

# Protecting people Promoting health

A public health approach to violence prevention for England

parenting  
youth PARTNERSHIP  
violence  
PREVENTION data. sharing  
wellbeing COMMUNITY  
domestic ABUSE

**Address for Correspondence**

North West Public Health Observatory  
@ The Centre for Public Health  
A WHO Collaborating Centre for Violence Prevention  
Liverpool John Moores University  
15-21 Webster Street  
Liverpool L3 2ET  
Tel: +44 (0)151 231 4511

Electronic copies are available at:

[www.cph.org.uk](http://www.cph.org.uk)  
[www.nwpho.org.uk](http://www.nwpho.org.uk)  
[www.preventviolence.info](http://www.preventviolence.info)

October 2012

ISBN 978-1-908929-20-4 (web)

This work was undertaken by the North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University, who received funding from the Department of Health; the views expressed in this publication are those of the authors and not necessarily those of the Department of Health. The document was completed as part of the national work programme of the public health observatories in England.

# Authors

Mark A Bellis, Karen Hughes, Clare Perkins and Andrew Bennett

# Acknowledgements

Many people have contributed to the development of this publication and we are very thankful for their support and guidance. We are especially grateful to colleagues from the Department of Health, the Home Office and the World Health Organization (WHO) Regional Office for Europe for their contributions to the document and its peer review. We are grateful to colleagues at the London School of Economics for their work on the costs of violence; and Gillian Holdsworth (NHS South East London) and Charlotte Alcock (MAC-UK) for providing information on their work. We would also like to thank Olivia Sharples, Katie Hardcastle and Emma Pemberton at the Centre for Public Health, Liverpool John Moores University, for their support.

# Authors' Contributions

The review of violence epidemiology, prevention intelligence and policy information was coordinated and collated by KH. Development and delivery of this document was led by MAB. CP reviewed violence prevention policy. All authors contributed to the development, editing and review of the text.

**Mark A. Bellis OBE** is Director of the Centre for Public Health and the North West Public Health Observatory. He also is the *UK Focal Point to the WHO for Violence and Injury Prevention* and a member of the Expert Advisory Panel on violence and injury prevention reporting to the WHO Director General.

**Karen Hughes** is a Reader in Behavioural Epidemiology at the Centre for Public Health and lead researcher for the Centre's collaborative work programme with the World Health Organization.

**Clare Perkins** is a Public Health Specialist and Deputy Director of the Centre for Public Health and North West Public Health Observatory.

**Andrew Bennett** is a practitioner at the Centre for Public Health specialising in social intervention to promote and protect health.

**The North West Public Health Observatory (NWPHO)** is one of nine Public Health Observatories in England and leads nationally for them on violence information, data and intelligence. The NWPHO is based at the Centre for Public Health which is a World Health Organization Collaborating Centre for Violence prevention.

# 10 key points from this document

- 1. There are 2.5 million violent incidents in England and Wales each year.** They result in 300,000 emergency department attendances and 35,000 emergency admissions into hospital (chapter 2).
- 2. Violence is estimated to cost the NHS £2.9 billion every year.** This figure underestimates the total impact of violence on health as, for instance, exposure to violence as a child can increase risks of substance abuse, obesity and illnesses such as cancer and heart disease in later life. The total costs of violence to society are estimated at £29.9 billion per year (chapter 3).
- 3. Much like many infections, violence is contagious.** For instance, exposure to violence, especially as a child, makes individuals more likely to be involved in violence in later life (chapter 4).
- 4. Violence shows one of the strongest inequalities gradients** with emergency hospital admission rates for violence being around five times higher in the most deprived communities than in the most affluent (chapter 4).
- 5. By adopting a public health approach violence can be prevented.** A range of different interventions throughout the life course can reduce individuals' propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require (chapter 5).
- 6. Data on violence are increasingly available** from health services, police, other routine sources and a variety of surveys. These identify individual and community level risk and protective factors. Such data can be used to target interventions at those most at risk and monitor progress (chapter 2). The inclusion of violence indicators in the national Public Health Outcomes Framework (chapter 6) means robust, comparable measures of trends in violence will be available for all localities.
- 7. A wide range of interventions are available to public health practitioners.** Programmes that support parents and families, develop life skills in children, work with high-risk youth and reduce the availability and misuse of alcohol have proven effective at reducing violence. Measures to ensure appropriate identification, care and support mechanisms are in place are important in minimising the harms caused by violence and reducing its recurrence (chapters 5 and 6).
- 8. In many cases health economic analyses are already available** that demonstrate significant cost savings where violence prevention programmes have been established (chapter 5). Some areas in England are already employing these measures. If other areas followed suit financial and health benefits would be substantial.
- 9. Violence prevention is a critical element in tackling other public health issues.** Violence impacts on mental wellbeing and quality of life, prevents people using outdoor space and public transport and inhibits the development of community cohesion (chapter 3).
- 10. Changes to public health and other public structures should help facilitate violence prevention.** The establishment of Public Health England and locally accountable health and wellbeing boards; the movement of public health teams into Local Authorities and the election of police and crime commissioners, can be used to create multi-agency plans for violence prevention in all localities. Such plans should use the strong evidence base behind public health approaches to violence prevention to ensure public sector, private sector and community assets all contribute to violence prevention and benefit from less violence (chapter 6).

# Table of Contents

1. Introduction	6
Who should read this document and why?	6
Seizing the opportunity to prevent violence	7
Summary	8
2. The extent and nature of violence	9
Violence in the general population	10
Child maltreatment	12
Youth violence	13
Intimate partner violence	14
Sexual violence	15
Elder abuse	16
Violence against health service staff	17
Local violence data and health data sources	18
3. The impact of violence	20
Acute impact of violence	21
Long term impact of violence	23
The economic cost of violence	25
4. Risk factors for violence	26
Understanding risk	27
Early life experiences	27
Peer relationships and gangs	28
Deprivation and social inequality	29
Alcohol and drugs	30
Cultural and social norms	31
Disability	31
Adult psychiatric disorders, childhood conduct disorder and violence	32
5. Preventing violence	33
Supporting parents and families	34
Developing life skills in children and young people	36
Working with high risk youth and gangs	38
Reducing the availability and harmful use of alcohol	40
Community interventions	42
Changing social norms that support violence	44
Identification, care and support	45
6. National policy and programmes	48
The role of public health services in tackling violence	49
Policies aimed at tackling the drivers of violence	51
Policies aimed at tackling violence	53
Protecting NHS staff from violence	57
International policy and programmes	58
7. Conclusions	60
Why now is the time to act on violence prevention	60

# 1. Introduction

## Who should read this document and why?

Violence is not something that just happens, nor is it normal or acceptable in our society. Many of the key risk factors that make individuals, families or communities vulnerable to violence are changeable, including exposure to adverse experiences in childhood and subsequently the environments in which individuals live, learn and work throughout youth, adulthood and older age. Understanding these factors means we can develop and adopt new public health based approaches to violence. Such approaches focus on the primary prevention of violence through reducing risk factors and promoting protective factors over the life course.

Interventions to achieve these goals have been tested and now form part of a growing evidence base of cost effective measures to reduce the harms associated with violence and prevent its occurrence. The impact of violence on the health of individuals and the costs it imposes on health care systems - £2.9 billion annually - are substantive (see box 1); akin to those for other major public health priorities such as smoking and alcohol.<sup>1</sup> Thus, the potential benefits of adopting an evidence-based approach to violence prevention are also substantive in terms of both improved population health and reduced health care costs.

This document outlines the extent (chapter 2) and impact (chapter 3) of violence nationally, covering violence in the general population as well as specific violence types that can impact dramatically on different sectors of society: child maltreatment, youth violence, intimate partner violence, sexual

violence and elder abuse. It also provides information on how to access local intelligence on violence and related harms (chapter 2).

The document describes some of the key risk and protective factors for violence (chapter 4) and collects together details of interventions and policy measures that have been effective in preventing violence (chapter 5), giving examples of where these are already being employed in England. It also outlines the policy frameworks already in place to support violence prevention (chapter 6).

The document should be read by those with a role in health policy, commissioning or delivery of public health services. However, any individual and organisation with an interest in violence prevention, safe guarding, troubled families and multi-agency working between health, criminal justice and education should find it of use.

### Box 1: Key national figures on the extent and cost of violence

Annual number of violence incidents <sup>2</sup>	2.5 million
Annual number of emergency department attendances for violence <sup>3</sup>	300,000
Annual number of emergency hospital admissions for violence <sup>a</sup>	35,000
Annual cost of violence to society <sup>b</sup>	£29.9 billion
Annual cost of violence to health services <sup>b</sup>	£2.9 billion

<sup>a</sup>England; all other figures cover England and Wales. Data from the North West Public Health Observatory, Centre for Public Health. <sup>b</sup>calculated by London School of Economics, see Appendix available separately.

## Seizing the opportunity to prevent violence

---

This document coincides with a number of changes to the NHS and public health system that may facilitate the implementation of violence prevention initiatives. Public health is being integrated into local government structures, allowing stronger connections between Directors of Public Health and local services aimed at addressing poverty, inequalities, education, housing, employment and crime. Preventing violence is pertinent to all these issues and is strongly related to inequalities, with the poorest fifth of society suffering rates of hospital admissions for violence five times higher than those of the most affluent fifth.<sup>4</sup>

Public health teams should be able to use the information in this document to ensure parental and social support, education, housing and other key services are aware of the roles they can play in violence prevention and the evidence base on which approaches are most effective. The Joint Strategic Needs Assessment process<sup>5</sup> also provides an ongoing local mechanism through which public health teams can ensure development of integrated approaches to violence prevention. Furthermore, Directors of Public Health in local authorities have a lead role and budgetary responsibility for tackling issues related to alcohol and drugs; both of which feature as major risk factors for violence (see chapter 4).

The Public Health Outcomes Framework includes a number of violence related indicators (see chapter 6) covering not just violence in general but also sexual and domestic violence. Such outcomes are aimed at encouraging local joint work on key public health issues. Directors of Public Health have the

opportunity to facilitate joint working on violence through the sharing of intelligence from health and criminal justice agencies in order to more effectively target interventions at populations and localities at greatest risk (see chapters 2 and 5). As well as informing this process, this document should help Directors of Public Health and their teams develop integrated approaches to community safety with Police and Crime Commissioners.

At a national level there is now an increasing recognition of the importance of a life course approach to violence that emphasises the need for primary prevention. The Home Office gang and youth violence plan<sup>6</sup> adopts such an approach, and the need to break an infective cycle within families, where violence is passed from one generation to another, is emerging as a key feature in helping troubled families.

Ensuring public health contributes effectively to these and other national developments should be possible through Public Health England. It is ideally placed to use and build on the information provided in this document and to ensure intelligence on violence and its relationship with health and wellbeing are available to national and local organisations. Together with local Directors of Public Health, Public Health England should also ensure that clinical services are aware of the roles they can play in the identification and prevention of violence, the benefits violence prevention brings to reducing pressures on their services and the importance of providing the best treatment and care to those affected.

## Summary

---

Preventing violence must be seen as a priority for public health, health care and multi-sectoral working in England. Violence is a major cause of ill health and poor wellbeing as well as a drain on health services and the wider economy. However, it is preventable using measures that save much more money than they cost to implement. Interventions, especially those in early childhood, not only prevent individuals developing a propensity for violence but also improve educational outcomes, employment prospects and long-term health outcomes. Abuse in childhood increases risks of violence in later life, but also risks of cancer, heart disease, sexually transmitted infections, substance use, and a wide range of health conditions that are currently stretching health care resources (see chapter 3).

Moreover, without safe and secure communities, measures to encourage people to exercise, socialise or adopt more sustainable lifestyles (e.g. using public transport) are more likely to fail as people feel trapped in their houses and cars and unable to engage with local communities. Even broader economic inequalities can remain stubbornly entrenched when investment in the poorest communities is inhibited by risks of violence to staff and customers.

The breadth of individuals and organisations affected by violence and the number that need to be coordinated in order to prevent it mean that public health is uniquely positioned to lead programmes on violence prevention, support the implementation of violence prevention activity by partner agencies and make a major contribution to integrated multi-agency working for violence prevention. This document is designed as a resource for those that wish to rise to this challenge.



# 2. The extent and nature of violence

Understanding the extent of violence, where and how it happens and who is affected can inform effective public health responses.

National surveys and data routinely collected by health services, police, social care services and other agencies can measure trends in violence and identify at risk population groups and communities. This chapter outlines the extent and nature of violence in the general population and for specific violence types: child maltreatment, youth violence, intimate partner violence, sexual violence, and elder abuse. Whilst this is not an exhaustive list of violence types, it covers many of the forms of violence with the largest public health impact in England today.

At a local level, the collation and sharing of multi-agency data on violence is critical in understanding the impact of violence on local populations, which groups or communities are most at risk, what types of interventions are needed and ultimately how effective they are at preventing violence. This chapter identifies some of the key health data sources on violence that can support multi-agency prevention activity.



## Violence in the general population

Violence causes around 35,000 emergency hospital admissions and over 300,000 emergency department attendances in England each year.

Violence is a major public health issue that affects millions of people across England. The Crime Survey for England and Wales (CSEW; formerly the British Crime Survey) estimated that just over two million violent incidents were committed against adults in 2011/12. Over half a million more were estimated to have been committed against children aged 10-15 years.<sup>2</sup>

Over the same period, police recorded around 762,500 violence against the person offences in England and Wales, including 550 homicides<sup>7a</sup> (see box 2.1). A further 53,665 sexual offences were recorded. Just under half of violent incidents recorded by police resulted in injury as did half of those reported by adults to the CSEW, compared with 69% of those reported by children.

The difference between violence reported through the CSEW and that recorded by police shows that many incidents of violence are not reported to criminal justice systems. However, violence that results in injury often requires health treatment. Health services therefore play a major role in identifying the extent of violence and at risk groups. There were 34,713 emergency hospital admissions for violence in England in 2010/11. Rates were highest in young males, and increased with increasing deprivation (see chapter 4).

Figure 2.2 shows emergency hospital admission rates for violence by local authority area. Rates are generally higher in the North of the country. For example, the North West had 124.1 admissions per 100,000 population compared with 44.5 per 100,000 in East of England.

### Box 2.1: Homicide

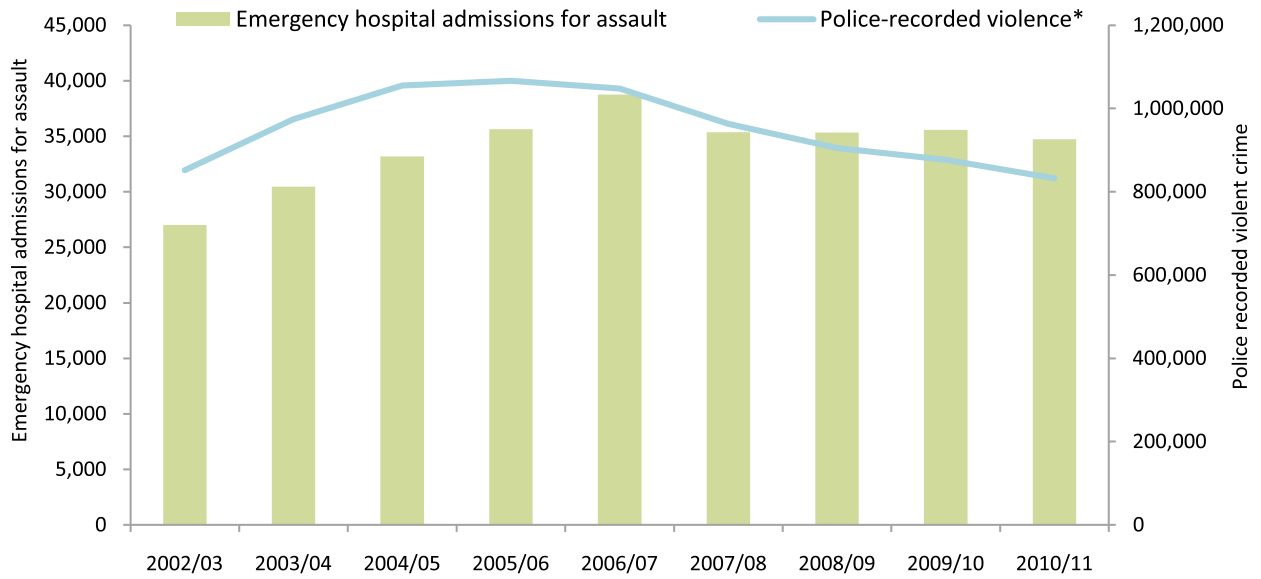
Homicide data from 2010/11<sup>8</sup> (covering 636 recorded homicides) show that over two thirds of victims were male. The risk of homicide was highest in children under the age of one. With the exception of infants, however, adults were more likely to be victims than children. Child victims were most commonly killed by parents or step parents and adult victims by friends and acquaintances (for male victims) or current or ex-partners (for female victims). Sharp instruments were the most common means of homicide, used in 36% of all offences in 2010/11. Shootings accounted for 9% and included the 12 victims of the Cumbria shootings in June 2010. Although 2010/11 saw a 5% increase in recorded homicide offences from the previous year, there has been a general downward trend in homicides over recent years.

For every hospital admission for violence, a further ten assault victims require treatment at emergency departments (EDs).<sup>3, 9</sup> ED assault attendances peak at weekend nights, and are often related to alcohol.<sup>10</sup> Rates of both hospital admissions and ED attendances for violence are highest in young males from deprived communities.<sup>4</sup>

The 1990s and early 2000s saw large increases in levels of violence across England. However, major data sources suggest that this trend has since halted and violence is now decreasing (see figure 2.1). There are advantages in the sharing of information between different sources in order to build a true picture of violence (see page 18).

<sup>a</sup>Some incidents initially recorded as homicide are later reclassified if a lesser offence, or no offence, is found to have taken place. Homicide figures are based on the year in which offences are recorded by police rather than the year they take place.

