WORLD HEALTH ORGANIZATION
EUROPE

International policy dialogue on youth and knife violence

Report of a WHO meeting supported and hosted by the Department of Health, England

London, United Kingdom and Northern Ireland

14 and 15 September 2009

April 2010

DH Department of Health

ABSTRACT

On 14 and 15 September 2009 the WHO Regional Office for Europe and the Department of Health of England jointly convened an international policy dialogue on 'youth violence using knives and other sharp implements' with a focus on the role of health systems in multisectoral response. The event, supported by the Department of Health of England, was held at The Royal Society and was attended by over 30 experts from several countries, representatives from WHO Headquarters, the Regional Office for Europe and the Department of Health. During the meeting the scale of the problem of youth violence using knives and other sharp implements was discussed, as were risk factors and social determinants. Experience on the latest evidence-based programmes was shared and the role of health systems was discussed in a multisectoral response in preventing youth violence with knives and other sharp implements. Strategies for a way forward were debated. The meeting agreed on the following priorities:

- Strategies to prevent youth violence involving knives and sharp weapons should focus on broader approaches to youth violence prevention.
- To tackle the risk factors effective measures include parenting programmes, life and social skills training, reducing access to and misuse of alcohol, decreasing access to lethal means, tackling social norms which reinforce the use of violence, and programmes to promote equity in communities including gender equity.
- Building on the work from this international policy dialogue, a European report on youth violence (including knives and other sharp implements) will be developed.

This report has been prepared by D Sethi, reviewed by A Butchart and laid out by M Gallitto.

Keywords

VIOLENCE - prevention and control
WOUNDS AND INJURIES - prevention and control
DECISION MAKING PUBLIC HEALTH EUROPE
ADOLESCENT BEHAVIOR
JUVENILE DELINQUENCY

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INTRODUCTION

Interpersonal violence causes significant deaths and human suffering every year, and poses a threat to social and economic development. Interpersonal violence is responsible for 55 000 injury deaths in the WHO European Region, and 4.4 million disability adjusted life years (DALYs) lost.

In 2002 the World Health Organization published the World report on violence and health which emphasized the public health approach to violence prevention. The World Health Assembly resolution WHA 56.24 promoted implementing the recommendations on the World report on violence and health. In the European Region, the WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the European Region, and the Recommendation of the Council of the European Union of 31 May 2007 on the prevention of injury and promotion of safety, have both placed violence and injury prevention on the public health agenda. In responding to the public health burden, an increasing number of countries have developed national policies, strengthened their surveillance systems, implemented evidence-based prevention programmes and engaged in capacity building.

The United Kingdom is one of the countries that has shown great commitment and considerable progress in the field of violence prevention. Violence prevention is integrated within public health policy and is at the forefront of action from other sectors too. The prevention of violence has been indicated as one of the priorities for collaboration between the WHO Regional Office for Europe and the Department of Health of England. In the frame of this collaboration, the WHO Regional Office for Europe, and the Department of Health England jointly organized an international policy dialogue on youth and knife violence. The workshop brought together different experts and stakeholders from various sectors, across Europe and internationally, and included policy makers, scientists and professionals working in the area of youth and knife violence in different settings.

The objectives of the workshop were to:

a) discuss the scale of the problem of youth violence using knives and other sharp implements and identify risk factors and examine the role of social determinants of health;
b) receive the latest evidence on examples of good-practice and exchange international experiences on implementing evidence-based programmes for preventing youth violence particularly focusing on knives and other sharp implements; and
c) define the role of health systems in a multisectoral response in preventing youth violence using knives and other sharp implements and debate strategies for a way forward.

The workshop consisted of plenary presentations with invited international speakers and include experts from the field of violence prevention from the United Kingdom, other European countries and internationally. In addition there were breakout sessions to explore examples of best

practice of preventing youth violence and explore opportunities for health systems' engagement in this. One of the outcomes of the workshop will be the formation of a working group of experts to take forward the writing of a report on youth and knife violence. It is hoped that this report will be presented at Safety 2010 which will be held in London in September.

