

Therapeutic Intervention for Peace (TIP) Report

Culturally Competent Responses to
Serious Youth Violence in London

September 2020

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**POWER
THE
FIGHT**

Research funded by the
Mayor of London's
Violence Reduction Unit

Foreword from Lib Peck

DIRECTOR OF MAYOR OF LONDON'S VIOLENCE REDUCTION UNIT



When we think of the effects of an incident of serious violence, we tend to focus on the perpetrator and the victim. But for every victim, there are relatives, friends, classmates, colleagues, and

communities who are also left to come to terms with and heal from tragedy.

We know that therapeutic services that support people can play an instrumental part in limiting the emotional and mental trauma suffered. These services can also help build resilience within affected communities and prevent perpetuation of further cycles of pain and trauma.

However, since our inception, the London Violence Reduction Unit has heard one message consistently and repeatedly from families and communities affected by violence: namely that the necessary therapeutic support, vital to addressing trauma, is not available.

This is why we commissioned Power the Fight to undertake research into what needs to change. Drawing on their expertise and lived experience, Power the Fight has reached out to young people, families and professionals to hear their views and shape recommendations for an improved service going forward.

The resulting report challenges us to think differently about the levels of support provided to communities.

Casting a critical eye over existing provision, it questions whether the support is accessible enough to reach the communities where it is most needed, pointing in particular to the inadequacy of support available for young people whose friends have been tragically killed. Where support is available, the report questions if it is offered at the most appropriate time and for long enough. Further, it challenges whether the right people are delivering it in the right way.

What emerges is a clear recommendation for more community-based trauma and crisis intervention; a strong acknowledgment of the role of trusted youth workers as often the frontline support for young people; and a powerful call for culturally competent community services with local delivery. Where appropriate, it foresees a role for young people to help shape the nature of that support.

We commissioned the research early in the year, and we are grateful to Power the Fight for adapting the research to cope with the difficulties of lockdown.

Of course, the longer-term consequences of the pandemic present much more profound challenges. COVID has disproportionately affected young people's mental health, educational outcomes and career opportunities. Coupled with the national questioning and protest against structural and systemic racism, the report's central call for more and better community based, culturally competent and young people focused services is even more apposite and pressing.

We are delighted that the London's Victims Commissioner Clare Waxman has endorsed the report's findings. We look forward to working with her, alongside health professionals and the very many community groups and individuals who to make the report's recommendations a reality.

Our immediate challenge is to advocate for change in existing policy and practice and to redirect some existing resources while lobbying for greater overall investment in community-based services.

Our longer-term hope is that with better therapeutic provision in place, we are able to more effectively address the causes and effects of serious violence, to help build sustainable resilience in communities, and to equip our young people with positive mental health.

Endorsement from Claire Waxman

LONDON'S VICTIMS' COMMISSIONER



"This report from Power the Fight is a hugely valuable contribution to our understanding of how best to support communities experiencing trauma as a result of serious youth violence.

As Victims' Commissioner for London, I know first-hand how important therapy can be in helping to heal from trauma. But therapy is not always seen as a viable or attractive prospect. We must always

be aware of any deficiencies and barriers in the system that prevent individuals or communities from getting the help they deserve.

This research makes a compelling case for services to be culturally competent in order to be truly effective. It is vital that people see themselves reflected in the services on offer and have confidence that they will be truly understood.

The report also underscores the significant value of community-based trauma informed approaches. I look forward to seeing how this excellent research goes on to inform and shape practice in London and beyond."

Foreword from Ben Lindsay

CEO OF POWER THE FIGHT



It is widely acknowledged that serious youth violence devastates the lives of young people, families and communities. What is less documented is how communities

best heal from such tragic circumstances, and furthermore, the existence of barriers for those impacted in terms of seeking professional support to move forward and to build resilience. For the past 20 years I have worked in a variety of roles including youth offending teams, community safety teams, the charity sector and church leadership. What has become clear is that communities impacted by youth violence do not easily access therapeutic support – specifically culturally competent therapeutic help. My experience is that while people may need and want access to therapeutic help, often they do not ‘fit’ the criteria for existing services. Even when they do, these services may not be ones that they would feel comfortable accessing. Meanwhile, more and more young people are suffering from the trauma of the amplification of youth violence in their local area through the news and social media.

While I do not subscribe to the perception that knife/gang crime across the UK is predominantly a Black issue, we have to acknowledge – especially in a London context – that knife crime disproportionately impacts Black and brown people (23% of all sharp instrument homicide

victims in England and Wales in 2019 were Black, despite Black people comprising only 3.4% of the population)¹. In addition, the number of Black and ethnic minority individuals in mental health professions is far from representative.

Evidence shows that race and gender are significant factors in the relationship between the prevalence of mental health conditions, access to treatment and positive health outcomes, suggesting serious gaps in the way in which diverse communities are being served². One of the questions this report seeks to answer is whether the lack of cultural competency among therapeutic professionals contributes significantly to the low uptake of therapy by Black and brown communities.

This report by Power The Fight draws on the views and experiences of young people, families and youth work professionals to demonstrate that the provision of a culturally competent therapeutic service would increase levels of engagement by those impacted by serious youth violence. The report has been made possible through funding from the Mayor of London’s Violence Reduction Unit. Our initial proposal was to deliver a pilot therapeutic service for young people and families impacted by youth violence. Led by Power the Fight’s Clinical Lead Dr Zeyana Ramadhan, the three-month pilot – termed “Therapeutic Intervention for Peace” (TIP) - was set to work with a South East London secondary school and other young people and families already engaging with Power the Fight, to create a co-designed, culturally competent therapeutic service which would build the resilience of local

¹ Office for National Statistics (2020) Homicide in England and Wales: year ending March 2019

² Race Disparity Audit 2017, Section 9 <https://www.gov.uk/government/publications/race-disparity-audit>

communities and enable therapeutic support in the direct aftermath of a critical youth violence incident. The project aimed to harness the impact of leading practitioners, local youth organisations, evidence-based models, proven mechanisms of delivery and a network of churches and charities to develop a scalable, community-based response that provided an effective therapeutic service for young people and families impacted by youth violence.

In response to COVID-19, we have had to adapt our plans significantly away from face-to-face work, but what has developed instead is a research report which provides strong foundations upon which to build such a service. The findings of this report are more relevant than ever as communities seek to rebuild and recover after the crisis of the pandemic. The report draws on qualitative and quantitative data from 102 young people, five families and 26 professionals to give a strong picture of community experiences of therapeutic services.

I would like to thank the extraordinary team: Lead Researcher and Evaluator Dr Elaine Williams, Clinical Lead Dr Zeyana Ramadhan, interviewers Ebinehita Iyere, Claude Murray and Lisa Harrison and all the participants. I am grateful to everyone at the Mayor of London's Violence Reduction Unit for their support during the completion of this report. My hope is that the findings of this report influence practice and make a lasting difference to the support available to communities impacted by youth violence.

A handwritten signature in white ink, appearing to be 'Ben Lindsay', with a stylized, cursive script.

Ben Lindsay

Founder & CEO of Power The Fight

About The Authors



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Dr Elaine Williams is a researcher and lecturer in Criminology at the University of Greenwich. She has a cross-discipline background in Anthropology, Sociology and Cultural Studies and her ESRC-funded PhD considered the politics of 'knife crime' in the context of deviance labelling. She is a critical criminologist, researching youth crime policy, politics and economics with a history of professional practice in youth and community development.



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Ebinehita Iyere is a youth practitioner working with young people who come into contact with the youth justice system and those who are impacted by violence in the community. Ebinehita has extensive experience working directly with young people using holistic, relational and creative methods to support their needs, as well as working with multi-agency professionals across systems and decision making. Ebinehita is the founder of Milk and Honey Bees, a creative and expressive safe space for Black Girls to flourish and put H.E.R (Healing, Empowerment and Resilience) first. Ebinehita is currently training as a Child and Adolescent therapeutic wellbeing practitioner.



BEN LINDSAY

Ben is founder of Power The Fight, a charity which launched in 2019 to train and empower communities to end youth violence. One of The Evening Standard's Progress 1000 London's most influential people for 2018, Ben is an experienced trainer and facilitator with more than 19 years' experience working with high risk young people in the field of gangs and serious youth violence. Ben was Chair of the Greenwich Independent Advisory Group until 2016. Between 2016 and 2020 Ben was lead pastor at Emmanuel New Cross church in South East London. He currently sits on the Mayor of London's Violence Reduction Unit reference group and on the cross-party Youth Violence Commission.



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Claude Murray is a qualified integrative counsellor and a registered member of the British Association for Counselling and Psychotherapy (BACP). His modes of practice incorporate Person Centred Counselling, Cognitive Behavioural Therapy (CBT) and Psychodynamic Therapy. Claude has over 14 years' experience in supporting young people and families. As a practitioner his holistic approach has enabled him to work on trauma units within the NHS, in addition to working within the education sector and criminal justice system. Claude has also worked for a number of leading youth charities and currently works at XLP, where he is Chief Safeguarding Officer and manages a nationally recognised mentoring service.



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Executive Summary

Executive Summary

BACKGROUND

The intention of this research was to evidence the experiences of young people, families and practitioners in order to improve the effectiveness of therapeutic responses to youth violence in London. In the context of increasing rates of interpersonal violence in the capital and renewed commitment to the public health approach, this research provides practical recommendations for the improvement of therapeutic services in London. The report draws on qualitative and quantitative data from 102 young people, five families and 26 professionals providing extensive analysis of community experiences of therapeutic services.



KEY FINDINGS

The following main findings of the report represent common experiences and key themes which were repeatedly evidenced across all research areas:

- 1** The majority of **young people surveyed had a high proximity to violence** (experiencing it either first-hand or through close friends), with experiences of violence most likely to lead to feelings of anger. Black and male respondents were less likely to talk about these feelings and more likely to deal with these feelings through retaliation.
- 2** Therapeutic services that fail to understand the broader contexts and causes of youth violence **risk harming young people further by making them feel they are the problem.**
- 3** The **language and culture of formal therapy can be a barrier** for engagement with practitioners urging for greater innovation and flexibility in how therapeutic interventions are defined and delivered.
- 4** **Marginalised groups often deeply distrust organisations and institutions** due to consistent experiences of structural harm through inequality in health care, education and criminal justice systems.
- 5** For Black people in particular, **trusting relationships with professionals rely greatly on representation and cultural competency**, with young people and families much more likely to speak with practitioners who share or understand their ethnic background and culture.
- 6** The **specific needs of women and girls in the context of community violence have been side-lined** by male-focused interventions, leading to an absence of long-term girls' projects, peer-to-peer support and parent groups for engaging families affected by trauma.
- 7** **Referral systems are currently not fit for purpose;** the threshold for engagement is too high and not effectively assessed, waiting lists are too long and there is a lack of ability to engage disenfranchised and socially marginalised groups.
- 8** In maintaining trusted and supportive relationships with socially marginalised young people and families, **frontline practitioners are often risking their own mental health and wellbeing** by becoming emotionally embedded in communities and feeling accountable for their safety.
- 9** **There is a fundamental lack of clinical supervision for these high-risk roles,** with many organisations having no internal referral process for their employees despite the harm their workers are continuously exposed to. This profession has a high 'burnout' rate.
- 10** **Practice based or professionals with "lived experience" are systemically undervalued** and structurally excluded from decision making at a strategic level, often made to feel culturally out of place, tokenised or exploited.
- 11** There is currently **no cohesive strategy or 'wrap around' package of support in place;** to provide immediate and long-term support for family and friends in the aftermath of a violent incident or traumatic loss.

RECOMMENDATIONS

The report concludes that effective therapeutic interventions to end youth violence are reliant on applied **cultural competency** and recommends pragmatic steps for service improvement.

The report's recommendations are aimed at institutions and Government bodies working with families and young people, including the NHS, Department for Education, Department of Health and Social Care, Ofsted, Youth Justice Board, Metropolitan Police Service, local authorities and youth charities.

These include:



Cultural Competency training at all system levels and **clinical supervision** for all front-facing practitioners.



Multi-layered intervention designs that combine formal, informal and creative therapies with long term engagement and community co-production.



Collaborative referral management systems and **community case mapping** for holistic work with young people and families.



Cohesive and effective partnership work, bringing together families, services, agencies and institutions through **culturally competent conduit organisations** that have the capacity to connect people and services.

CONCLUSIONS

The timing of this report is of particular pertinence. As the world responds to the economic challenges of the COVID-19 pandemic and global protests' push for action against the harms of institutional racism, this is a moment of both uncertainty and opportunity. This report's findings evidence both the importance of long-term investment in therapeutic responses to serious youth violence, and the current inadequacies of an approach that does not take into consideration the cultural, social and individual barriers for effective engagement. The choices made within this moment will be decisive and it is hoped that the evidence and recommendations presented here can provide practical models for much needed change.

Part One:

Introduction & Review

Part One: Introduction & Review

1. INTRODUCTION

Part One of this report will outline the current context of youth violence in London, considering recent crime figures, incarceration rates and evidence of heightened anxiety and fear amongst teenagers in the capital. Key terms and approaches within this report will be defined, describing what is meant by a 'therapeutic intervention for peace' (TIP), along with a discussion of the aims and methods of this research.

2. RATES OF YOUTH VIOLENCE

According to the Office for National Statistics (ONS), the number of offences involving knives recorded by police in England and Wales in 2019 was the highest on record³. In the same year, the number of teenagers stabbed to death in London hit an 11-year high⁴. There were 45,627 offences involving knives or sharp instruments recorded by police in 2019, a 7% rise year on year, and 49% higher than 2011 when comparable records began⁵. Equally as concerning are statistics from the Youth Justice Board stating that the average custodial sentence length given to children increased by more than six months over the last ten years. This has increased from 11.4 to 17.7 months. The number of children held in youth custody on remand increased by 12% in the last year and accounted for 28% of all children in youth custody⁶.

While this data may be shocking, numbers of fatalities and incarcerated young people are only some aspects of the youth violence spectrum. How does youth violence impact the average young person? A survey in London by the Mayor's Office for Police and Crime (MOPAC) in 2018 of almost 8000 11-16-year olds asked the question: **'What are the issues perceived as a big problem in your local area and at school?'** The top four answers for both their local area and school included 'Violence', 'People Joining Gangs' and 'People Carrying Knives'⁷. These are not young people who have been in the criminal justice system; these are average school-aged children in London. The fear, anxiety and collective trauma amongst young people in London are increasingly evident, yet responses to violence are predominantly reactive or punitive.

3 Office for National Statistics (2019). Crime in England and Wales: year ending March 2019. London: Office for National Statistics

4 Mackintosh, T., & Lee, S. (2019). "London knife crime: Number of teenagers stabbed to death hits 11-year high" BBC News, London, 23rd November. <https://www.bbc.co.uk/news/uk-england-london-50507433>

5 Office for National Statistics (2019). Crime in England and Wales: year ending March 2019.

6 Youth Justice Board (2020). Youth Justice Statistics (2018-2019), 30th January. London: Ministry of Justice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/862078/youth-justice-statistics-bulletin-march-2019.pdf

7 Ramshaw, N., Charleton, B & Dawson, P. (2018). Youth Voice Survey, MOPAC Evidence and Insight. London: MOPAC.

3. THE PUBLIC HEALTH APPROACH

Inspired by Scotland's successes in reducing violence and murder rates since 2005, the Mayor of London's Violence Reduction Unit (VRU) has taken a public health approach to tackling violence in the capital since it was launched by Sadiq Khan in September 2018⁸.

Whereas increasing levels of enforcement and the severity of punitiveness might seem the obvious answer to violence, the public health approach places more of an emphasis on addressing the root causes of violence. By seeing violence as a consequence of a range of social factors such as adverse early-life experiences or harmful societal influences, the VRU can co-develop interventions that seek to prevent violence from escalating or even occurring in the first place. Within this model, therapy and therapeutic approaches are central to effective interventions, enabling individuals and communities to identify and resolve traumas that contribute to cycles of violence and harm.

The VRU is implementing a public health model in order to stabilise and reduce violence across London in the long term. It aims to do this by:

- 1 Understanding the major causes of violence and co-ordinating cross-system action across London to tackle them locally or at scale
- 2 Listening to and involving communities in the VRU's work, and building communities' capacity to deliver the most effective long-term violence reduction solutions
- 3 Learning from past experiences through using evidence – be it from research, data, or evaluation – to revise and improve approaches wherever possible

The VRU recently published its Serious Incident Toolkit⁹. During the development of this product, it became apparent that there were opportunities to develop a wider package of support that could influence, advise, and provide guidance to communities across London on how best to deal with a serious incident. The VRU recognises the importance of timely crisis intervention and bereavement support services for young people whose friends have been tragically killed.

Through this research report the VRU looks to improve the availability, quality, and access to support for families, young people, and the local community in the aftermath of a serious incident. It aligns with the VRU's strategy of supporting communities to be stronger, safer and more resilient through empowering them to lead from within in constructing sustainable futures.

This research is also intended as a contribution to an important base of evidence. It presents extensive experiences of young people, families, and professional practitioners in London in order to evaluate the current context of therapeutic interventions and provide practical recommendations for reform.

⁸ London Violence Reduction Unit Strategy (2019). London.gov.uk, Available at: <https://www.london.gov.uk/moderngovmb/documents/s64359/Appendix%20-%20VRU%20Strategy.pdf>

⁹ Serious Violence Incident Toolkit (2019). London.gov.uk, Available at: https://www.london.gov.uk/sites/default/files/csp_-_serious_incident_toolkit.pdf

4. CULTURAL COMPETENCY IN THERAPEUTIC INTERVENTIONS

The need for cultural competency in the context of therapy and therapeutic interventions is central to the findings and discussion of this report. The term 'cultural competence' itself is not new and has been extensively researched and promoted within the field of counselling, psychotherapy, health care and social work for several decades¹⁰. Along with similar models of 'cultural humility'¹¹ and 'cultural sensitivities'¹² the term emphasises the need for practitioners to be educated on and understand 'the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, and mental or physical disability'¹³.