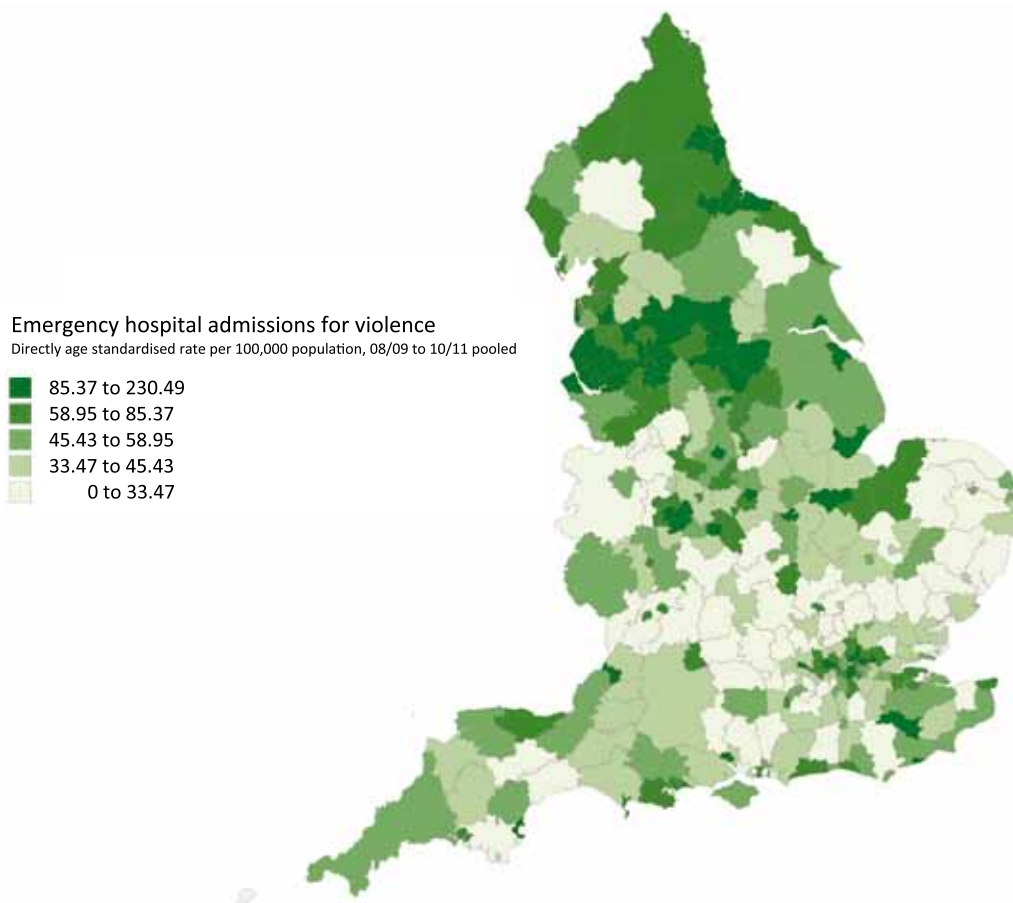
**Figure 2.1:** Trends in emergency hospital admissions for violence and police-recorded violence, England



\*Violence against the person and sexual offences

Source: North West Public Health Observatory, Centre for Public Health; Home Office

**Figure 2.2:** Emergency hospital admissions for violence by local authority area of residence, directly age standardised rate per 100,000 population\*



Source: North West Public Health Observatory, Centre for Public Health

\* Annual rate averaged over three years, 2008/2009 to 2010/2011

## Child maltreatment

The NSPCC estimates that as many as one million secondary school students in the UK have suffered severe maltreatment at some point during their lives.

A significant proportion of children suffer abuse and neglect. All forms of child maltreatment are under-reported and only a small proportion of cases are likely to come to the attention of services.

**Child abuse or maltreatment** includes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child’s health, survival, development or dignity in the context of a relationship of responsibility, trust or power.<sup>11</sup>

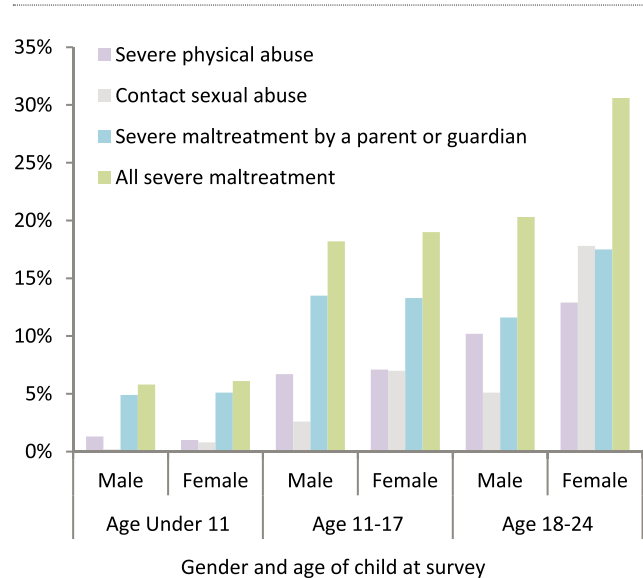
The NSPCC estimates that as many as one million secondary school students in the UK have suffered severe maltreatment<sup>a</sup> at some point in their lives.<sup>12</sup> In a study conducted by the NSPCC in 2009, one in five (18.6%) 11-17 year olds reported having been severely maltreated, mostly at the hands of parents or guardians (13.4%).<sup>13</sup> Six percent reported some form of maltreatment by parents or guardians in the past year.

Across their lifetime, 6.9% of 11-17 year olds had experienced severe physical abuse and one in twenty (4.8%) had suffered contact sexual abuse.<sup>13</sup> Girls were at greater risk of sexual abuse than boys. In two thirds of all sexual abuse cases the perpetrators had been other children or young people. Over a fifth of those who had been physically hurt by a parent or guardian had not told anybody about it, rising to over 80% of cases of sexual assault by a peer.

The NSPCC study also surveyed young adults aged 18-24 and parents of children under the age of 11 (see figure 2.3). In 18-24 year olds, the proportion reporting parental neglect during childhood had not changed from those identified in a survey of the same age group in 1998.<sup>14</sup> However, levels of emotional abuse and harsh physical punishment had decreased, along with some measures of physical and sexual violence.

In 2010/11, the NSPCC received nearly 36,000 contacts from people who were worried about a child.<sup>15</sup> As of March 2011, 42,330 children in England were the subject of a child protection plan - meaning they have been assessed as being at risk of significant harm of abuse.<sup>16</sup>

**Figure 2.3: Percentage of children and young people having ever suffered severe abuse or neglect, 2009, UK\***



Source: Radford et al, 2011<sup>13</sup>

\*Data collected via a random probability sample of children, young adults and parents in the UK. Survey included 2,160 parents or guardians of children under age 11; 2,275 children aged 11-17, with additional information provided by parents or guardians; and 1,761 young adults aged 18-24.

<sup>a</sup>Including severe physical and emotional abuse by any adult, severe neglect by parents or guardians and contact sexual abuse by any adult or peer.

## Youth violence

In 2010/11, there were 13,000 emergency hospital admissions for assault among 13-24 year olds. One in seven involved a knife or sharp object.

The Crime Survey for England and Wales (CSEW) shows that young people aged 16-24 suffer higher levels of violence than other adult age groups. In 2011/12, 11.0% of males and 5.7% of females aged 16-24 reported having been a victim of violence in the past year.<sup>2</sup> In the previous survey, half of all violence reported by adults was estimated to have been committed by 16-24 year olds.<sup>17</sup>

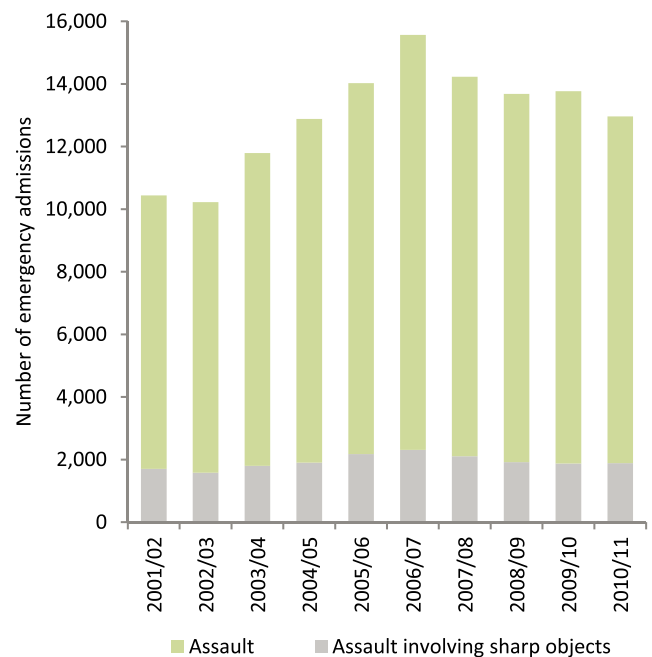
Since 2009, the CSEW has also surveyed 10-15 year olds. In 2011/12, 7.6% of 10-15 year olds reported suffering a violent crime in the past year, equating to an estimated 566,000 violent crimes in this age group across England and Wales. Over two thirds of incidents resulted in injury.<sup>2</sup>

The CSEW figures reported here exclude more minor forms of violence against children,<sup>a</sup> yet bullying in school and the community can also have severe impacts. In 2009, a survey of over 250,000 10-15 year old school children in England found that almost half (46%) had been bullied at school and a fifth (21%) had been bullied elsewhere at some point during their lives. One in three (29%) had been bullied in the past year.<sup>18</sup>

Gang and knife-related youth violence has become a key cause of concern in England. Throughout the early to mid 2000s, both fatal and non-fatal violence involving young people increased. Homicides in 13-24 year olds peaked in 2007/08 (at around 180)<sup>19</sup> and emergency hospital admissions for violence peaked in 2006/07 (at over 15,000; figure 2.4). While both measures have since reduced, hospital admission rates for violence remain higher than they were a decade ago.

In 2010/11 there were 12,963 emergency hospital admissions for assault among 13-24 year olds. One in seven (1,886) involved the use of knives and other sharp objects. Across the whole population, the peak age for emergency admission to hospital due to violence is 18 years<sup>4</sup> (see chapter 4, figure 4.2).

**Figure 2.4:** Emergency hospital admissions for assault, 13-24 year olds, England



Source: North West Public Health Observatory, Centre for Public Health, 2012

Many incidents of youth violence (and other types of violence) involve alcohol, which can increase risks of both perpetrating and being a victim of violence (see chapter 4). Across England and Wales, one in five incidents of violence occur in or around pubs, bars or nightclubs.<sup>17</sup> Analyses of ED data show that assault attendances peak at weekend nights, when a large proportion of assault patients are young males who have been drinking at bars and nightclubs.<sup>10, 20</sup>

<sup>a</sup>The CSEW provides two measures of violence against children – a 'preferred' measure that accounts for the severity of an offence and a broad measure which includes all reported incidents, including low-level incidents between children. The preferred measure is reported here.

## Intimate partner violence

Almost 900,000 women and 600,000 men in England and Wales are estimated to have suffered abuse at the hands of an intimate partner in the past year.

Intimate partner violence is any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship.<sup>11</sup> It can be perpetrated by existing or past partners and is one of the most common types of violence towards females. However, both genders can be victims as well as perpetrators. For women in particular, risks of victimisation are highest in young adulthood.<sup>21</sup>

The 2011/12 CSEW<sup>2</sup> estimated that around one in four women and one in seven men aged 16-59 have suffered abuse at the hands of an intimate partner since the age of 16. In the past year, intimate partner violence was reported by 3.6% of men and 5.4% of women, equating to almost 600,000 men and 900,000 women.

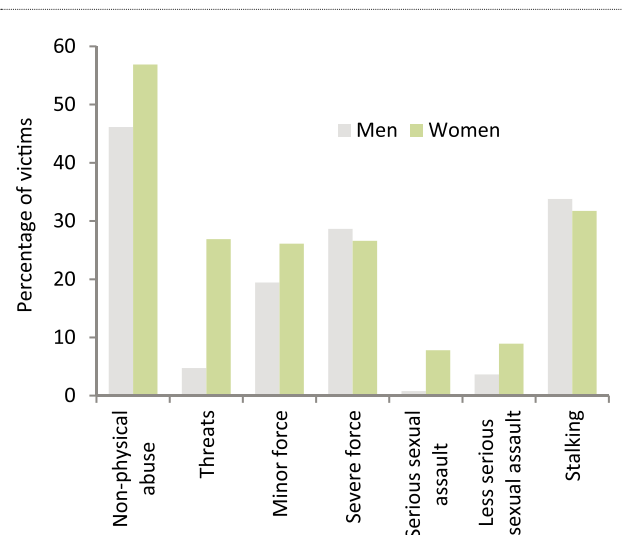
In the 2010/11 survey, a quarter (27%) of victims reported having sustained a physical injury in their most recent episode of abuse, and 39% reported mental or emotional problems (see chapter 3). A fifth of victims had told no-one about the abuse. A third had told someone in an official position, mostly police, followed by health professionals.<sup>8</sup>

Some victims of intimate partner violence suffer abuse repeatedly over a long period of time. A third of those who have experienced abuse since the age of 16 report this to have lasted for more than one year. One in three past year victims report having suffered more than one incident of abuse and around 6% of female and 3% of male victims report being abused more than 20 times.<sup>22</sup>

Among victims of both genders, the most common forms of intimate partner abuse are non-physical,

including emotional and financial abuse (see figure 2.5). However females are more likely to suffer sexual assault and threats of violence than males. They are also more likely to experience longer periods of abuse, repeat victimisation, physical injury and emotional harm,<sup>22</sup> and to report their abuse to police or health professionals, than males.<sup>8</sup>

**Figure 2.5:** Types of intimate partner violence suffered by victims in the last year, 2010/11



Source: British Crime Survey 2010/11<sup>8</sup>

While all intimate partner violence is under-reported, some forms can be particularly hidden. For example, there are estimated to be at least 5,000 to 8,000 reported cases of forced marriage in England each year,<sup>23</sup> whereby one or both spouses do not (or cannot) consent to the marriage and duress is involved.<sup>24</sup> Around 85% of such cases involve female victims, who can suffer domestic violence, rape, damage to mental well-being and other harms. Attempts to avoid or escape forced marriage can be met with serious, sometimes fatal, violence.<sup>25</sup>

## Sexual violence

Over 400,000 women and 80,000 men in England and Wales are estimated to have suffered a completed or attempted sexual assault in the past year.

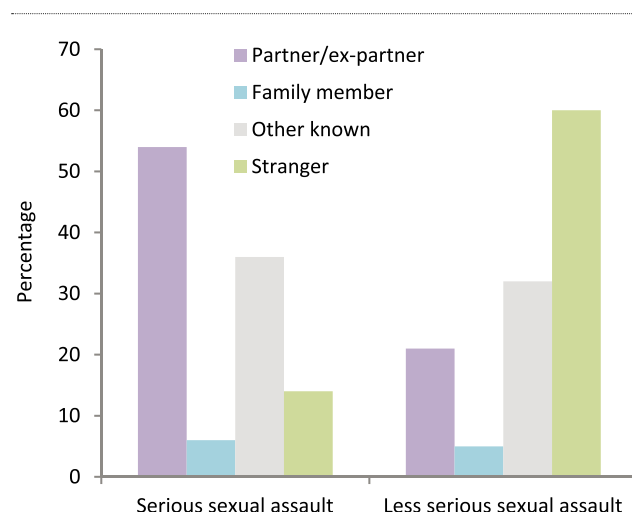
In 2011/12, 53,665 sexual offences were recorded by police in England and Wales, including around 16,000 rapes and 22,000 sexual assaults.<sup>7</sup> One in three rapes recorded by police involved child victims under the age of 16. Sexual violence is known to be widely under-reported, with only one in ten adult victims of serious sexual assault reporting the incident to police.<sup>21</sup>

The term **sexual violence** covers a wide range of abusive acts directed towards an individual's sexuality, including sexual assault, rape, sexual coercion, sexual bullying and female genital mutilation.

The CSEW includes a self-completed module to gather data on sexual assault experienced by adults. In 2011/12 it estimated that around one in five women (19.6%) and 2.7% of men had suffered a sexual assault since the age of 16.<sup>2</sup> Three percent of women and 0.3% of men reported an actual or attempted sexual assault in the previous year, equating to around half a million adult victims. Young women were at greatest risk of sexual assault, with prevalence of past year victimisation rising to 7.9% in 16-19 year old females. Certain population groups can also be at increased risk, including sex workers<sup>26</sup> and gay and bisexual men.<sup>27</sup>

The perpetrators of serious sexual assault are most often known to victims. Over half of female victims in 2009/10 were assaulted by partners or ex-partners. Only 14% were assaulted by strangers. Conversely, most less serious sexual assaults such as indecent exposure and sexual threats were committed by strangers<sup>21</sup> (see figure 2.6).

**Figure 2.6:** Perpetrators of sexual assaults experienced by women since the age of 16



Source: British Crime Survey 2009/10

Alcohol is a common feature of sexual assault. Over a third of offenders and a quarter of victims of serious sexual assault are thought to have consumed alcohol prior to the incident.<sup>21</sup> Surveys suggest that there is a negative attitude towards female victims of sexual violence among a sizeable minority of the population, particularly if they have been drinking, using drugs or flirting with the perpetrator prior to the assault.<sup>28</sup>

Sexual violence can also manifest through forced marriage (see page 14), human trafficking and female genital mutilation (FGM).<sup>a</sup> <sup>25</sup> The extent of all these forms of violence is largely unknown and estimates should be treated with caution. Police research in 2009 estimated that 2,600 trafficked women were involved in off-street prostitution markets across England and Wales.<sup>29</sup> A 2007 study estimated that 66,000 women in England and Wales had FGM, and 33,000 girls were at high risk of existing or future FGM.<sup>30</sup>

<sup>a</sup>For further information on these issues see the Report from the harmful traditional practices and human trafficking subgroup: *Responding to violence against women and children - the role of the NHS*<sup>25</sup>

## Elder abuse

One in forty older patients seen by the average general practitioner or family physician will be suffering from abuse or neglect.

Older people can be vulnerable to abuse and neglect in their own homes (e.g. by family members, friends or carers) and in communal establishments such as care homes. Awareness of elder abuse has increased over the last few decades yet it remains a largely hidden form of violence.

**Elder abuse** has been defined as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, which causes harm or distress to an older person.

