Violent crime is like infectious disease – and we know how to stop it spreading

July 24 2018, by Samira Shackle

Usually, facial trauma doesn't kill you, but it can cause significant disfigurement. Working as a maxillofacial surgeon in Glasgow in the early 2000s, Christine Goodall treated hundreds, if not thousands, of patients with injuries to the neck, face, head and jaw.

Sometimes, the injuries were caused by a baseball bat, with shattered bones and bruising as bad as that from a car accident. More often than not, it was a knife. A slash across the forehead or cheek, leaving a scar etched across the face; a machete wound to the jaw, slicing through the skin and breaking the bone underneath.

One young man came into the hospital in the middle of the night, with a knife wound across his face. Goodall dreaded the morning ward round the next day, when she would have to tell him that it would be impossible to reduce the appearance of the scar. But his reaction surprised her. "He was very offhand about it," she says. "Some of his friends came to see him later that afternoon and I realised why it wasn't going to be a problem for him – because they all had one. He'd just joined the club." The incident has stayed with her, an indication of how bad the situation in her city had become.

In 2005, the United Nations published a report declaring Scotland the most violent country in the developed world. The same year, a study by the World Health Organization (WHO) of crime figures in 21 European countries showed that Glasgow was the "murder capital" of Europe. More than 1,000 people a year required treatment for facial trauma

alone, many of them as the result of violence.

Goodall, who has spent most of her life living and working in Glasgow, would stitch up the wounds and work to repair the damaged tissue. But for most patients, the problems continued long after they were discharged. Chronic pain, post-traumatic stress disorder, self-medication with alcohol and drugs.

Often, the same people would come back through the accident and emergency departments again and again, repeated victims and perpetrators of violent attacks. "We were really good at patching injuries up," says Goodall. "But I started to think: what can we do to prevent them coming here in the first place?"

Humans engage in a wide array of risky behaviours that can lead to serious health problems: smoking, overeating, sex without protection. It has long been the accepted wisdom that doctors should encourage patients to change their behaviour – give up smoking, go on a diet, use a condom – rather than wait to treat the emphysema, obesity-related heart attacks, or HIV that could be the result.

Yet when it comes to violence, the discussion is often underpinned by an assumption that this is an innate and immutable behaviour and that people engaging in it are beyond redemption. More often than not, solutions have been sought in the criminal justice system – through tougher sentencing, or increasing stop-and-search (despite substantial evidence that it is ineffective in reducing crime). Is enforcement the wrong tactic altogether?

In 2005, Karyn McCluskey, principal analyst for Strathclyde Police, wrote a report pointing out that traditional policing was not actually reducing violence. These reports always include a list of recommendations. "One was tongue-in-cheek," recalls Will Linden, who

worked for McCluskey as an analyst at the time. "'Do something different.' I don't think it was meant to stay in there. But the chief constable said, 'Okay, go do something different.'"

McCluskey's team, led by her and her colleague John Carnochan, started by pulling together evidence on the drivers of violence. "Particularly in Scotland, it was poverty, inequality, things like toxic masculinity, alcohol use, all these factors – most of which were outside the bounds of policing," says Linden.

Next, they looked around the world to find and learn from pioneering programmes working to prevent violence. This was the foundation of the Violence Reduction Unit (VRU), of which Linden is now the acting director. It took elements of those programmes and focused on garnering support from a range of Scottish agencies – the health service, addiction support, job centres and a host of others. Since the VRU was launched in 2005, the murder rate in Glasgow has dropped by 60 per cent.

The number of facial trauma patients passing through Glasgow's hospitals has halved, Goodall says, and now stands at around 500 a year.

The VRU's strategy is described as a "public health" approach to preventing violence. This refers to a whole school of thought that suggests that beyond the obvious health problems that result from violence – the psychological trauma and physical injuries – the violent behaviour itself is an epidemic that spreads from person to person.