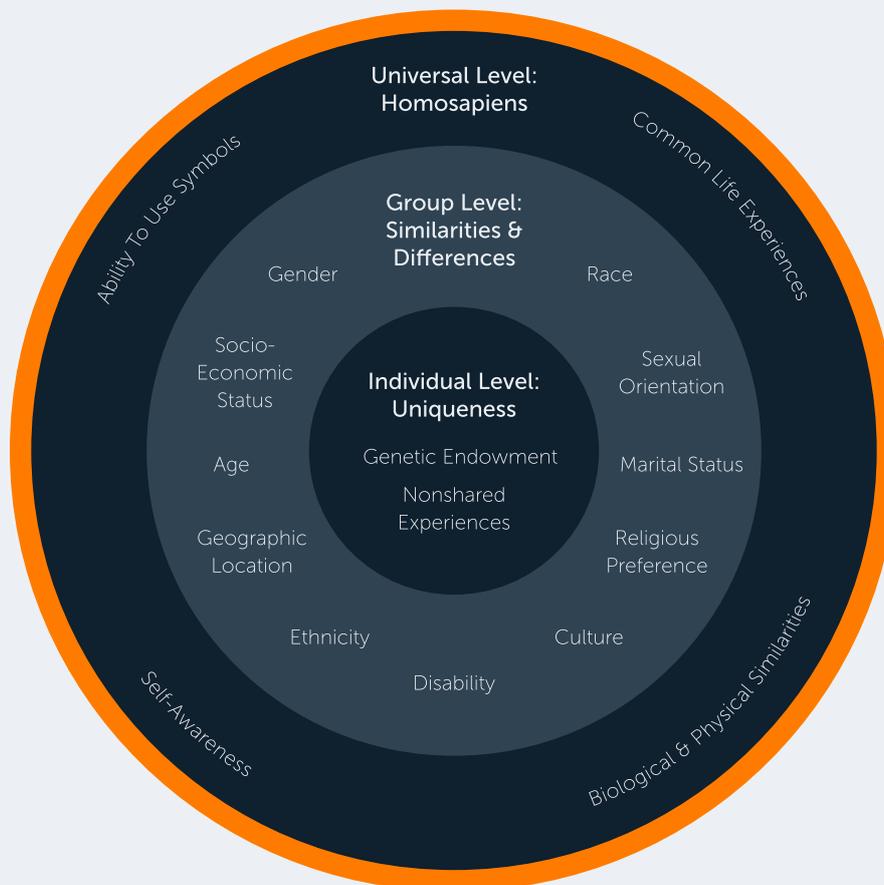


Fig. 1¹⁴

10 Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development*, 20,64–88

11 Fisher-Borne, M., Montana, J., Martin, C & Martin, S. (2015). From Mastery to Accountability: Cultural Humility as an Alternative to Cultural Competence. *Social Work Education*, 34:2, 165-181

12 Nadan, Y., & Ben-Ari, A. (2013). What can we learn from rethinking 'multiculturalism' in social work education? *Social Work Education*, 32, 1089–1102

13 National Association of Social Workers (2015). *Standards and Indicators for Cultural Competence in Social Work Practice*. Washington, DC. <https://www.socialworkers.org/LinkClick.aspx?fileticket=PonPTDEBrn4%3D&portalid=0> ;p15

14 Figure adapted from: Sue, D. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29, 790–821: p793.

Advocates of cultural competency use a tripartite framework of personal identity to draw attention to the limitations of traditional therapeutic interventions. The contention is that clinical psychology focuses on the outer sphere of universal behaviours and the inner sphere of unique experiences, but overlooks the group level similarities and differences in the middle sphere of personal identity¹⁵ (see Figure 1). This oversight of group difference is thought to be caused by the discipline's 'belief in the universality of psychological laws and theories... and the invisibility of monoculturalism'¹⁶. Increasingly, psychologists are recognising that this Euro-American centred approach is limited in its application to racially and culturally diverse societies.

The British Psychological Society has acknowledged the underlying socially conditioned prejudices within the discipline of psychology and the inherent bias of models of mental health that reflect Western therapeutic practice¹⁷. However, disproportionate rates of access and engagement with therapeutic services in the UK remain significant.

Social power and privilege in psychological services is often an unspoken barrier to who is referred for certain services and who accesses them. It is estimated that 75% of people with mental health problems in England may not be getting the access to treatment that they need¹⁸. In terms of treatment inequalities, those least likely to receive treatment are found to be aged between 16-24¹⁹, male²⁰, and from BAME groups²¹. London is one of the most ethnically and socially diverse cities in the world. For the public health approach to be successfully implemented here the recognition of group level experiences, identities and power dynamics is vital. A culturally competent approach challenges the notion of cultural blindness and incorporates difference and diversity as essential features of effective practice.

This research recognises that the framework of 'cultural humility' is advantageous for identifying the fluidity of cultures and the importance of individual and institutional accountability in addressing inequalities²². However, the term 'cultural competency' is used within this report in respect of its more established model of practice in social work. It provides a pragmatic approach based on three aspects of competency: **'(a) cultural awareness—of practitioners' own cultural values, beliefs, and attitudes; (b) knowledge—of diverse people and their needs as well as attitudes that enhance the practitioner–client relationship; and (c) skills—abilities used to combine awareness and knowledge about others'**²³. Awareness of self, knowledge of others and the skill to apply this understanding in practice is the framework that will be applied within this report, along with a progressive understanding of cultural competency as a mechanism of institutional change and ongoing critical self-reflection.

15 Sue, D. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29, 790–821

16 *ibid*: p790.

17 The British Psychological Society (2017). *Practice Guidelines*; 3rd Edition. Leicester: The British Psychological Society. <https://www.bps.org.uk/news-and-policy/practice-guidelines> ; p33

18 Davies, S.C. (2014). "Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence" London: Department of Health. <https://mrc.ukri.org/documents/pdf/chief-medical-officer-annual-report-2013/> ; p14

19 *ibid*: p14

20 McManus S, Bebbington P, Jenkins R, Brugha T. (eds.) (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/556596/apms-2014-full-rpt.pdf

21 Mental Health Foundation (2016). *Fundamental Facts about Mental Health 2016*. London: Mental Health Foundation; p42

22 Fisher-Borne et al (2015) *From Mastery to Accountability*: p165

23 Danso, R. (2018). Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work*, 18 (4), 410–430: p415

5. AIMS AND METHODS

This report aims to document the experiences and perspectives of practitioners, young people and families on therapeutic responses to serious youth violence, providing evidenced recommendations for effective models of therapeutic engagement and service reform. The methods were designed to answer three core research questions:

- 1 How effective are current therapeutic responses to serious youth violence in London?**
- 2 What limitations currently impede effective use of therapy in this context?**
- 3 How can this be improved in the future?**

As social distancing policies for the COVID-19 health crisis were in place throughout the data collection phase of this research, the methods were carefully considered to ensure no harm was caused to participants. A sample of 14 professionals working across the sector were interviewed via video call, using the authors' networks to identify experience and build on existing rapport to encourage sharing at a distance²⁴. Due to the sensitivity of the topic and the challenges of virtual interviews, a smaller sample of five parents and guardians were contacted, allowing time for therapeutic aftercare where needed²⁵. This extensive qualitative data was thematically analysed and common or reoccurring experiences are discussed below.

In addition to these semi-structured interviews, an open-ended questionnaire was completed by 12 further professionals in related roles and their answers included in this analysis²⁶.

It was central to the design of this research that young people were included. Ideally this would have been done in person, but as this was not possible and given the increased risk of psychological harm through virtual in-depth interviews, the data from this sample group was collected through anonymous online surveys. A total of 102 respondents between the ages of 11 and 24 answered 15 questions online. Using a combination of multiple choice and scaled questions the results are presented throughout this report, providing reflection on the topics discussed. Along with identity features such as gender, age and ethnicity the report collected data designed to measure three aspects of youth experience: **proximity to physical violence, responses to community violence and barriers to talking therapies**²⁷.

Due to the sensitivity of the topic the youth survey was not distributed openly online but rather through the authors' networks, using contact details held by youth organisations and youth centres, and families known to the authors. Whilst this opportunity sample risked bias in the data, this was an ethical method under social distancing conditions and allowed practitioners to support young people through existing relationships and ensure no harm was caused. The breakdown of respondents is testament to the diverse engagement of the team, with the sample being made up of 62 Black young people (61%), 24 white (24%), one Asian (<1%), eight young people of mixed ethnicity (8%) and seven respondents who identified as other ethnicities not listed (7%).

24 See Appendix A for professional interview schedule

25 See Appendix B for family interview schedule

26 See Appendix C for professional questionnaire

27 See Appendix D for youth survey questions

YOUNG PEOPLE SURVEYED BY ETHNICITY

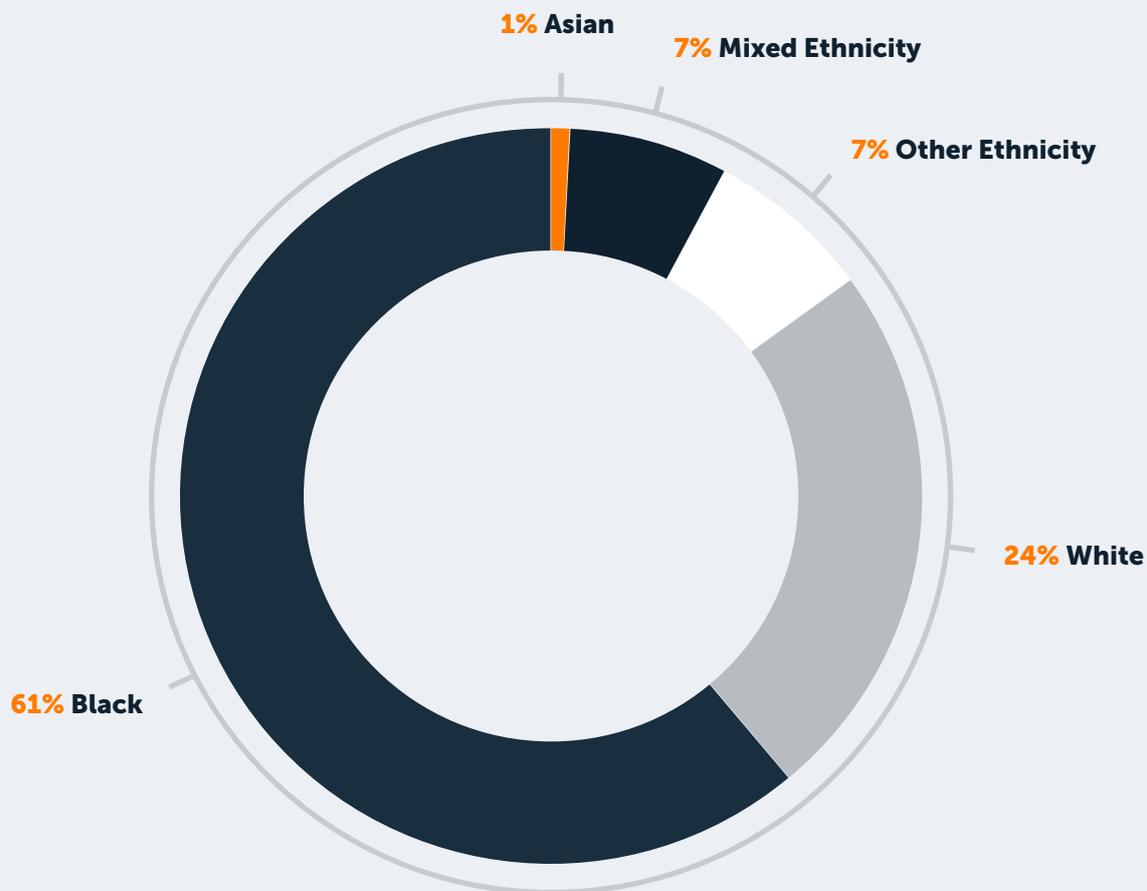


Fig. 2

The sample is an accurate representation of the ethnicity of secondary school aged children in London which in 2019 was found to be 72% Black and minority ethnic²⁸. Of the sample, 49 identified as female (48%) and 53 identified as male (52%), 39 were aged 16 and under (38%), 46 were aged 17-21 (45%) and 14 were aged 22-24 (14%).

6. CONCLUSION

The intention of this research was to evidence the experiences of young people, families and practitioners to improve the effectiveness of responses to youth violence in London through a therapeutic intervention for peace. In the context of increasing rates of interpersonal violence in the capital and renewed commitment to the public health approach, this research provides practical recommendations for the improvement of therapeutic services in London.

²⁸ Greater London Authority (2019). London Education Report: Secondary Education 2019. London: City Hall. https://www.london.gov.uk/sites/default/files/3.secondary_september_2019.pdf ; p5

Part Two:

Therapy in the Context of Violence

Part Two: Therapy In The Context Of Violence

1. INTRODUCTION

In Part Two of this report the research seeks to understand the context of violence in the everyday lives of contemporary young people. The results discussed here will suggest that interpersonal or physical violence between young people is only one component of a complex context of multiple, interacting harms experienced by marginalised young people. Understanding the context of physical violence within broader structures of harm was seen by participants to enable effective therapeutic interventions. Along with professional and family perspectives, data from the youth survey will be presented here with reference to youth proximity to normalised violence and how unresolved trauma can perpetuate violence in communities.

2. UNDERSTANDING VIOLENCE

The analysis in this research is informed by existing social theories of violence that identify its various forms and interacting harms. The external structures of inequality that exist outside us and cause disproportionate harm on populations (such as economic deprivation, social marginalisation, racism and sexism) are understood as forms of **'structural violence'**²⁹. The internalised harm caused by these structures through the daily social encounters that reproduce them, is known as **'symbolic violence'**³⁰, a non-physical violence against the self in which the conditions of inequality are seen as self-caused or self-justified. Previous research on violence has established that when the harms of structural violence and **symbolic violence combine, brutality becomes normalised** at the micro-level³¹. This normalisation of interpersonal violence as routine encounters between marginalised groups in deprived areas has been defined as 'everyday violence'³².

It has previously been identified that interpersonal violence in London is spatially specific, concentrated in areas of the city that have higher levels of deprivation, lower house prices, less cohesive communities and lower average education levels³³, suggesting structural harm correlates with physical violence. Ethnographic research has also evidenced the relationship between structural and physical forms of violence in London, linking the economic impact of deindustrialization in the capital to generational

29 Galtung, J. (1969). Violence, Peace, and Peace Research. *Journal of Peace Research*, 6(3), 167–191

30 Bourdieu, P., & Wacquant, L. J. (1992). *An invitation to reflexive sociology*. Chicago: University of Chicago Press

31 Bourgois, P. (2001). The power of violence in war and peace: Post-Cold War lessons from El Salvador. *Ethnography*, 2(1), 5-34

32 Schepher-Hughes, N., & Bourgois, P. (2004). *Violence in war and peace*. Malden: Blackwell Pub

33 Wieshmann, H., Davies, M., Sugg, O., Davis, S., & Ruda, S. (2020). *Violence in London: what we know and how to respond*. The Behavioural Insights team. <https://www.bi.team/wpcontent/uploads/2020/02/BIT-London-Violence-Reduction.pdf>

worklessness, cultural shifts and normalised violence³⁴. This theoretical position was supported by the findings of this research, with participants consistently drawing attention to the broader contexts of violence. These themes are discussed below in relation to economic deprivation, domestic violence, internalised harm and normalised violence.

3. FINDINGS FROM RESEARCH

a. Economic Deprivation

Throughout interviews and questionnaire responses, professionals consistently identified poverty and deprivation as one of the core influences on young people's choices, actions and behaviours. In its basic form the lack of resources such as food, clothes or electricity were seen to be pushing young people into what several participants described as a mindset of 'survival'. As one Intervention Manager described:

"I thought I knew what poverty looked like, until I started to go to some young people's homes and I've seen real poverty... no furniture, no carpet, might only have one bed but there's no sheets. May have a fridge, no food in there, might be a bottle of milk in there. No electricity. And...the parents were working as well, but working in such low paid occupations... So that drives young people and their families to strive to get something to feed their family".

Working poverty from low wages along with unreliable zero-hour contracts and the delays and insufficiencies of Universal Credit were noted by professionals as causal features of extreme deprivation. This is a view that is supported by recent research into child poverty in the UK³⁵. In many interviews professionals described young people with a burden of responsibility to provide for their siblings or a desperation to **"get a hustle"** in order to help struggling parents. The same Intervention Manager quoted above stated:

"I know of many young people that have gone out and they're selling drugs or doing whatever they're doing to make money, and they're giving the money to their mum or to their dad, and it's their way of putting income into the family" (Intervention Manager).

Many participants highlighted the vulnerability of young people in this context who can easily become groomed and exploited by 'olders', and in some cases enslaved or sexually abused by organised drug dealing networks such as those known as 'county lines'. Professionals were consistent in their assertion that the primary concern for marginalised young people is financial stability, but with formal pathways to economic success increasingly unattainable, violence becomes an unavoidable risk for those surviving extreme deprivation.

Austerity measures in the UK from 2010 onwards were seen by many participants as having increased the structural and social harms experienced by young people. The cuts to services and closures of youth centres - along with the loss of detached youth workers and mentors and the increased economic stresses on households, lack of housing security and overcrowding - were seen as severely

34 Hobbs, D. (2013). *Lush Life: Constructing Organised Crime in the UK*, Oxford: Oxford University Press

35 Joseph Rowntree Foundation (2020), UK Poverty 2019/20. Available at: <https://www.jrf.org.uk/report/uk-poverty-2019-20>

exacerbating the rates and intensity of violence between young people. More broadly, the diminishing opportunities and lack of investment in young people that the ideology of austerity has communicated were seen to have left a lasting pessimism and feelings of social abandonment. Practitioners described:

"...there is austerity, there is a lot of pessimistic views on being able to live a life of legitimate existence. So violence is fuelled by poverty, it's fuelled by, with respect, a lack of opportunity out there, I think... And I think you can have a thing with austerity in regards to people not feeling their worth"

(Custody Intervention Coach).