DAY ONE – 14 SEPTEMBER 2009

The meeting was opened by Mark Davies who welcomed participants on behalf of the Department of Health in England. He emphasised the importance of socioeconomic determinants for youth violence and the government response to the public concern about the recent series of cases of youth stabbings with knives. Dr Alex Butchart welcomed participants on behalf of WHO and thanked the Department of Health for their support in this area of interpersonal violence. Dr Dinesh Sethi set the scene by explaining the need for a report on youth violence and knives, which would present the burden of youth violence, define risk factors, assess evidence-based measures and debate policy options. The format of the meeting was a series of expert presentations followed by panel discussions to cover the themes of scale of the problem, risk factors and response. The meeting ended with small group work on developing evidence based policy response.

Session 1. The scale of the problem. Chair Claire Phillips.

There were a series of presentations in the first session which focused on the scale of the problem, followed by a discussion. Scotland was reported to have homicide rates that were higher than many countries in Europe, and thrice higher than the rate in England and Wales. Among male youth, rates were even higher and many of the homicides were due to knives, the carrying of which is prevalent. Data presented from East Glasgow showed high indices of socioeconomic deprivation, high male homicide rates and youth gangs. To tackle the problem at a national level, a 10-year strategic plan for violence prevention had been developed which is multi-faceted, focusing on enforcement, attitudinal change and primary, secondary and tertiary prevention. This approach incorporates rigorous policing practice with little tolerance to violence or the carrying of knives. It also features a strong emphasis on primary prevention, with a multisectoral approach involving different agencies with a shared agenda. Trend data from England and Wales showed general reductions in all violence as reported by the British Crime Survey with an overall risk of 3% in 2008/9. A weapon was used in 21% of violent incidents, with knives only used in 7% and glassware in 5%. The peak age groups for assault related offending (cases notified to and by police) is 12-17 years. Whereas the overall number of sharp instruments used for homicides has been stable over time, the highest number killed is in people under the age of 20 years and there was a small peak between 2005-2008 but this seems to be declining. These data are in contrast to the recent claims of an epidemic by the

media. In England, the Tackling Knives Action programme was established in 2008 to focus on ten high-risk geographical areas; surveillance data from these areas suggest there may be a recent fall in serious stabbings after peaking in 2006-8. More research is needed to understand these changing trends in knife violence in youth.

National data presented from the United States of America showed youth homicide rates to be several times higher than in high-income European countries. Rates had peaked in the early 1990s, and levelled off for the last 10 years. The peak age for perpetration was 15-19 years; assaults were most likely to occur in the home or in the street, and were crime- or dispute-related. Assaults disproportionately affected young males from ethnic minority and African-American groups. By far the most common weapon were firearms, and knives were only used in 8% of assaults, though this proportion was higher in school children. Research suggested that almost half of school children admitted to carrying a weapon at least once in the last 30 days and a high proportion had antisocial or delinquent behavioural problems. It was emphasised that preventive interventions to correct youth violence needed to disrupt developmental pathways to violence and address all levels of the ecological model. From South Africa, homicide rates in males from Cape Town were reported as ten times higher than the world average and for females as seven times higher. Youth aged 15-24 years had the second highest homicide rates after the 25-34 year olds, and knives were responsible for about a third of deaths. Rates were highest in African males and there had been an upward trend in youth homicide rates. Alcohol is an important risk factor, being present in half of the homicides and the socioeconomic fabric was also emphasised as an important determinant. Immediate prevention measures in the Western Cape included gun control laws and a liquor bill to regulate sales. Longer-term strategies included multisectoral preventive approaches supported by a strong injury surveillance system.