One of the primary indicators that someone will carry out an act of violence is first being the victim of one. The idea that violence spreads between people, reproducing itself and shifting group norms, explains why one locality might see more stabbings or shootings than another area with many of the same social problems.

"Despite the fact that violence has always been present, the world does not have to accept it as an inevitable part of the human condition," says the WHO guidance on violence prevention.

It says that "violence can be prevented and its impact reduced, in the same way that public health efforts have prevented and reduced pregnancy-related complications, workplace injuries, infectious diseases, and illness resulting from contaminated food and water in many parts of the world. The factors that contribute to violent responses – whether they are factors of attitude and behaviour or related to larger social, economic, political and cultural conditions – can be changed."

But across much of the world, being tough on crime is a vote winner, which makes this a hard sell. How did Glasgow do it? As they investigated what it actually means to treat violence as a health problem, the VRU looked first to Chicago.

In the 1980s and early 1990s, American epidemiologist Gary Slutkin was in Somalia, one of six doctors working across 40 refugee camps containing a million people. His focus was on containing the spread of tuberculosis (TB) and cholera.

Containing infectious diseases relies heavily on data. First, public health officials map out exactly where the most transmissions of the disease are occurring. Then they can focus on containing the spread in these areas. Often, this containment happens by getting people to change their behaviour so that a rapid effect can be seen even when larger structural factors can't be tackled.

For instance, diarrhoeal disease is often in large part caused by poor sanitation and water supplies. It takes a long time to improve plumbing systems – but in the meantime, thousands of lives can be saved by giving people oral rehydration solutions.

Slutkin followed these steps to contain outbreaks in the Somali refugee camps, and again later, when he worked for the WHO on AIDS prevention. Whatever the exact nature of the infectious disease in question, the steps to contain it were roughly the same. "What do they have in common? All of these things spread," Slutkin tells me in his office in Chicago. "Heart disease doesn't spread, strokes don't spread."

Changing behavioural norms is far more effective than simply giving people information. To change behaviour – whether it's using rehydration solutions, avoiding dirty water or using condoms – credible messengers are essential.

"In all of these outbreaks we used outreach workers from the same group [as the target population]," says Slutkin. "Refugees in Somalia to reach refugees with TB or cholera, sex workers to reach sex workers with AIDS, moms to reach moms on breastfeeding and diarrhoeal management."

After more than a decade working overseas, Slutkin returned to his native Chicago in the late 1990s, exhausted from the perpetual travel and constant exposure to death. "I wanted a break from all these epidemics," he says. It hadn't occurred to him that America had difficulties, too. He had been consumed, for years, by the panic of epidemics and the struggles of poorly developed countries. But he returned to a different kind of problem: a skyrocketing homicide rate.

His ideas about tackling this problem began as a nerdy project, born of the obsession with graphs and charts he had developed abroad: he gathered maps and data on gun violence in Chicago. As he did so, the parallels with the maps of disease outbreaks he was accustomed to were unavoidable. "The epidemic curves are the same, the clustering. In fact, one event leads to another, which is diagnostic of a contagious process. Flu causes more flu, colds cause more colds, and violence causes more

violence."

This was a radical departure from mainstream thinking about violence at the time, which primarily focused on enforcement. "The idea that's wrong is that these people are 'bad' and we know what to do with them, which is punish them," says Slutkin. "That's fundamentally a misunderstanding of the human. Behaviour is formed by modelling and copying. When you're in a health lens, you don't blame. You try to understand, and you aim for solutions."

He spent the next few years trying to gather funding for a pilot project that would use the same steps against violence as the WHO takes to control outbreaks of cholera, TB or HIV. It would have three main prongs: interrupt transmission, prevent future spread, and change group norms.

In 2000, it launched in the West Garfield neighbourhood of Chicago. Within the first year, there was a 67 per cent drop in homicides. More funding came, more neighbourhoods were piloted. Everywhere it launched, homicides dropped by at least 40 per cent. The approach began to be replicated in other cities.