"I firmly believe that young people of today feel as though no-one cares about them, and so it's almost as if there's this anarchy amongst the youth community whereby they feel as though, "Do you know what? No-one cares about us, so we're just going to carve out our own pathway, we're going to do things our way" (Local Authority Manager – Alternative Provision).

b. Domestic Violence

In nearly all interviews and in many questionnaire responses practitioners referred to Domestic Violence (DV) or Adverse Childhood Experiences (ACEs) in some way within the discussion of youth violence. In many instances this was discussed in the context of 'unresolved trauma', with one participant explaining:

"...a lot of young people are seeing people that they live with, parents and guardians, being physically assaulted and again not having anywhere to - for want of a better word - dump that. They are carrying that anger and it is expressing itself in a different, unfortunately in a negative way"

(Youth Worker).

Other participants who work with young people in youth custody settings described how prolonged exposure to abuse and violence in the home, or an absence of love and healthy attachments, presents in many young people as long-term developmental harm, anxiety, distrust and defensiveness:

"...imagine a child...over 13 years of being in an environment that's not healthy for them, what is that going to do to a child's mind? It's going to impact and impair their development. They will constantly be in a state of hypervigilance... everybody's a threat to me. I don't care who you are...you're a threat to me and to my wellbeing" (Intervention Manager).

"the more I have been in the environments I have been in... the more I have realised trauma is real. People are dealing with voids in their life from when they were so young, and they have never recovered from it. How can you expect someone to move on if you've never addressed those issues that happened when they were a kid?" (Custody Intervention Coach)

One participant pointed out that despite adult domestic violence contributing the biggest statistical representation of knife homicides and killing on average two women a week³⁶, this context does not receive anywhere near the heightened media reporting that violence between young people does. This disproportionate media attention to youth in the context of interpersonal violence has been established by previous research³⁷. It is suggested in this report that this news-value inspired separation of interpersonal youth violence from the family context of violence has been restrictive to effective intervention, with therapeutic professionals consistently emphasising the need for inter-generational holistic approaches. As one psychotherapist described, the instances of physical interpersonal violence are rarely as significant to the young person as traumas that happened in their younger years:

“people that I see now who come in for therapy, who’ve been stabbed multiple times recently, they talk about that... but usually that’s not even the biggest thing that’s affected them, that’s just what’s happened today. The profound things are how they felt when they were little and couldn’t help somebody, or not feeling loved by a parent. Those are the bigger things that, I think ... it affects them more than the incident of violence on the street today”.

c. Internalised Harm

A further recurring aspect of the context of youth violence mentioned during interviews and questionnaires was young people’s internalisation of the external harms and structural violence enacted on them. Practitioners described the psychological impact of a double trauma; of not being nurtured or safe at home as a primary trauma and feeling excluded and marginalised by institutions outside of the family as a secondary trauma:

“...there are some societal systems and structures which continue to perpetuate the trauma in terms of rejection and identity...I think a lot of that happens in our most significant institutions like school, like jobs, like the benefits system and various other social structures”

(Youth Development Practitioner).

Social marginalisation alongside childhood trauma was seen to manifest as a lack of self-confidence and self-esteem in young people, who were then likely to see the power of violent enterprises such as drug dealing as **“one of the only options you really do have to feel good about yourself in some capacity, to have some kind of status.”** The impacts of social exclusion were described as particularly acute when combined with racial marginalisation and structural racism. Participants described how young Black people devalue themselves as a result of the racism they experience:

“I will say particularly Black children, there’s something around internalised racism for me, that they are almost conditioned to hate the image of themselves...they experience racism...whether it be how they’re stopped and searched...or public perception of fear of them... the fact that you’re ‘othered’, you’re seen as different, that does something to your internal psyche, and it

36 Office for National Statistics (2019) Homicide in England and Wales: year ending March 2018

37 Jewkes, Yvonne (2004). Media and crime. Key Approaches to Criminology. London, UK: Sage; Cook, E., & Walklate, S. (2020). Gendered objects and gendered spaces: The invisibilities of ‘knife’ crime. Current Sociology <https://doi.org/10.1177/0011392120932972>.

damages it...And you therefore come...to hate the image of yourself"

(Therapeutic & Families Intervention Lead, Youth Offending Service).

One practitioner who works predominantly with young people in custody described how the structural violence of extreme deprivation combines with the symbolic and internalised violence of adverse childhood experiences, resulting in a detachment from 'normality' through multiple abandonments:

"They go from hour to hour not knowing if they are going to be able to have a meal, not being able to go home to a place where they call home. Not... hearing that they are loved or being told well done. Feeling stupid, feeling inept, feeling that their whole existence is futile...I sit in front of people that are so detached from what we deem as normality because they feel abandoned"

(Custody Intervention Coach).

For girls, this sense of low self-worth was seen to produce an additional vulnerability of gendered violence and emotional abuse. They were described as being at increased risk of 'manipulation' or 'grooming' with marginalised girls more likely to 'seek validation' from men and boys without clear understanding or replicable models of healthy relationships. Intervention projects and support services that respond to violence were seen to prioritise boys, producing yet another sense of exclusion and abandonment. When girls were included in responses, an over-simplistic emphasis on their victimisation and exploitation crucially overlooked the pivotal and powerful positions girls hold in their communities; both in initiating and preventing violence.

Acknowledging the internalised dynamic of social and structural inequality was seen by practitioners as crucial to effective therapy for young people, recognising **"the work that it takes to get them to a place where they feel safe and secure"**. Moreover, the actions and practices of professionals within therapeutic settings can potentially reinforce a sense of 'othering' for young people if they do not understand the contextual experiences of violence described in this report. As one youth and community worker described, **"many individuals have stated the therapist found their life more fascinating therefore glorifying it rather than helping"**. They went on to explain the kinds of insensitive and marginalising questions asked by culturally incompetent therapists such as: **"You got stabbed, how did it feel? How many times? Did you know who done it? Have you ever held a gun or stabbed someone? I saw someone in the news was killed and I thought of you?"** The consistent accounts from practitioners of young people and families feeling judged, misunderstood or pathologized by therapists, suggest that many therapeutic services currently reinforce the traumatic effects of marginalisation rather than act to resolve them.

d. Normalised Violence

There were many aspects of the contexts described by participants which suggested that the everyday brutalities of growing up under deprived and traumatic conditions have normalised interpersonal violence between young people. Exposure to violence in the home was seen as a strong factor in the normalisation of violent behaviour, along with the escalation of conflict, self-aggrandising and constant exposure to violence through social media. One practitioner who had worked with young people for over twenty-five years expressed concern that young people were **"hardening"** in response to these conditions, explaining: **"it's like they have become desensitised to it - it's the norm... it's made it a lot more difficult to try to give them exit strategies and work with them"**. Another participant remarked on the normality with which young people would recount a violent event to her, saying: **"they'd talk about it like it was having a KitKat"**.

Interviews with family members affected by loss through interpersonal violence highlighted a devastating frequency and intensity of violence that could occur during everyday encounters. One participant reflected on the novelty of being asked about these events during the interview and how she had never thought to talk about the numerous losses of friends as a distinct cause of trauma:

“...this is the first time I’ve ever spoken about it, actually being asked questions... normally when I speak about it I’m almost talking about it as if I’m going to the shop. So I’m quite emotionally removed from it... I think you’re kind of constantly in a state of – maybe...like traumatic disorder - like you’re living in it and then another person dies and another person dies, so you don’t actually recover from it. I didn’t even think to ask for support, I felt like...this is life” (Family Member).

Behaviours which practitioners stated were unacceptable for previous generations, such as taking a dispute to someone’s family home and bringing violence to their parents and siblings, or attacking someone in broad daylight in the morning, were now common practice. Practitioners explained that for the minority of young people for whom violence is an everyday threat, knife carrying has become the norm – to the extent that they report feeling **“naked”** without one. Commenting on the ordinariness of extreme violence, one youth worker recalled:

“I remember some of kids talking about doing swapsies and they weren’t talking about swapsies of Pokemon cards, they were talking about swapsies of knives. ‘Oh look at my zombie’, ‘Oh look at my zombie, let’s trade”.

Many participants observed that contemporary conflicts were more unruly than previous generations, with some referencing austerity as a causal factor through the lack of visible presence of youth workers and an absence of adult and peer support that was previously available in the safe spaces of youth centres. This alienation of young people from inter-generational influence was seen as removing the social rules, as one practitioner described:

“I think there’s a big shift in terms of, back in the day there used to be a respect element – the youngsters used to respect the olders, there was a system... Now there is no system, everybody can be bad, you know what I mean? And youngsters stabbing older people, older people stabbing younger people... it’s very much unruly” (Youth Worker).

The experiences of practitioners and families suggest that for a minority of young people, physical violence has become a normalised occurrence and that recent generational shifts have intensified the risk and potential harm in everyday activities like going to school or walking to the shop. The results of the youth survey supported these findings, demonstrating high proximity to violence across all demographics.

When proximity to violence was measurement on a scale where 5 represented first-hand experience and 1 represented tertiary knowledge through news media, the mean score for all participants was 3.9. When compared by ethnicity this average increased to 4.2 for Black young people and reduced to 3.2 for white young people. Compared by gender the average increased to 4.2 for males and 3.6 for female respondents. When asked about how often they worry about their safety there were consistent averages across all groups, ranging between 2.5 and 2.9. There were five participants who responded at the highest level of 5, 'always worried'; of these two were female, three were male and all were young Black people.

PROXIMITY TO PHYSICAL VIOLENCE AND PERCEIVED SAFETY
 (as average scores compared by demographic)

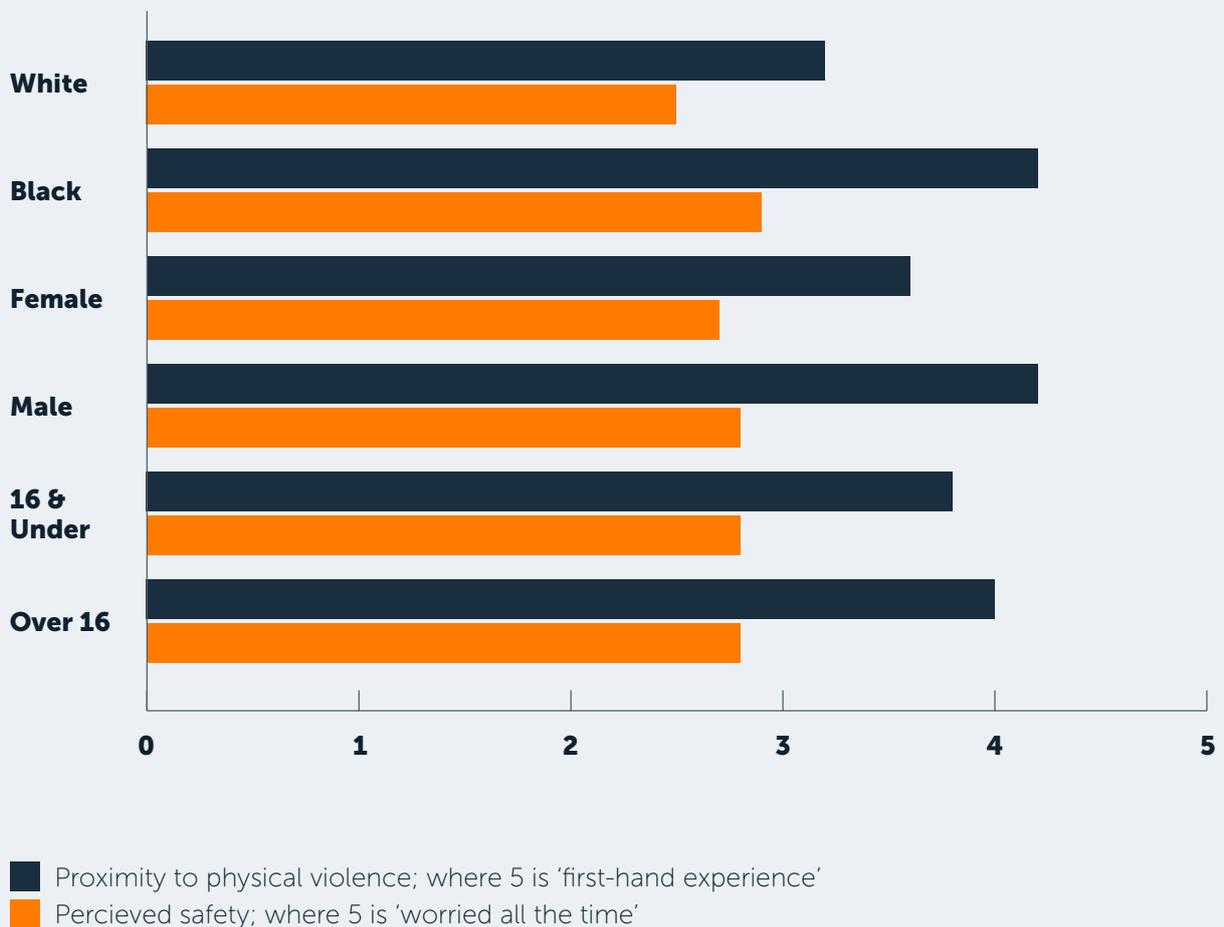


Fig. 3

A general proximity to violence was understood by professionals to increase the risk of violent retaliation, even from young people who were otherwise not involved in violent enterprises. This was described as a result of unresolved and unprocessed feelings of anger and frustration over the loss of someone close:

“A lot of young people have lost people and a lot of the times there is...that sense of retaliation...never been involved in street life or anything, but when... someone has been taken from them... that is where their anger goes, because they don’t...have anywhere to put that frustration safely, so it comes out in another way” (Custody Intervention Coach).

This was reiterated in the experiences of families who frequently described an anger and volatility amongst the friends of their child in the aftermath of extreme violence and loss. Without access to therapeutic support, families described how friends of their child **“bottled things up”** that would then **“come out in aggressive and horrible ways”**.



A high likelihood of feeling anger and some desire for retaliation were represented in the youth survey results when asked about proximal violence. Using multiple choice answers (selecting as many as they wanted), young people were asked how they might feel in the event of themselves or a friend being a victim of violence, and what they might do to cope with these feelings. Their answers to these two questions are compared by proportional representation of demographics below.

Responses to question: 'If myself or a friend had been a victim of violence it would make me feel...'

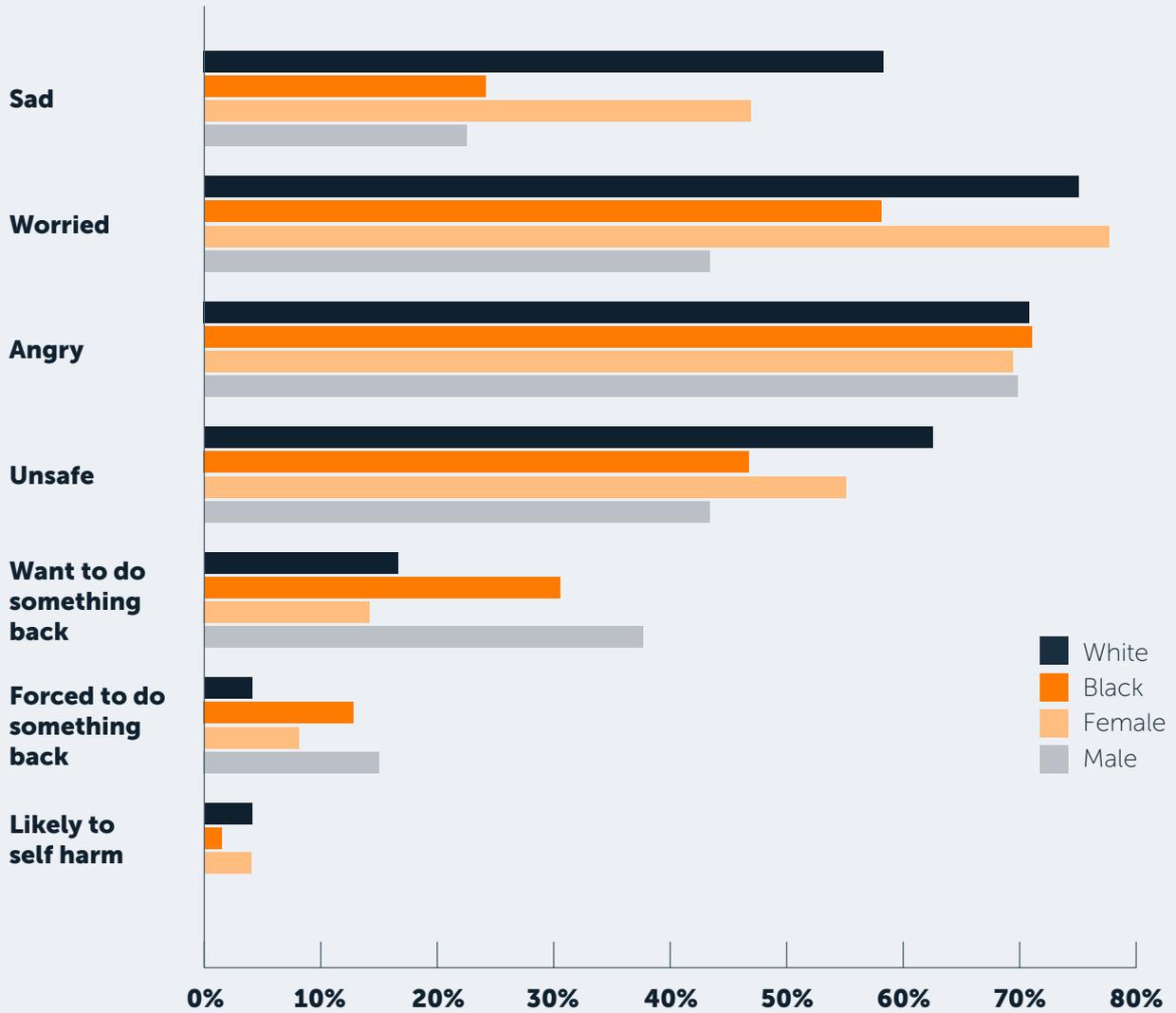


Fig. 4

Responses to follow up question: 'How are you likely to deal with these feelings?'