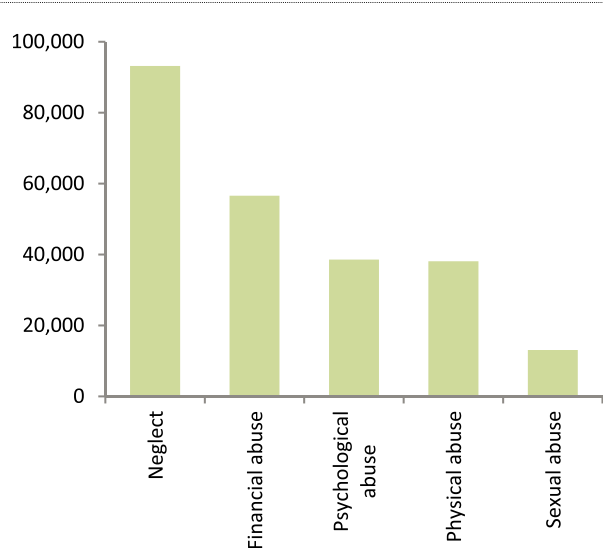
The UK National Prevalence Study of Elder Maltreatment in 2006 found that 2.6% of older people (aged over 65) living in private households had been maltreated by family members, close friends or care workers in the past year.<sup>31</sup> This was calculated to equate to 227,000 individuals, or an estimated one in forty older patients for the average GP or family physician.

The prevalence of maltreatment was highest in those aged 85 and over, at 4.1%. Overall, females were more likely to report maltreatment (3.8%) than males (1.1%). The most common form of maltreatment reported was neglect (1.1%), followed by financial abuse (0.7%), psychological abuse (0.4%), physical abuse (0.4%) and sexual abuse (0.2%) (see figure 2.7).

The estimates provided by the UK prevalence study are likely to be conservative, as it did not include some of the most vulnerable populations such as those with severe dementia or living in communal establishments. In a study of family carers of people with dementia living at home, half reported having

ever committed some form of abusive behaviour towards their dependent with a third (34%) reporting abusive behaviour in the past three months.<sup>32</sup> Verbal abuse was the most common type of abusive behaviour reported.

**Figure 2.7:** Estimated number of older people living in private households that were maltreated in the past year, UK, 2006



Source: Biggs et al, 2009<sup>31</sup>

Almost half a million older people in England receive essential home care paid for, at least in part, by local authorities. An enquiry into this home care found that whilst half of those consulted were satisfied with the care they received, there were failures elsewhere. Examples included the failure to provide adequate nutrition, regular theft of money, disregard for privacy and dignity, and the use of unnecessary physical force.<sup>33</sup>

With an ageing population, growing numbers of older individuals are requiring care and support. By 2035, it is estimated that almost a quarter (23%) of the English population will be aged 65 or over.<sup>34</sup>



## Violence against health service staff

8% of NHS staff report having experienced physical violence from patients, their relatives or other members of the public in the past 12 months.

The 2011 NHS staff survey found that 8% of NHS staff had been physically assaulted by a patient, relative or other member of the public in the past year, and that 15% had suffered harassment, bullying or abuse. Ambulance service staff were most likely to report violence, followed by those working in mental health services and acute trusts (figure 2.8). Fifteen percent of participants reported harassment, bullying or abuse (and 1% physical violence) by a manager or colleague.<sup>35</sup>

A 2009 survey of frontline NHS staff<sup>36</sup> suggested that younger staff and male staff were most likely to have experienced a physical assault, with those working in emergency departments, nursing and security roles at increased risk. Over a third of staff who had been verbally abused, and a fifth of those

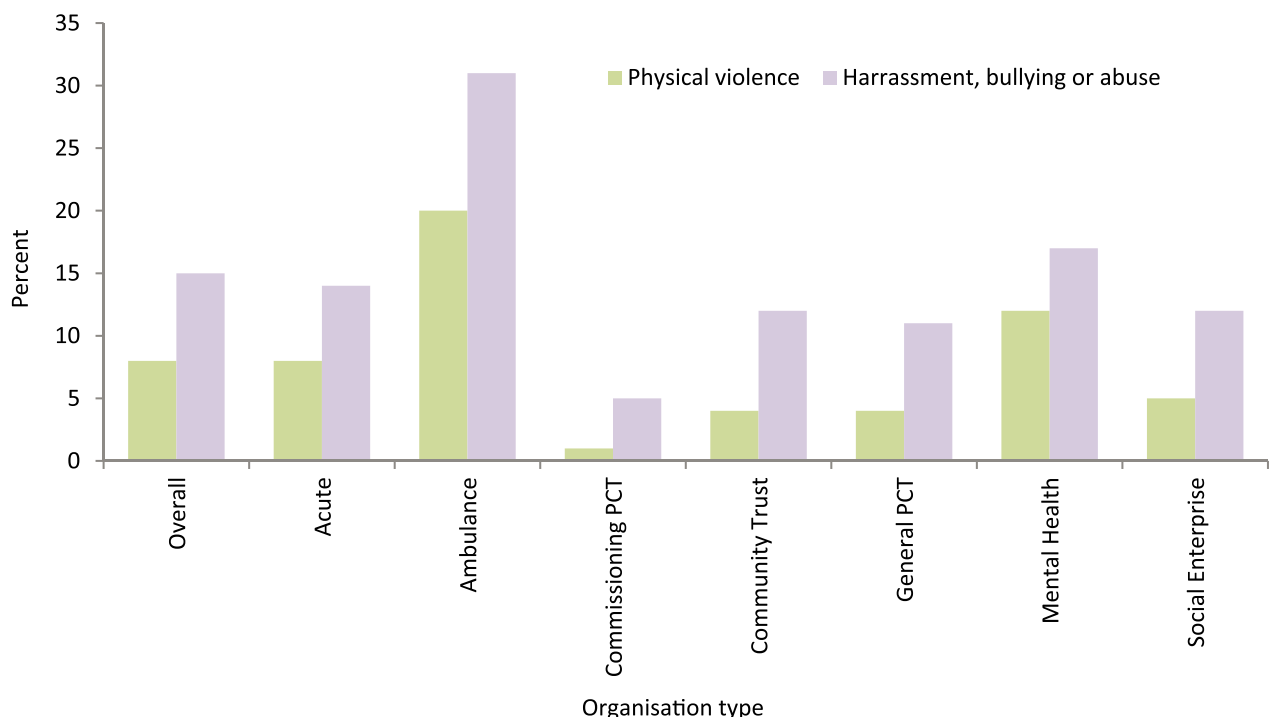
physically assaulted, did not report the abuse. Among staff who had been abused, some of the main contributory factors were thought to be:

- The patient's mental health condition;
- Individuals being under the influence of alcohol;
- Length of time waiting to be seen by a health professional; and
- Difficulties understanding information or instructions.

The Royal College of Nursing lone worker survey found that six out of ten nurses working in the community had been verbally abused in the last two years and over one in ten had been physically assaulted.<sup>37</sup>

The costs of violence against NHS staff have been estimated at £60 million per year<sup>38</sup> (see chapter 3).

**Figure 2.8:** Percentage of NHS staff reporting abuse from patients/service users, their relatives or other members of the public in the past 12 months



Source: 2011 NHS Staff Survey<sup>35</sup>

## Local violence data and health data sources

---

The availability and use of local data on violence is important in understanding how violence impacts on local populations, which groups or communities are most at risk, and consequently what types of interventions are needed where.

There are several sources of data that can be used to measure violence locally, including that from police, health services, child protection services, victim services and advocacy organisations. Datasets that are collected nationally and available at local authority level are provided through the VIPER system (see box 2.2). More detailed exploration of data can be conducted locally to identify when, where and how violence happens and the types of people it involves.

Police data are typically used to identify the timing and location of assaults to target operational activity to address violence, such as enforcement activity in pubs and clubs. These analyses are often undertaken by police and community safety partnerships. Health data, particularly ED data, can make a valuable contribution to this work (see box 2.3 and chapter 5).

Importantly, health data can also be used to identify the types of individuals suffering violence and the communities in which they live, and consequently

can inform the development and targeting of primary prevention, including early life interventions (see chapter 5). Major health data sources include:

### Hospital admissions data

---

The Hospital Episodes Statistics (HES) system routinely collects data on patients admitted to NHS hospitals. HES identifies violence as an external cause of admission. Available data include patient demographics (e.g. gender, age, ethnicity, area of residence) and certain types of violence (e.g. use of a sharp object). Hospital admissions generally represent more serious forms of violence.

### Emergency department data

---

EDs collect patient information including cause of attendance and demographics. EDs in England use a range of different computer systems to collect data and consequently the level of data available varies. However, a minimum attendance dataset is fed in to the HES system, which identifies assault as an attendance category. Due to variable data quality, statistics are currently experimental. Nevertheless, at a local level ED data can be shared with local partners to inform violence prevention.

#### **Box 2.2: VIPER: the Violence Indicator Profiles for England Resource**

VIPER is an online resource that provides access to local authority level data on violence. Hosted by the North West Public Health Observatory, key indicators provided by VIPER include:

- Police recorded violence against the person offences
- Police recorded sexual offences
- Emergency hospital admissions for violence
- Hospital admissions for unintentional and deliberate injuries in children aged 0-17 years
- Mortality from suicide and undetermined injury

For each indicator, numbers and rates are provided for each local authority in England. Rates are also displayed in comparison to regional and national averages.

VIPER can be accessed at [www.preventviolence.info/viper](http://www.preventviolence.info/viper)

ED data sharing is a key government priority as demonstrated by the Coalition Commitment on Information Sharing to tackle violence.<sup>39</sup> This is supported by the College of Emergency Medicine (CEM) guideline for the collection and sharing of enhanced data between EDs and Community Safety Partnerships to support violence prevention (see box 2.3). This approach to violence prevention is informed by work that has taken place in Cardiff.<sup>40</sup> A range of resources to support data sharing are available at [www.publicinnovation.org.uk/Data\\_Sharing.html](http://www.publicinnovation.org.uk/Data_Sharing.html), including an e-learning toolkit, case studies to demonstrate progress in England and findings from the latest national audit on progress towards delivering the Coalition Commitment.

### Ambulance data

There is currently no national system for recording ambulance data, thus its content and availability will vary, yet key data items can include call out location, patient demographics, assault type and outcome. The role of ambulance data in violence prevention has yet to be explored in detail, but already feeds into injury surveillance systems in some areas (see box 2.4).<sup>41</sup>

### Box 2.4: Local health data on violence

To support local decision-making, health data have been used to develop local violence profiles for all local/unitary authority areas in the North West. Using hospital admissions, ED attendance and ambulance call out data, the profiles identify the extent of violence, its impact on health services and at risk groups and communities. They also provide details of whether local EDs are following the CEM guidelines. In Wirral Local Authority, the profile shows that:

- Health data record around 300 hospital admissions, 1,200 ambulance call outs and 1,600 ED attendances for assault in Wirral each year.<sup>a</sup>
- Health treatment demand for violence has decreased over recent years.
- Males, those aged 18 to 35 years, and those who live in the most deprived areas are most at risk of violence leading to health treatment.

### Box 2.3: The College of Emergency Medicine guideline for information sharing to reduce community violence

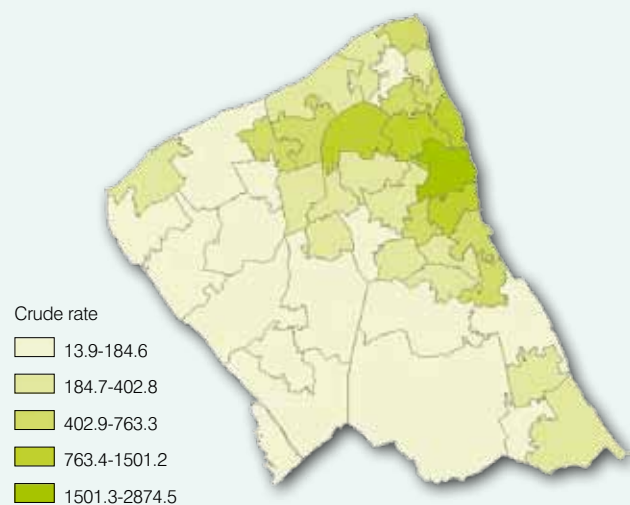
1. EDs should routinely collect, electronically wherever possible, data about assault victims at registration. Receptionists should collect the **date and time** of the assault, the **location** (name of pub, club, school, street etc) of the assault in free text and which **weapon** (fist, foot and so on) was used.
2. There is no need for a formal information sharing agreement between the ED and the Community Safety Partnership (CSP).
3. This data should be shared with the local CSP and crime analysts in an anonymous and aggregate form.
4. Senior emergency physicians should be supported to participate in CSP meetings.

The Department of Health is supporting work to promote the collection and sharing of enhanced violence data in all EDs in England.

- Wirral is fully compliant with the CEM guidance and routinely shares enhanced data on violence.

<http://nwpho.org.uk/violenceprofiles/>

### Ambulance call outs for assault per 100,000 population 2008-2010, Wirral\*



\*By middle super output area

<sup>a</sup>There were 2,822 recorded violence against the person offences in Wirral in 2010/11

# 3. The impact of violence

Violence damages physical and emotional health and can have long-lasting negative impacts across a wide range of health, social and economic outcomes. It increases individuals' risks of a broad range of health damaging behaviours – including further violence – and reduces their life prospects in terms of education, employment and social and emotional wellbeing.

The burdens of violence fall heaviest on victims and their families, but also affect those who witness violence, live in violent communities and fear violence in public space. Addressing these burdens

places significant costs on public resources, including health services, criminal justice agencies, education and social services.



## Acute impact of violence

The acute consequences of violence include physical and emotional injury, disruption to education, employment and housing, and restrictions to social behaviours. This section highlights some of this immediate impact.

### Physical injury

Violence can cause significant physical injury to victims, which in the worst cases can be fatal or leave individuals with permanent disabilities or disfigurement. In 2011/12, just under half of violence recorded by police resulted in injury<sup>7</sup> as did half of that reported by adults to the CSEW, and 69% of that reported by children.<sup>2</sup>

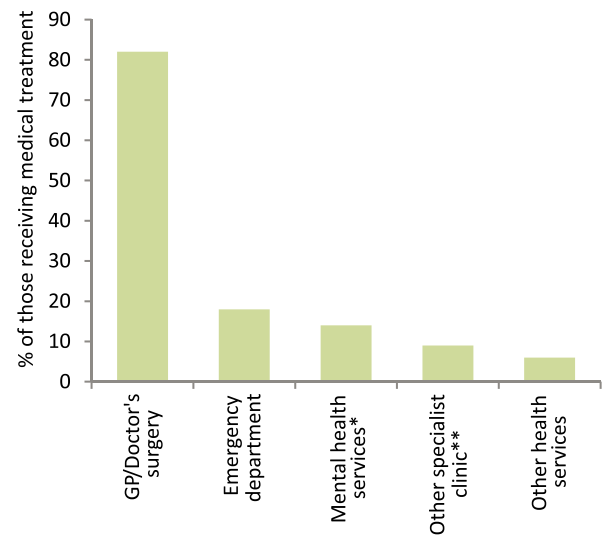
In the 2010/11 British Crime Survey (BCS), 27% of those reporting intimate partner abuse in the past year had sustained a physical injury. Minor bruising or a black eye (19%) and scratches (13%) were the most common injuries sustained. Over one in 20 victims suffered severe bruising or bleeding from cuts and 2% had internal injuries or broken bones or teeth.<sup>8</sup> Over a quarter (28%) of individuals who had suffered physical or emotional effects from intimate partner violence in the past year sought medical treatment. GP or doctors' surgeries were the most common services accessed (see figure 3.1).

The 2009/10 BCS measured the impact of serious sexual assault (since the age of 16). In addition to a variety of physical injuries reported, 4% of victims had become pregnant as a consequence of sexual assault and 3% had contracted a disease.<sup>21</sup>

### Mental and emotional impact

All forms of violence can impact on mental and emotional wellbeing. The BCS found that 39% of those reporting past year intimate partner violence, and 54% of those suffering serious sexual assault since age 16, had experienced mental or emotional issues. Other consequences

**Figure 3.1** Health services accessed by victims of intimate partner abuse



\*Specialist mental health and psychiatric services  
\*\*Including family planning and sexual health clinics

Source: British Crime Survey 2010/11<sup>8</sup>

included victims stopping trusting people, having difficulties in relationships and stopping going out so much. Around one in twenty in both groups had attempted suicide.<sup>8, 21</sup>

Self-harm and suicide can also stem from youth violence, including bullying. Children involved in bullying as either victims or perpetrators are at increased risk of self-injury and suicidal behaviour.<sup>42</sup>

Violence in the community can have negative impacts on individuals' emotional and mental wellbeing, even if they are not directly victimised themselves. For example, young people living in communities affected by gang violence and crime (e.g. muggings) may constantly fear for their safety in public places. Exposure to community violence through victimisation, witnessing or even just hearing about violence has been associated with post traumatic stress and internalising (e.g. anxiety) and externalising (e.g. aggression) problems in young people.<sup>43</sup>

## Impact on employment and education

---

Individuals who suffer physical or emotional injury through violence will often have to take time out of education or employment as a consequence. The BCS found that one in ten individuals who had experienced intimate partner abuse in the past year had needed to take time off work, and 4% had lost their job or had to give up working.<sup>22</sup>

Victims of bullying in schools and workplaces may also take prolonged periods of absence due to stress or fear, or feel forced to change schools or jobs. Further, violence in schools and workplaces can impact on victims' educational or professional performance. For example, ED nurses that have been exposed to violence at work can suffer stress and have difficulty remaining cognitively and emotionally focused<sup>44</sup> (see box 3.1).

### **Box 3.1: Impact of abuse against NHS staff**

A quarter of NHS staff that experience verbal or physical abuse from patients or the public suffer emotional or psychological distress as a consequence. One in twenty report feeling less safe in the workplace following incidents of abuse. Five percent of those experiencing physical violence, and 1% suffering verbal abuse, had to take time off work. Other impacts include having less job satisfaction, being less able to perform their role and having more negative attitudes towards patients and the public.<sup>36</sup>

## Social impact

---

Violence can affect the relationships victims have with family, friends and intimate partners. For example, individuals who are sexually assaulted may reject intimacy with a non-abusive partner, or be rejected themselves.