"When we were trying to control outbreaks of HIV, it was all about changing your thinking about whether you'd have risky sexual behaviour," says Slutkin. "That's much harder to change than violent behaviour. People don't want to change sexual behaviour but they don't actually want to have violent behaviour." Although there were many deeper structural factors contributing to Chicago's violence – poverty, lack of jobs, exclusion, racism and segregation – Slutkin argued that lives could be saved by changing the behaviour of individuals and shifting group norms.

As in many places, discussion of violence in Chicago often takes on a

highly racialised tone. The city is deeply racially segregated. Many South Side neighbourhoods are over 95 per cent African American; others are more than 95 per cent Mexican American. Most of these areas are severely socioeconomically deprived and have suffered years of state neglect. Homicide rates can be up to ten times higher than in more affluent, predominantly white areas of Chicago.

But Slutkin emphasises that this clustering is less to do with race and more to do with patterns of behaviour – usually among a small section of the population, usually young and male – that are transmitted between people. "Language dictates the way people respond, so we don't use words like 'criminal' or 'gang' or 'thug' – we talk about contagion, transmission, health," he says.

Today, Slutkin's organisation Cure Violence is based in the public health department of the University of Illinois, Chicago. A poster in the corridor bears a photo of a young boy, with the slogan "Don't shoot. I want to grow up" underneath.

The organisation now works in 13 Chicago neighbourhoods, and versions of the programme run in New York, Baltimore and Los Angeles, as well as in other countries around the world. It trains local organisations who then find credible people in the area to do the work.

Although there is a level of debate about Cure Violence's use of statistics, the method's overall effectiveness has been shown by numerous academic studies. A 2009 study at Northwestern University found that crime went down in all neighbourhoods examined where the programme was active.

In 2012, researchers at Johns Hopkins School of Public Health looked at four parts of Baltimore that were running the programme, and found that shootings and homicides fell in all four. The results are frequently

striking. In San Pedro Sula, Honduras, the first five Cure Violence zones saw a drop from 98 shootings during January–May 2014 to just 12 in the same period in 2015.

Demetrius Cole is 43, a gentle, softly-spoken man who spent 12 years in prison. He grew up in an area of Chicago afflicted by violence and, at the age of 15, saw his best friend die in a shooting. Nonetheless, he had a stable home life and stayed out of gangs. He planned to join the Marines.

When he was 19, a close friend bought a new car. Some other boys from the neighbourhood tried to steal the car, and they shot Cole's friend. Cole didn't stop to think. He retaliated. In those few minutes, his life changed entirely. While his friend was left paralysed, unable to work again, Cole was sent to prison for his response.

"I reacted off emotion like you see out here today," he says. Since October 2017, he has been working for Cure Violence in West Englewood, a South Side district of Chicago. He finds people in the same situation he was once in, and tries to persuade them to pause. "We try to show them this is a dead end. I tell them, there's only two ways this thing is going to end. You're going to go to jail or you're going to die."

Cole works as a "violence interrupter", employed by Cure Violence to intervene in the aftermath of a shooting to prevent retaliations, and to calm people down before a dispute escalates to violence.

"My job is to interrupt transmissions," Cole tells me. "We try to come up with different kinds of ways to deter these kids from the ways they're used to thinking, and give them a different outlook."

Violence interrupters use numerous techniques, some borrowed from cognitive behavioural therapy. Cole reels them off. "Constructive shadowing", which means echoing people's words back to them;

"babysitting", which is simply staying with someone until they have cooled down; and emphasising consequences. "A lot of kids don't know where their next meal is coming from, their mother's getting high," says Cole. "People say everything is common sense. No. Sense is not common to a lot of people."

Interrupters' ability to be effective depends on their credibility. Many, like Cole, have served long prison sentences and can speak from experience. Most also have a close relationship with the local community. They can respond when a shooting takes place, for instance by convincing loved ones not to retaliate. But they are also aware if conflict is brewing between two individuals or rival groups, and can move to defuse the tension or suggest peaceful alternatives.