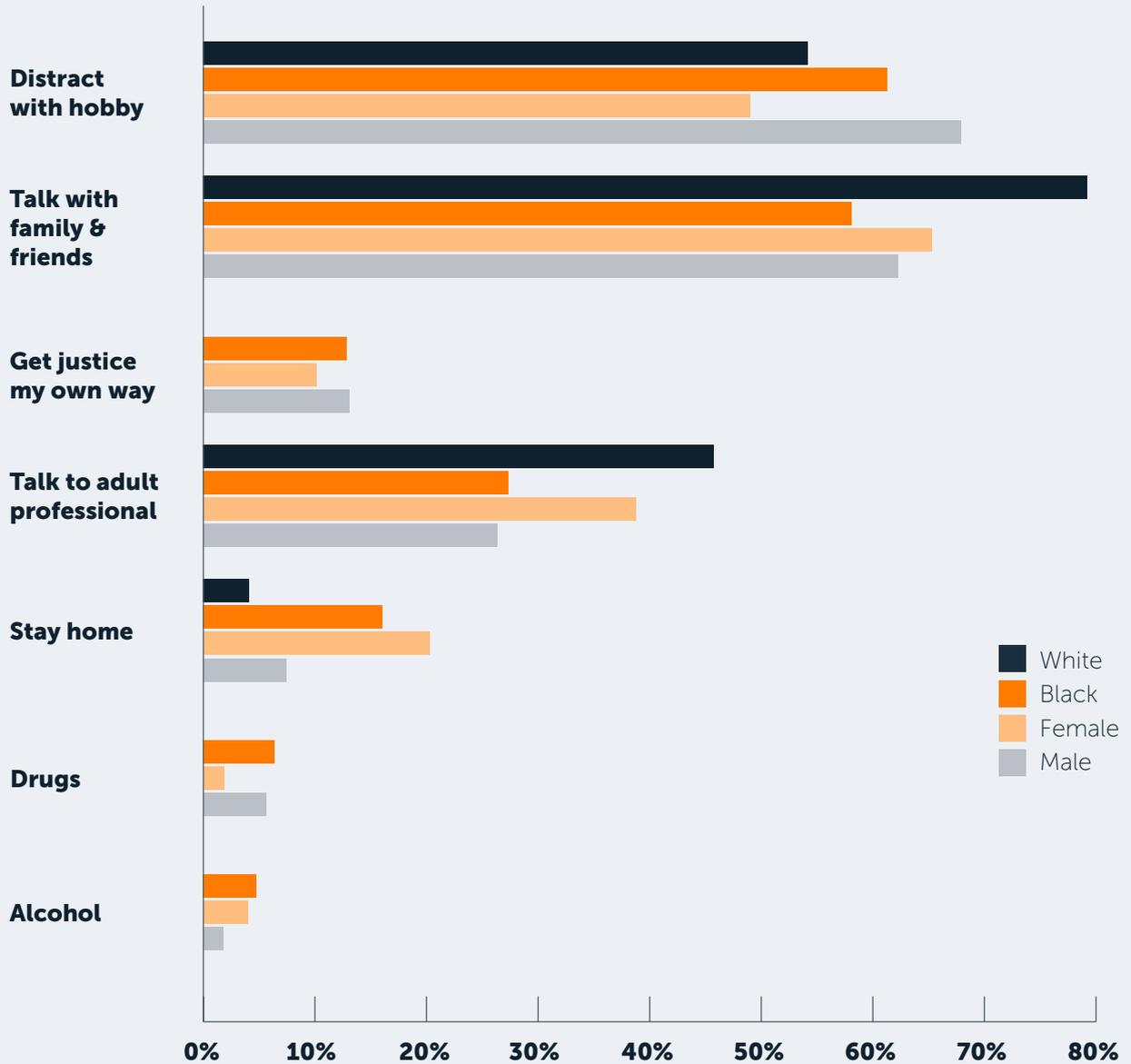


Fig. 5

These results suggest the most consistent feeling across all demographics was 'anger'. However, white and female were the groups most likely to express feelings of 'worry', 'sadness' or 'unsafety', whilst Black and male were the groups most likely to express feelings of retaliation; wanting or feeling forced to 'do something back'. Their coping strategies suggest that white and female groups were more likely to talk with family, friends or adult professionals, while Black and male groups were most likely to distract with a hobby or seek justice through active retaliation. Whilst caution should be taken against drawing strong conclusions from this limited data, these findings do support the qualitative data from interviews, suggesting that unresolved anger from traumatic loss is leading to violence as a coping strategy - particularly amongst Black and male groups who are less likely to speak about or address these feelings in therapeutic settings.

4. KEY POINTS AND RECOMMENDATIONS OF PART TWO

Key Points

- 1 A public health response to serious youth violence must recognise the conditions of extreme marginalisation as forms of violence in themselves. Deprivation, racism, sexism and social exclusion are structural harms that become internalised and act to normalise interpersonal violence.
- 2 Domestic violence and adverse childhood experiences cause long-term trauma that lead to developmental harm and hypervigilance, but violence in the home is often overlooked as a causal factor of youth violence.
- 3 The cuts to youth services through Austerity measures since 2010 have intensified structural violence against young people and increased the likelihood of traumatic childhood experiences and feelings of social abandonment.
- 4 The specific needs of women and girls in the context of community violence have been sidelined by male focused interventions.
- 5 The majority of young people surveyed had a high proximity to violence (experiencing it either first-hand or through close friends), with experiences of violence most likely to lead to feelings of anger. Black and male respondents were less likely to talk about these feelings and more likely to deal with these feelings through retaliation.
- 6 Therapeutic services that fail to understand the broader contexts and causes of youth violence risk harming young people further by making them feel they are the problem.

Recommendations

- 1 Cultural Competency training for therapeutic services that work with marginalised young people and families, ensuring practitioners understand physical violence in the context of structural violence and the internalised harms of systemic inequality.
- 2 Therapeutic services to prevent youth violence should be intergenerational, working with the whole family to improve wellbeing and safety in the home.
- 3 Invest in culturally competent therapeutic services for young people in order to help process feelings of anger and prevent a cycle of retaliation.

Part Three:

Social & Cultural Barriers to Therapeutic Referrals

Part Three: Social & Cultural Barriers to Therapeutic Referrals

1. INTRODUCTION

During the semi-structured interviews youth professionals were asked about their experiences of referring or delivering therapeutic services to young people and families in the past, in addition to whether they had experienced challenges or barriers in facilitating a therapeutic approach. Invariably professionals stated that they had experienced challenges. The key themes of current restrictive aspects of therapeutic practice are discussed below, along with examples of good practice provided by participants which demonstrate how these obstacles can be overcome.

2. THE CHALLENGES OF THERAPY

In this report the term 'therapeutic intervention' refers to a model of therapy which has its values embedded in a strong therapeutic relationship evolving from transparency and trust between practitioner and client. Addressing issues of difference and openly acknowledging the differences which may be apparent between therapist and service user are essential. Whilst this research acknowledges that it is imperative to use evidence-based therapies where there is a clear clinical need to do so, **the discriminatory pattern of unequitable access to therapy from Black and minority ethnic groups must also be addressed through an evolving and innovative therapeutic model.** In this research the term 'therapeutic intervention' includes a multitude of modalities and established therapies including but not limited to; Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy, individual and group work, creative workshops, music and art therapy. The following challenges identified in this research demonstrate the importance of less formal, indirect therapies - whilst maintaining a commitment to clinical approaches.

3. FINDINGS FROM RESEARCH

a. Language of Therapy

Many participants described that a common challenge for delivering therapy with young people and families is that the word 'therapy' itself has negative connotations. Although some participants thought this was improving as mental health awareness has increased in recent years, there were consistent accounts of young people refusing therapy services because they didn't want to be seen as **"mad"** or **"crazy"**. One frontline youth worker explained this aversion within the context of powerlessness and identity, describing how refusing therapy was a way to claim some autonomy whilst protecting status and self-image:

“...the minute you mention a therapist they’d be like ‘No bruv, no, I’m not about that!’... they don’t want it to affect their status or they don’t want it to affect how they even see themselves when they’re already so powerless...So they want to have control of their image in some capacity and for them not accessing mental health is probably a way that they do it”

(Senior Programmes & Partnerships Manager).

This view was reinforced by another experienced youth worker who explained how young people misjudge the rejection of therapy as evidence of strength of character, whilst having little understanding of what therapy actually is or its benefits. **A reported preference was expressed amongst young people of talking to their youth workers instead of being referred to a therapist**, highlighting the unique relationship young people have with frontline workers as trusted professionals.

The negative connotations of therapy language and mental health **“labels”** were seen by several practitioners as being too deeply ingrained to change. They advised instead that therapeutic interventions should be renamed in order to increase engagement with services:

“maybe we’ve got to stop calling it therapy. Stop calling it mental health assessment. Call it reasoning, I don’t know what you want to call it”.

Others suggested that clear explanation, accessible terminology and education on what therapy is (and what it entails) by trusted professionals can break down the stigma and negativity associated with its language. However, there were also consistent accounts from youth workers that first encounters with therapeutic professionals were ‘make or break’. Even after extensive persuasion and support, a bad first experience would permanently end a young person’s engagement. This highlights the need for a smooth, well-coordinated and supportive referral process which does not stop at the point of entry.

b. Trust & Representation

A frequent barrier to therapy identified throughout interviews and questionnaires was the deep distrust that many young people and families have of the agencies, institutions and services that have systemically failed them in the past. In some cases, this was seen as a direct impact of austerity and the cuts to services:

“I’m seeing more than ever...a real distrust in services. I think austerity has made it worse, every service has been cut so much, so many...have been failed by Social Services, by the police over and over again, harassed more than ever...with Section 60 getting worse for them”

(Senior Programmes & Partnerships Manager).

Practitioners recognised that in most cases they are approaching individuals who have had long term contact with systems of intervention which have not been positive experiences. Even when trying to do something new or different the practitioners are still perceived by the young people in the first instance as yet another system:

"A lot of the young people...in prison, they've come through the system already whether it's been Social Care, school, and lot of adults and systems have failed them.... So now ...I'm another system, and it's like 'who's this guy?'"

(Intervention Lead)

"... I think there is this whole stigma that CAMHS is part of the system, I think, you know? And the system that is against the youth population. So, 'why should we go and tell them our secrets?'"

(Local Authority Manager – Alternative Provision)

This precautionary distrust based on previous experience was seen to be particularly present amongst young Black people who have been disproportionately targeted and harmed within systems known to be institutionally racist³⁸. Examples of the differential treatment of young Black people was referenced by multiple participants in the contexts of prejudiced social workers, targeted policing, harsher treatment in courtrooms and in prisons, along with discrimination in schools and the healthcare system. With reference to the realities of everyday and systemic racism experienced by young Black people, participants consistently felt that the dominance of white, middle class women as therapeutic professionals presented a significant barrier to therapy. One participant expressed that when a young Black person has previously been **"let down"** by a therapeutic professional, this unconscious bias can prevent a connection being formed:

"...A young person's walking into a room, seeing a white woman, 40s, 50s – 'you ain't going to understand my struggle'... I know when I walk into a room, 20 young people, if they're all Black, 90% of them I've already engaged... Whereas you've got a white person coming in now, it's like 'looks like the man who sentenced me...like the police officer that interviewed me...like my teacher that got me expelled.' ...you're reminding them of people that have previously let them down" (Intervention Lead).

Another participant described this as an unspoken connection based on shared social experiences which can aid understanding and trust between a young Black person and a Black therapist:

"...when they're confronted by a therapeutic person that is middle class or white and not from their background, there's a real difficulty of understanding. I think as a Black man walking into a room with other Black people, there's automatically sometimes...a connection because you know where I'm coming from... There's not enough Black people who are coming from these sort of backgrounds...that are in therapeutic positions...I don't think it's encouraged or even supported enough" (Youth Worker).

38 MacPherson, W. (1999). The Stephen Lawrence Inquiry. Report of an Inquiry. The Stationary Office, UK; The Lammy Review (2017). An Independent Review into the Treatment of, and Outcomes for, Black, Asian and Minority Ethnic Individuals in the Criminal Justice System. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf.

The need for more Black male therapists was expressed by several participants as well as the suggestion of fast-tracked pathways, promotion and support for Black practitioners already working with young people to upskill into clinical roles. Similarly, participants expressed the importance of creating safe and trusting spaces through employing female, Black and Asian therapists:

"...our women are Black and Asian so it would make no sense to just have a woman who is the typical image of a therapist, a white older woman who comes from a very middle class status background, because we know that in our way of working resonance is gold...I think resonance builds trust"

(Senior Programmes & Partnerships Manager).

"...when you've got someone like myself who's a Black lady, who they can warm to – some of my young people have said 'You're like a mother figure to me, you're someone that I can trust'... It breaks down...those barriers...in most cases I've found. So I think representation is definitely a key factor and...I don't think there is enough representation"

(Local Authority Manager – Alternative Provision).

Touching on the reasons for the lack of Black and minority ethnic representation at a clinical level, one participant pointed out that the same is not true of the health and social care system, where Government bursaries, initiatives and recruitment have supported diverse professionals into these roles. However, when it came to preventative therapeutic training this was not prioritised for funding as much as reactive services, leaving expensive therapeutic courses out of reach for many marginalised groups. She explained:

"I think if they did open it out in the same way they did for social care professionals, they would see an influx of people who would actually want to embark on a...qualification of some sort, so they can actually be really effective with these young BAME children"

(Local Authority Manager – Alternative Provision).

The importance of financial support to increase representation was also highlighted by a Black psychotherapist who explained that his career in this field had been entirely dependent on a bursary he received through the Tavistock and Portman Foundation that prioritised Black and minority ethnic applicants. Conversely, one Black male therapist explained how institutional racism almost stopped him from pursuing a career in counselling after a potential tutor accused him of being 'in a gang' based on historic offences from ten years previous. He described:

"...she asked questions pertaining to my convictions then looked at me deadpan and asked "are you in a gang?"...I was lost for words, I asked "how can I be in a gang and work for one of the leading youth charities in the country?" which she could see on my application...I felt stereotyped, judged and discriminated against. I left in disbelief and concluded this college was not for me".

It is clear that **class, race and gender, in the context of structural inequality and differential social experiences, are instrumental in the therapy setting** for building trust and **"resonance"**. These same structural factors of marginalisation currently restrict pathways into clinical roles, limiting

the representation of professionals in this field. **Participants were keen to point out that race alone is not a signifier of shared experience or cultural competency in professional settings. However, what is clear from the results of this research is that for many young Black people and families, middle class white professionals within a therapy setting can be triggering - prompting traumatic memories of structural racism and systemic harms they have experienced through education systems, healthcare, policing, social services or the judicial system.**

In this sense, not being **“able to see that there are similar faces doing these roles”** becomes a fundamental barrier to just **“getting someone into the room”**.

The results from the youth survey support the importance of understanding, shared experiences and trusted introductions in the engagement of young people in talking therapies. When asked to rate the importance of various attributes of an adult professional they would be willing to speak to about a violent incident (with 10 as most important, 0 as least important), there were clear trends to responses and notable differences between ethnic groups and ages. In the distribution graphs (Fig 6 and Fig 7) the coloured lines represent the full range of answers (excluding outliers shown as dots) whilst the coloured boxes represent the interquartile range; the distribution of answers when the top 25% and bottom 25% of answers are excluded. Within the boxes X shows the mean average and the horizontal line is the median average.