Fear of violence in the community can also damage social cohesion and prevent individuals from going out and participating fully in society. For example, studies have shown that many children with learning disabilities are scared to go out due to fears of being bullied.<sup>45</sup> Experience and fear of abuse also affects the lives of large numbers of adults with disabilities, for example by preventing them from using public transport, going out at night or going to places where they fear abuse may occur.<sup>46, 47</sup>

## Health behaviours

---

Violence can impact on a wide range of health behaviours, even in the short term. For example, victims of violence can suffer disruptions to eating or sleep patterns, and may turn to alcohol or other drugs as a form of self-medication or coping mechanism.<sup>48</sup> Fear of violence in the community can also limit use of parks and other public places for physical exercise. For example, concerns around safety and crime may prevent parents from taking their children to playground areas and lead them to restrict outside play.<sup>49, 50</sup>

## Homelessness

---

Victims of violence may be forced to leave their homes to escape intimate partner violence, child maltreatment, forced marriage or harassment and abuse in the community, for example. The BCS found that 42% of intimate partner violence victims that lived with their abusive partner had left home for at least one night due to the abuse.<sup>8</sup> Family conflict and violence are among the key causes of homelessness among young people.<sup>51</sup>

## Long term impact of violence

The impact of violence can be long lasting and affect individuals and communities across a broad range of physical, social and economic outcomes. This impact is particularly damaging when individuals are exposed to violence at an early age,<sup>52</sup> where it can contribute to poor health and well-being prospects across the life course.

Examples of negative outcomes associated with childhood violence include:

### Poor school achievement

Children who suffer from abuse and bullying are at risk of low academic performance, absenteeism and school drop-out, and are less likely to progress to university.<sup>53, 54</sup>

### Reduced economic prospects

Child abuse is associated with reduced levels of employment and earnings in adulthood. A study in the USA found that maltreatment in childhood reduced adults' peak earning capacity by around US\$5,000 per year.<sup>55</sup>

### Behavioural problems

Child maltreatment increases individuals' risks of behavioural problems in childhood, adolescence and early adulthood, including conduct disorder and delinquency.<sup>52, 56</sup>

### Substance abuse

Exposure to violence in childhood is associated with increased drug use and alcohol consumption, and the development of substance abuse problems (see box 3.2, figure 3.2).<sup>52, 57, 58</sup>

### Poor mental health

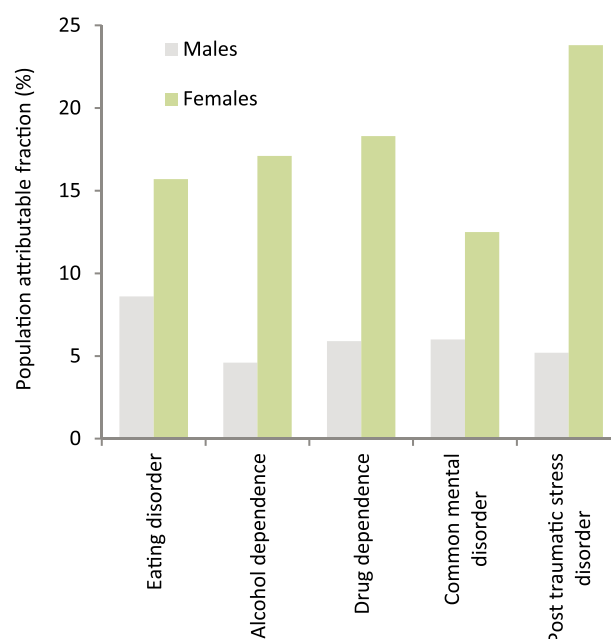
Child abuse is a major contributor to mental health conditions throughout the life course, including depression, anxiety, post traumatic stress disorder, psychosis and suicide<sup>57, 59-61</sup> (see box 3.2, figure 3.2).

### Box 3.2: child sexual abuse and mental health

A study analysing data from the 2007 Adult Psychiatric Morbidity Survey in England found strong relationships between sexual abuse in childhood and adult psychiatric disorders. For example, adults who reported contact sexual abuse before age 16 were three times more likely to have a common mental disorder than non-affected adults.

At a population level, the authors estimated that 17.4% of post traumatic stress disorders, 14.9% of eating disorders, 10.9% of common mental disorders, 9.8% of drug dependence disorders and 7.0% of alcohol dependence disorders could be attributed to childhood sexual abuse. These attributable fractions were highest in females (see figure 3.2).<sup>61</sup>

**Figure 3.2:** Contact child sexual abuse: population attributable fractions for adult psychiatric disorders



Data from the 2007 Adult Psychiatric Morbidity Survey, a random sample of the English household population aged 16 and over (n=7403). The population attributable fraction estimates the proportion of adult psychiatric disorders that are attributable to contact sexual abuse experienced before the age of 16.

Source of data: Jonas et al, 2011<sup>61</sup>

## Poor sexual health

Child abuse increases the risk of later sexual health problems. For example, child sexual abuse has been associated with greater numbers of sexual partners, sexually transmitted infections, teenage pregnancy, and involvement in the sex trade.<sup>52</sup>

## Poor physical health

Child maltreatment is associated with increased use of health services and poorer adult physical health, including disability and a wide range of chronic health conditions (see box 3.3, figure 3.3).<sup>57, 60, 62</sup>

### Box 3.3: ACEs and adult health

The Adverse Childhood Experiences (ACE) Study in the USA has provided strong evidence of the enduring effects of childhood violence on health. Seven categories of ACE were studied covering child abuse, exposure to domestic violence at home and other measures of household dysfunction (see box 4.2, chapter 4). Individuals with ACEs were found to have increased risks of a wide range of harmful behaviours and health conditions. The more ACEs individuals had, the more comorbid outcomes they suffered. Figure 3.3 shows the increased risk of a range of behaviours and conditions for adults with four or more ACEs, compared to those with none. For example, adults with four or more ACEs were around twice as likely to be severely obese, to smoke, and to suffer stress, cancer, ischaemic heart disease or stroke.<sup>57, 60</sup>

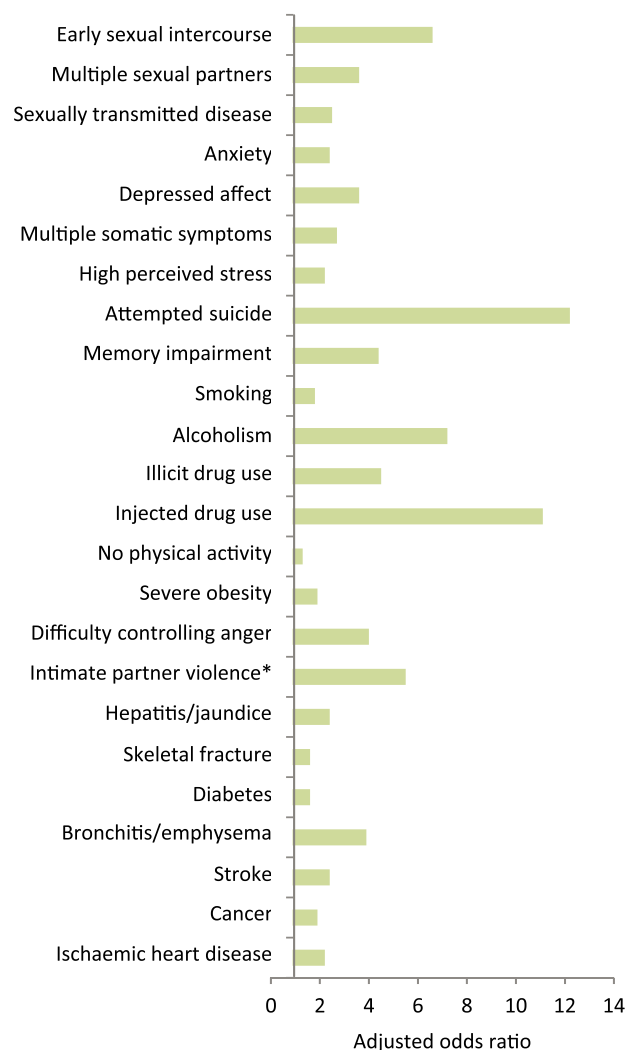
## Further violence

Exposure to violence in childhood increases individuals' risks of further victimisation and of becoming perpetrators of violence themselves in adolescence and later life. For example, children who are abused or who witness domestic violence at home are at increased risk of youth violence (see chapter 4)<sup>63</sup> and of both suffering and perpetrating intimate partner violence in adulthood.<sup>64</sup>

## Worsening inequalities

Disadvantaged groups suffer higher rates of violence (see chapter 4). This can reduce economic participation, social well-being and health outcomes for people in these groups and contribute to increasing inequalities. In males aged 17-19 years, violence accounts for 20% of the difference between the richest and poorest communities in emergency hospital admissions.<sup>4</sup>

**Figure 3.3:** The ACE Study (USA): increased risk of behaviours and health conditions amongst individuals exposed to four or more ACEs



An adjusted odds ratio (AOR) >1 shows an increased risk of those with 4+ ACEs having the outcome, compared to those with no ACEs.

\*perpetrating intimate partner violence.

Data from Felitti et al, 1998,<sup>60</sup> Anda et al, 2006<sup>57</sup>



## The economic cost of violence

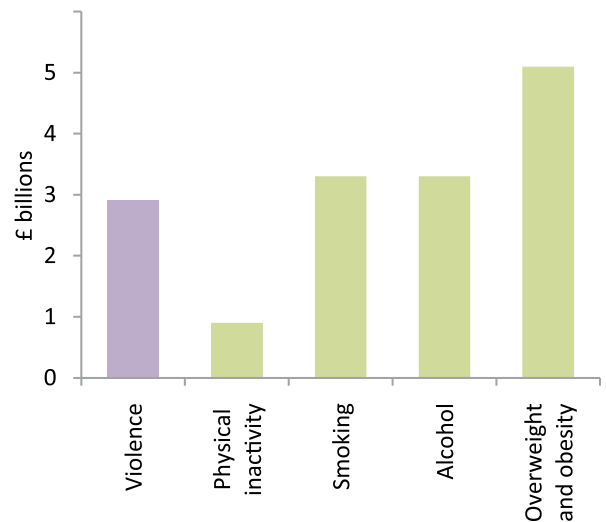
Violence and abuse impose major economic costs on victims and their families, and on public services, businesses, communities, and wider society. The costs of violence to the NHS are equivalent to those for other major public health issues including alcohol and tobacco (see figure 3.4).<sup>1</sup>

The Home Office estimated the economic and social costs of violent crime in England and Wales in 2003/04 to be £26.9 billion; accounting for three quarters of the overall costs of crime.<sup>65</sup> An independent analysis by the London School of Economics has updated these figures for 2008/09 using a revised version of the Home Office methodology<sup>65</sup> adjusted for changes in levels of violence, changes in the costs of violence and under-reporting of domestic violence.

The analysis estimated the total economic and social costs of violence in 2008/09 to be £29.9 billion. Most of these costs fell on the victims of crime, but there was also a sizeable impact on the public sector including the NHS. For example, dealing with the physical and mental health consequences of violent crime was estimated to have cost the health service around £2.9 billion. The costs of violent crime to the criminal justice system were £4.3 billion.

The overall cost of violence of £29.9 billion in 2008/09 is about 15% higher than that calculated by the Home Office for 2003/04. However all of this difference is accounted for by the inclusion of under-reported domestic violence. Between 2003/04 and 2008/09 the number of violent incidents recorded by both police and the BCS actually fell meaning that without adjusting for under-reporting, the estimated cost of violence would also have fallen. A separate study calculating the costs of domestic violence estimated these to have been around £15.7 billion in 2008, including £1.7 billion in health care costs.<sup>66</sup>

**Figure 3.4:** Annual costs of selected public health issues to the NHS\*



\*Violence costs were calculated separately from those for other conditions using a different methodology. Non-violence costs taken from Scarborough et al, 2011<sup>1</sup>

Even accounting for under-reporting of domestic violence, calculations of the overall costs of violence are likely to be conservative. Using a different methodology, a study on the costs of violence against women and girls in England and Wales estimated this at £40.1 billion in 2006/07.<sup>67</sup> The overlapping costs covered sexual violence (£25.7 billion), domestic violence (£20.1 billion), violence towards women in prostitution (£2.1 billion), violence against black and minority ethnic women (£1.6 billion) and trafficking (£1.1 billion).

Comprehensive estimates of the costs of other forms of violence, including elder abuse, child maltreatment and youth violence are generally lacking. However, it is clear from what we do know that preventing violence will generate large economic savings to health and other services, as well as improvements to public health and social and economic well-being (see chapter 5).

# 4. Risk factors for violence

There is no single reason to explain why some people or populations are vulnerable to violence. Instead, a wide range of factors relating to individuals, their relationships, and the communities and societies in which they live can interact to increase or reduce vulnerability to violence.

This section highlights some of the important factors affecting violence. Understanding which factors can make individuals vulnerable to violence can help identify at risk populations and target preventive interventions accordingly. Viewing the

ways in which these risk factors come together and influence patterns of behaviour throughout the life course provides insights into the key points at which interventions to break the cycle should be implemented.



## Understanding risk

A wide range of factors can affect individuals' risks of involvement in violence. These risk factors can be cumulative in effect, and can interact in different ways to affect vulnerability to violence. They can also be moderated by various protective factors. For example, children who grow up in neighbourhoods where there are high levels of crime and socio-economic deprivation can be at increased risk of involvement in violence. However, supportive parenting, strong social cohesion and individual factors such as high resilience can moderate this risk.

The World Health Organization uses an ecological model to show the interaction between risk factors for violence at the individual, relationship, community and societal levels. Figure 4.1 uses this model to show some key risk factors that are common to many types of violence.<sup>68</sup> Different types of violence also have specific risk factors.

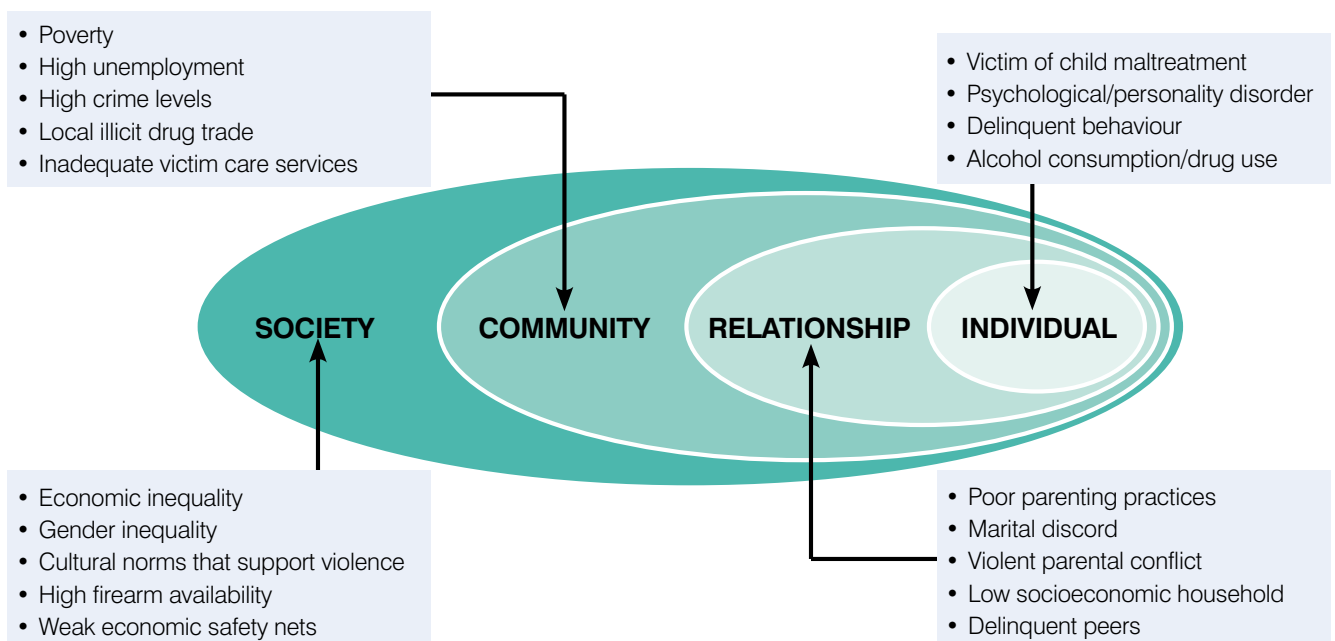
This section highlights a number of key risk factors for violence across the life course, as well as identifying specific risk factors for different violence types.

## Early life experiences

Many of the factors that affect individuals' risks of violence arise through their circumstances and experiences in early life. For example, children can be at greater risk of maltreatment if they are born to parents that are young, single, who suffer from mental health conditions or substance abuse, or that have violent relationships (see box 4.1). The links between these early life risk factors and child abuse can arise from poor bonding between parents and children and poor parenting skills and resources.

The experiences that children have early in life also impact on their risks of involvement in violence in adolescence and adulthood. Particularly during the first few years of life, children's brains are shaped by their experiences and the environments in which they grow up. Exposure to abuse or severe neglect can cause the brain to develop with a focus on short term survival, at the cost of longer term well being.<sup>69</sup> Abuse and neglect in childhood can contribute to children having lower self-esteem, poorer social skills, poorer mental wellbeing and to consider violence as a normal way of resolving conflict.

**Figure 4.1:** Some cross-cutting risk factors for violence



Adapted from World Health Organization, 2004

#### **Box 4.1: Examples of risk factors for child abuse**

- Unplanned pregnancy
- Single parent household
- Young, poor parents
- Socially isolated parents
- Parental alcohol consumption and drug use
- Domestic violence in the home
- Child disability or illness
- Child behavioural problems

A wide range of studies have shown that children who suffer violence and other adverse childhood experiences are at increased risk of further victimisation and of becoming perpetrators of violence in later life (see box 4.2). For example, adult sex offenders are more likely than non-sex offenders and non-offenders to have suffered childhood sexual abuse.<sup>70, 71</sup> While most victims of childhood sexual abuse do not become abusers, a UK study found that around one in ten former male victims of child sexual abuse had committed a sexual offence themselves by their early twenties, mostly against children.<sup>72</sup>

#### **Box 4.2: Adverse childhood experiences**

Children who suffer adverse experiences as they grow up are at increased risk of violence later in life (as well as other health harms, see chapter 3, box 3.3). The Adverse Childhood Experiences (ACE) study in the USA has shown that individuals who have been abused or who lived in dysfunctional households in childhood (e.g. with domestic violence, family breakdown or substance use) have higher levels of violence as adults.<sup>57, 64</sup> A study of adolescents found that those who had suffered ACEs were more likely to perpetrate bullying, fighting and dating violence, to carry weapons and to have self-harmed and attempted suicide than those who had not.<sup>63</sup> Risks of all forms of violence increased with the number of ACEs suffered.