"We may not be able to reach everybody, but for the few people we do reach, it's a beautiful thing," says Cole. He laughs as he talks about a young man he's been working with. "He was a mess. All the other little guys looked up to him. He was the man over there, always fighting. His transformation was just – now all the other guys see him working, and they want to come into the centre to get a job."

Grand Crossing, another South Side area, is the site of one of Cure Violence's newest centres. Opened in December 2017, it sits on a busy street, a nondescript shop front deliberately chosen as a neutral space for different rival groups.

When I visit one spring afternoon, a boy in his late teens with a visible facial scar sits in the reception. In the office, staff are playing dominoes, the baseball game on the TV in the background. Young men from the area pass in and out to speak to their outreach workers and use the computers.

Demeatreas Whatley, the site supervisor, is catching up on paperwork in

the back office. Whatley has been working for Cure Violence on and off since 2008, when he got out of prison after 17 years and decided he needed to do something different with his life. His first assignment was in Woodlawn, the area he grew up in.

Ignoring the protestations of his family, he moved onto the block worst afflicted by gang tension, and worked day and night to build up "peace treaties" between the feuding groups of young people. This entailed initially convincing the two groups to stay out of each other's way, and then gradually working on individuals to shift their views about violence and help them to find work or get back into education. "I knew I was making a difference when I saw the old folks back out on the porch again drinking their coffees," he says.

Although it must always be adapted for each location, Cure Violence follows roughly the same steps when establishing itself in a new place.

First, map the violence to see where it clusters. Whatley shows me an A4 photocopy of a map of Grand Crossing, with specks indicating where homicides were taking place. The streets and blocks where the specks cluster are the main focus. Next, hire credible workers with a local connection. "The type of guys we look for are respected in the community, and might already be stopping fights, trying to help guys calm down their nonsense," he says.

These interrupters patrol the streets on their beat, getting to know shopkeepers, neighbours – and building links with the young men and women deemed to be the highest risk. "They're able to know if it's been a fight or if there's a fight brewing," says Whatley. "That's what makes violence interrupters successful. You have to be there."

The centre employs 11 interrupters, who typically spend at least six of the eight hours in a shift out in their neighbourhoods, as well as four

outreach workers, who interact with participants on a more long-term basis. Over a period of six months to two years, outreach workers try to change attitudes to violence, as well as connecting people with job opportunities, counselling or education.

"You have to have a few tricks up your sleeve," says Jermaine Peace, an outreach worker at Grand Crossing. Sometimes, he might hook someone's interest by telling them he can help them get photo ID, like a driving licence. "Some of these boys and girls think no one cares," he says.

"Once you start showing you care and you call them, they may call one day and say, 'Man, I ain't ate in two days.' You go over there and buy them something to eat, you get more chance to talk to them." Peace uses these openings to try to change their outlook on violence. Outreach workers assist with whatever their clients need – referring them to addiction treatment, finding jobs, or even buying new clothes to wear to interviews.

The work is challenging, particularly in the younger age bracket where peer pressure is strong. One young man Peace was working with was recently shot dead, just as he was starting to engage with the process.

While Slutkin emphasises how quickly this model can be effective in reducing homicides, and how it costs less than mass incarceration, there is no escaping the fact that it takes a lot of workers to get results. Some of Chicago's gang territories are very small, just a few blocks. A violence interrupter respected in one area may be unknown, or even mistrusted, in another. To work, there must be at least one interrupter with strong connections in each district, so that if a conflict erupts, someone with the trust of the group can mediate.

Cole uses local connections in West Englewood, building up

relationships with people who can then help him reach others. "I've been there. It's hard coming back from prison and back into society," says Cole.

"If people know of you and know your history, you're able to stop a lot of things when it comes to shootings and killings. I'm able to show people: you can do this, you can change."