Fig. 6

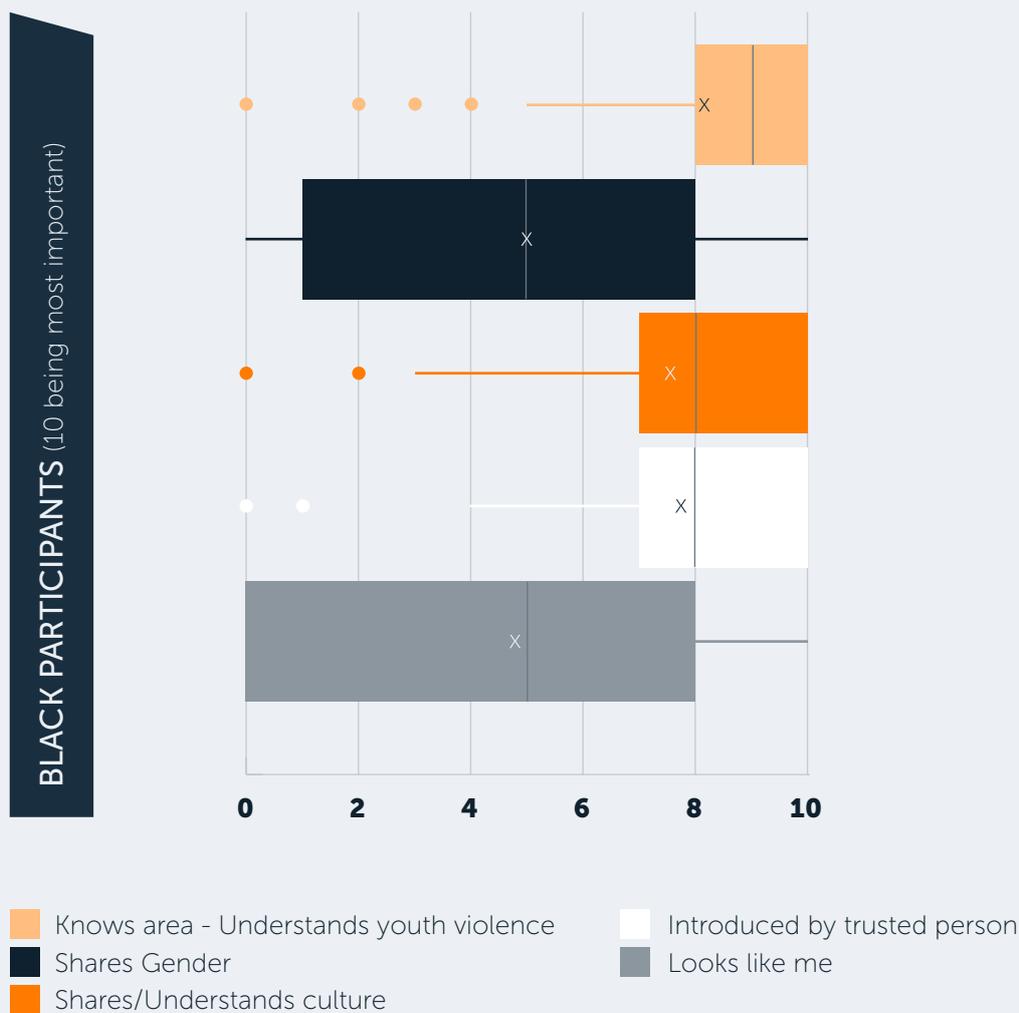


Fig. 7

For both Black and white groups it was significantly important that the adult professional knew their local area and understood the context of youth violence in this setting. The mean average answer for white and Black participants was above 8 for this question, with slightly less distribution amongst Black participants – for whom the majority rated 8 or above for importance. Sharing the same gender as the professional was less significant for both groups, with charts demonstrating a broad distribution of answers and mean averages near 5 for both groups. However, this attribute was more important for older respondents, with the average answer increasing to 7.4 for participants aged between 22 and 24.

A therapeutic professional sharing or understanding the young person’s cultural heritage was more significant for Black participants, with the majority of answers falling between 7 and 10 of rated importance and mean average rating of 7.6. For white participants there was less of a pattern; a wider distribution of answers spread across the centre of the scale, producing a mean average of 4.3. The adult professional being introduced by someone the young person trusted had high importance for both groups, with a similar range of responses and the majority of answers for both groups falling between 7 and 10 in the scale of importance.

Finally, when asked the importance of the therapeutic professional 'looking like them' there seems to be no clear pattern of responses from Black participants; answers ranged from 0 to 10 with the majority distributed evenly from 0 to 8. With white participants however, this was notably unimportant, with the majority of this group answering 3 and below and a mean average answer of 1.3. This suggests that white participants were not concerned by the idea of a therapist looking different to them, whereas Black participants were less certain.

The results of this research clearly indicate that trust within therapeutic settings is fundamentally linked with representation; vulnerable and marginalised groups benefit greatly from feeling seen and understood through shared cultural and social experiences within the room. This is particularly pertinent when considering the historical and ongoing harms inflicted on these groups by systems and services that are institutionally classist and racist. Whilst the criminal justice system is over-represented by young Black people and adults³⁹, the opposite is true of the therapeutic profession. **The findings of this research strongly suggest that in order to reduce the former, we must significantly increase the latter; allowing young people and families affected by violence (in all its forms) to access therapeutic spaces which feel safe and trusted, and where their social identities are represented and understood amongst the professionals in the room.**

c. Social and Cultural Contexts: Race, Faith and Gender

In addition to representation, practitioners identified specific examples of cultural contexts as presenting challenges for referring marginalised groups to therapy. **Firstly, there were consistent accounts of African, Caribbean and Asian families not thinking therapy was for people like them**, perceiving therapy as a **"modern"** or **"British"** phenomenon and being far less likely to have had previous experiences of therapy in their family. As one therapist pointed out:

"in some cultures they don't even have the word for mental health. They have the word crazy! But there's not a word for mental health".

Given the structural hardships and systemic injustices faced by migrant communities in Britain, it is not surprising that participants consistently recognised a defensiveness and reluctance to share personal details amongst Black and Asian groups. Described as a strongly embedded rule of **"you don't talk your business"** or **"you don't talk de tings!"** multiple participants explained a cultural taboo around speaking on personal and family issues:

"Black, Asian, working class, it's not a normal thing for us to go chat about our lives... 'I don't know if I can talk about that, should I be talking, am I snitching?' That was probably the key challenge we face, and actually making them feel safe to talk, which is the first thing" (Senior Programmes & Partnerships Manager).

"My dad... he's a Black man and it was very much 'What happens in this house stays in this house, keep your business to yourself.' So counselling or therapy of some sort was always seen as a middle class white people thing" (Family Member).

39 The Lammy Review (2017)

For Black men and boys, along with family “pride” and integrity there was an expectation of hyper-masculinity, in which they should “man up and get on with things”. Similarly, Black women and girls were expected to be the backbone of families – carrying everyone through the aftermath of trauma by “bottling it up and being the strong woman”. To overcome this challenge, practitioners again stressed the importance of having therapists who share the ethnicity and culture of their clients. Describing this as **“having a mirror”**, one participant recalled how one Black woman had thanked staff after she received therapy from a Black female therapist, saying:

“Thank you so much for making me sit down with someone from the same background as me who could make me feel like this conversation was normal, when at home it’s not normal”.

Race was seen to intersect with faith, as participants described that many of their Black and Asian clients had strong religious beliefs and belonged to faith groups which could sometimes discourage therapeutic engagement. With reference to Christianity, one participant explained how prayer is sometimes seen as a substitute for therapy, saying:

“...Christians that believe that you just pray it all away, you don’t need to talk about it, we’ll just pray about it...Yes, it’s great to pray but that person still needs to work through some stuff”.

Another described how **“religious people”** may believe that their mental health is in God’s hands, saying:

“God will take care of me, I don’t need any of that, God is my therapist”.

This was seen to be consolidated by a feeling of loyalty to their church or mosque - that they shouldn’t receive **“outside advice”** and should only take their problems to a faith leader.

However, there were also accounts from practitioners where the community context of faith groups uniquely positioned them to facilitate inter-generational therapeutic interventions. **One participant described a highly effective therapy project that was run in parallel with church meetings. Through this the church was not only able to engage young people through relationships that had developed over years within the youth club, but they were also able to work with parents who made huge progress very quickly, improving the whole family context through a community model of intervention.** This example demonstrates that whilst faith can be a cultural barrier if therapy is perceived to be in opposition to religious beliefs, **when faith leaders were included in a community model of intervention they held great influence and potential for effective, long-term, generational therapeutic intervention.** The 2020 Youth Violence Commission report made this one of their key recommendations: “All professionals working with vulnerable young people should make an enhanced effort to harness the full potential of faith organisations in reducing serious violence between young people”⁴⁰.

The gendered understanding of interpersonal violence as predominately a male issue was also seen to be a barrier to effective therapeutic provision. Not only were girls and women seen by practitioners and families to be equally present and affected by the situational contexts of extreme violence, but

40 Irwin-Rogers, K., Muthoo, A., Billingham, L. (2020). The Youth Violence Commission; Final Report. The Youth Violence Commission, <http://yvcommission.com/wp-content/uploads/2020/07/YVC-Final-Report-July-2020.pdf> ; p64, 74

accounts from family members affected by loss consistently expressed an emotional and logistical dependence on the labour of women to organise, communicate and facilitate all the administrative and social requirements in the event of a tragedy. **Participants described liaising with police, the media, lawyers, witnesses, local authorities, housing offices, tax offices and their extended family** – whilst simultaneously trying to protect their children and younger siblings from trauma by appearing ‘well’. Due to disproportionate social and care responsibilities, **women and girls were recognised as less likely to engage with therapeutic support** as the demands of everyday life left no opportunities to do so.

Mothers interviewed in this research who had lost children in violent circumstances frequently stated that **offers of therapeutic support by statutory services ended when the court case finished – which in fact was the time when they had the most capacity to engage**. The counselling that was offered prior to the trial was for predefined terms; a six- or eight-week programme of therapy. Multiple women felt that the effectiveness of this counselling was impeded by the knowledge that it was coming to an end at a fixed point, feeling rushed to recover and saying to themselves within therapy sessions:

“you have to get yourself together because you can’t rely on this anymore because it’s going to be gone”.

Many mothers felt that long-term support would have provided crucial accessibility to women with fluctuating availability and needs during the extended grieving process of losing a child.

d. Improving Therapeutic Services and Referral Systems

The final theme identified as a barrier to effective therapy (and one of the most fundamental limitations) **was the recognition that referral systems in many cases were oversubscribed, uncoordinated and lacked the ability or expertise to deliver quality therapeutic services**. Practitioners described a reluctance to make referrals to some agencies based on the past experiences of young people they worked with, with one stating:

“CAMHS was always appalling and I got to a point as a professional when I just refused to make referrals to them unless I really had to”
(Youth Development Practitioner).

Practitioners and families expressed consistent frustration with the high threshold of trauma required for a referral to be made and described waiting months, sometimes years, for a first appointment.

Many practitioners felt they did not know who or what they were trying to get young people to agree to engage with, which made it very difficult to connect the services or follow up a referral. One professional described handing out flyers for services which they had no specific knowledge of in order to promote to young people. Oversubscribed services added to the feelings of disconnection, with practitioners describing how opportune moments for engagement were often missed. **Participants frequently shared experiences of young people being told they did not meet the threshold for a therapeutic referral, despite the practitioner knowing they were suffering trauma from a particular incident**. It was frequently expressed by participants that young people downplayed how affected they had been when speaking to services on the phone and that the ‘RAG-rated’ (red, amber, green) risk assessment system used by CAMHS was not sufficient in recognising the needs of young people.

Several practitioners felt frustrated with the lack of effort made by some therapeutic services to engage or continue to work with particular families when referrals were made:

“if they find a hard to reach family or the family’s not really engaging they just give up, they don’t try different avenues and different ways to engage that group... ‘you’re a hard group, let’s close the case’... I don’t understand it”
(Youth Engagement Co-ordinator).

This point was reiterated in several interviews, with practitioners urging a change in the CAMHS policy whereby a case is dropped if a child does not engage within the first three appointments. As one participant described:

“...the young person, the family might be difficult to work with...because they’ve gone through some crazy stuff in their lifetime. What I’m fed up of people saying is ‘this young person didn’t engage with me.’ ...If they’re not responding to me... I’ve got to come up with a different approach. It’s not their job to engage with me!” (Intervention Lead)

This position was supported by many practitioners who felt the onus of engagement needed to shift from the young person and families to the professionals, in recognition of their previous adverse experiences with systems and institutions and the need to restore trust gradually with marginalised groups.

In one instance a youth worker explained how they had arranged for the CAMHS worker to attend their centre to encourage young people to feel more comfortable and willing to engage. However, they still found it challenging to get the worker to connect with the young people. **The youth worker felt this was down to the therapist’s approach in not allowing for relationships to build informally, saying:**

“They still didn’t get the importance of things like needing to be around at lunch time to play table tennis and build relationships, and then it feed from that place that the therapeutic interventions would take place, you know?”

In another example one organisation felt they could no longer put their families on twelve month waiting lists or wait twelve weeks for an assessment for an ineffective referral. Instead they crowdfunded to employ their own culturally competent therapists who were able to engage clients who were the first in their families to attend therapy.

Participants felt that the selection of therapists in most referrals was arbitrary, described as **“just throwing a random person”** at the case. Youth Workers felt they had **“no relationship”** with the referred services. The bureaucracy of interventions was described as **“just filling out the papers and then ‘done’”** and as passing young people and families from agency to agency, without consideration of who or what kind of therapy would be best for them. Participants described how the process could leave young people feeling further rejected and marginalised by services that were meant to help them.

When asked what kinds of therapy they had seen work with young people and families, practitioners identified a variety of creative and innovative therapeutic activities which might not be seen as ‘traditional therapy’. Examples included **art therapy, creative arts, music therapy and lyric writing, drama therapy, play therapy, Lego therapy, sand therapy, regular group work and informal**

chats, healthy eating sessions, growing plants, going for coffee, getting food together or an environmental break through a residential trip to the countryside. Whilst participants were able to identify more formal forms of therapy such as **Cognitive Behavioural Therapy, Eye Movement Desensitisation Reprogramming (EMDR), mindfulness or functional family therapy**, it was felt that effective strategies needed to be flexible, adaptive, integrated and unobtrusive.

One participant described their approach as **“by any means necessary”**, including attending housing appointments with families or offering to support them in meetings with teachers. This participant expressed that until a family’s **“basic needs”** are met they are not going to be ready for therapy. Participants agreed that the type of therapy should be secondary to the relationship, with one practitioner explaining:

“it’s not the particular type of treatment, it’s the relationship. That’s the important thing, and that’s the thing that takes time... To get to someone’s deepest anxieties, especially young people, you’re not going to get there without the ability to make connections” (Psychotherapist).

One the most successful models discussed during interviews emphasised **the importance of bringing together all the various professionals from across all sectors to provide a full case map of a young person and their family before devising an intervention.** Along with providing an instrumental case background and family context, this conversation between agencies was crucially able to ask:

“Who has got a record of engaging with this young person and their family? Where does the knowledge lie?”

Given the failures of the faceless referral systems described by other participants, the findings of this report suggest **a collaborative case mapping approach should be adopted and coordinated London-wide.** This collaborative and joined up referral process provides ‘contextualised safeguarding’⁴¹, recognising that interventions that only look at one sphere of harm in isolation (home or family) cannot also safeguard from other contexts of harm (school or neighbourhood).

⁴¹ Firmin, C. (2015). Peer on Peer Abuse: Safeguarding Implications of Contextualising Abuse between Young People within Social Fields, Luton: University of Bedfordshire.

4. KEY POINTS AND RECOMMENDATIONS OF PART THREE

Key Points

- 1 The language of formal therapy can be a barrier for engagement with practitioners, who urge greater innovation and flexibility in how therapeutic interventions are defined and delivered.
- 2 Marginalised groups often deeply distrust organisations and institutions due to consistent experiences of structural harm through inequality in health care, education and criminal justice systems.
- 3 Intersectional experiences of social exclusion through race, class and gender were seen to present particular barriers for initial engagement in therapeutic services. There is an absence of long-term girls' projects, peer-to-peer support and parent groups for engaging families affected by trauma.
- 4 For Black people in particular, trusting relationships with professionals relies greatly on representation and cultural competency, with young people and families much more likely to speak with practitioners who share or understand their ethnic background and culture.
- 5 Faith can be a barrier if religious individuals believe therapy to be incompatible or irrelevant to their belief system, but it can also provide unique opportunities for holistic engagement. The long term, inter-generational, community positioning of faith groups can provide crucial engagement with families and young people if faith leaders support therapeutic services.
- 6 Referral systems are currently not fit for purpose; the threshold for engagement is too high and not effectively assessed, waiting lists are too long and there is a lack of ability to engage disenfranchised and socially marginalised groups.
- 7 Effective therapies include a variety of creative and adaptive approaches, devised and coordinated to best suit the client, through collaborative and inclusive case mapping.

Recommendations

- 1 Cultural Competency training for therapeutic services that work with marginalised young people and families, ensuring practitioners understand intersectional experiences of race, class, gender and faith in the context of trauma.
- 2 Increase the representation of Black and brown clinical therapists through targeted recruitment, funded placements and bursaries.
- 3 Normalise the language of therapy and increase informal therapeutic capacities by upskilling existing frontline workers, faith leaders and key community figures through introductory therapeutic training.
- 4 Reform referral policies and implement a community case mapping approach, bringing together professionals across all relevant sectors to devise interventions that best fit the client.
- 5 Use innovative multi-layered models of engagement that focus on therapeutic relationships instead of fixed-term formal interventions – providing ongoing flexible support that is accessible for all, including women and girls affected by traumatic loss.

Part Four:

Connection Power as a Conduit for Effective Therapy

Part Four:

Connection Power as a Conduit for Effective Therapy

1. INTRODUCTION

In Part Four of this report the results are discussed through the themes of knowledge and connection as a conduit for therapy. The evidence presented here will highlight the value of lived experience and the unique ability of embedded practitioners to build trusting relationships with groups suffering multiple forms of extreme marginalisation. However, this position of being authentically 'between two worlds' is seen to come at great risk to practitioner's mental health and wellbeing. Current failures to adequately support practitioners within these roles will be discussed here, along with recommendations for how a culturally competent conduit organisation could connect people to services through valued and community-based practitioners.

2. CONNECTION & INFORMATION POWER

The focus of this report is on therapeutic interventions to reduce violence and is not intended as a critique of youth work practice. This work has been done with much closer focus on youth work than that presented here⁴². However, as participants frequently emphasised the pivotal role frontline youth practitioners play in supporting referrals and delivering therapeutic work with young people, aspects of youth work practice will be discussed here. To contextualise these responses it is important to note that the traditional value of youth work - to build supportive non-judgemental relationships with young people - has been increasingly challenged and restricted by business models of intervention which insist on measurable outcomes and targeted engagement⁴³. It is not suggested here that the value of youth work lies solely in its ability to connect young people to therapeutic services, but rather that in many cases the youth work itself has therapeutic value which should be recognised.

This research considers how the expertise of valuable practitioners can be connected to the services where this engagement is most needed, without putting frontline workers at increased risk of harm or restricting their ability to maintain supportive relationships with young people. The discussion will consider the importance of conduit organisations that have the '**connection power**'⁴⁴ to bring the right people together in mutually beneficial collaboration, in addition to '**information power**' to know and understand the complex contexts that must be navigated within this work.