The impact of ACEs on health is currently being examined through at least one study in England. To promote research and enable consistent measurement of associations between ACEs and risk behaviours the World Health Organization has developed an international ACE questionnaire.<sup>76</sup> ACEs covered include:

- Emotional, physical or sexual abuse
- Emotional or physical neglect
- Violence against household members
- Living with household members who were substance abusers, mentally ill, suicidal or imprisoned
- Having one or no parents, or experiencing parental separation or divorce
- Bullying, or exposure to community or collective violence

Experiencing childhood abuse also increases individuals' risks of developing health damaging behaviours such as substance use, eating disorders and unsafe sexual behaviour, and of poor physical and mental health outcomes (see chapter 3, box 3.3).

#### **Peer relationships and gangs**

The relationships that young people form with peers can impact on their risks of violence. Having delinquent friends increases a person's risk of involvement in violence<sup>73</sup> as well as other anti-social behaviour, while disengagement from delinquent peer groups can reduce violent behaviour.<sup>74</sup>

There are two types of delinquent youths: early onset delinquents, who have conduct disorders (see page 32) from early childhood and whose aggressive and antisocial behaviour can persist into adulthood; and a larger group of late onset delinquents who adopt delinquent behaviour in adolescence but generally grow out of this as they become young adults.<sup>75</sup> Early onset delinquents may seek out delinquent peers who have similar behaviours to themselves, while late onset delinquents may develop anti-social behaviour as teenagers by mimicking the behaviour of their peers.

Gang membership is particularly associated with violence, including robbery, assault, rape and weapon use. Preventing gang violence is a key government priority (see chapter 6). Violence can be used by gangs, for example, to generate and maintain respect, defend territory, obtain resources and punish transgressions.<sup>77</sup> Gangs tend to be concentrated in areas of high deprivation and attract disadvantaged and excluded youths, many of whom experience problems at home and school.

**Box 4.3: Examples of risk factors for youth violence**

- Male gender
- Neglect and abuse in childhood
- Personality traits e.g. hyperactivity/conduct disorder
- Poor family functioning
- Domestic violence in the home
- Delinquent peers and gang involvement
- Living in a high crime area
- Alcohol consumption
- Social inequality

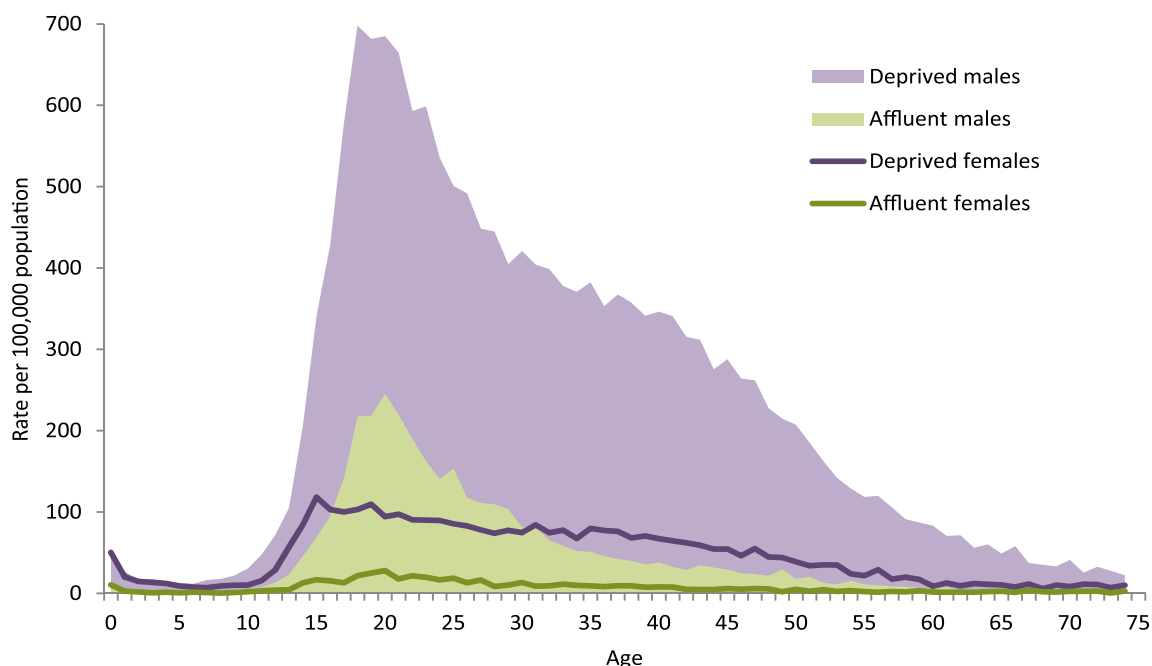
These young people may value the bonds brought by gang membership, see few opportunities for succeeding in life and view violence and crime as the only options for achieving status, resources and wealth.

**Deprivation and social inequality**

There are strong relationships between deprivation and violence, which are likely to reflect a clustering of risk factors for violence in poorer areas such as low education, unemployment, teenage parenting, single parent families, higher crime rates and substance use.

Across England, emergency hospital admission rates for violence are around five times higher in the most deprived communities than the most affluent.<sup>4</sup> While violence in all deprivation groups peaks in late adolescence and young adulthood, the ratio of violence from richest to poorest is greatest in childhood and mid-adulthood (when adults are often parenting; see figure 4.2). In women from the most deprived communities, violence peaks at around age 15 and only reduces slowly through adulthood. In fact, up to adolescence and after the age of around 30, females from the most deprived quintiles have higher rates of hospital admissions due to violence

**Figure 4.2:** Annual rates of emergency hospital admissions for violence across England, by age, sex and deprivation\*



\*Most and least deprived quintiles, based on IMD

Source: Bellis et al, 2011<sup>4</sup>

than males from the most affluent communities. At least in part this will reflect intimate partner abuse occurring throughout both adolescence and adulthood (see box 4.4).

Importantly, studies have shown that inequality is more important in predicting violence than poverty itself. This is thought to be linked to factors such as poor social trust and relationships in unequal societies.<sup>78</sup>

#### **Box 4.4: Examples of risk factors for intimate partner and sexual violence**

- Female gender
- Younger age
- Lower household income
- Being single, co-habiting, separated or divorced
- Living in areas of high physical disorder
- Alcohol consumption (perpetrators and victims)
- Controlling and jealous partner
- Childhood abuse (perpetrators and victims)
- Gender inequality
- Cultural norms tolerant of violence

### **Alcohol and drugs**

Alcohol consumption is a risk factor for many types of violence, including child abuse, youth violence, intimate partner violence, sexual violence and elder abuse. Around half of all violence in England and Wales is thought to be committed by individuals who are under the influence of alcohol (44% in 2010/11<sup>17</sup>), while a fifth of all violent incidents occur in or around drinking premises.<sup>17</sup>

Individuals who start drinking at an earlier age, who drink frequently and who drink in greater quantities are at increased risk of involvement in violence as both victims and perpetrators.<sup>79</sup> Importantly, alcohol has a dose responsive relationship with violence, with the acute risks of violence increasing with the amount of alcohol consumed.<sup>80</sup> Violence that occurs under the influence of alcohol can also result in more serious injury.<sup>81, 82</sup>

Alcohol and violence can be linked in many ways, including:

- Alcohol consumption can affect physical and cognitive functioning, reducing self-control, the ability to process information and the ability to recognise warning signs for violence;
- Beliefs that alcohol causes aggression can lead to the use of alcohol as preparation for violence, or to excuse violent acts;
- Dependence on alcohol can mean individuals neglect care responsibilities;
- Poorly managed pubs, bars and nightclubs (e.g. crowding, poor staff practice, poor cleanliness, cheap drinks) can create environments where violence is more likely;
- Alcohol can be used as a coping mechanism by victims of violence;
- Alcohol and violence can be linked through shared risk factors that make people vulnerable to both behaviours.

The availability and accessibility of alcohol within society contributes to levels of violence. For example, communities that have a greater density of alcohol outlets typically see higher levels of violence (see chapter 5).<sup>83, 84</sup>

Illicit drugs are also strongly linked to violence. In around a fifth of all cases of violence in England and Wales, victims perceive the perpetrator to have been under the influence of drugs.<sup>17</sup> Drug use can increase individuals' risks of both perpetrating and being a victim of violence, while victims of violence can be at increased risk of drug use.<sup>85</sup> Different drugs have different effects. Some, such as cocaine and other stimulants, can be associated with increased aggression while others may increase risks of victimisation, for example with sedative effects putting people at risk of sexual assault.

The links between drugs and violence can be similar to those for alcohol, for example through drug use

altering cognitive functioning and affecting care giving practices, and shared risk factors making individuals vulnerable to both violence and drug use. However, violence is also an inherent part of illicit drug markets, which lack legal means of resolving business conflicts. For example, violence can be used in the drug trade to enforce the payment of debts, resolve competition between dealers and punish informants.<sup>86</sup>

### Cultural and social norms

---

Rules and expectations of behaviour in specific cultural or social groups can support violence and maintain harmful traditional practices such as forced marriage (see page 14), female genital mutilation (see page 15) and honour-based violence (box 4.5).

There are many different cultural and social norms that can contribute to violence.<sup>87</sup> For instance, traditional beliefs that men have a right to control or discipline women through physical means make women vulnerable to violence by intimate partners and place girls at risk of sexual abuse. Cultural acceptance of violence as a private affair hinders outside intervention and prevents victims from gaining support, while in many cultures victims of violence feel stigmatised, stopping incidents from being reported. Cultural intolerance, dislike, and stereotyping of 'different' groups within society (e.g. based on nationality, ethnicity, sexual orientation) can also contribute to violent or aggressive behaviour towards such groups.

Cultural and social norms persist within society because of individuals' preferences to conform, given the expectation that others will also conform. A variety of pressures can maintain harmful norms with, for example, individuals experiencing both the threat of social disapproval or punishment for norm violations, and guilt and shame where norms of proper conduct have been internalised. Cultural and social norms do not necessarily reflect an individual's attitudes or beliefs, although they may well influence them.

### Box 4.5: Honour-based violence

Honour-based violence is a term used to refer to any type of violence committed in the name of 'honour'.<sup>25</sup> In the UK, it predominantly occurs in communities where concepts of honour and shame are bound up in behavioural expectations, and perceived damage to honour can impact on a family or group's social standing and acceptance.<sup>88, 89</sup> Victims are mostly women who are thought to have brought shame on their family or community by contravening, or being perceived to have contravened, traditional cultural and social norms. Examples can include defying parental authority, adopting 'western' clothing, behaviours or attitudes, and having relationships or sex before marriage. Victims can be ostracised from their family and community, and suffer violence ranging from psychological abuse to, in extreme cases, murder.<sup>89</sup>

The Department of Health has published a report discussing the role of the NHS in responding to honour-based violence and other harmful traditional practices<sup>25</sup>

### Disability

---

Factors such as exclusion from education and employment, stigma and discrimination, a need for personal assistance with daily living, reduced physical or emotional defences and communication barriers can make disabled individuals vulnerable to violence. This can include, for example, abuse and neglect in homes and community care settings, bullying in schools and hate crime in communities. Systematic reviews have shown that both disabled children and adults are at increased risk of violence, and have suggested that those with mental health or intellectual impairments can be particularly vulnerable (see box 4.6).<sup>90, 91</sup>

#### **Box 4.6: Violence and disability**

Disabled children are around three times more likely to experience physical and sexual violence than their non-disabled peers, and over four times more likely to suffer emotional abuse and neglect.<sup>91</sup> Disabled adults also have increased risks of violence, and particularly those with mental illnesses. One in four adults with mental illness report having experienced violence in the past year.<sup>90</sup> The prevalence and risk of violence against individuals with other impairment types is still largely unknown due to a lack of high quality research.

The UK has an ageing population<sup>34</sup> and growing numbers of older people are requiring care and support. Worsening health and increasing dependence on others to carry out daily living activities can increase older people's risk of elder maltreatment (see box 4.7 for other risk factors for elder maltreatment). Older people with cognitive impairment such as Alzheimer's disease and other forms of dementia can be at particular risk. For example, a study of family carers of people with dementia in Essex and London found that over half of carers reported having undertaken some form of abusive behaviour towards those they care for, most commonly verbal abuse.<sup>32</sup>

#### **Box 4.7: Examples of risk factors for elder abuse**

- High levels of dependence
- Mental and cognitive disorders
- Carer alcohol consumption and drug use
- Carer financial problems
- Carer burnout
- Social isolation
- Lack of social support
- Age discrimination

Violence can be a major cause of disability and can exacerbate the impact of disability.<sup>92</sup> For example, studies from the US have shown that disabled women who experience violence have poorer health<sup>93</sup> and higher levels of unemployment<sup>94</sup> than non-abused disabled adults.

#### **Adult psychiatric disorders, childhood conduct disorder and violence**

As well as being vulnerable to victimisation, research shows that adults with psychiatric disorders can be at increased risk of perpetrating violence.<sup>95</sup> Personality disorders in particular are associated with violence<sup>96</sup> and are highly prevalent among violent offenders. An English study of incarcerated serious violent offenders found 62% had antisocial personality disorder.<sup>97</sup>

The risks of violence in individuals with psychiatric conditions can be moderated by other factors, including childhood conduct disorder. In England, for example, a study of individuals with severe mental illness found that those with childhood conduct disorders were at increased risk of aggression and perpetrating violence, compared to those without a history of childhood conduct disorder.<sup>98</sup>

Childhood conduct disorder can thus be a marker for persistent antisocial behaviour and aggression in adolescence,<sup>75</sup> developing into personality disorder and violent offending in adulthood. The strong associations between childhood conduct disorders, adult psychiatric disorders and violent behaviour reinforce the importance of identifying and addressing conduct disorders in children (see chapter 5).<sup>99</sup>



# 5. Preventing violence

Violence and abuse can be prevented. There are a wide range of strategies that can be used to address risk factors for violence and promote protective factors across the life course. Some can be implemented universally and others are targeted specifically towards at risk groups. This chapter summarises evidence on the effectiveness of violence prevention interventions, focusing particularly on primary prevention approaches and the role of health services.

The cyclical nature of violence means that primary prevention approaches that prevent people from becoming victims or developing violent tendencies can protect them from violence throughout life. A comprehensive violence prevention strategy

must integrate the types of interventions outlined in this document with criminal justice policies and strategies directed at macro-level social factors such as access to education, employment opportunities and income equality.



## Supporting parents and families

---

Interventions that develop parenting skills, support families and strengthen relationships between parents, carers and children can have long lasting violence prevention benefits. They can prevent child abuse and improve child behaviour, reducing children's risks of involvement in violence in later life. They can also be cost-effective.

### Home visiting programmes

---

Home visiting programmes provide intensive early years support for vulnerable parents whose children are at risk of poor outcomes. Visits are conducted by public health nurses or other health professionals and typically start during pregnancy. They promote healthy child development by improving parenting skills and helping parents to find jobs or pursue other opportunities to improve the family's circumstances. There is strong evidence that these programmes can promote positive outcomes including better parenting practices and maternal mental health, reduced child maltreatment and fewer child behaviour problems.

One of the most widely used and researched home visiting programmes is the Nurse Family Partnership (NFP). Developed in the USA, NFP provides prenatal health advice and support, child development education, and life coaching for vulnerable first time mothers. Visits start early in pregnancy and continue through to the child's second birthday. NFP has been found to reduce child maltreatment, criminal behaviour and welfare service use by mothers,<sup>100</sup> as well as serious criminal behaviour by children (particularly girls) in adolescence.<sup>101, 102</sup> The programme has been found to generate a saving of US\$2.88 for every US\$1 invested. Savings are greatest when NFP is targeted at high risk groups.<sup>103, 104</sup>

The NFP model is being implemented in England through the Family Nurse Partnership programme (see box 5.1).

### Box 5.1: Family Nurse Partnership

The Family Nurse Partnership (FNP) programme is implementing the NFP model in a growing number of sites across England. Each site has up to eight family nurses who provide intensive home visiting for vulnerable young first time mothers. FNP is often delivered through Sure Start Children's Centres (see box 5.2), with family nurses working closely with other health visitors, midwives and professionals from other agencies where needs are identified. The government has committed to double provision of FNP across England by 2015, and a randomised controlled trial of the programme is underway.<sup>105</sup> The Department of Health is leading this work, and is also working to expand the provision of health visiting services across England.<sup>106</sup>

Another example of the impact of home visiting on violence comes from the Early Start programme in New Zealand. Early Start is delivered by family support workers with nursing or social work backgrounds, who assess vulnerable families' needs and work with them to resolve problems, providing support and mentoring through the child's preschool years. It has been associated with reduced child abuse (measured by parental-reported physical assault), lower hospital attendance for childhood injury and fewer child behaviour problems.<sup>107</sup>

## Parenting programmes

Parenting programmes aim to develop parental skills, improve parenting styles and strengthen relationships between parents and their children. Programmes can be delivered to all parents but are often targeted at high risk families and children with conduct disorders, where they can have the greatest benefits. There is good evidence that parenting programmes can improve both parenting practices and child behaviour.

One of the best known parenting programmes is Triple P (Positive Parenting Programme), which aims to prevent child problems by strengthening the skills, knowledge and confidence of parents. Developed in Australia, Triple P offers different levels of support ranging from media-based information to one-on-one sessions and parenting seminars, with intensive modules for at-risk families. It has shown benefits in reducing child abuse and child behavioural and emotional problems.<sup>108-110</sup> Triple P is often delivered by health professionals and can be provided in a range of settings, including health centres, schools and community centres.