In Glasgow, Christine Goodall didn't only see patients immediately after they'd been attacked. Sometimes people would come to her months, even years after their injury, desperately seeking a solution. One young woman came in a year after she'd been slashed across the face with a Stanley knife by an abusive partner. The attack had left a huge scar, and there was nothing surgery could do to fix it.

"She was really pretty. She'd been outgoing, had a job, all the usual stuff, but she didn't feel able to leave the house, let alone work," says Goodall. "You know when people really sob? It was just heart-wrenching. I left the consultation feeling hopeless." Goodall decided she had to do something, and in 2008, with two other surgeons, founded a charity called Medics Against Violence. The charity became a partner of the Violence Reduction Unit.

When the VRU was being established in 2005, Karyn McCluskey and John Carnochan of Strathclyde Police had searched the world for possible solutions to Glasgow's problem with violence. What they eventually came up with blended together Gary Slutkin's approach with that of David Kennedy, a Boston-based criminologist.

Kennedy's model, which launched in Boston in the 1990s, entails gathering together gang members and giving them an option: renounce violence and get into education or work, or face tough penalties. This meant ramping up traditional penal measures – increased stop-and-

search and stricter sentencing for knife possession – alongside preventive measures in line with the public health approach.

Will Linden, the acting director of the VRU, argues that this was politically necessary. "Before we went to services to get them to do things differently, we had to show that the police were doing the best we could but it still wasn't enough," he says. If at first the emphasis was fairly equally spread between stricter policing and preventive work, today Linden estimates that around 90 per cent of the funding and emphasis is on prevention. "If we hadn't had that evolution, we'd spend most of our time firefighting the press about being soft on crime," he says.

The VRU is run by the police force, with support from the Scottish government. This is highly unusual – Scotland has the world's only police force to have formally adopted a public health model. Cure Violence in Chicago operates through the university, while similar programmes in New York and Baltimore are administered through the cities' health departments. Slutkin, a purist on the public health model of violence, says it is "horrible" for police to administer it, since police are often part of the problem.

But alongside police, a whole range of public officials – from doctors to social workers – are involved. Goodall's Medics Against Violence goes into schools to educate children about knife crime and to get them to think practically about how to respond if, for instance, a friend told them they had a knife.

It also employs "navigators" who, like Chicago's violence interrupters, intervene directly after violent incidents to defuse tension and help people find support. Glasgow's navigators are not assigned to specific localities; instead, they work in accident and emergency departments and approach people who come in after a violent incident. "A lot of people

come into A&E plotting revenge and it's very important that they leave not doing that," says Goodall.

In the violence prevention industry, this is referred to as a "reachable, teachable moment", when someone is more receptive than usual to help. "Pain is an incredible motivator for change," says Linden. After an initial conversation, the navigator follows up by helping the person get drug or alcohol treatment, job opportunities or therapy. They try to move quickly.

"When someone wants to change, you have to be able to adapt and move," says Linden. "In six or 12 weeks, they'll be in a different mindset. We make sure if we refer someone, they're not in a queue." This requires significant cooperation between different agencies.

McCluskey and Carnochan had stumbled on the public health approach during their research into violence prevention, but they soon discovered a growing international network of highly data-driven work. They joined the WHO's Violence Prevention Alliance, a global umbrella organisation that shares studies from around the world. "Something that works in Jamaica might not work in Scotland unless you tweak it – but it is really useful to see what others are doing and what works," says Goodall.

Tailoring an idea to a specific locality is key – but the WHO breaks the public health approach to violence down into four steps. The first is uncovering as much basic knowledge as possible about all aspects of violence. The second is investigating why violence occurs – looking at causes, correlations and risk factors. The third is exploring ways to prevent violence using this information. The fourth is implementing these strategies.

"Its starting-point is the strong conviction that violent behaviour and its consequences can be prevented," says the WHO's guidance. To see a

serious effect, this work needs massive levels of collaboration – and longer than a four- or five-year election cycle. Linden notes that Scotland has an unusual level of political consensus, with successive governments funding this work.