A review of the literature showed that weapon carrying among youth was prevalent in many European countries, and could be as high as 30%. Violent assaults involved knives in 5-7% of cases and threats had been carried out using knives in 10% (15% males and 6% females). The burden is high, resulting in serious injury, disability and scarring and psychological trauma. The costs of knife violence were estimated at GBP 1.3 billion for England and Wales. Risk factors were similar to those for youth violence generally. Prevention options included those with potentially immediate effect aimed at controlling weapon carrying, and the longer term developmental interventions focusing on addressing alcohol, safer school environments, developing life skills, and building safe and nurturing relationships. Approaches to tackle these needed to be multisectoral, have an evaluative culture and be supported by injury surveillance systems. It was proposed that strategies to prevent youth violence involving knives and sharp weapons should not focus solely on the weapon. In a presentation on gangs and youth violence

it was reported that urban neighbourhood transformation over the last 30 years in the United Kingdom has led to concentrations of populations who are socio-economically deprived, have high levels of unemployment and educational underachievement, and where high proportions from ethnic minority groups live. An estimated 25% of youth and children are living in such neighbourhoods. These neighbourhoods have a high prevalence of gangs who are involved in the drug trade and use violence, including with knives, for coercion, conflict and control. It is an imperative to focus on socio-economic determinants of the problem and use innovative approaches for community integration as well as criminal justice approaches.

Discussion of the problem

In the discussion there was broad agreement among participants that strategies to prevent youth violence involving knives and sharp weapons should focus on broader approaches to youth violence prevention and not solely on weapon carrying. There is a tension between violence prevention activities focusing on disrupting the developmental pathways to youth violence which require longer term investments and the more immediate enforcement policies, which are seen as “quick fixes”. Policy advisors often found it difficult to justify investments in violence prevention activities which are medium to long-term in their scope. It was proposed that these arguments should be based on the evidence that “quick fix” strategies using tougher policing and criminal justice approaches do not work in the longer term, in contrast to strategies which promote child and youth development. These messages should be communicated clearly. Investment in early years development initiatives as a key violence prevention policy was advocated. These should be part of a multi-factorial violence prevention and reduction policy response, which includes criminal justice responses for public reassurance, thus allowing the space for violence prevention and reduction initiatives to take effect. Such a strategy should be broad and multifaceted, ensuring investment across a range of initiatives. In responding to youth violence (with knives or other means), it was proposed that both drugs and poverty should be tackled, though poverty and socioeconomic factors were the most important. There followed a brief discussion of the importance of different risk factors in youth violence. It was agreed that while there were commonalties between many different contexts, an understanding of local contexts was critical to fashioning and implementing an appropriate prevention strategy.

DAY TWO – 15 SEPTEMBER 2009

Session 2 Risk factors. Chair Dr Robertas Poivilaitis

In the presentation on the social determinants of youth violence, risk factors were discussed in the context of the public health approach, ecological model and life course approach. Using the life course approach, preventive programmes being promoted in England and Wales were discussed. Homicide rates in Finland were double that of the EU and among the highest in Western European countries. Hunting is a common past time and knife ownership is a tradition, though the carrying of sharp instruments is restricted legally. Risk factors in Finland were alcohol, drug abuse, mental illness, the economic recession and the resulting cuts to public health interventions and access to weapons. In the presentation on alcohol as a risk factor for youth violence, the evidence confirmed an increase in alcohol consumption and alcohol-related harm in the United Kingdom and other European countries. From Scotland a 'booze and blade' culture was presented as a long standing problem. A survey of young offenders showed a strong association between alcohol and weapon use, either knives or glassware. Alcohol could make the consequences of violence worse with a greater likelihood of knife use.

- horizontal mechanisms for implementation and concrete actions to be implemented; coordination easier locally
- good data to understand the underlying social and demographic dynamics (vulnerable groups, gender, age, socio-economic groups);
- resources are important, but much can be done through synergy, redeployment and reprioritization;
- focus on early prevention and detect the signs of violence early in life course; and
- strengthen support to victims of violence (including medico-legal assistance).

