support service has become more effective and streamlined, increased its sustainability and visibility and moved from being a pilot project to becoming a bona fide integral service offered by the hospital to treat young people affected by violence.

The data collected over the past 6 years combines findings on changes in YP's outcomes based on quantitative assessments and their views of the service. Also presented here were details of the working methods of YWs. In addition, clinical staff and other stakeholders' views were explored around the integration, effectiveness and future sustainability of the service.

### 8.1 KEY SUCCESSES OF THE INTERVENTION:

The following section summarises the key successes of the intervention based on the data collected in the current evaluation term:

#### SUSTAINABILITY & PARTNERSHIPS:

- Successful embedment in the hospital infrastructure, especially in Paediatric A&E which has led to consistent referrals and an increase in awareness and satisfaction with the service.
- An inspection by the Care Quality Commission of St. Thomas' hospital in September 2015 highlighted the auxiliary services attached to the Emergency department, including OYS, as a source of 'outstanding practice': "The specialist support units active within the urgent and emergency department including alcohol, toxicology, homeless, youth support and play therapy for children" (<sup>46</sup>p.31).
- Securing funding to expand the service by recruiting another full time YW.
- Securing funding for an external evaluation 2010-2016 and working alongside the evaluation team to achieve shared goals.
- Creating positive relationships with services involved in young people's care, including the safeguarding team at St. Thomas', statutory services in Lambeth and Southwark, such as YOT and CAMHS, local schools and local crime partnerships.
- Funding by MOPAC and local authority CCG with prospects of recurring funding.
- Exporting the service to another site (Oasis service at North Middlesex hospital) and continuous shared development work and joint learning.

#### EFFICACY:

- A good rate of service uptake and drop in the rate of service attrition, overall demonstrating an increase in service use and service utilisation.
- Changes in psychological and lifestyle risk factors demonstrated to be sustainable over the short and long term, as indicated by a sub sample of intervention completers.

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<sup>46</sup> Care Quality Commission (2016) Guy's and St. Thomas' NHS Foundation Trust: Quality report. [viewed on <http://www.cqc.org.uk/provider/RJ1>]

- Positive endorsement of the service by service recipients and stakeholders within and outside of the hospital.
- A trend towards reduced admissions amongst cases with history of repetitive attendances.
- Achieving Level 2 validation by Project Oracle, a hub of social research collating evidence-based practice for youth interventions in London.

## NETWORKING

- Sharing good practice with existing services across the country and beyond by playing an active role in networking and communicating.
- Creating more sustainable partnership with Redthread at King's hospital and carving out communication routes for joint case management.

## WORKING PRACTICES

- Consolidating the methods of the intervention so that they are more streamlined and gradually becoming more consistent and well defined.
- Demonstration of impact of service on young people through consistent undertaking of research questionnaires (including data collection and follow up of young people requiring a significant investment of time), thus enabling service evaluation over the long term.

## 8.2 KEY CHALLENGES FOR THE INTERVENTION

- An ongoing key challenge is that of recurrent sources of funding, ideally with buy-in from hospital /local CCG to ensure continuity and ownership of the service.
- Demand greater than resources - currently not reaching the threshold of demand with a backlog of pending cases. It is likely this will be resolved with the recruitment of a second full time worker in Aug 2016.
- A data sharing agreement with adjacent hospital trusts (especially King's) is needed to facilitate greater follow up of cases and charting of accurate attendance and outcome records.
- If validation at level 3 by Project Oracle is considered to be desirable, funding needs to be sought in order to develop the intervention methods and an accompanying evaluation to meet their standards of validation.
- Having not secured funding for further evaluation, consideration needs to be given to the means through which the service will continue to evaluate the outcomes of YP to ensure the evidence base is sustained. This will require the necessary resourcing and management.
- Increasing the numbers of YP who engage with the service and or understanding barriers to service uptake.