"Just calling violence a disease and saying we need to interrupt the flow isn't going to stop it," he says. "Call it the public health approach, call it prevention – it doesn't matter a damn, if you don't actually use evidence-based approaches to address the real problem."

Despite the ever-growing bank of evidence, governments are sometimes reluctant to properly invest. "The difficulty is not how to reduce violence, it is the way people understand the problem," Slutkin tells me, his frustration visible. He draws a parallel to AIDS and the stigma attached to those who contracted it during the first outbreaks in the 1980s.

On a sunny evening in downtown Chicago, I watch Slutkin give a talk to an audience of young professionals. In Chicago, homicides reached a 20-year high in 2017 and President Donald Trump threatened to send in "the feds". Slutkin presents graphs showing that every time Cure Violence's funding is cut in a certain area, shootings spike, and when it returns, they drop. (Critics argue that it is impossible to draw conclusions about causality due to other factors at play.)

"Despite massive amounts of data, it's hard to get funding for this," Slutkin tells the audience. "Mass imprisonment has no good data – but it's funded. This is the only epidemic health problem not being tackled by the health department."

Whatley, the site supervisor at the Grand Crossing branch, has experienced these funding cuts first-hand, repeatedly losing his job and being rehired in the ten years since he started working for Cure

Violence. The project he originally worked on, in his home area of Woodlawn, was cancelled. The old folks no longer drink their coffees out on the porch.

Where could a public health approach to violence be introduced next? One possibility is London, where in 2017 knife crime among under-25s reached a five-year high. In recent months, the Metropolitan Police commissioner, Cressida Dick, and the mayor, Sadiq Khan, have been among those calling for a public health approach.

"The futility of speaking to families and telling mothers their children have died has spurred a lot of us to think: what more could we have done to have actually stopped it happening?" says Duncan Bew, clinical lead for trauma and emergency surgery at King's College London Hospital.

Bew has treated countless victims of knife attacks. The demographic of patients changes throughout the day. There is always an increase in young victims (between the ages of 11 and 20) in the hours after school finishes. Bew estimates that up to half the people he sees have a "violent penetrating injury", usually a knife or gun wound. This is a contrast to the rest of the UK, where – particularly outside urban areas – most trauma patients are victims of car accidents.

It never stops being shocking when someone arrives in school uniform with a devastating knife wound. But surgeons learn to focus on the ones who survive, and from a medical perspective, the younger the patient, the easier they are to treat. Their bones are more malleable. They heal faster.

As in many other places, solutions in London have mostly been sought through enforcement – mandatory sentences for knife possession, an increase in stop-and-search, and the formation of a "gangs database" which sends letters to young people and their parents threatening legal

repercussions. Academic studies have found that this database, like stop-and-search, is racially discriminatory. (In Manchester, most of the people on the database are from ethnic minorities, even though most people arrested for serious youth violence are white.)

The exact way that the public health approach is implemented varies around the world, but the unifying thread is the idea of believing that people are capable of change, and backing up this belief with investment. To be effective, it requires a degree of strategy and top-level input to accompany grassroots work.

"They managed to do that in Scotland by being brave, burying the hatchet, saying we're all going to work together and take a chance," says Bew.

Numerous violence-prevention projects that roughly adhere to the public health ethos are already in place in London. Bew co-founded a charity, Growing Against Violence, that goes into schools to educate young people about knife violence. Another organisation, Red Thread, operates a navigator programme across four inner-city A&Es. Grassroots community organisations educate and support people to prevent violence.

But for the most part, these projects are underfunded, or funded only on a short-term basis, which hinders their work. More general youth services and street work have been devastated in the capital over the last eight years. An average of 36 per cent has been cut from London boroughs' youth services, with some cutting more than 50 per cent.

This has led to a situation where referral services like Red Thread can struggle to find organisations to refer young people to after interventions.