42 Ord, J. (2007). Youth Work Process, Product and Practice: Creating an authentic curriculum in work with young people, Lyme Regis: Russell House Publishing; Verschelden, G., Coussée, F., Van de Walle, T. and Williamson, H. (Eds.) (2009). The history of youth work in Europe, Relevance for youth policy today. Strasbourg: Council of Europe Publishing <https://www.youthcoop.pt/wp-content/uploads/2019/10/History-of-youth-work-Vol-1.pdf>

43 Taylor, T. (2010). Defending democratic youth work. The Journal of Contemporary Community Education Practice Theory. Vol.1 No.2 Spring 2010 p3-10; Davies, B. (2013). 'Youth work in a changing policy landscape', Youth & Policy, No 110.

44 Sweeney, C., & Bothwick, F. (2016). Inclusive Leadership: The Definitive Guide to Developing and Executing an Impactful Diversity and Inclusion Strategy. Prentice Hall: Financial Times.

3. FINDINGS FROM RESEARCH

a. The Risk of Experience

The long-term trusting relationships and emotional investment in individuals and families that effective practitioners make (and are expected to make by their employers) were often described during interviews as coming at great risk to their own mental health and wellbeing.

Youth workers described multiple experiences of highly traumatising and re-traumatising work, for which they frequently received **no clinical supervision**. In the absence of statutory or effective therapy for frontline staff, highly valuable workers described reaching breaking point, either in response to a particularly triggering case or as an accumulative 'burn out' from vicarious trauma and the weight of accountability for **"at risk"** lives. Two participants described this experience:

"...when you're working with those kinds of young people, you're giving them your heart...when that young person that you're working with dies or that family member dies, a part of you also dies... You take that stuff personally, 'what could I have done better? ...I should have been with this young person more often.' There's many times ...when I find I've suffered from burnout"
(Youth Engagement Co-ordinator).

"...you think 'If only I'd taken that more time to speak to him or if only I'd probed a bit more.' And you...internalise this guilt and it's round and round your head, and you're not sleeping properly and...you wake up distressed. All you can see is that young person's face...it doesn't disappear, and so you do turn to drink or whatever..." (Local Authority Manager – Alternative Provision).

A sense of deep responsibility was felt by embedded front-facing practitioners, with high levels of introspection and guilt in the event of loss or harm to those they worked with. Yet youth workers, along with other frontline staff such as teachers, youth offending workers and family therapists, frequently expressed no referral for supervision or aftercare was made for them by their institution or employer. In some cases professionals were encouraged to find someone to talk to by themselves, leading to further harm through **"opening a whole can of something"** or **"opening wounds"** with untrained and unqualified colleagues who were unable to close or resolve these traumas.

The effects of austerity were seen to have increased the pressures on frontline practitioners whilst reducing budgets which might have funded clinical supervision. One participant described how the failings of systems and other professions put unbearable pressures on youth workers to redeem trust and integrity through being constantly available and always 'going the extra mile'. He described the additional emotional labour and the importance of clinical supervision this way:

"The problem is in youth work, you know, we don't really switch off, do we? ...I have given my word for someone, if I don't follow through now they probably won't trust a professional again... if other professionals had done their job... then they wouldn't have let a young person down. So now I'm picking up the baggage...That takes its toll because I don't want to let someone down... you need clinical supervision - an opportunity to talk is massive"
(Custody Intervention Coach).

Along with the evident risks of occupying this pressured space, one experienced practitioner and youth project manager described how 'lived experience' can become exploited by organisations who need to validate their work in funding bids and public relations but are not authentically invested in developing their practitioner's careers. She explained:

"The term 'lived experience' in this sector needs to be reconsidered, especially around serious youth violence. It has become so oppressive and recreates structures that people often do not want to see. It provides a glass ceiling to some professionals as organisations use these stories and keep them on the 'low level' jobs while benefiting off their claps at conferences".

This practitioner went on to describe that when she developed professionally and wanted to be seen for her management skills, degree and career achievements rather than her 'story', people in the organisation no longer wanted to listen. Along with similar descriptions from practitioners who have had their 'insider' knowledge dismissed or undervalued in management meetings, **this account suggests that rather than viewing lived experience as an asset for cultural competency and effective practice, it is seen as a quality that excludes professionals from decision making roles. This limits them to a redemptive narrative that symbolically validates organisations which are otherwise disconnected from the communities they work within.**

Overall, 'lived experience' was seen as a quality that was overlooked or superficially exploited without due care or respect for personal risks associated with this unique positioning. In several interviews youth work practitioners described how others see their work as **"something you fall into"** rather than a **"real job"**, or as an **"underrated profession"**, whilst clearly describing highly demanding working conditions, extensive responsibilities and deep cultural competency in practice. The consistency of experience across practitioners, along with the lack of support and recognition they described, suggests that youth workers are currently acting as the invisible, under-valued or exploited conduits for effective intervention; providing vital links between young people and services with little recognition of the personal risk, time and expertise required to perform this crucial role.

b. Listening to Practitioners

Whilst lived experience, shared backgrounds or insider knowledge of communities were seen to enable effective relationships with young people, practitioners described how these same attributes acted to exclude them from boardrooms, senior management positions and strategic decision making. Several participants explained their frustration at the lack of diverse representation at leadership level, making reference to a feeling of **"tokenism"** where one or two Black practitioners from the local area would be present but were unable to have significant influence in the decision-making process:

"I was second in command to the CEO - I was also the only Black person on the senior leadership team. I was the only person that was from the borough, so a lot of the stuff that I was bringing up in terms of safety...it was still very much a voting system...I couldn't do a lot of the stuff that I wanted to do because...other people on that same table didn't understand... Same thing at Board level...they will claim, 'We've got one Black person on the Board' so we're covered" (Youth Engagement Co-ordinator).

Another participant described the lack of empathy in senior management meetings which were dominated by those with little experience of the realities they were discussing, leading her to feel like an imposter in the room where decisions were being made that she disagreed with:

“There’s a significant lack of lived experience, and then empathy that I think comes from that...Just the complexity of some of that stuff... I’ve often felt like the imposter in those spaces...coming to a space where the approach is so the opposite of what I believe is actually the right thing to do”

(Youth Development Practitioner).

Alongside this frustration with strategic misdirection, participants felt that organisations were more concerned with how things looked from the outside: **“too worried about their reputation... but not enough about their staff or the young people”**. Participants expressed concern that the phrase ‘trauma informed’ was another of **“these rolling terms that come around”** but which would not lead to any significant change. They also expressed a view that the increasing **“outcome focus”** of interventions was detracting from the holistic approach which built meaningful relationships with young people and their families. This shift towards a managerial, business model delivery of youth services is a trend that has been explored and evidenced in previous research⁴⁵. However, the evidence from this research demonstrates the practicalities of this shift in intention; top-down models of interventions are **silencing frontline workers and dismissing their experiences within the services they risk their wellbeing to deliver**. As one participant explained:

“...sometimes I’m there at these meetings and I’m saying the points of view from on the ground level - you’re kind of looked at funny...the problem is you’re working from the top down, where really we should be working from the ground up, and hearing about what the people are doing on the ground... rather than someone in that Board room... who doesn’t have any experience of that on the ground stuff, making strategic decisions” (Youth Worker).

The results of this research strongly suggest that the chasm between experience and influence, from those on the ground to those producing strategy, is fundamentally restricting the effectiveness of current therapeutic interventions. The youth survey data in this report demonstrates the importance of trusted adults who understand the complexities of current youth violence and can act as intermediaries between young people and therapeutic professionals. The accounts of youth workers who were interviewed reinforced this. If organisations and statutory services genuinely intend to deliver effective therapeutic responses to youth violence, **the voices of frontline workers must be heard** and a proportional representation of practitioners should be present at all strategy meetings.

c. Culturally Competent Conduits for Therapy

Whilst the close and trusting relationships developed by empathic and dedicated workers were not recognised or valued through internal procedures, the success of organisational outcomes and strategic interventions was often seen to be entirely reliant on the groundwork, ingenuity and integrity of culturally competent practitioners who acted as conduits for successful referrals. Frontline workers described the lengths of persuasion and consistent encouragement it took to ensure a young person would turn up at a specific appointment, for example, or to convince a young person to give another professional a chance to form a relationship with them. Three practitioners described:

⁴⁵ Taylor, T. (2010). Defending democratic youth work.

"...many times, they've only got on board with things because it was me that encouraged them" (Youth Worker).

"I always try to escort my young people to a new provision that I was referring them to... it's only really when you've worked with our client group that you understand the intricacies of those things - calling them 10 times that morning, messaging them some inspirational quotes - there's a lot that goes into that" (Youth Development Practitioner).

"The resistance is there...ten times out of ten they will say 'Yes I do trust you but I don't necessarily trust therapists' and I'll say... 'Do you think I'd give you someone who I don't think would get you?' And then they're like 'Oh, yeah, maybe not!'" (Senior Programmes & Partnerships Manager)

The openness, cultural resonance and self-confessional approach needed to facilitate this trusting relationship was often seen by participants as incompatible with the work identities of particular professionals who work with young and families, or as being outside the remit of their knowledge and experience. This contradiction was consistently raised regarding teachers in mainstream education. **The lack of diverse representation of ethnicity and social class were seen to contribute to teachers being 'out of touch' or unable to relate to marginalised groups in the classroom, with many teachers seen as acquiring their knowledge of youth violence from sensationalist news media and thus lacking understanding of the complex vulnerabilities** as discussed in Part Two of this report. This strongly suggests there would be benefits from cultural competency training for teachers and school management teams.



The results from the youth survey support these findings, with white respondents being almost four times more likely to speak to their teacher about a violent incident than Black participants.

This was a trend that was reflected across institutional bodies, with white participants consistently more likely to talk to the police, youth workers and therapists, whilst Black respondents under the age of 16 were the demographics most likely to talk to 'no one'.

“If a violent incident happens between people I know I would consider talking about it with...”

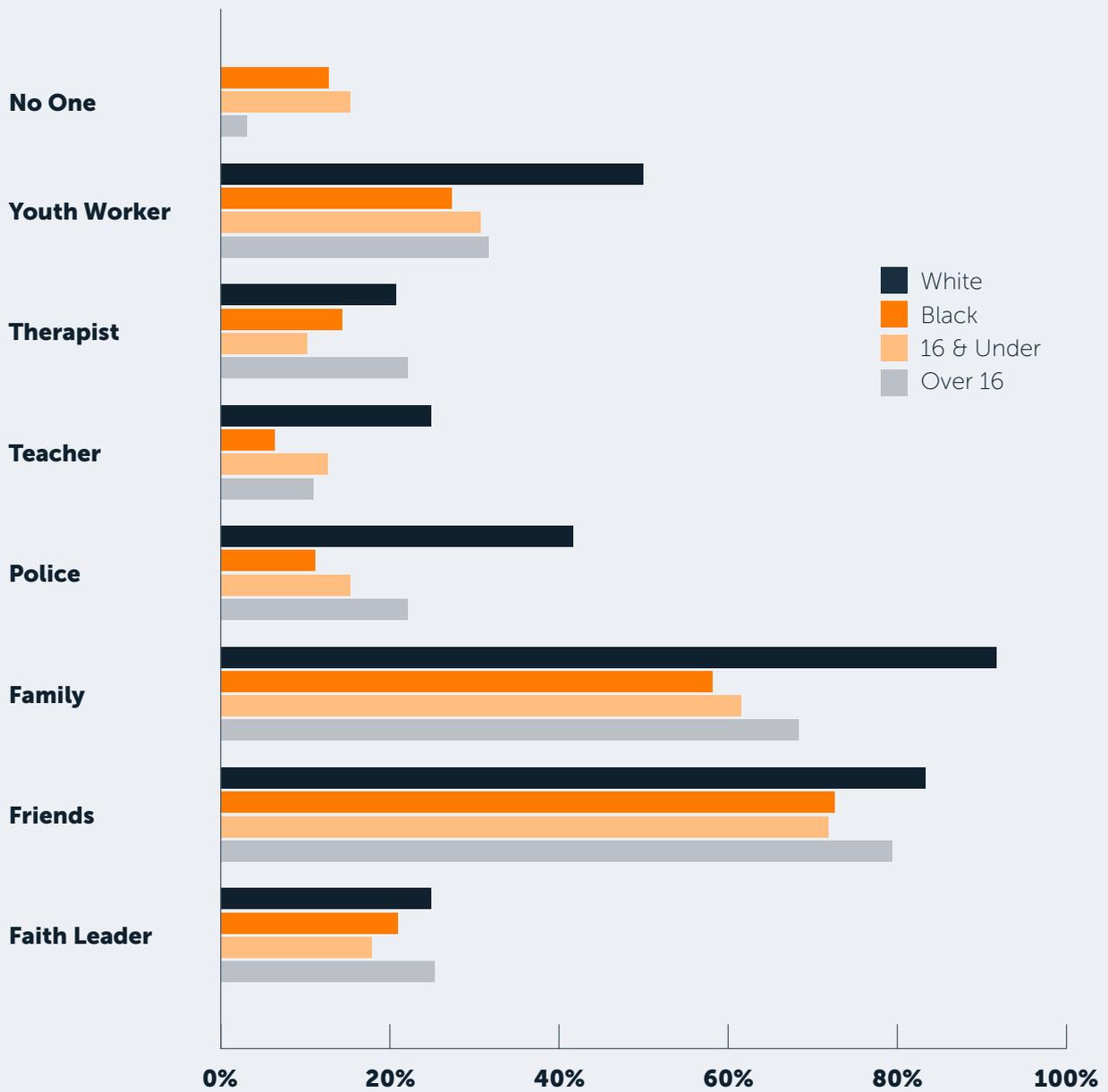


Fig. 8

Beyond individual bias however, the school environment itself was seen to limit teachers' ability to provide or connect young people to therapeutic services. With increasing pressures on teachers to secure academic results and retain students through behaviour management, the measures of success were described as misleading. Whilst remaining in education and achieving qualifications are key factors to achieving financial stability in the future, simply keeping young people in the classroom when there is unresolved trauma and ongoing violence in their everyday lives is not centring their wellbeing: **"keeping them in a school where they're in a classroom with 30 other children and not the attention and the support they need - that's not the solution"**. Many participants described the futility of an educational approach that expects young people who have had multiple friends killed in violent conflicts or have witnessed extreme violence in their home to be able to sit calmly in a room ready to learn without any therapeutic support. As one family member (who also works with young people) explained:

"you're never going to get what you need out of this child if they've got a hundred-and-one other things going on and they're losing friends [to violence]".

Teachers and practitioners working in school settings described how their ability to provide therapeutic referrals for students and their families had been significantly hindered by the impacts of austerity, which had reduced the external services that previously supported this approach. One teacher who had been working in London schools for 18 years described the effects of ten years of austerity this way:

"what's happened is that much of the external support for these students has pulled away, and there's quite an undercurrent of anger and disaffection amongst families that's been long running now... we used to work with an excellent full-time Connexions youth worker and...he would be pulling together for those students; the careers, the youth work, everything...It was excellent... And then gradually the funding for him got cut...The loss of that kind of provision, I think, has been significant" (Deputy Headteacher).

The cuts to these essential external 'packages' of advocacy, relationship building and youth development were expected to be compensated for by the school and provided by teachers who had neither the time, experience nor training to do so. This was seen as putting teachers in the difficult position of trying to perform an authoritative role within class and needing students to **"be a bit intimidated"** at times, whilst also attempting to provide pastoral support. One Assistant Headteacher described how this extension of duties beyond a teacher's remit made her feel at risk:

"sometimes as a leader you feel quite vulnerable, dealing with really high-level issues when really, teachers...have some additional training but really we're trained to be teachers. You end up taking on a lot of issues that really lie outside your formal training".

Another teacher felt that without reliable external partners the offers of support felt like empty gestures, saying:

"it can be quite a tokenistic relationship in which you're saying 'We want to support you as a family' but actually you don't really have much to offer..."

You could do a referral to Social Services but actually the threshold is so high that you're probably not going to get that early help".

Participants agreed that teachers **"can't wear a hat for everything"** and that in their role as formal educators they are already pushed to the limit of their responsibilities and duties. It was felt by practitioners that **schools urgently need the support of external organisations that have the capacity to act as conduits for therapeutic services and interventions with students and their families.** This need was particularly exposed when schools experienced the loss of a student or in the event of serious violence in close proximity to, or on, their campus. Teachers described how the school's response during these moments was **"ad-hoc"** and lacked coordination without any clear protocol in place. Families interviewed also felt that no systems were in place to provide support for the friends of their child in the aftermath of their death, or that schools didn't know how to deal with children's responses in the immediate aftermath of loss.

These findings suggest that in recognition of the skill, dedication and expertise required to build trusting and meaningful relationships with marginalised young people and families, this responsibility should be managed and facilitated by an external, culturally competent organisation. Whilst teachers and school management teams would benefit from training in this area, much of the experience and positioning required to fulfil this role successfully is outside of their remit and supervision, and often incompatible with other responsibilities. **Through long-term partnerships with schools, organisations with connection and information power would be able to bridge the gap between services, becoming conduits for effective therapeutic intervention and community support.**

d. A Community Response

The final theme discussed in Part Four of this research considers the findings which suggest therapeutic responses need to **be guided, co-produced and co-delivered by communities themselves.** This was a particularly prominent suggestion during interviews with families who had lost loved ones in traumatic or violent circumstances. In cases of child-loss or violent deaths there was seen to be a specific need for connection with others who had experienced the same kind of trauma, with participants commenting on a sense of **"peace"** that was only achieved by speaking with those **"journeying with you"** or **"walking in your shoes ahead of you"**. Whilst families recalled adequate and friendly support from police Family Liaison Officers, Victim Support and the Witness Protection Team, they consistently expressed that these professionals did not have the capacity or long-term consistency to provide meaningful therapeutic relationships.