### 8.3 EVALUATION OUTPUTS AND DISSEMINATION

The evaluation team has been able to disseminate the study and intervention widely. The following is a list of outputs produced between 2010 -2016 by the evaluation team with contribution by the intervention team. It should be noted that to date, it is the only/first evaluation of a UK hospital-based violence intervention with findings relating to the impact of the service on YP's psychological and lifestyle risk outcomes over time.

1. Two peer-reviewed journal articles, as follows:
  - i. Ilan-Clarke, Y Bunn, A, DeMarco, J, Bifulco, A, Criddle, J & Holdsworth, G (2013) Setting-up a Youth Violence Prevention Project in a London hospital Emergency Department. *Journal of public mental health*,12 (2), pp 80-92.
  - ii. DeMarco, J, Ilan-Clarke, Y., Bunn, A., Isaacs, T., Criddle, J., Holdsworth, G. & Bifulco, A. (2016) Improving mental health and lifestyle outcomes in a hospital Emergency Department based Youth Violence Intervention. *Journal of Public Mental Health*, 15 (3), pp. 119-133.
2. Twelve reports charting the evaluation of the intervention over 6 years 2010-2016, including focus group, staff surveys, interviews with YP, YP's outcomes, and general assessment of intervention organisational application.
3. Presentations at two professional conferences: Stockholm Criminology Symposium [2013] and the Howard League [2014]. Poster presentation at King's Health Partnership Event [2011] and a presentation at Evelina Grand Round [2011].
4. First HBVI Network event, 'Healing the Wounds of Violence' seminar day produced by Middlesex University (2015), funded by the Knowledge Exchange university fund.
5. Presentation at a number of local interest group events including within academic settings.
6. Contributions to press releases and funding applications by Oasis UK.
7. Supporting the validation for Project Oracle at level 2 including the Theory of Change.

### 8.4 EVALUATION STUDY LIMITATIONS

- In spite of multiple efforts to retrieve patient information regarding ED attendances at King's hospital, this was not forthcoming. This means that any data available about the rate of reattendance of YP at EDs is incomplete.
- As is common in this field, retention of the sample for research purposes has been challenging and resulted in limited numbers with potentially selective characteristics in the long term follow up.
- A comparison with data from North Middlesex OYS was attempted, however due to limited figures, with very few YP having gone through the service to completion, it was excluded from the current report.
- The lack of a control group, drawn out of the sample of YP presenting to the service, presents a key limitation of the evaluation.

## 8.5 SUSTAINABILITY OF THE INTERVENTION AND THE FUTURE

Sustainability of the project is essential to give the service continuity and a base from which to plan its development. Over the years the project has moved from a pilot funded by GSTT as an innovative project, to part funding by various local councils and services in Lambeth and Southwark. The latest year of funding has seen a shift towards greater sustainability in the form of funding by MOPAC's Victim Fund and Lambeth and Southwark Clinical Commissioning groups (CCG). This move will ultimately afford the service much sought after continuity if the opportunities for recurring funding are realised. Ongoing ownership by the hospital (through CCGs) or local councils and agencies invested in outcomes of the project such as MOPAC, represent a clear endorsement of the service; however there will need to be efforts put in to ensure the service continues to demonstrate its efficacy.

Capturing data which fits in with the impact vision and goals of the various funding bodies from whom OYS hope to receive continuous funding and using this to evidence their practice, needs to be incorporated into the business plan and allocated resources to complete this (especially due discontinuation of the external evaluation). Consideration should be given to aligning the London-based HBVIs' methods of data collection and case management, and therefore to potentially adopting the measures currently in use by Redthread, to achieve comparable outcome data.

Another mark of greater sustainability has been the incorporation of the service's physical location in with the ED auxiliary staff, in a new purpose built office. This facilitates greater interaction with ED service management and in turn affords the service the recognition of a bona fide 'in house' service.

In the long term, standardising the methods of the intervention and replicating these in additional hospitals around the region or country is desirable. The first such 'sister' site is already in place in the form of the Oasis intervention at North Middlesex.

## 8.6 RECOMMENDATIONS

### EVALUATION

As the service will be continuing with no external evaluation it is recommended that there be a strategy put in place to decide how and what data will be continually collected.