But Bew is optimistic that this is a moment when there is genuine cross-party support for "doing something different", as Scotland decided to in 2005. London is an immensely diverse city – not just in its ethnic demographics, but in the variation in patterns of violence.

Bew suggests that some of the areas worst affected might suit a Chicago interrupters model, with people working in the streets. Elsewhere, more holistic support and poverty reduction, like Scotland's VRU, might be most effective. "What we can't have is communities having a sense of futility, that violence is inevitable. They deserve better," he says. "Violence does exhibit similar patterns to contagious disease. We know that. It can be prevented."

Thirteen years after it was established, the VRU has retained its flexibility and openness to new ideas. In 2012, Iain Murray, a policeman working for the VRU, travelled to Los Angeles to visit Homeboy Industries, a catering company that employs former gang members.

In addition to providing employment for a year for former violent offenders, Homeboy Industries gives mentoring, psychotherapy and a host of other support. Murray came back inspired, thinking how to put a "Scottish spin" on it.

The result is Braveheart Industries, a social enterprise run by the VRU. Its main business is Street and Arrow, a food truck that sits in the Partick area of Glasgow, dishing up peri-peri chicken burgers and fish tacos. It hires former violent offenders for a year, and provides intensive mentoring from a navigator as well as regular psychotherapy and assistance with literacy, housing, parenting or anything else that is required. Participants must have a criminal history, they must abstain from drugs and alcohol, and they must be ready to change.

"We've got to understand what the problems are," says Murray, standing

outside the food truck on a typically erratic Glasgow day, intermittent sunshine punctuated by bursts of rain. "The police for years have been experts at detection and enforcement. I'd much rather be top of the cliff putting a fence up, stopping somebody jumping over, as at the bottom of the cliff waiting until they've jumped. That's the public health approach as far as I'm concerned. You're engineering out issues, rather than waiting for them to happen."

Allen, 27, has been working at Street and Arrow for three months. When I ask how long he had spent in prison, he isn't able to tell me: he's lost track, but according to Murray, he's been sent to prison 27 times. "I didn't come from a supportive background, so I chose the wrong path – drink, drugs, violence, chaos, prison," says Allen, a tall, well-built man who avoids eye contact. "That was my life. It's hard to escape once you start."

After his last prison stint, he went into rehab. Someone there told him about Street and Arrow. He applied for a job, and was shocked when he got it. "I came up here with nothing, and I mean nothing," he tells me. "But the more I was away from the chaos, the more my life just got better and better."

He pauses, trying to think of a way to express the changes. "I see people with cars now and I just… that's not something I ever thought about doing. Now I've got plans to start my driving licence. I just want a peaceful life. I never wanted that before, I just wanted to take drugs." The rain suddenly stops and the sun comes out. Allen gestures at the sky. "In my area when it was sunny it made me even more anxious as there were more people out, with knives," he says. "I'm not anxious when it's sunny anymore. I've got a future ahead of me."

For many participants, apparently simple things can be a challenge: arriving on time, taking orders, wearing a uniform. The navigators

support them through this so that at the end of a year, they're prepared for a normal job. At the same time, there are echoes of Chicago's interrupters, modifying behaviour to prevent the transmission of violence. The navigators build a relationship with trainees and help them change their responses to conflict.

"It cushions the blows a wee bit," says Alan Gilmour, a navigator at Street and Arrow. "Life is in session. Normally something goes wrong, you kick off: anger, alcohol. We support them through that, work out how they can handle it. You see that maturity and growth in a short space of time."

The programme has been highly successful, with 80 per cent of participants staying out of prison and going on to other employment. Murray has noticed the drastic difference in Allen.

"I know from my previous roles in policing over the years, I could have arrested that guy ten times in a row and I wouldn't have made a blind bit of difference to his behaviour. By supporting him and connecting with him, I can make a long-term, sustainable change to his behaviour," he says.

"I cannot believe how good that guy is. I cannot get him to leave work. It's remarkable to see. You start caring about them and they start caring about themselves."

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