Discussion on risk factors

The panel discussion held after the presentations on risk factors raised a number of important issues. An attempt was made to distinguish risk factors from situational determinants, and to focus on those important risk factors for youth violence and sharp implements which were highly prevalent and modifiable. For instance, there is good evidence to show that alcohol misuse is closely associated with interpersonal violence in many different environments. Early usage of alcohol often progressed to drug use, thereby increasing the risk of violence. It was noted that an important consideration about alcohol is that its use is modifiable as it is regulated and policy action can be directed to reducing access and alcohol-related harm. Mental health problems were an important risk factor for the perpetration of violent acts and conversely exposure to violence may cause mental health problems. There may be risk factors which are common to both youth violence and mental health problems. Childhood experience of violence was a risk

factor which required attention. In Norway, a lot is already known about important risk factors for youth violence at all levels of the ecological model and these were being targeted in the violence prevention approaches. It was noted that it was also important to tackle "risk conditions". There was interaction between individual risk conditions and thresholds, whereby once thresholds of exposure were crossed, violence would be perpetrated. It was important to link risk factors to causal pathways to attain a better understanding of risk and protective as well as modifying factors. Social inequities and poverty are important determinants of violence and needed to be on the agenda, albeit being least amenable to short term change.

In preparation for the next day, the group were asked to consider 6 preventive interventions and how investment in these might be promoted to governments and donors. These initiatives could be packaged and promoted as evidence-based initiatives to prevent violence or as the 'WHO best buys' for violence prevention:

- parenting programmes and promoting life skills
- social skills training
- decreasing access to and misuse of alcohol
- decreasing access to lethal means (knives and sharp implements, pesticides / chemicals, guns)
- tackling social norms which reinforce the use of violence / gender norms
- programmes to promote equity in schools etc / gender equity

Session 3. The response. Chair Dr Alex Butchart

A broad range of government initiatives were developed as the policy response to youth violence and knife crime in England and Wales. The efforts were multisectoral and multiagency and it was proposed that these had contributed to the fall in levels of violence after a recent peak. Key work by the Department of Health included strengthening work on sharing of injury surveillance data, focusing on family based interventions for prevention, programmes for alcohol and substance misuse and investments in mental health support for youth offenders. Government guidance had been developed on the consumption of alcohol by children and youth in order to limit alcohol related harm. When developing prevention policy, the incorporation of evidence-based measures into policy is one of the challenges faced. Policy development is influenced by politics and is influenced by demands from the public and media. The influential role of the media and public opinion had to be taken into account and taken advantage of. There is a need to challenge the idea in young men's minds that they are fighting for their community. Advocacy could be used more effectively to influence the policy process. In this respect, it was proposed that WHO had a role to work with local stakeholders to influence such processes through advocacy.

A presentation from Sweden showed that though fatal homicides were stable, rates of non-fatal youth violence are increasing in Scandinavian countries. This was attributed to the fact that more injured people are surviving and that there was more complete reporting. Amongst youth, knives were most often used as a weapon. In Sweden, a similar media and public outcry to that in the United Kingdom, had taken place 20 years ago in response to reports of knife violence in youth. At the time, social exclusion was identified as a risk factor and binge drinking and violence were found to be strongly connected. The policy response has been through social inclusion programmes and a restrictive alcohol policy. Recently, violence has increased in deprived sections of society in association with the increased inequalities. In Finland, knives and sharp instruments were the most common form of violence. Forty percent of the homicides are committed by young people. In response, the Finnish Safety Plan has been developed, which has a series of preventive measures which target different risk factors at all four levels of the ecological model. There is a national plan and considerable investment ensuring that national policy is implemented at the local level. These measures also target alcohol related violence.

Discussion on the response to youth and knife violence

A number of important areas were discussed on responses to youth and knife violence:

- Information sharing and partnerships with cross-agency working on youth and violence.
- Education in schools about bullying and conflict resolution.
- Safer urban public spaces.
- Greater investment in equity.
- Linking indicators for violence prevention to ongoing parenting and social skills development programmes for violence prevention in addition to those on violence reduction.
- Research and evaluation of programmes.
- More investment in approaches other than exclusion from schooling and incarceration.