Another widely used parenting programme is Incredible Years, which provides parents and teachers with strategies to manage child aggression and skills to help children control their emotions and strengthen their social skills. When delivered through Sure Start in Wales to parents of children at risk of conduct disorder, Incredible Years was found to reduce problem behaviours in children, reduce parental stress and depression, and be cost effective.<sup>111, 112</sup>

Triple P, Incredible Years and other evidence-based parenting programmes are used across England and have shown positive impacts on parenting and child behaviour, with Triple P found to have the most benefits in reducing child conduct problems.<sup>113</sup> Specifically, parenting interventions are an effective treatment for child conduct disorder.<sup>114</sup> An

economic analysis of parenting interventions for five year old children with conduct disorders in England estimated they could generate savings of £9,288 per child over 25 years - eight times more than the intervention cost. Of these savings, £1,278 per child would be accrued by the NHS (see Table 5.1).<sup>115</sup>

**Table 5.1: Gross savings from parenting interventions at age 5, per child with conduct disorder (2008/09 prices)**

	SAVINGS BY AGE (£s)			TOTAL PER CHILD
	6	7-16	17+	
NHS	168	912	197	1278
Social services	24	29	14	67
Education	132	304	0	437
Criminal justice	0	1247	340	1588
Voluntary sector	3	6	5	15
Victim costs (crime)	0	3361	810	4171
Lost output (crime)	0	995	232	1227
Other crime costs	0	377	129	506
<b>Total</b>	<b>£328</b>	<b>£7233</b>	<b>£1727</b>	<b>£9288</b>

Adapted from Knapp et al, 2011<sup>115</sup>

Some parenting programmes are specifically designed to be delivered in health settings. For example, the SEEK (Safe Environment for Every Kid) programme in the USA has trained health care providers to identify and address risk factors for child maltreatment in parents, including substance use, depression, stress and intimate partner violence. The training is combined with on-site social worker services to provide support to at-risk families and referrals to other agencies. SEEK has been associated with reduced child maltreatment, measured through involvement in child protective services, medical problems relating to possible neglect and self-reported child assault by parents.<sup>116</sup>

Health professionals also have a key role in identifying and addressing risk factors for violence. For example, health visitors can be trained to effectively identify and reduce post natal depression through brief psychological interventions.<sup>117</sup>

## Developing life skills in children and young people

---

Programmes that develop life and social skills in young people can help protect them from violence by building their social and emotional competencies, teaching conflict-avoidance skills and providing broader skills to help them find employment and avoid poverty and crime. They can prevent violence and other health risk behaviours among young people, particularly when targeted towards at-risk children early in life.

### Preschool programmes

---

Preschool programmes develop young children's physical, social, emotional and cognitive skills before they enter formal education. Programmes can be universal, but are often targeted at children from disadvantaged communities. Preschool programmes are widely used in England through initiatives including Sure Start (box 5.2), which offers child and family support in dedicated children's centres.

Most evidence on the violence prevention impact of preschool programmes comes from the USA. For example, the High/Scope Perry preschool programme has been subjected to a long-term evaluation that has followed participants up to the age of 40, and has shown benefits in reducing violent crime. The programme serves children up to age four in deprived areas, working to develop skills including decision making, language, problem solving and empathy. It also provides parent training and home visits. The High Scope/Perry programme has been estimated to have generated US\$17 in savings for every US\$1 invested.<sup>118</sup>

Another preschool programme with long-term evidence of effectiveness is the Chicago Child-Parent Center (CPC). This serves children in deprived areas and provides preschool enrichment, parent training, outreach services and ongoing family-support when children enter school. CPC has been associated with reduced child abuse and less violent offending in participating children by early adulthood.<sup>119-121</sup> By age 21, the programme was estimated to have saved over US\$7 per US\$1 invested.<sup>122</sup>

### Box 5.2: Sure Start Children's Centres

Sure Start Children's Centres provide preschool children (up to age five) and their families with child education, childcare services, support for parents, family health services and employment support. Broader Sure Start services cover children through adolescence. Some services are available universally, while others are targeted at disadvantaged families. An evaluation found that three year old children from deprived Sure Start areas had more positive social development and social behaviour than children from equivalent non-Sure Start areas, while their parents had less risk of negative parenting.<sup>123</sup>

### Social development programmes

---

Social development programmes develop children's social skills to help them form positive relationships. They typically cover skills such as problem solving, conflict resolution, empathy, anger management, and assertiveness. They can be delivered universally but are sometimes targeted at high-risk groups. These are usually, but not always, school-based interventions.

PATHS (Promoting Alternative Thinking Strategies) is a widely-used social and emotional development programme for primary school children that focuses on self-control, emotional understanding, positive self-esteem, relationships and problem solving skills. In the USA, it has been associated with reduced aggression, hyperactivity and disruptive

behaviour in participating children.<sup>124</sup> Positive outcomes have also been reported when PATHS has been delivered to UK school children.<sup>125</sup>

Another evaluated social development programme is Second Step. This includes a series of lessons covering three core areas of empathy training, impulse control and anger management. It has shown benefits in improving problem behaviour and social competence in children when implemented in both the USA and Europe.<sup>126, 127</sup>

The Seattle Social Development Project in the USA has combined social development with teacher training and parent education. It has shown benefits in reducing violence, substance use and risky sexual behaviour in adolescence,<sup>128</sup> with educational, economic and mental and sexual health benefits that are sustained into adulthood.<sup>129</sup> Economic evaluation of the project estimated it saved US\$3.14 for every US\$1 invested.<sup>103</sup>

In England, an economic analysis of school-based social and emotional learning programmes to prevent conduct problems found these could generate substantial savings to the public sector, including savings to the NHS after four years. After ten years, cost savings were estimated at £10,000 per child, with £1,000 accrued by the NHS.<sup>115</sup>

In older children and young adults, life skills programmes can focus on healthy relationships and gender norms with the aim of preventing sexual and intimate partner violence. Evidence for their effectiveness is mixed but some positive results have been seen. For example, the Safe Dates programme in the USA targets 12-18 year olds and aims to develop relationship skills (e.g. conflict resolution), address social norms (e.g. dating violence, gender stereotypes) and raise awareness of support services for those affected by violence.

It has been found to reduce perpetration of sexual, physical and psychological violence against dating partners, with some benefits also seen in reducing victimisation.<sup>130</sup>

---

### Academic enrichment programmes

---

Academic enrichment programmes provide study support and recreational activities for children outside school hours. When targeted specifically at high risk children in the USA, programmes have shown mixed and even negative effects.<sup>131</sup> However, evaluation of broader programmes in the UK have suggested they can help reduce risk factors for violence, particularly when delivered in disadvantaged areas.<sup>132, 133</sup>

---

### Bullying prevention programmes

---

All schools in England are required to implement measures to prevent bullying. One of the most widely researched bullying prevention programmes is the Olweus programme, developed in Norway. This uses a whole-school approach which includes: implementation of clear school rules and management structures for bullying; training for staff; a classroom curriculum for students; awareness-raising for parents; improvements to the physical school environment; and the use of evaluation tools. The programme has shown benefits in reducing child reports of both perpetrating and being a victim of bullying.<sup>134</sup>

Many schools in England have signed up to UNICEF UK's Rights Respecting Schools Award, which helps schools use the United Nations Convention on the Rights of the Child as a framework for its values. A qualitative evaluation of the Award suggested it may reduce bullying, along with providing other benefits to both schools and pupils.<sup>135</sup>

## Working with high risk youth and gangs

---

Delinquent behaviour, criminal activity and gang membership in youth are key risk factors for involvement in violence. Interventions that work with high risk youth to change their behaviour can be important in preventing future violence.

### Talking therapies

---

Talking therapy is an umbrella term used for a range of approaches that address emotional and behavioural problems through conversation with a therapist. Components vary, but can include problem solving strategies, skills training, behavioural analysis and modification of dysfunctional beliefs. In Canada, cognitive behavioural therapy delivered to 6-11 year olds with conduct problems has been associated with reductions in aggression and delinquency, particularly in girls and older children.<sup>136</sup>

### Family therapies

---

Family therapies aim to address family problems, increase communication and interaction, and improve family conflict resolution. They can reduce anger, bullying and delinquency in young people.<sup>137, 138</sup>

Multisystemic Therapy (MST) is an intensive community intervention for high risk 11-17 year olds and their families that aims to prevent out of home placements and re-offending. Therapists use approaches such as cognitive behavioural therapy, and work with families to improve parenting skills, strengthen family cohesion, increase young people's engagement with education and training and tackle underlying health problems in the family. A study in the USA found that young offenders who had received MST in adolescence had lower arrest and recidivism rates over 20 years later, compared with those who had received individual therapy.<sup>139</sup> A randomised controlled trial of MST compared to usual services delivered by youth offending

teams in London found that while both measures reduced non-violent offending and anti-social behaviour, larger improvements were seen in MST youth. While violent offending also reduced significantly in both groups, there were no differences between groups.<sup>140</sup> However, some benefits were seen for MST in reducing parental reports of youth aggression.

### Family interventions

---

In England, the family intervention approach works intensively with families with multiple and complex needs, most of which are referred through young people's and youth offending services. A dedicated key worker engages with the whole family to identify and address their needs, with the aim of strengthening the functioning of the family as a unit and within the community. Monitoring of family intervention programmes in England suggests that domestic violence and child protection issues are common features in families engaged in the programmes, both being identified in around a third of families. Upon exiting the programme, around two thirds of families with domestic violence and half with child protection issues were reported to no longer have these problems.<sup>141</sup>

### Gang-focused strategies

---

Youth gangs can be associated with high levels of violence. Strategies that address gang-violence, encourage gang members to change their behaviours and prevent young people from joining gangs can be important in preventing violence.

Research on effective approaches to preventing gang involvement is currently limited.<sup>142</sup> However, in the USA multi-agency strategies that have targeted police enforcement activity at high risk gang members and provided these individuals with social support and opportunities for education, training, employment and health services (e.g. substance use services) have reduced violence, including homicides.<sup>143</sup>

---

### Mentoring programmes

Mentoring programmes partner at-risk youth with an older peer or adult who can provide emotional, social and academic support. The evidence for their effectiveness on violence is limited, but some programmes have shown positive results. For example, an evaluation of a school-based mentoring programme in the USA focusing on self-esteem, relationship building, goal setting and academic enrichment reported positive effects on bullying, physical fighting and depression.<sup>144</sup>

---

### Hospital based programmes

Hospital settings can provide opportunities for accessing and intervening with high risk youths injured through violence. This can include providing mentoring, brief interventions, counselling services, and individual or family assessment and referral to services. Although more evidence on the effectiveness of such programmes is needed, positive results have been reported.<sup>145</sup> For example, a programme in the USA provided mentoring for 10-15 year old youths attending ED with assault injuries, combined with parent home visits. This was found to have benefits in reducing aggression and delinquency.<sup>146</sup> Also in the USA, a study delivering screening and brief intervention among youth attending EDs found this reduced peer violence and alcohol consumption.<sup>147</sup>

The South East London Violence Prevention Model is piloting an ED-based programme to address violence through data sharing, capacity building and focused activity with high risk youth. The Model incorporates a youth service, provided by specialist staff, through which vulnerable young people presenting at the ED are identified, assessed and referred to appropriate support services such as one-on-one mentoring and peer group support. The Youth Service also provides training for ED staff in youth risk assessment and referral, and works with other agencies to promote an evidence-based approach to violence prevention.<sup>148</sup>

---

### Community-based interventions

Community-based interventions can seek to engage young people at risk of violence or gang involvement in activities that promote positive lifestyles and enhance wellbeing. For example, the charity MAC-UK ([www.mac-uk.org](http://www.mac-uk.org)) has collaborated with young people involved in gangs in London to develop the Integrate<sup>®</sup> model, which aims to address mental health problems and the social inequalities which contribute to them. Through Integrate<sup>®</sup>, a multi-disciplinary team involving psychologists, youth workers and social workers engage with groups of antisocial young people, providing one-on-one 'street therapy' in the community; supporting the young people to lead activities such as music, sports, theatre and cookery; and helping them access education, training and employment. An initial ethnographic evaluation of the scheme has suggested that it can engage hard-to-reach, vulnerable young people and promote positive psychological changes.<sup>149</sup>

## Reducing the availability and harmful use of alcohol

---

The consumption of alcohol is strongly associated with violence. Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have important violence prevention impacts.

### Reducing the density of alcohol outlets

---

Greater density of alcohol outlets is associated with higher levels of violence and alcohol consumption.<sup>83,84,150</sup> In Australia, for example, studies have shown that changes in both on- and off-licensed alcohol outlets affect violence. Increases in on-licensed premise density can impact particularly on assaults in inner-city areas (where bars and nightclubs tend to be concentrated), while increases in off-licensed premises can impact particularly on violence in suburban areas, including domestic violence.<sup>84</sup>

Few studies have measured the impact of reduced outlet density on violence, largely due to alcohol outlet densities not having reduced in countries where studies have been undertaken. However, the limited evidence available suggests that this would reduce violence.<sup>151-153</sup>

An evidence review on behalf of the National Institute for Health and Clinical Excellence (NICE) concluded that reducing the number of outlets in a given area would be an effective way of reducing alcohol-related harm.<sup>154, 155</sup>

### Controlling alcohol sales times

---

Studies examining the impact of changes in alcohol sales times show mixed results, but generally find that increased alcohol sales hours lead to increased alcohol consumption and related harm, including violence.<sup>155, 156</sup> In England, studies examining the impact of the Licensing Act 2003 have found no evidence that violence increased

following the introduction of extended licensing hours<sup>157, 158</sup> (possibly due to strong nightlife policing<sup>159</sup>) although the timing of violence was seen to have shifted further forward into the early hours of the morning. In Australia, however, a study in Perth examining the impact of extended bar opening hours (permitted to remain open until 1am rather than midnight) found that violence in and around bars that extended their opening hours increased.<sup>160</sup>

In Newcastle, Australia, pub closing times in a central nightlife area were restricted in 2008\* following complaints about violence and disorder. This was associated with a relative reduction of 37% in recorded night-time assaults (10pm to 6am; measured over 18 months post-intervention).<sup>161</sup>

### Controlling the price of alcohol

---

Increasing the price of alcohol can reduce both alcohol consumption and violence.<sup>152, 162-165</sup> The University of Sheffield has estimated the preventive impact of a range of alcohol pricing strategies including minimum unit prices for alcohol.<sup>166</sup> The government has committed to introducing a minimum price for the sale of a unit of alcohol (8gms).<sup>167</sup> At 50p per unit, this could lead to around 10,000 fewer violent crimes a year.<sup>166</sup> At higher levels, reductions in violence could be even greater.

In Canada, minimum alcohol prices have been used at the state level for several years. In British Columbia, a study estimated that a 10% increase in the minimum price of alcoholic drinks reduced their consumption by 3.4%.<sup>168</sup>

\*Hours were reduced from 5am to 3am, with a 'lock-in' preventing entry after 1am. A legal challenge changed hours to 3.30am closing (1.30am lock-in) after the first four months.



### **Box 5.3: Controlling access to alcohol**

Local agencies have a range of powers to control access to alcohol through the Licensing Act 2003 and related legislation. For example, through the Police Reform and Social Responsibility Act 2011, Early Morning Restriction Orders will allow local authorities to restrict late night alcohol sales in areas where they are causing problems. Local health bodies are responsible authorities under the Licensing Act 2003, meaning they are automatically notified when a license application or review is instigated. The Alcohol Strategy (2012) committed to consult on introducing a health-related licensing objective specifically related to cumulative impact. This would allow health to be considered in relation to cumulative impact policies (that enable local authorities to limit the growth of alcohol outlets in an area).<sup>169</sup>

### **Reducing problem drinking**

---

Interventions that focus on harmful and hazardous drinkers can have benefits in preventing violence. For example, a study in the USA found that screening and brief intervention (SBI) among youth attending EDs reduced peer violence and alcohol consumption.<sup>147</sup> SBI has also shown positive impacts when delivered by physicians and nurses in primary care settings.<sup>170</sup>

More intensive programmes have also reported positive results. For example, cognitive behavioural therapy with non-dependent drinkers has been found to reduce their risks of perpetrating abuse,<sup>171</sup> while programmes with partners of problem drinkers have shown benefits in reducing intimate partner violence.<sup>172</sup>

## Community interventions

---

Community interventions can bring together multi-agency partnerships at a local level to identify and address risk factors for violence. They typically implement a range of co-ordinated enforcement and preventive approaches, often focusing on youth or alcohol-related violence.

### Community youth violence prevention

---

Strong partnerships between schools, families, communities and public services can support effective youth violence prevention. For example, in the USA the Communities that Care (CtC) programme provides a structured approach for communities to enable them to identify local risk and protective factors for youth delinquency and select appropriate interventions. These can include school-based life skills programmes, parenting programmes and community-based support for youth. A study found that children from CtC communities were less likely to become involved in substance use and delinquent behaviour, including violence, than children from non-CtC communities.<sup>173</sup>

The government's **Ending Gang and Youth Violence**<sup>19</sup> strategy (see chapter 6) identifies the need for strong community partnership to implement prevention and identify and support young people involved in violence. Health services have a key role throughout this work.