Parents and families shared some positive experiences of statutory services that offered six or eight weeks of counselling, but consistently felt that this was not long enough and was often offered at the wrong time. Several family members described how their counselling finished at the start of the trial where they were repeatedly exposed to the perpetrator, CCTV footage or mobile phone videos of the incident, as well as extremely traumatic courtroom experiences. Three different families described how, after the case was finished or their programme of counselling had ended, they felt expected to 'move on' and 'get over it' - feeling they no longer met the criteria for therapeutic services despite often being in urgent need of referral:

"...you can have it for 6 weeks or 8 weeks and then it's like, you know, you've got to just get on with life, move on... after the case... everybody goes, you know?...Victim Support will do so much - but after that it's pretty much like, yeah, see you, goodbye".

“...you kind of think ‘I must be over it by now’ because everybody else is... getting on with their lives but it’s like, my life’s never going to be the same... you’ve got to fit into this criteria and if you don’t then you can’t get the help”.

“The counsellor said ‘You’ve had your eight sessions and Victim Support will pay for that and I’ll let them know that I do think you need more sessions, but we’ll probably need to pick it up after court.’ And then they didn’t get back in touch with me”.

It was after returning to work following the court case that parents and family members described having breakdowns and panic attacks from unresolved trauma and lack of ongoing therapeutic support. Reflecting this, as well as the value families had found in speaking with others who had experienced similar losses, participants felt extended counselling provision should be offered alongside community led, peer-to-peer support groups for those suffering both grief and trauma in this context. It was consistently expressed that parents and families needed very practical advice and knowledge from people who had been in the same position as them:

“in the initial stages of shock and trauma...you’re pretty much left bare, left on your own, to try and work out – or not work out – what happens next... kind of working your way through the darkness”.

The accumulation of administrative tasks in the aftermath of loss were consistently mentioned as difficult and traumatic. Requirements such as registering the death, autopsy arrangements, applying for compensation of support with funeral costs, planning a funeral, making arrangements for what happens to the body, informing the council of changes in circumstances, contacting housing associations, cancelling phone contracts, communicating with criminal justice representatives, speaking with the press - or trying not to speak to the press – were all unknown and daunting tasks to perform whilst simultaneously processing loss and trauma.

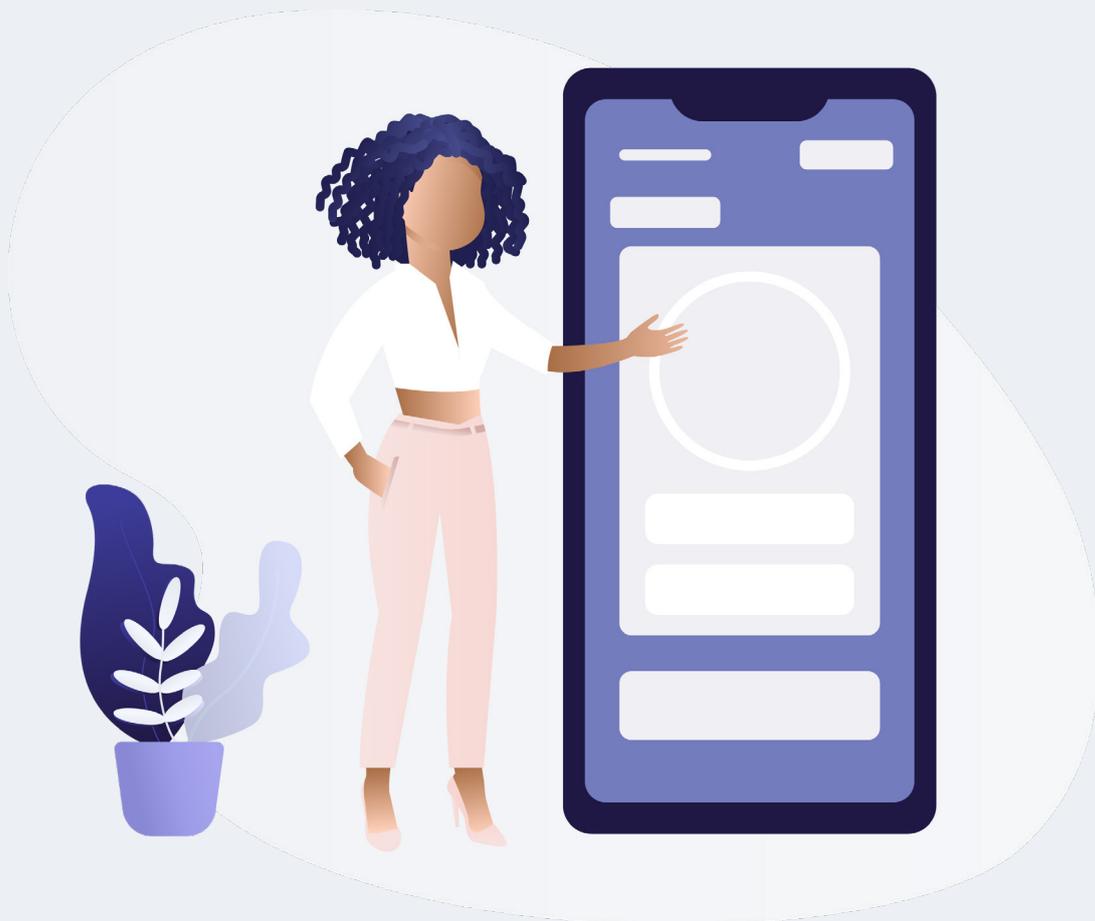
Families felt there was an urgent need for a **“wrap-around support package”** that could immediately respond in the event of tragedy, **not only to provide consistent support “for as long as you need it” but also to link families to other families with experiences of this kind of loss. These peers can answer questions and talk through what will happen and what to expect in very practical and realistic terms.** As one mother explained, what they needed was people who had been through this experience themselves:

“...somebody to come round and...guide us through the whole procedure... and don’t worry, one minute you might feel good and the next minute you might feel bad, that’s all natural”.

Family participants expressed that therapeutic support was only offered to biological parents, with some unable to get referrals for stepfathers. It was advised by all families interviewed that the response needed to include the whole family – younger children and siblings as well – who have seen and experienced trauma in the unfolding aftermath. Extending community-led support to the close friends of the deceased was also seen as essential, with particular concerns raised around unresolved trauma leading to anger and further violence.

Whilst it is clear from the results of this research that much more can be done to engage young people who have experienced loss within their friendship groups in therapeutic activities, the data from the youth survey demonstrated a strong current preference for talking with friends and family in the event of violent incident (see Figure 8).

This suggests that alongside improving engagement with marginalised young people, the wider community needs to be equipped and empowered; providing parents with knowledge through peer-to-peer support groups and providing informal and creative, community-based therapies which incorporate all ages. Interviews with families suggested that in addition to providing packages for schools in the aftermath of incidents, external organisations that are already competently grounded and active in communities can act as therapeutic bridges, empowering and supporting communities to organise and come together to support one another “for as long as you need it”.



4. KEY POINTS AND RECOMMENDATIONS OF PART FOUR

Key Points

- 1 In maintaining trusted and supportive relationships with socially marginalised young people and families, frontline practitioners are often risking their own mental health and wellbeing by becoming emotionally embedded in communities and feeling accountable for their safety.
- 2 This profession has a high 'burnout' rate with practitioners suffering breakdowns from continual exposure to trauma and the frequency of highly traumatic events amongst the individuals they work closely with.
- 3 There is a fundamental lack of clinical supervision for these high-risk roles, with many organisations having no internal referral process for their employees despite the harm their workers are continuously exposed to.
- 4 Practice based or professionals with "lived experience" are systemically undervalued and structurally excluded from decision making at a strategic level, often made to feel culturally out of place, tokenised or exploited.
- 5 Service cuts from austerity measures have increased the work required to rebuild trust in communities, removed external specialised support for institutions and put unrealistic expectations on schools to be 'everything to everyone'.
- 6 There is currently no cohesive strategy or 'wrap around' package of support in place to provide immediate and long-term support for family and friends in the aftermath of a violent incident or traumatic loss.

Recommendations

- 1 Urgently provide culturally competent, clinical supervision for all frontline practitioners. Organisations and institutions are responsible for the wellbeing of their employees when their work is reliant on high-risk relationships and exposure to trauma. Therefore, all youth and community charities, youth offending services, schools, social services, and other front facing services must have referral processes in place for either internal or external clinical supervision for their workers.
- 2 Professionals with practice backgrounds and expertise in engagement through insider knowledge or "lived experience" should be valued and represented throughout the management structure of institutions – with equal or greater representation in strategic meetings.
- 3 Culturally Competent external organisations to provide schools with sustained pastoral care and counselling for staff, parents and young people, acting as conduits for therapeutic interventions and clinic referrals.
- 4 Conduit organisations with connection and information power in communities should be centrally funded to facilitate community responses to violence, connecting people with shared experiences of trauma and providing on-going open access therapeutic support for men, women, boys and girls of all ages.

Part Five:

A Blueprint for Culturally Competent Reform

Part Five: A Blueprint for Culturally Competent Reform

1. INTRODUCTION

This report has presented the findings from research with five families, 26 practice-based professionals and 102 young people in London. Exploring themes of contextualised violence, cultural barriers to therapy and connective conduits for therapeutic engagement, this research concludes with a blueprint for culturally competent reform.

Due to COVID-19 this report was significantly adapted from its first intention as we were unable to deliver and evaluate the pilot therapeutic project originally designed. The conditions of social distancing also restricted our ability to conduct face-to-face research and undoubtedly altered the dynamics of the interviews conducted online with our participants through video calls. Being unable to conduct qualitative research with young people was another disappointing yet unavoidable limitation of this research and it is recommended that future research place high priority on the experiences of young people in their own words.

Time constraints and the sensitivity of the topic limited the sample size for the youth survey. The quantitative data in this report indicates clear trends across demographics of respondents, but further research is recommended to discover if the same patterns exist across a much larger number of young people and outside of the potential bias of an opportunity sample. It is also recommended that further research is needed on cultural competency specifically in the UK context, with much of the current literature originating in the US and having a focus on American policy and social histories.

Despite these limitations the research was able to gather extensive amounts of data in a short length of time and the analysis revealed compelling themes and consistencies across sample groups. Throughout the results it is evident that current therapeutic responses to serious youth violence are significantly impeded by a lack of awareness and knowledge of cultural difference and cultural contexts. This limited understanding and relatability were apparent in both the interactions between therapeutic practitioners and clients, and the structural power dynamics of therapeutic institutions themselves. Culturally incompetent approaches were seen to reduce the success of referrals through poor rates of engagement with therapeutic services and increase the risk of further harm on vulnerable and marginalised groups through misrecognition and misunderstanding.

It is important to note that the emphasis on structural forces throughout this research ultimately calls for a social and economic shift; reversing the extensive harms of austerity by providing long term investment in communities and young people, eradicating racism, ending child poverty and building a more equal society. Whilst we collectively mount pressure for these systemic solutions, this report sets out a plan for immediate implementation to achieve therapeutic intervention for peace in London.

2. WHO?

Who Can Deliver Culturally Competent Therapeutic Interventions?

- 1 Trusted
- 2 Trained
- 3 Representative
- 4 In Partnership

- 1 The short answer to this question is: **trusted practitioners can deliver culturally competent therapeutic interventions.** A therapeutic relationship requires trust, which is why young people and families belonging to groups that have been socially marginalised or historically harmed by institutions are unlikely to want to engage with services. This is especially likely if the intervention is seen to be culturally and visibly white and middle class. However, this research has demonstrated that overcoming these barriers is possible. There are many practitioners with unique expertise, shared experiences, or contextual understanding who maintain meaningful and effective therapeutic relationships with marginalised groups. There are several ways this good practice can be incorporated into service reform.
- 2 **Cultural competency training** for front-facing services that work with marginalised young people and families would ensure practitioners understand intersectional experiences of race, class, gender and faith in the context of trauma, and could interpret physical violence within the context of structural violence and systemic inequality. **It is essential that this training is delivered by an organisation that is authentically positioned to provide awareness and knowledge of cultural difference, ideally Black or minority ethnic led, with a demonstrable record of effective youth and community engagement.**
- 3 An **increased representation of Black and Asian therapists** would facilitate trust in therapeutic environments, breaking down initial cultural stigmas and social barriers for groups marginalised by race. This report suggests diversity in clinical therapeutic roles is greatly needed and should be prioritised through targeted recruitment and funded bursaries for Black, Asian and minority ethnic practitioners.
- 4 For services and institutions that cannot facilitate the levels of trust required to effectively refer or deliver therapeutic interventions, **partnership work** with external organisations should be statutory. This report suggests **schools in particular should be provided with centrally funded pastoral partnerships with external organisations,** providing counselling for staff, parents and young people and an incident response team for immediate wrap-around support in the event of extreme violence.

3. WHAT?

What do Culturally Competent Therapeutic Services Look Like?

- 1 Therapeutic Innovation
- 2 Collaborative Referral Systems
- 3 Long Term Engagement
- 4 Gender Specific Work

- 1 Therapeutic services that are culturally competent centre the needs of clients, to meet young people and families 'where they are at' and adopt holistic approaches that are comfortable, safe and accessible for them. In this sense **'what' the therapy does or looks like will be different in every context.** This report proposes an innovative multi-layered model of engagement that focuses on **therapeutic relationships, not fixed-term formal interventions.**

THERAPEUTIC ENGAGEMENT MODEL

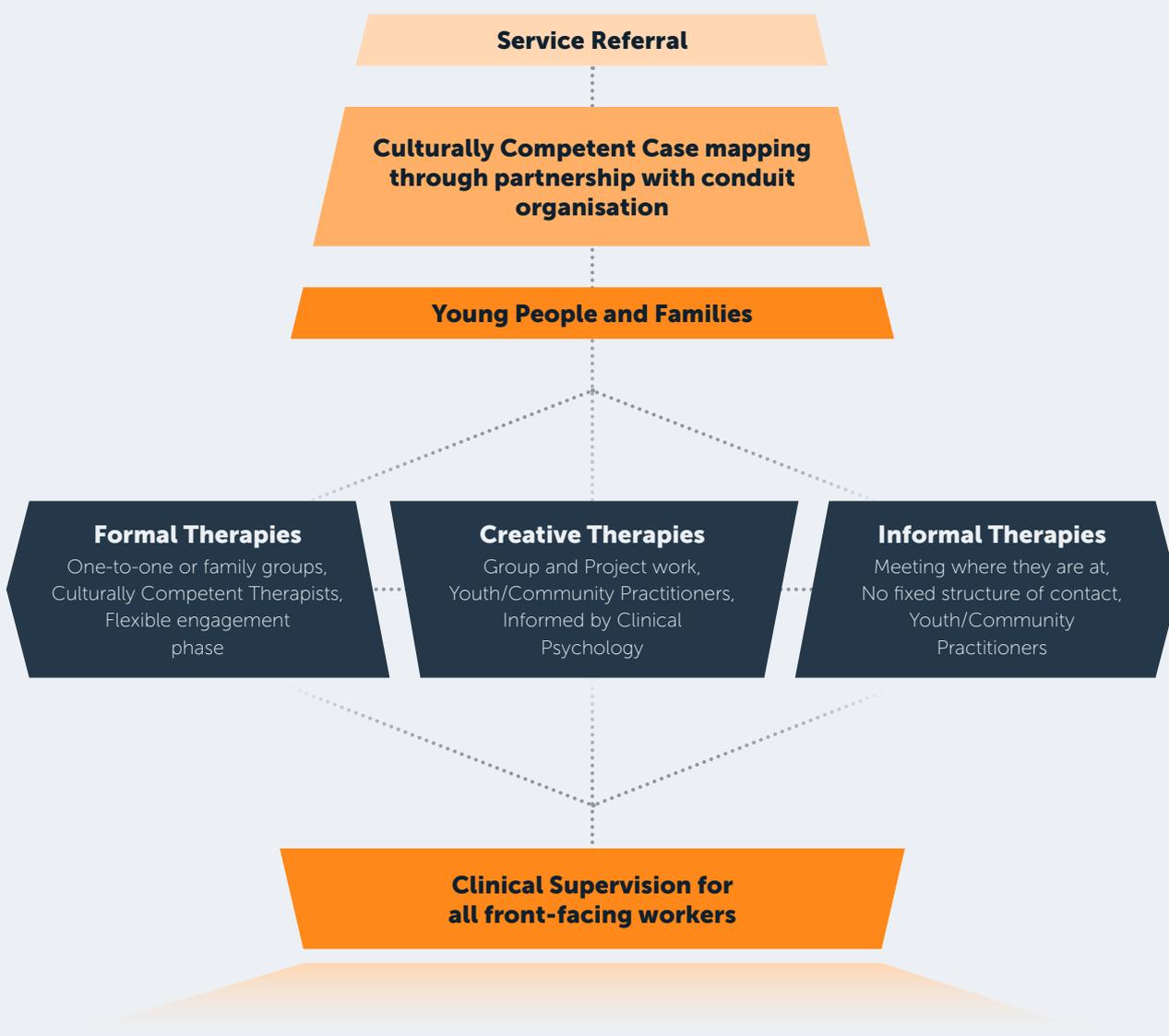


Fig. 9

- 2 In this integrative model, informal, creative and formal therapies are equally valued, with referrals including a phase of **collaborative case mapping**; a process in which the knowledge of all relevant services and institutions is brought together to devise a therapeutic approach that is most likely to be effective for each individual young person and family.
- 3 One layer of this approach is formal programmes of therapy with clinical therapists, whilst a second layer provides **long term engagement through accessible therapies** such as **creative group work with young people and peer-to-peer parent support groups, co-produced with communities**. For those unable to engage in either of these styles, a third layer of regular contact with embedded youth and community workers can provide **informal therapeutic relationships**, with a potential for supported referral to other therapies on their terms. Practitioners that have already established unique trusting relationships with marginalised groups should be provided with the opportunity to **up-skill through therapeutic training**, in recognition of the therapeutic value of these existing connections.
- 4 This reform calls for a commitment to **gender specific work** in therapeutic responses to violence. For too long the understanding of trauma in the context of violence has centred the effect on boys and men, failing to recognise the central role girls and women play both in the violence itself and in the articulation of community trauma. Mothers, sisters, aunts and cousins experience the trauma of violent loss whilst continuing to perform gendered care responsibilities and are expected to carry their families and communities through crisis. Culturally competent therapies must recognise this specific experience, devising **therapeutic services that speak directly to the needs of girls and women**.