- Consider adopting (with permission) elements of Redthread risk assessment in order to enable cross comparison of outcome measures. If retaining the WDYT, which currently forms the basis of the risk assessment, consider if there is benefit in using the updated version currently in use by the YJB. Ensure that all staff are trained to interpret and integrate outcomes into service plan.
- Develop links and data sharing pathways to examine reattendance rates with comparable and/or neighbouring hospitals, especially King's hospital.
- Consider whether it is possible to administer the risk assessment to all YP who present to the ED, even those who do not take up the intervention, as this could potentially inform the working practices of violence prevention teams.

## PRACTICE

- Ensure that YWs presence onsite is matched with the pattern of typical attendance by YP, in terms of time and days.
- To ensure uniformity in methods and ultimately replicability, there is a need to develop the staff manual to include the identification of which methods are specifically used to address risk factors.
- Consider reporting to clinicians with feedback on individual cases they have referred.

## WIDER IMPACT

- Update the aims and objectives of the intervention going forward, to ensure that these are guiding all activity undertaken.
- Identify key personnel to join the steering group, in line with revised aims of the service.
- Consider whether and how validation by Project Oracle at level 3 can be achieved, and whether the possibility exists for securing funding for an external evaluator who can be secured for the sole purpose of achieving that goal.
- Consider how funding for a UK-wide network could be achieved, with the aim of coordinating the activities undertaken by the various HBVIs and supporting new emerging programmes, taking a lead from our US-based colleagues in the NNHVIP.

## 8.7 CONCLUSIONS

The current independent evaluation has found that OYS service continues to provide effective intervention for young people at risk of, and involved in, violent lifestyles. Over the years the service has embedded itself successfully in the hospital infrastructure as well as the wider network of HBVIs in the UK.

Anchoring the intervention in an existing community charity which has supported the service through funding applications, providing student workers and volunteers, providing management and development work, supplying resources and enabling the channelling of service recipients through its wide network of other services and connections has been a key strength of the service.

The status of this service as one which effectively treats those YP at risk of further escalation into violence, is another key strength. Whilst it is not reaching those who are in dire physical state who are seen in major trauma centres, it is providing effective early intervention. Early intervention is a key goal for Southwark and Lambeth strategic plans for violence reduction and it is clear that the current programme falls neatly within the public health approach to violence being implemented by those agencies. Service recipients and stakeholders alike have endorsed the OYS and it is likely to continue to be a dynamic and resourceful player in the future of hospital based violence intervention services in the UK.

## 9. APPENDICES

### APPENDIX 1: FUNDING SOURCES FOR OYS 2010-2016

Year 1- GSTT Charity

Year 2- GSTT Charity

Year 3- GSTT Charity

Year 4- Southwark Youth Service, Lambeth Community Safety, MET Police

Year 5- Southwark Youth Service, Lambeth Community Safety, Lambeth & Southwark Public Health

Year 6- Southwark Youth Service, Lambeth & Southwark Public Health

Year 7 - Lambeth and Southwark CCG, and the MOPAC victim's fund.

## APPENDIX 2: PREVIOUS REPORTS (AVAILABLE FROM AUTHORS)

Report 1: Baseline data on the Youth Violence Prevention Programme (January 2011)

Report 2: The Focus group: Views of YP in South London on Youth Violence (February 2011)

Report 3: Report on Steering group interviews (April 2011)

Report 4: Staff questionnaire – Baseline findings (May 2012)

Report 5: Interim Report (September 2012)

Report 6: Results from interviews with YP (June 2013)

Report 7: Staff Questionnaire – Follow up findings (June 2013)

Report 8: Quantitative findings about YP (July 2013)

Report 9: Qualitative findings with project staff (July 2013)

Report 10: Evaluation of Guy's & St. Thomas' violence intervention project: Final report. Middlesex University (Oct 2013).

Report 11: Evaluation of Guy's & St. Thomas' violence intervention extension: Interim report (Oct 2014)

Report 12: Evaluation of Guy's & St. Thomas' violence intervention extension: 2013-2015 (Oct 2015)