### Managing drinking environments

---

A fifth of all violence in England and Wales occurs in or around drinking venues, and strategies to manage drinking environments can be important in reducing this violence. Often, a small number of problem premises account for a large amount of violence in a nightlife area, with poor management and other factors in these premises contributing to increased intoxication and problems.<sup>174</sup> Interventions include

targeted enforcement in high risk premises,<sup>175, 176</sup> training for bar and door staff,<sup>177</sup> the development of codes of practice for bars,<sup>178</sup> and broader security measures such as street lighting, safe late night transport and CCTV.<sup>179</sup>

Multi-agency programmes that implement a range of such measures can have most impact.<sup>180</sup> For example, the STAD project in Sweden has implemented interventions such as bar staff training, house policies for licensed premises and increased enforcement of alcohol laws. STAD was associated with a 29% reduction in violence and was found to be cost effective.<sup>181, 182</sup> A similar programme in Finland (PAKKA) found reductions in alcohol service to 'drunk' actors, largely attributed to increased surveillance and sanctions.<sup>183</sup> However, an Australian intervention focusing on nightlife safety (e.g. high profile policing, CCTV, ID scanners) was found to have had no preventive effect on alcohol-related ED injury attendances,<sup>184</sup> suggesting that a broader focus is required to affect alcohol consumption rather than just manage its consequences.<sup>159</sup>

### ED data sharing

---

The collection of data on the location of assaults resulting in ED attendance (see chapter 2) can effectively contribute to local violence prevention.<sup>101,85,186</sup> In Cardiff, enhanced ED data were used alongside police data to target policing and other violence prevention activity in nightlife environments through a multi-agency partnership. This was associated with significant reductions in hospital admissions for violence, compared to increases seen in similar

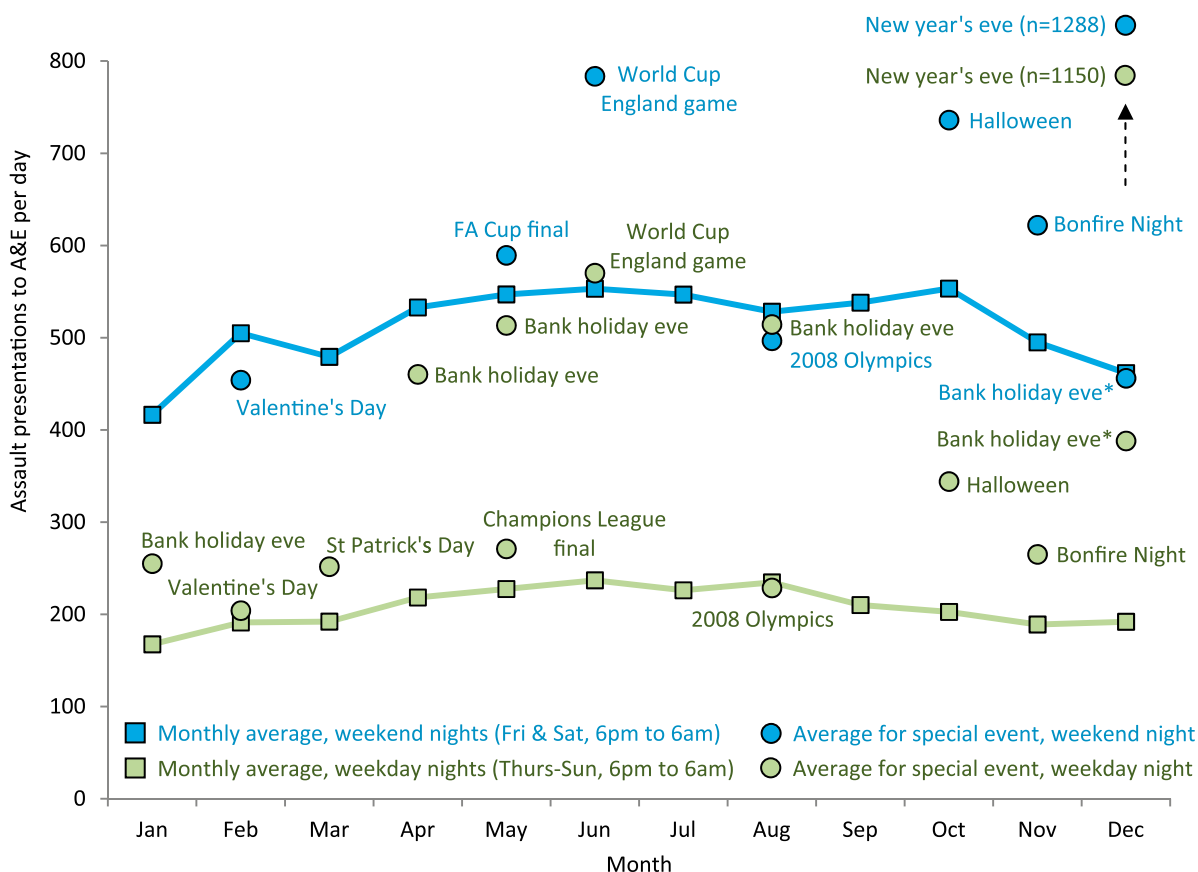
areas without data sharing.<sup>186</sup> ED data sharing has also shown benefits in informing and supporting local violence prevention in a number of areas in England, including the Wirral,<sup>10</sup> Cambridge, Derriford, Stockton and Northamptonshire. Case studies outlining progress in these areas can be found at [www.publicinnovation.org.uk/Data\\_Sharing.html](http://www.publicinnovation.org.uk/Data_Sharing.html).

Emergency department data can also be used to examine the demographics of assault patients as well as calendar patterns in violence, to identify when violence may be elevated and which groups can be most affected. For example, national HES A&E data (experimental statistics) has been used to examine calendar patterns in nighttime assaults (figure 5.1), showing particular increases on holidays including New Years Eve, Halloween, Bonfire Night and the nights preceding bank holidays.

## Environmental design and green space

Environmental improvements to public space can influence levels of violence. They can also benefit mental and physical health by promoting social interaction, increasing perceptions of safety and promoting physical exercise. Strategies can include improving neighbourhood infrastructures (e.g. better transport and street lighting<sup>187, 188</sup>) and increasing access to green space. For example, in a study in the USA, urban public housing residents that lived in buildings with more nearby green space reported lower levels of aggression, violence and mental fatigue than their counterparts with less green space.<sup>189</sup> A different study found that the presence of greenery in common spaces in a large public housing development was associated with greater use of, and social activity in, the outdoor space.<sup>190</sup>

**Figure 5.1:** Recorded nighttime assault presentations to English A&E services, (average) per night by month and for selected holidays, sporting events, and other celebrations



\*Includes Christmas Eve. Data from the national HES Accident & Emergency experimental system (2008/9–2010/11). Assaults included are those reported between 6pm and 6am. Presentations during this 12 hour period are all allocated to the date on which the period begins. Data show averages when events fall on weekend (blue) and other nights (green). National HES A&E data are not complete but are shown to illustrate calendar patterns in nighttime assaults. Figure based on: *Bellis MA, Leckenby N, Hughes K et al. Nighttime assaults: using a national emergency department monitoring system to predict occurrence, target prevention and plan services. BMC Public Health 2012;12:747.*

## Changing social norms that support violence

---

Social and cultural norms – behavioural rules or expectations within a social group – can strongly influence violent behaviours, including child maltreatment, violence towards women and elder abuse. Interventions that challenge social norms aim to prevent violence by making it less socially acceptable.

Despite the potential of social norms programmes in preventing violence, there is currently a lack of research available to identify their effectiveness.<sup>191</sup>

### Mass media campaigns

---

Mass media campaigns can deliver violence prevention messages to broad populations via television, radio, the Internet and printed materials. They raise awareness of violence and seek to change social norms by, for example, correcting misperceptions of norms and attaching social stigma to violence. Given the difficulty in evaluating mass media campaigns, little is known about their effects on violence. However, in general, campaigns can encourage discussion and debate and drive other prevention work.<sup>192</sup>

### Legislation and policy

---

Legislation can be an important tool in changing social norms and behaviours. Laws that make violent behaviour an offence send a message to society that violence is not acceptable. In Sweden, for example, legislation was implemented to abolish physical punishment of children by caregivers in 1979. A variety of evidence suggests that both public support for, and the use of, physical punishment towards children declined after its implementation.<sup>193, 194</sup>

An example of recent violence prevention legislation in England is the Female Genital Mutilation Act 2003, which made it illegal to practise FGM in the UK and to take UK nationals or permanent residents abroad for FGM. Enforcement of such legislation is a critical element in ensuring it is effective.

Policy responses can also be important in changing norms and deterring abuse. Examples include the Dignity in Care campaign (see box 5.4) and work to raise awareness of, and strengthen responses to, violence against NHS staff (see chapter 6).<sup>195</sup>

#### **Box 5.4: Dignity in Care**

The Dignity in Care campaign aims to change attitudes towards older people in care by raising awareness of the need for dignity and respect, and motivating health and social care workers and the public to take action. The Commission on Dignity in Care for Older People, set up by the NHS Confederation, the Local Government Organisation and AGE UK, is developing recommendations for hospitals and care homes to help them identify the causes of failures in the care system and deliver dignity in care.

### Social norms programmes

---

Social norms programmes are often used with children and youths to challenge norms and stereotypes that support violence, including youth violence and bullying. Many focus on preventing violence against women. For example, the Safe Dates programme in the USA addresses gender stereotypes and aims to change social norms around dating violence (see page 37).<sup>130</sup> Other examples include programmes that challenge attitudes supportive of rape (e.g. that a woman is partly responsible for rape if she is drunk).<sup>196</sup>

## Identification, care and support

---

Programmes that identify victims of violence and provide effective care and support are critical for protecting the health and wellbeing of victims and breaking cycles of violence. Health settings can be ideal places to identify and support victims of violence.

### Screening programmes

---

Screening tools can be used by health professionals in a range of settings to aid detection of violence in patients. They consist of a series of questions designed to identify common signs of abuse. Most research has focused on screening for intimate partner violence in women. Here, screening can facilitate the identification and disclosure of abuse, and be acceptable to patients.<sup>197-199</sup> However, the ability of screening to protect against future violence once victims have been identified is less clear. Reviews have concluded that there is insufficient evidence to support routine screening for all women in health care settings, with the possible exception of antenatal services.<sup>199, 200</sup> One review found four components that supported screening in health settings: institutional support; effective screening protocols; thorough and ongoing staff training; and immediate access or referral to support services.<sup>198</sup>

A review of screening tools for intimate partner violence suggested that the HITS (Hurts, Insults, Threatens and Screams) scale represented the best short screening tool for use in health settings.<sup>199</sup> This asks patients four simple questions about the frequency of abusive behaviour by their partner.<sup>201, 202</sup>

For vulnerable groups such as children and older people, screening tools should be used with caution. Studies suggest individuals can be falsely identified as being at risk (e.g. signs of chronic illness in older people) while the completion of tools by caregivers may make them unreliable. However, tools can be used to identify risk factors for abuse perpetration in carers (e.g. child abuse<sup>116</sup>).

### Training for health professionals

---

Training programmes for health care staff can raise awareness of violence, the signs and symptoms of abuse, and reporting and referral procedures. A review of training programmes on child abuse for medical staff found they could improve knowledge, attitudes and perceived self-competency to manage child abuse issues.<sup>203</sup> Training has also shown benefits in improving knowledge and attitudes around intimate partner violence, and improving rates of screening and referral to support services, at least in the short term - suggesting that ongoing training is required.<sup>204</sup>

In England, the IRIS (Identification and Referral to Improve Safety) programme provides practice-based training sessions for primary health care staff, a prompt to ask about abuse in the medical record system and referral pathways to a domestic violence advocate. In a randomised controlled trial it was found to improve identification and referral of women experiencing abuse.<sup>205</sup>

The Department of Health has produced a domestic abuse training manual for health care professionals.<sup>206</sup>

### Advocacy programmes

---

Advocacy programmes provide support to victims of violence and their families. Services include the provision of information, counselling, referrals to services, and assistance in dealing with social and legal services. Interventions such as brief support and counselling can be implemented in health (e.g. primary care<sup>207</sup>), criminal justice or community

settings. A review of advocacy services for female victims of intimate partner violence found that brief advocacy reduced minor (but not severe) physical abuse, while intensive advocacy reduced physical abuse in the medium term (two years) but not shorter or longer term.<sup>208</sup>

### Sexual Assault Referral Centres (SARCs)

---

SARCS provide round the clock care and support to people who experience sexual violence. A SARC service includes health care and access to forensic recovery and the criminal justice system. In addition to a health needs assessment, SARCs also screen for sexually transmitted infections and HIV, provide emergency contraception, forensic recovery and follow-up with onward referrals to other health, care and specialist sexual violence voluntary sector services, including counselling and support. Forensic recovery in SARCs is currently undertaken by doctors. In a few SARCs, protocols and training within consultant-led SARC teams is enabling sexual assault nurse examiners to develop their skills and roles. In 2012, there were thirty-three SARCs in England.

After attending a SARC, clients are assigned an independent sexual violence adviser (ISVA) who provides ongoing advocacy and support to access services and help them progress through the criminal justice system, should they choose to do so. ISVAs operate throughout England working with voluntary and community services as well as SARCs.<sup>209</sup>

While the impact of SARCs on sexual assault victims' outcomes has yet to be robustly studied, other models of specialist sexual assault care have shown benefits. A review of sexual assault nurse examiner programmes that provide specialist medical care and ongoing support to victims found they could be psychologically beneficial, offer comprehensive medical care, obtain forensic

evidence correctly and accurately, and facilitate the prosecution of rape.<sup>210</sup>

### Multi-Agency Risk Assessment Conferences (MARACs)

---

In England and Wales, MARACs provide an enhanced response to high-risk victims of domestic violence through risk assessment, shared data and co-ordinated service provision. Referral can be undertaken by a wide range of agencies, including health services. Once identified, victims' needs are discussed at regular multi-agency meetings to enable appropriate responses to be developed and implemented. All discussion and data sharing takes place with the individual's consent. Initial research suggests that MARACs can reduce re-victimisation and improve the safety of victims.<sup>211</sup>

### Out of home care for abused or abusive children

---

Removal of a child from an abusive home is often only undertaken as a last resort, with a number of parent and family interventions showing benefits in preventing further abuse (e.g. parent-child interaction therapy<sup>212, 213</sup>). Thus, children who are placed in out of home care are likely to have suffered severe and ongoing maltreatment.

While there is a need for further research to examine the most effective models of out of home care, several studies have found that children placed in foster care following maltreatment have improved outcomes than those who remain at home.<sup>213</sup> Enhanced foster care, that provides tailored support to children, their caregivers and (where relevant) their families has shown better outcomes than standard foster care.<sup>213</sup> For example, multidimensional treatment foster care (MTFC) has been found to promote resiliency in domains including behavioural adjustment, social competence, school success, interpersonal relations and caregiver stress.<sup>214</sup>

## Psychological interventions

---

Psychological treatments aim to address the emotional and mental health problems that result from violence. For example, early trauma-focused cognitive behavioural therapy can prevent chronic post traumatic stress disorder (PTSD), and has been found to be more effective than other types of counselling.<sup>215, 216</sup> Psychotherapy can also improve mental health among adults and children who have suffered childhood sexual abuse.<sup>217</sup>

As well as their use in supporting victims, psychological interventions can be used with carers to help to reduce emotional distress. Activities can include anger management, depression management and cognitive behavioural therapy. These types of programmes have been found to improve coping strategies in, for example, carers of elderly dependents who are at risk of perpetrating abuse.<sup>218</sup>

## Respite care

---

Respite programmes provide care for dependent individuals to give caregivers a break from the burden of their responsibilities. Evaluations of day care schemes for elderly patients, for example, suggest that they can reduce perceptions of caregiver burden, worry and strain, as well as depression and anger. However, more research is needed to identify their impact on elder abuse.<sup>219</sup>

## Criminal justice interventions

---

A range of criminal justice measures can support victims of violence. For intimate partner violence, for instance, protection orders (e.g. court orders that prevent abusers from contacting their partner) can reduce re-victimisation rates.<sup>220</sup> In England and Wales, Specialist Domestic Violence Courts (SDVCs) provide a co-ordinated multi-agency response to intimate partner violence, involving specialist trained police, prosecutors and court staff, independent advisors to support victims through the criminal justice system, and special measures to protect victims in court. SDVCs can facilitate successful prosecutions and improve feelings of safety in victims.<sup>221</sup>

# 6. National policy and programmes

Tackling violence and the root causes of violence requires strong and effective action across government. It also requires collective action with and between local government, health services, police, voluntary groups, local communities and other key stakeholders.

This chapter highlights some of the key policies and programmes that aim to prevent violence and support the victims of violence. Firstly, it looks at the role of public health services in the delivery of the government's goals. It then outlines relevant

policies and programmes that focus on the root causes of violence and on the impact of violence on different parts of the community. The final part of this section highlights international policy on violence prevention.





## The role of public health services in tackling violence

---

Public health services have an important role to play in tackling violence. *The Coalition: our programme for government - freedom, fairness, responsibility*<sup>39</sup> highlights a number of key areas in which public health approaches to violence prevention could achieve government programme goals including: supporting parenting and early interventions with children and families; tackling alcohol; gun and knife crime; and hate crimes.

The White Paper *Healthy lives, healthy people: our strategy for public health in England*<sup>222, 223</sup> sets out the government's long-term vision for the future of public health in England. The aim is to create a 'wellness' service - *Public Health England* - and to strengthen both national and local leadership. Working with other agencies, public health services in the new public health system will have a role in tackling violence and abuse.

Directors of Public Health, located within local authorities, will be tasked with looking widely at issues including crime reduction, violence prevention, responses to violence and reducing levels of reoffending, which can also prevent health inequalities.<sup>224</sup> They can do this through links to existing partnership working and through new relationships, for example with incoming Police and Crime Commissioners.

Through the *Health and Social Care Act*, Directors of Public Health in local authorities are responsible for the public health aspects of the promotion of community safety, violence prevention, responses to violence, and local initiatives to tackle social exclusion. These statutory changes take place from 1 April 2013.

Using their ring-fenced public health budget and the new Health Premium (a financial incentive to reward progress on specific public health outcomes) where appropriate, local authorities will be responsible for working in partnership to tackle issues such as social exclusion (including through intensive family interventions), social isolation amongst older people and community safety including violence prevention.

Local authorities will also be responsible for the commissioning of specialist domestic violence services in hospital settings, and voluntary and community organisations that provide counselling and support services for victims of violence.

The NHS Commissioning Board will also be responsible for commissioning a number of public health functions with its share of the ring-fenced public health budget. This will include collaborating with police forces and pooling their respective budgets to jointly commission SARC's on a supra-local basis. This move follows a number of reports which recommended that quality and access to SARC's would be improved through NHS commissioning and provision of services that are based on clinical governance. Both the *Stern Review*<sup>225</sup> and the independent report *Responding to violence against women and children- the role of the NHS*<sup>226</sup> urged the Government to transfer funding and commissioning responsibility for sexual assault services to the NHS to improve services. The cost-benefit case was made in a study by University of Birmingham on the *Feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination from the police to the NHS*.<sup>227</sup>

The *Health and Social Care Act* requires the new statutory health and wellbeing boards to use the joint strategic needs assessment (JSNA) as a starting-point to develop a joint health and wellbeing strategy (JHWS). This will span the NHS, social care, public health and other sectors that are key to addressing the wider health determinants of health.<sup>228</sup>

Of critical importance is the need for high quality intelligence. The *Violence Indicator Profiles for England Resource* (VIPER – see chapter 2) provides data on violence including hospital admissions for violence and police recorded violent crime data for every local authority in England.