There was also a discussion on the value of ‘evidence’ and how evidence is translated into policy. It was noted that whereas evidence on programmes for youth violence prevention is available to academics, it is not as readily accessible to policy makers. Consequently, policy actors tended to reach for policy responses that they were more familiar with, such as those on crime reduction and retribution measures, rather than evidence based initiatives. Knowledge about effective interventions needed to be widely disseminated and actively promoted targeting policy makers and their advisors. In this regard the six best interventions for violence prevention were discussed. These need to be packaged as best buys to promote them to policy makers. Their implementation should be done collectively for maximal benefits. The ecological model, and the requirement for a multi-sectoral and multi-faceted policy approach to violence prevention and reduction was stressed. More investment was needed for outcomes-related

research into longer term prevention programmes. The methodological rigour of criminological research should be improved and investment made only into projects with rigorous design and evaluation. It was however stressed that good programme evaluation is expensive, is over a long time period, and requires capacity for implementation.

REPORTING ON SMALL GROUP WORK ON INTERVENTIONS. CHAIR DR DINESH SETHI

Group 1: Facilitator Mr Martin Teff

The group reported on the experience of violence prevention programmes from the five countries represented (Finland, Lithuania, Norway, Sweden, United Kingdom,). They highlighted that although there was much primary prevention work being undertaken, it was not necessarily labelled as such. Many of the programmes were evidence-based, but were being implemented in areas and cultures which are different from where the interventions were developed and so required better evaluation. It was proposed that one of the best ways to encourage policy makers to invest in violence prevention is the development of an economic model to promote the best programmes. Harnessing the media in getting issues on the agenda was also stressed. Advocacy efforts needed to be more proactive and the message about the effectiveness of primary prevention efforts needed to be consistently delivered by the different partners in order to reorient these into the main stream of policy options. There is a need for more research on the scaling up of proven interventions as well as the need for research on new interventions. There was a specific concern about the need to re-orient priorities for resource poor environments.

Group 2: Facilitator Dr Linda Dahlberg

Group two endorsed the six best buys (“the six pack for violence prevention”) and examined how the package of interventions could be tailored for national and local contexts.

- Good parenting is critical to the prevention of violence in the long-term. Although benefits are realised in the longer term, it was also important to examine short-term outcomes, such as reductions in child maltreatment and parent satisfaction as a means of promoting investment.
- Life skills training. These should start at a younger age and be linked to parenting programmes.
- Alcohol related harm. Whereas it was considered whether drugs should be included in this, it was proposed that alcohol should be kept separate because it is a legal substance and amenable to regulation. Alcohol advertising was highlighted as an area

for action. Substance (drug) misuse should be addressed under other areas such as parenting, life skills training and changing social norms.

- Reducing access to lethal means. Regulatory and policy action were needed to reduce the lethality of outcomes of violence. These depended on political and cultural contexts.
- Changing social norms. These were difficult to change in the short term, but a carrot and stick approach was proposed. The idea that violence is a violation against human rights should be promoted as a social norm.
- Programmes to promote greater equity. These should not be limited to gender alone but should also tackle inequality in access to opportunities which may drive interpersonal violence.

On the matter of evidence on violence prevention, it was suggested that WHO could provide an easily accessible interface and repository of the evidence on violence prevention initiatives. One had been developed in collaboration with WHO and is available at www.preventviolence.info. There was also special mention on the Blueprints for Violence Prevention in the United States of America, and that a European repository would be useful. Such repositories need to be updated, and this requires resources.

Conclusions

There is a significant burden of youth violence and in most European countries knives and sharp instruments were the most common weapon used. Participants agreed that strategies to prevent youth violence involving knives and sharp weapons should focus on broader approaches to youth violence prevention and not solely on weapon carrying. Risk factors for youth violence included a poor family environment, poor relationships, social inequities and deprivation, alcohol and drugs misuse and societal attitudes to violence. Knowledge about effective interventions needed to be widely disseminated and actively promoted targeting policy makers and their advisors. There is a need for greater evaluative research with more widespread use of violence outcome indicators. Effective programmes promoted as the six best buys for violence prevention included: parenting programmes and promoting life skills, social skills training, reducing access to and misuse of alcohol, decreasing access to lethal means, tackling social norms which reinforce the use of violence and gender norms, programmes to promote gender equity and equity generally in communities. Building on the work from this international policy dialogue, a European report on youth violence (including knives and other sharp implements) will be developed and will distill some of these issues further.