4. HOW?

How Can Services Deliver Culturally Competent Therapeutic Interventions?

- 1 Support for existing workers
 - 2 Clinical Supervision
 - 3 Internal power dynamics
 - 4 Conduit Organisations
- 1 This research has evidenced the high levels of trauma and distress that effective frontline practitioners are exposed to through close relationships with marginalised communities. Yet charities, organisations, schools, social services and youth justice services that rely on these connections were seen to undervalue practice-based roles and fail to provide adequate therapeutic support for employees. To consider how culturally competent therapeutic interventions can be delivered, a service model must take the sustainable wellbeing of valuable practitioners into account, as well as **supporting the career development of practitioners into senior leadership roles**.
 - 2 It is a strong recommendation of this report that **all front facing services must have referral processes in place for either internal or external clinical supervision for their workers**. Without these structures in place, people are at risk of experiencing a decline in their mental health and wellbeing. Clinical supervision is also a significant factor in establishing

a culturally competent and reflective therapeutic services, encouraging practitioners to be more aware of themselves and their cultural positioning, enabling learning from both good and challenging experiences.

- Organisations can only claim to practice cultural competency in their services if they demonstrate the same knowledge and understanding in their internal structures. Accounts from Black practitioners of being tokenised, excluded from decision making or exploited for the validity of their 'lived experience' suggest that **institutional racism and cultural power dynamics urgently need to be addressed within the sector**. This report recommends the use of conduit organisations that are Black or minority ethnic led to facilitate therapeutic referrals, challenge the imbalance of power, and provide authentic models of cultural competency.

SERVICE AGREEMENT STRUCTURE

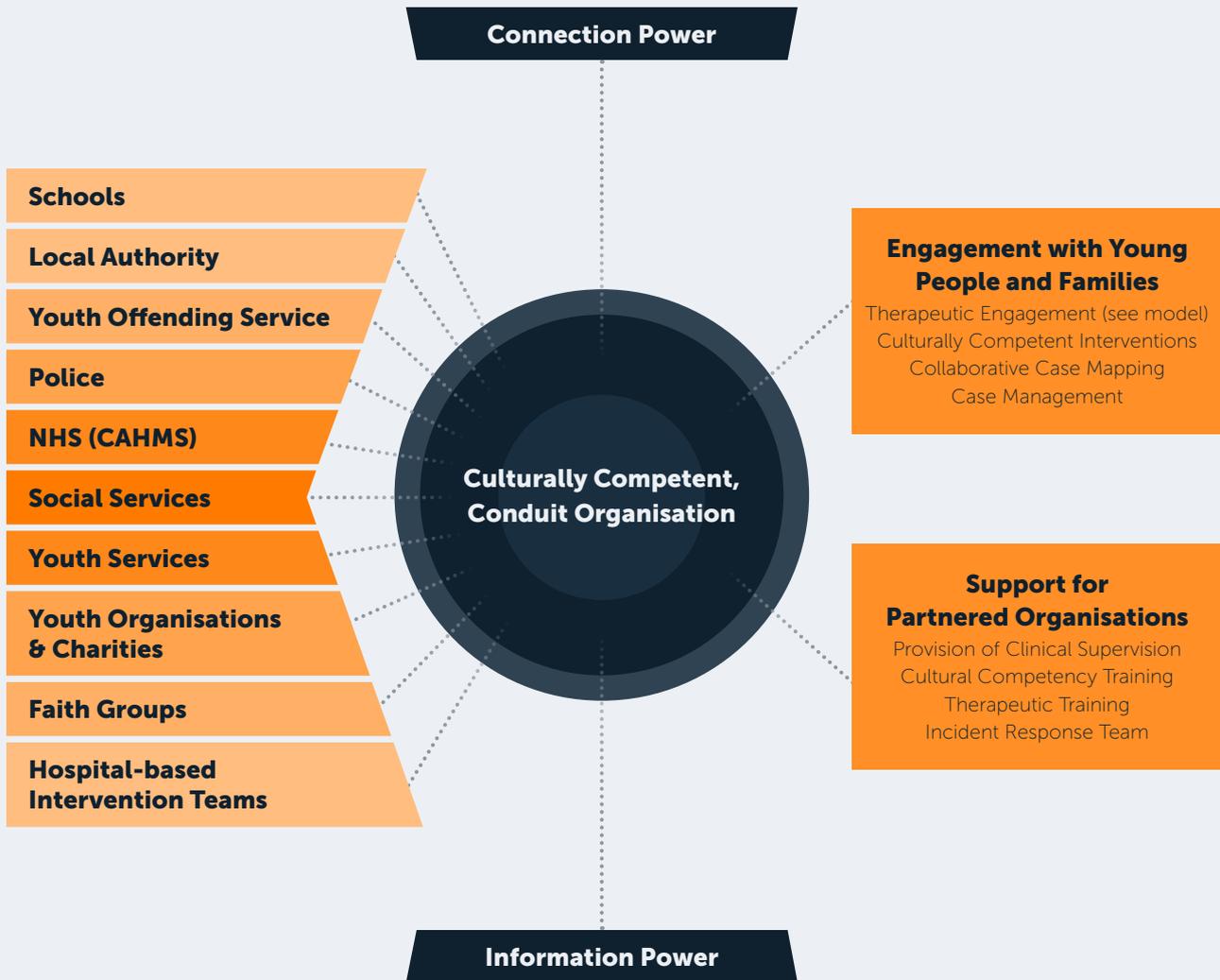


Fig. 10

- 4 The conduit model depicted above represents a service agreement with multiple agencies to manage therapeutic referrals for marginalised young people and families. This is a cross sector connection service that communicates with schools, local authorities, youth offending services, police, mental health services, hospital based intervention teams, social services, youth organisations and faith groups. **The conduit organisation, ideally Black or minority ethnic led, provides collaboration and cohesion between services and is equipped with connection and information power in the communities in which it works.** It provides a dual service; engaging young people and families in therapeutic services through a multi-layered approach (see Fig. 10) and supporting partnered organisations with training, clinical supervision and incident response.

This model represents in practical terms how culturally competent therapeutic services can be made accessible for diverse communities facing multiple layers of marginalisation. Most frontline services have good intentions and genuinely want to connect young people and families to quality therapeutic services, but simply lack the means, knowledge or connections to do so effectively. By funding an external culturally competent organisation to collaboratively case manage referrals all parties benefit, providing a mutually beneficial service agreement that can transform therapeutic responses to violence.

5. WHY?

A Call to Action: Why Reform is Needed Now

This research has evidenced the extreme marginalisation experienced by young people and families who are exposed to the devastating effects of multiple forms of violence, both physical and structural. The trauma of domestic abuse, exploitation and the normalised brutalities of everyday life are compounded by the conditions of economic deprivation, social exclusion and institutional racism. Ten years of austerity have further blighted communities - stripping back welfare, corroding living standards, and cutting public services that provided crucial support structures for young people and families.

Recognising the environmental and social context of serious youth violence, the recent shift towards a public health approach has been greatly welcomed by many working in the sector. The impact of the 2020 Youth Violence Commission Report⁴⁶ and the investment in regional Violence Reduction Units (VRUs)⁴⁷ provides hope for committed policy reform. However, many of us are familiar with the risk of popular policies that sound transformative in theory but provide little substantial change in practice. With this in mind, this report is published at a crucial moment.

Therapy and therapeutic relationships are central to the success of the public health approach; thus it is vital that the cultural contexts, institutional harms and social barriers presented in this report are directly addressed within these reforms. If not, this research suggests public health interventions will fail to engage those most in need, perpetuating the exclusionary forces that act to marginalise vulnerable groups. The blueprint for service reform recommended in this research represents the experiences of practitioners, families and young people directly exposed to the realities of normalised violence in London. **Now more than ever is the time for evidence-informed action, ensuring that investment in public health to reduce violence produces culturally competent therapeutic interventions for peace.**

⁴⁶ Irwin-Rogers, K., Muthoo, A., Billingham, L. (2020) The Youth Violence Commission; Final Report.

⁴⁷ *ibid*; p6

CLOSING REMARKS

This report was written in the unprecedented times of the COVID-19 public health crisis and during the anti-racist protests that are occurring globally, triggered by the killing of George Floyd by police in Minneapolis, USA. The Government report into disproportionate Black, Asian and minority ethnic deaths from COVID-19 published in June 2020 have amplified discussions of structural racism in public health, finding that ‘the pandemic exposed and exacerbated longstanding inequalities affecting BAME groups in the UK’⁴⁸.

In this context the authors stress the importance of this report with both apprehension and anticipation. On one hand, the imminent economic recession caused by COVID-19 will undoubtedly threaten public spending. Therefore, we urge that therapeutic services are protected from potentially devastating spending cuts in the future. On the other hand, the importance of cultural competency has gained impetus in recent months, as many institutions begin to acknowledge racism within their internal structures and practices for the first time. In both respects the choices made within this moment will be decisive and it is hoped that the evidence and recommendations presented here can provide practical models for much needed change.

48 Public Health England (2020). Beyond the Data: Understanding the impact of COVID-19 on BAME groups, Wellington House: PHE Publications, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf

Appendix A

PROFESSIONAL INTERVIEW SCHEDULE

Thank you for agreeing to take part in this study. We are currently conducting research on therapeutic responses to serious youth violence in London and you have been identified as an experienced professional who could share experiences of working in this field in order to improve provision for communities in the future. This research report looks at how communities and organisations can work effectively to provide support for young people and families who have experienced the trauma of extreme inter-personal violence. Do you have any questions about the research or the consent forms before we start?

- 1 How would you describe your profession and how long have worked in this sector?
- 2 In your everyday work does your organisation currently provide an internal counselling service for young people and/or families in the event of a traumatic violent event?
- 3 If you have had experience of this process, how long on average does it take for a young person or family to be seen by a counsellor/therapist?
- 4 In your experience, do young people and families engage with the therapy offered?
- 5 In your experience, have you recognised any social or cultural barriers that might prevent young people and families wanting to speak to counsellors/therapists?
- 6 What kind of therapists or therapy have you recognised to be most effective for the groups that you work with and why?
- 7 What would you say are the biggest challenges within your work when it comes to handling cases of serious youth violence?
- 8 Have you seen any changes in the kinds of cases or challenges within your work in recent years?
- 9 From your professional/personal perspective, can you share what you deem to be some of the key contributing factors that cause serious youth violence?
- 10 Finally, does your organisation provide any therapeutic support for you? i.e. counselling or clinical supervision?

Many thanks again for your time. If you have any questions now or later please feel free to ask and if you need further support about any of the topics discussed our contact details on the debrief form I'm sending to you now.

Appendix B

FAMILY INTERVIEW SCHEDULE

Thank you for agreeing to take part in this study. We want to understand what needs families, loved ones and communities have following an incident of serious youth violence. I will be asking some questions regarding the loss of someone close to you to youth violence. Do you have any questions about the research or the consent forms before we start?

- 1 I would like to start by asking what do you think could have helped you and your family after you suffered your loss?
- 2 Did you access any support after your experienced your loss?
- 3 What services did you know of that were available to you and your family/friends?
- 4 Looking back now, what would you have liked to see offered to you and your family?
- 5 Who did you reach out to? Did you have friends or family that reached out to you? Where did you feel support came from?
- 6 Would anything have helped you get support more quickly?
- 7 Is there anything that could have helped a year later and in the subsequent years?
- 8 Now you know what it feels like to experience such a loss what would you want services to do differently?
- 9 For other people that may experience this kind of tragedy what would you suggest that could help?
- 10 Who or what do you think could have supported and enabled you to access a service in such a difficult time?

Is there anything else that you would like to add that we haven't covered?

Thank you so much for taking part in this interview. Often, we don't remember much of the detail straight afterwards. All we experience is the emotional response. If there are things you struggled to remember that is perfectly normal. I want you to feel safe and supported afterwards, are you able to try and make sure that you are not alone? What helps you move on with the rest of your day? This may raise feelings of frustration and sadness. Please call me if you need to following the interview.

Appendix C

PROFESSIONAL QUESTIONNAIRE

Dear...

Power the Fight are currently conducting research on therapeutic responses to serious youth violence in London and you have been identified as an experienced professional who could share experiences of working in this field in order to improve provision for communities in the future.

This research report looks at how communities and organisations can work effectively to provide support for young people and families who have experienced the trauma of extreme inter-personal violence. In recognition and respect of your limited time there are 10 open ended questions below that we anticipate will take around 20 minutes to complete. We would greatly appreciate if you could add your answers to a reply email and return to this same address by 31st May 2020.

Your data will be anonymised and your identity protected within this research. Replying to this email will be seen as agreeing consent for your answers to be used (anonymously) within this research and your email will be deleted once your responses are collected.

For more information on this project please see the participant information document attached and if you have any questions you wish answered please do not hesitate to contact us. We thank you in advance for your time and response and look forward to sharing the final report with you.

- 1 How would you describe your profession and how long have worked in this sector?
- 2 In your everyday work does your organisation currently provide an internal counselling service for young people and/or families in the event of a traumatic violent event?
 - a. If yes, what is your process for providing this?
 - b. If no, could you give details of any external services you use and your process of referral?
- 3 If you have had experience of this process, how long on average does it take for a young person or family to be seen by a counsellor/therapist?
- 4 In your experience, do young people and families engage with the therapy offered?
- 5 In your experience, have you recognised any social or cultural barriers that might prevent young people and families wanting to speak to counsellors/therapists?
- 6 What kind of therapists or therapy have you recognised to be most effective for the groups that you work with and why?
- 7 What would you say are the biggest challenges within your work when it comes to handling cases of serious youth violence?
- 8 Have you seen any changes in the kinds of cases or challenges within your work in recent years?

- 9 From your professional/personal perspective, can you share what you deem to be some of the key contributing factors that cause serious youth violence?
- 10 Finally, does your organisation provide any therapeutic support for you? i.e. counselling or clinical supervision?

Many thanks again for your time in completed this questionnaire. Please see the attached debrief form for contact details if you feel affected by any of the questions asked.

Sincerely,

...

Appendix D

YOUTH SURVEY

Content Warning: This survey asks sensitive questions on the topic of youth violence. If you are happy to continue your answers will remain anonymous and will be used to improve services that support young people in London.

I understand and I'm happy to continue. (select)

1 Gender (select one)

- Male
- Female
- Non-Binary
- Prefer not to say

2 Age (select one)

- 11-16
- 17-21
- 22-24

3 Education status: (select one)

- In school
- In college
- At university
- Working
- NEET (Not in Education, Employment or Training)

4 How would you describe your ethnicity? (select one)

- Black
- White
- Asian
- Mixed
- Other

5 Which of the following best describes what you know of serious youth violence? (select one)

- I've seen it first-hand (5)
- I see it through my friends (4)
- I hear about it in the news all the time (3)
- I hear people talk about it sometimes (2)
- I don't really hear much about it (1)

6 Do you worry about your own safety? (select one)

- Yes, all the time (5)
- Yes, often (4)
- Only occasionally (3)
- No, not really (2)
- No, never (1)

- 7** Do you believe violence between young people can be prevented? (Select one)
- No, it's just the way it is now (5)
 - No, but it could be reduced (4)
 - Not sure (3)
 - Yes, most of it can be (2)
 - Yes, it can be stopped (1)
- 8** If a violent incident happens between people I know I would consider talking about it with...
(select all that apply)
- Family member
 - Friends
 - Teachers
 - Youth worker
 - Mentor
 - Faith leader
 - Therapist/Counsellor
 - Police
 - No one
- 9** If myself or a friend had been a victim of violence it would make me feel...
(select all that apply)
- Worried
 - Angry
 - Sad
 - Unsafe
 - Violated
 - Forced to do something back
 - Like I want to do something back
 - Likely to self harm
 - Nothing
- 10** How are you likely to deal with these feelings? (select all that apply)
- Talk to an adult professional (youth worker, therapist, counsellor)
 - Talk with friends and family
 - Try to forget
 - Try to get justice my own way (retaliate)
 - Take it out on others
 - Stay home
 - Distract myself with a hobby (music, football, gaming etc)
 - Drugs
 - Alcohol
 - Nothing
- 11** If you were going to talk to an adult about it, how important would it be that the person knows about your area and understands why violence happens between young people?
(Select 0-10, where 10 = Very Important and 0 = Not important at all)
- 12** If you were going to talk to an adult about it, how important would it be that the adult is the same gender (male/female) as you?
(Select 0-10, where 10 = Very Important and 0 = Not important at all)

- 13** If you were going to talk to an adult about it, how important would it be that the person shares or understands your cultural heritage (ethnic background/accent/ways of speaking)?
(Select 0-10, where 10 = Very Important and 0 = Not important at all)
- 14** If you were going to talk to an adult about it, how important would it be that the person was introduced to you by someone you trust?
(Select 0-10, where 10 = Very Important and 0 = Not important at all)
- 15** If you were going to talk to an adult about it, how important would it be that the person looked like you?
(Select 0-10, where 10 = Very Important and 0 = Not important at all)

This is the end of the survey. If you have been affected by any of the questions asked and would like to receive a follow up email for support you can leave an email address below. Otherwise please select 'Submit' to save your answers. (enter email address)

**POWER
THE
FIGHT**

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