The CD-ROM with all presentations is a separate annex to this report and consensus by the respective authors has been granted unanimously and verbally at the closure of the meeting.

ANNEX 1: SCOPE AND PURPOSE

INTERNATIONAL POLICY DIALOGUE ON YOUTH AND KNIFE VIOLENCE

LONDON, UNITED KINGDOM – 14 AND 15 SEPTEMBER 2009

Scope and Purpose
508.8492-02

ENGLISH only
12 April 2010

Interpersonal violence causes a significant number of deaths and human suffering every year, and poses a threat to economic and social development. Interpersonal violence is responsible for 55 000 injury deaths in the WHO European Region, and 4.4 million disability adjusted life years (DALYs) lost.

In 2002 the World Health Organization published the *World report on violence and health* which emphasized the public health approach to violence prevention. The World Health Assembly resolution WHA 56.24 promoted implementing the recommendations on the *World report on violence and health.* In the European Region the WHO Regional Committee for Europe resolution EUR/RC55/R9 on the prevention of injuries in the European Region and the Recommendation of the Council of the European Union of 31 May 2007 on the prevention of injury and promotion of safety, have both placed violence and injury prevention on the public health agenda. An increasing number of countries have developed national policies, strengthened their surveillance systems, implemented evidence-based prevention programmes and engaged in capacity building.

WHO Regional Office for Europe, and the Department of Health England are jointly organizing an international policy dialogue on youth and knife violence. This will have a focus on the role of health systems in multisectoral response. The policy dialogue is supported by the Department of Health.

The United Kingdom is one of the countries that has shown great commitment and considerable progress in the field of violence prevention. Violence prevention is integrated within public health policy and is at the forefront of action from other sectors too. Violence prevention has been indicated as one of the priorities for collaboration between the WHO Regional Office for Europe and Department of Health of England. In frame of this collaboration, a report on youth violence from knives and other sharp implements is being developed.

The workshop will bring together different experts and stakeholders from various sectors, across Europe and internationally, and will include policy makers, scientists and professionals working in the area of youth and knife violence in different settings. The policy dialogue aims to define the scale of the problem of youth violence using knives and other sharp implements, examines risk factors and evidence based programmes and debate strategies for a way forward. It will examine closely the role of social determinants, availability of sharp implements and alcohol as risk factors for violence. Whereas the main focus will be in youth, the review will also recognize that in the East of the Region many of the victims are young adults. The policy dialogue will be an opportunity to understand the scale of the problem and an opportunity to share learning from international experience in this area.

The objectives of the workshop will be to:

a. discuss the scale of the problem of youth violence using knives and other sharp implements;
b. identify risk factors and examine the role of social determinants of health;
c. receive the latest evidence on examples of good-practice;
d. exchange international experiences on implementing evidence-based programmes for preventing youth violence particularly focusing on knives and other sharp implements;
e. define the role of health systems in a multisectoral response in preventing youth violence using knives and other sharp implements;
f. debate strategies for a way forward.

The workshop will consist of plenary presentations with invited international speakers and include experts from the field of violence prevention from the United Kingdom, other European countries and internationally. In addition there will be breakout sessions to explore examples of best practice of preventing youth violence and explore opportunities for health systems' engagement in this. One of the outcomes of the workshop will be the formation of a working group of experts to take forward the writing of a report on youth and knife violence. It is hoped that this report will be presented at Safety 2010 which will be held in London in September 2010.

ANNEX 2: PROVISIONAL PROGRAMME

INTERNATIONAL POLICY DIALOGUE ON YOUTH AND KNIFE VIOLENCE

LONDON, UNITED KINGDOM – 14 AND 15 SEPTEMBER 2009

Provisional programme
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MONDAY, 14 SEPTEMBER 2009

13.00 – 14.00 **Registration and buffet lunch**

14.00–15.40 **Setting the scene**
Chair: Ms Claire Philips, Department of Health of England

14.00 – 14.10 Welcome on behalf of the Department of Health of England
Mr Mark Davies

14.10 – 14.20 Welcome on behalf of the World Health Organization
Dr Alex Butchart

14.20 – 14.40 Youth violence in Europe and purpose of report
Dr Dinesh Sethi, WHO Regional Office for Europe

14.40 – 15.10 The problem
Mr John Carnochan, Violence Reduction Unit, Strathclyde Police

15.10 – 15.40 Youth violence and knives: findings from England and Wales
Dr Alana Diamond, Violent Crime Research, Home Office

15.40 – 16.10 **Tea**

16.10–18.00 **Theme: Scale**
Chair: Prof Peter Donnelly , University of St Andrews

16.10 – 16.30 Youth violence and knives in the USA
Dr Linda Dahlberg, Centres for Disease Control and Prevention, USA

16.30 – 16.50 Youth and knife violence: South Africa
Dr Richard Matzopoulos, South African Medical Research Council

16.50 – 17.10 Youth and knife violence review - scale of the problem
Ms Karen Hughes, Liverpool John Moores University

17.10 – 17.30 Violence and youth gangs in England
Prof John Pitts, University of Bedfordshire

17.30 – 18.00 Panel discussion on scale of the problem

19.30 – 21.00 **Dinner at Chino Latino in the Riverbank Park Plaza**

TUESDAY, 15 SEPTEMBER 2009

9.00–10.40 **Theme: Risk factors**
Chair: Dr Robertas Povilaitis, Vilnius University

9.00 – 9.20 Social determinants of violence
Mr Damian Basher, Department of Health of England

9.20 – 9.40 Strong knife culture doesn't show in violent crime practices
Chief Superintendent Seppo Sivula, Ministry of Interior, Finland

9.40 – 10.00 Alcohol as a risk factor for youth violence and knives
Dr Alasdair Forsyth, Scottish Centre for Crime and Justice Research, Scotland

10.00 - 10.40 Panel discussion on risk factors

10.40 – 11.10 **Tea**

11.10–13.00 **Theme: Response**
Chair: Dr Alex Butchart, World Health Organization

11.10 – 11.30 Policy response in England
Ms Claire Philips, Department of Health of England

11.30 – 11.50 Public health policy response
Prof Peter Donnelly , University of St Andrews

11.50 – 12.10 Youth violence and knives: experience from Sweden on scale, risk factors and response
Prof Felipe Estrada, National Council for Crime Prevention, Sweden

12.10 – 12.30 Policy response: the Finnish Safety Plan
Prof Jukka-Pekka Takala, National Council for crime prevention Finland

12.30 – 13.00 Panel discussion on policy response

13.00 – 14.00 **Lunch**

14.00–15.30 **Parallel sessions – small group work**

Group 1: Risk Factors
Facilitator: Mr Martin Teff, Department of Health of England

Group 2: Interventions
Facilitator: Dr Linda Dahlberg, Centres for Disease Control and Prevention, USA

15.30 – 16.00 **Tea**

16.00–17.00 **Closing session**
Chair: Dr Dinesh Sethi, WHO Regional Office for Europe

16.00 – 16.10 Reporting back group 1

16.10 – 16.20 Reporting back group 2

16.20 – 16.50 Discussion on next steps

16.50 – 17.00 Closing remarks by the Department of Health of England

ANNEX 3: LIST OF PARTICIPANTS

INTERNATIONAL POLICY DIALOGUE ON YOUTH AND KNIFE VIOLENCE

LONDON, UNITED KINGDOM – 14 AND 15 SEPTEMBER 2009

List of participants
508.8492-05
ENGLISH only
12 April 2010

Finland
Mr Seppo Sivula, Ministry of Interior

United Kingdom of Great Britain and Northern Ireland
Mr Mick Hurley, Home Office
Mr Ian Tumelty, Home office
Andy Newsam, Youth Justice Board
Mary Wyman, Youth Justice Board

Temporary Adviser

Professor Mark Bellis, Liverpool John Moores University,
United Kingdom of Great Britain and Northern Ireland

Dr Ragnhild Bjornebekk, Norwegian Police University College
Norway

Dr Linda Dahlberg, Centre for Disease control and prevention
United States of America

Mr John Carnochan, Scotland Police
United Kingdom of Great Britain and Northern Ireland

Alana Diamond, Home Office
United Kingdom of Great Britain and Northern Ireland

Professor Peter Donnelly, University of St Andrews
United Kingdom of Great Britain and Northern Ireland

Professor Felipe Estrada, National Council for Crime Prevention
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Dr Alasdair Forsyth, Glasgow Caledonian University
United Kingdom of Great Britain and Northern Ireland

Dr Roger Grimshaw, King's College London
United Kingdom of Great Britain and Northern Ireland

Ms Karen Hughes, Liverpool John Moores University
United Kingdom of Great Britain and Northern Ireland

Mr Leslie Ralph Kelly, London School of Hygiene & Tropical Medicine
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Professor Alastair Leyland, MRC Social and public health sciences unit
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Mr Richard Matzopoulos, University of Cape Town
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Dr Rachel Partridge, NHS Dorset
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United Kingdom of Great Britain and Northern Ireland

Dr Robertas Povilaitis, Vilnius University
Lithuania

Ms Noreen Sheikh-Latif, Centre for Public Innovation
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Mr Mark Davies, Director, Health Inequalities and Partnerships
Mrs Claire Phillips, Deputy Director, Cross Government Programmes
Ms Maggie Davies, Principal Advisor, International Health Inequalities
Mr Martin Teff, Social Exclusion and Knife Crime Policy Lead
Mr Damian Basher, Public Health Adviser, Stakeholder and Partner Relationships
Ms Cathy James, Mutli-systemic therapy project lead, Social Care; Local Government

WORLD HEALTH ORGANIZATION

Headquarters

Dr Alex Butchart, Programme Coordinator, Violence Prevention

Regional Office for Europe
Dr Dinesh Sethi, Programme Manager, a.i., Violence and Injury Prevention team

WORKSHOP SECRETARIAT

Ms Bryony Lloyd, International Support and Development Officer, Department of Health
Ms Cristina Fumo, Secretary, Violence and Injury Prevention team, WHO/Europe
Ms Manuela Gallitto, Programme Assistant, Violence and Injury Prevention team, WHO/Europe

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Iceland
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Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

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On 14 and 15 September 2009 the WHO Regional Office for Europe and the Department of Health of England jointly convened an international policy dialogue on 'youth violence using knives and other sharp implements' with a focus on the role of health systems in multisectoral response. The event, supported by the Department of Health of England, was held at The Royal Society and was attended by over 30 experts from several countries, representatives from WHO Headquarters, the Regional Office for Europe and the Department of Health. During the meeting the scale of the problem of youth violence using knives and other sharp implements was discussed, as were risk factors and social determinants. Experience on the latest evidence-based programmes was shared and the role of health systems was discussed in a multisectoral response in preventing youth violence with knives and other sharp implements. Strategies for a way forward were debated. The meeting agreed on the following priorities:

- Strategies to prevent youth violence involving knives and sharp weapons should focus on broader approaches to youth violence prevention.
- To tackle the risk factors effective measures include parenting programmes, life and social skills training, reducing access to and misuse of alcohol, decreasing access to lethal means, tackling social norms which reinforce the use of violence, and programmes to promote equity in communities including gender equity.
- Building on the work from this international policy dialogue, a European report on youth violence (including knives and other sharp implements) will be developed.

This report has been prepared by D Sethi, reviewed by A Butchart and laid out by M Gallitto.

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