The new Public Health Outcomes Framework *Healthy lives, healthy people: improving outcomes and supporting transparency*<sup>229</sup> sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system:

- Increased healthy life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

A set of supporting public health indicators help focus understanding of progress year by year nationally and locally on those things that matter most to public health. The indicators, which cover the full spectrum of public health and what can currently be realistically measured, are grouped into four domains:

- improving the wider determinants of health;
- health improvement;
- health protection; and
- healthcare, public health and preventing premature mortality.

Three indicators, which focus on domestic abuse, violent crime (including sexual violence) and older people's perceptions of community safety, will be used to measure progress on tackling violence (see box 6.1).

The Public Health Outcomes Framework together with the NHS and Adult Social Care Outcomes Frameworks will provide a coherent and comprehensive approach to tracking national progress against an agreed range of critical outcomes.

#### **Box 6.1: Public health outcomes framework: public health indicators related to violence**

##### **Domestic abuse**

Tackling domestic abuse as a public health issue is vital for ensuring that some of the most vulnerable people in our society receive the support, understanding and treatment they deserve. The more we can focus in on interventions that are effective, the more we can treat victims and prevent future re-victimisation.

##### **Violent crime (including sexual violence)**

The inclusion of this indicator enables a focus on the interventions that are effective and evidence-based, including a greater focus on prevention and treatment, which need to be considered alongside criminal justice measures for a balanced response to the issue.

##### **Older people's perception of community safety**

Perception of safety is an important factor in helping older people to maintain their independence and activity and to avoid social isolation. This indicator will encourage good links between public health and other parts of local government (e.g. the police) to encourage health and wellbeing boards and public health professionals to consider perceptions of safety as key to improving health and wellbeing.

## Policies aimed at tackling the drivers of violence

---

### No health without mental health: a cross-government mental health outcomes strategy for people of all ages<sup>230</sup>

---

The government has made it clear that the Coalition's success will be measured by the nation's wellbeing, not just by the state of the economy, recognising that mental health is central to quality of life and economic success. It is also interdependent with success in improving education, training and employment outcomes and tackling some of the persistent problems that affect society, from homelessness, violence and abuse, to drug use and crime. Financial insecurity, being homeless, drug use, alcohol consumption and experiencing violence are all strongly associated with poor mental health.

The goals of the mental health strategy are:

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination.

A good start in life and positive parenting promote good mental health, wellbeing and resilience to adversity throughout life. Many mental health problems start early and are associated with a number of known risk factors, including inequality.

To support mental health objectives, the Department of Health has committed to recruit 4,200 new health visitors who will lead and deliver the Healthy Child

Programme, which places greater emphasis on health promotion, prevention and early intervention. Other commitments include encouraging data sharing between EDs and other partners to identify violence, in partnership with the Home Office (see page 19).

### Reducing demand, restricting supply, building recovery: supporting people to live a drug free life<sup>231</sup>

---

The government's drug strategy aims to tackle drug dependence and promote a recovery-led approach to help people rebuild their lives. The strategy recognises that a clear association exists between mental illness and drug and alcohol dependence. The approach adopted by this strategy, of promoting mental wellbeing, preventing mental illness and early intervention as soon as the problem arises, will also help to reduce the risk of substance misuse across the population. The strategy has recovery at its heart by:

- Putting more responsibility on individuals to seek help and overcome dependency;
- Placing emphasis on providing a more holistic approach, by addressing other issues to support people dependent on drugs or alcohol, such as offending, employment and housing;
- Aiming to reduce demand for drugs;
- Taking an uncompromising approach to crack down on those involved in the drug supply both at home and abroad; and
- Putting power and accountability in the hands of local communities to tackle drugs and the harms they cause.

## The government's alcohol strategy<sup>169</sup>

---

The government's alcohol strategy aims to address irresponsible drinking and the harms caused by alcohol through long-term, sustained action by local agencies, industry, communities and government. A reduction in alcohol-fuelled crime, including violent crime, is an ambition of the strategy, along with reductions in the numbers of: people binge drinking; adults drinking above NHS guidelines\*; 11-15 year olds drinking and the amounts of alcohol consumed; and alcohol-related deaths. The strategy also aims to promote behavioural change so that people do not think it is acceptable to drink in a way that causes harm to themselves or others.

The strategy sets out plans for ending the availability of cheap alcohol and irresponsible promotions; providing local areas with additional powers and resources to challenge unacceptable behaviour and address problem premises; securing industry support in changing drinking behaviours; and supporting individuals to make informed choices about healthier and responsible alcohol consumption.

Key violence-related components of the strategy include:

- The introduction of a minimum unit price for alcohol (see chapter 5);
- Provision of stronger powers for local areas to control the density of licensed premises (see chapter 5) – including consulting on introducing a health-related licensing objective for this purpose;
- Providing support for hospitals to tackle drunken behaviour in EDs;
- Encouraging all hospitals to share non-confidential information on alcohol-related injury with police and other agencies (see chapter 2).

\*No more regularly than 3-4 units per day for men and no more regularly than 2-3 units for women

## Police Reform and Social Responsibility Act 2011<sup>232</sup>

---

The Police Reform and Social Responsibility Act 2011 included provision for a package of measures to overhaul the Licensing Act 2003 and give communities greater tools and powers to tackle alcohol-fuelled crime and disorder. These include:

- Early morning restriction orders, which will enable licensing authorities to place restrictions on the sale of alcohol in all or part of their areas between midnight and 6am;
- A late night levy, which will allow licensing authorities to raise funds from late night premises to help cover the cost of policing the latenight economy.

Importantly, the act made local health bodies responsible authorities under the [Licensing Act 2003](#). This enables them to make representations regarding new license applications and request reviews of existing licences where they have relevant evidence to do so.

The government has established an Alcohol Network as part of the Public Health Responsibility Deal,<sup>233</sup> which has to date involved retailers, producers, industry representative organisations and health non-governmental organisations (NGOs). The network seeks to deliver pledges in support of the core commitment: *"We will foster a culture of responsible drinking, which will help people to drink within guidelines."*

For example, the Responsibility Deal includes a pledge for £800,000 to increase investment in Community Alcohol Partnerships (CAPs) that aim to reduce underage drinking and related anti-social behaviour.

## Policies aimed at tackling violence

### Violence against women and girls (VAWG)

The Coalition government is determined to prevent violence against women and children, to protect and support victims and to bring offenders to justice. A cross-government strategy *Call to end violence against women and girls*<sup>234</sup> aims to prevent violence against women and girls from happening in the first place by challenging the attitudes and behaviours which foster it and intervening early to prevent it.

The government has committed £28 million in Home Office funding over four years to improve specialist local services and support for victims of rape, sexual assault and violence. *Call to end violence against women and girls: action plan*<sup>235</sup> (see box 6.2) outlines 88 actions for responsible government departments; *Call to end violence against women and girls: taking action – the next chapter*<sup>236</sup> reviews progress and updates the plan, including new actions to help keep women safe.

As part of the action plan, the government committed to implementing domestic homicide reviews, which were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). Domestic homicide reviews cover both intimate partner violence and family violence, including honour-based violence. The responsibility for establishing reviews lies with Community Safety Partnerships, which convene a review panel comprising police, health professionals and other relevant bodies. The aim of the review is to learn from what has happened and to improve policies and practice at local and national levels. Multi-agency guidance on conducting these reviews has been published by the Home Office.<sup>237</sup>

*Improving services for women and child victims of violence: the Department of Health action plan*<sup>238</sup> aims to lay the foundations for embedding high quality evidence-based practice within the NHS in response to violence and abuse and is

#### **Box 6.2: Call to end violence against women and girls: action plan for the Department of Health**

- Support community engagement work to tackle female genital mutilation (FGM)
- Develop training for health visitors to provide support to families when they suspect violence against women or children (VAWC) may be a factor
- Work with NICE to produce public health guidance on preventing domestic violence
- Consider the findings of a study examining the impact of transferring commissioning and budgetary responsibility for forensic sexual assault work from the police to the health service
- Fund the development of a Diploma in the Forensic and Clinical Aspects of Sexual Assault
- Launch e-learning training for GPs on VAWC
- Carry out further research on the health aspects of VAWC
- Develop a needs assessment toolkit on sexual violence to provide a local dataset that can inform local statutory assessments
- Produce two short informative films for the NHS Choices website on child sexual exploitation and FGM
- Ensure that all government press releases on VAWG issues contain the national domestic violence and national stalking helpline contact details
- Raise awareness in the Department of Health and other government departments to ensure staff have an understanding of VAWG, and where to seek help and support
- Clarify the issues around Female Genital Cosmetic Surgery through the inquiry that Sir Bruce Keogh is conducting into cosmetic surgery and other cosmetic interventions.

set around four key themes: awareness-raising; workforce, education and training; improving quality of services; and evidence and information. A range of resources have been produced for commissioners to support VAWG work (see box 6.3).

### **Box 6.3: Resources for commissioners to support action to end VAWG**

#### **Commissioning services for women and children who experience violence or abuse – a guide for health commissioners<sup>239</sup>**

This guidance aims to support health commissioners – in particular those that commission primary care, mental health, maternity care and sexual health services – to improve the commissioning of services for women and children who are victims of violence. It aims to improve health and wellbeing outcomes for these vulnerable individuals, even as the NHS goes through a period of considerable change. The guidance provides suggested outcome measures, case examples (including service specifications to download) and advice on how to include the needs of victims of violence in Joint Strategic Needs Assessments – with the aim of managing the transition and developing these services in a way which will help them adapt to the changes to the NHS and public health.

#### **Response to sexual violence needs assessments (RSVNA) toolkit: informing the commissioning and development of coordinated specialist services for victims of sexual violence<sup>240</sup>**

This document provides guidance to local area partnerships conducting a Response to Sexual Violence Needs Assessment to underpin the Joint Strategic Needs Assessment.

To ensure that the actions and milestones set out in this strategy are delivered, a VAWG Inter-Ministerial Group (IMG) is chaired by the Home Secretary and meets on a quarterly basis. The IMG addresses issues across government and monitors progress on the delivery of the strategy. A cross-departmental VAWG Delivery Board reports to the VAWG IMG.

The *NHS Operating Framework 2011/12*<sup>241</sup> states that NHS organisations should properly identify women and children affected by sexual violence or abuse and ensure suitable care pathways are in place to provide sensitive, ongoing care. The framework also identifies that all acute trusts should share non-confidential information with Community Safety Partnerships to support reductions in the number of violence-related attendances in EDs through better targeting of local interventions to reduce violence.

From April 2013, the NHS Commissioning Board will commission SARC's jointly with police constabularies on a supra-local basis. The Board will eventually become responsible for both forensic medical examination services and SARC's, when commissioning responsibility and funding for the forensic medical aspects transfer to it from the Police. This follows the Public Health White Paper series *Healthy Lives, Healthy People - Consultation on the funding and commissioning routes for public health*,<sup>242</sup> in response to recommendations for improved quality of services, made in independent reviews on how public authorities handle rape cases<sup>243</sup> and on the NHS response to violence against women and children.<sup>226</sup>

Commissioning of female genital mutilation clinics will be the responsibility of Clinical Commissioning Groups whilst commissioning of specialist domestic violence services which have until now been commissioned by PCTs will be transferred to local authorities.

## Safeguarding children

---

Following the *Munro review of child protection*,<sup>244</sup> the government is reforming the child protection system and working to reduce the bureaucracy faced by those with safeguarding responsibilities. A consultation on revised safeguarding statutory guidance is seeking to replace existing guidance with three short and precise documents:

- *Working together to safeguard children*, providing guidance on what is expected of organisations, individually and jointly, to safeguard and promote the welfare of children;
- *Managing cases: the framework for the assessment of children in need and their families*, providing guidance on undertaking assessments of children in need; and
- *Statutory guidance on learning and improvement*, detailing proposed new arrangements for Serious Case Reviews, reviews of child deaths, and other learning processes led by Local Safeguarding Children Boards.

The revised guidance aims to place trust in social workers, health professionals, police, early years professionals, teachers and youth workers, allowing them to undertake their work without being hampered by unnecessary rules and targets.

## Safeguarding adults

---

The White Paper, *Caring for our future: reforming care and support*, sets out the government's vision for a reformed adult care and support system. The system aims to promote wellbeing and independence at all stages to improve people's lives and reduce their risk of requiring intensive care and support. A key principal underpinning the reforms is that all people are treated with dignity and respect, and are safe from abuse and neglect.<sup>245</sup>

The Department of Health has produced a series of guidance documents setting out the role of health services in safeguarding adults.<sup>246</sup>

## Troubled families

---

The Troubled Families programme<sup>247</sup> commits the government to working with local areas to turn around the lives of 120,000 troubled families. A troubled family is one that suffers from at least five of the following characteristics:

- No one in the family is in work;
- Living in poor or overcrowded housing;
- No parent has any qualifications;
- Mother has mental health problems;
- At least one parent has a longstanding illness, disability or infirmity;
- A low income; and
- An inability to afford a number of food and clothing items.

A significant proportion of these families are likely to suffer domestic violence problems. Estimates of numbers locally will be agreed and a plan of action for dealing with each family will be drawn up. This programme will run primarily on a payment-by-results basis to incentivise local authorities and other partners to take action to "turn around" the lives of troubled families in their area by 2015.

The government will also fund a national network of troubled family coordinators in each (upper-tier) local council. They will operate at a senior level to oversee the programme in their area. Success will be measured by:

- Numbers of children back into school;
- Reduction of criminal and anti-social behaviour;
- Parents on the road back to work; and
- Reduction of the costs to the taxpayer and local authorities.

## Gang and youth violence

---

Following the disorder in August 2011 in cities across England, the Prime Minister asked the Home Secretary to lead a review, alongside the Secretary of State for Work and Pensions, into the growing problem of gangs and gang violence. *Ending gang and youth violence: a cross-government report including further evidence and good practice case studies*<sup>19</sup> looks into the problem of gang and youth violence, analyses its causes, and identifies what can be done by government and other agencies to stop violence and improve the lives of those involved. It sets out plans to make this happen through:

- Providing support to local areas to tackle the problem;
- Preventing young people becoming involved in violence in the first place, with an emphasis on early intervention and prevention;
- Developing pathways out of violence and gang culture for young people;
- Using punishment and enforcement to suppress the violence of those refusing to exit violent lifestyles; and
- Partnership-working to join up the way local areas respond to gang and other youth violence.

*Getting it right for children, young people and families. Maximising the contribution of the school nurse team*<sup>248</sup> sets out a new vision and model for school nursing services. It identifies a number of

fundamental roles of school nurses in improving children's and young people's health and wellbeing, including identifying children and young people in need of early help and, where appropriate, providing support to improve their life chances and prevent abuse and neglect. This includes working with children and young people at risk of becoming involved in gangs or youth violence.

## Hate crime and violence

---

*The Equality Strategy – Building a Fairer Britain*<sup>249</sup> outlines the government's commitment to putting in place more effective measures to tackle hate crime and the violence that often accompanies it. The strategy aims to:

- Promote better recording of all hate crimes, but particularly those which at present are often not centrally recorded, for example, against disabled people and lesbian, gay, bisexual and transgender people;
- Encourage those who experience hate crime to report it;
- Continue work with the Independent Advisory Group on Hate Crime;
- Continue to be alert to crimes being committed against members of all faith communities and work with local people to safeguard people and property; and
- Promote good practice in responding to all forms of hate crime.



## Protecting NHS staff from violence

---

In 2003, the NHS established a dedicated service to protect NHS staff and property in England. The major focus of the NHS Security Management service was to protect NHS staff from violence and abuse and to ensure that appropriate action was taken against those who abuse, or attempt to abuse, NHS staff.

This programme of work introduced a requirement for each health body in England to have a Local Security Management Specialist, who receive professional training and work with police to prevent violence against NHS staff. It also developed a range of training programmes for NHS staff and security managers, including a national syllabus for conflict resolution training aimed at all frontline staff.

The Criminal Justice and Immigration Act 2008 created a criminal offence of causing a nuisance or disturbance on NHS premises and provided powers for police or authorised NHS staff to remove persons suspected of committing this offence. The Department of Health has produced guidance on use of this legislation.<sup>250</sup> This focuses on preventing problems before they arise and using non-physical methods to de-escalate situations when they do occur. A three year programme has trained staff at over 80 hospitals in implementing this legislation.

Other features of the programme include the development of guidance for lone workers in the NHS and the distribution of personal safety equipment to such staff.

In 2011, the NHS Security Management Service was incorporated into the newly established NHS Protect, which leads work to identify and tackle crime across the health service.

NHS Protect has the key objectives of:

- Educating and informing those who work for or use the NHS about crime in the health service and how to tackle it;
- Preventing and deterring crime in the NHS by removing opportunities for it to occur or re-occur; and
- Holding those who have committed crime against the NHS to account by detecting and prosecuting offenders and seeking redress where viable.

Preventing and addressing violence, harassment and abuse against NHS staff remains a key priority within NHS Protect. For example, in 2011 a three way agreement was signed between NHS Protect, the Association of Chief Police Officers and the Crown Prosecution Service to strengthen responses to violence against NHS staff, ensuring that the strongest possible action is taken against offenders.

## International policy and programmes

---

There are a wide range of programmes being undertaken at international and European levels to prevent violence and strengthen global capacity for violence prevention. Here we focus on the work of the World Health Organization, which operates a global programme to promote a public health approach to violence prevention.

The Forty-Ninth World Health Assembly adopted Resolution WHA49.25 in 1996, declaring violence a major and growing public health problem across the world. In this resolution, the Assembly drew attention to the serious consequences of violence – both in the short-term and the long-term – for individuals, families, communities and countries, and stressed the damaging effects of violence on health care services. The Assembly asked Member States to give urgent consideration to the problem of violence within their own borders, and requested the Director-General of the World Health Organization (WHO) to set up public health activities to deal with the problem.

The first *World report on violence and health*<sup>11</sup> is an important part of the World Health Organization's response to Resolution WHA49.25. It is aimed at both researchers and practitioners. The latter include health care workers, social workers, those involved in developing and implementing prevention programmes and services, educators and law enforcement officials.

Within Europe, the WHO Regional Office for Europe advocates reducing violence and unintentional injury by promoting a public health approach based on evidence and multi-sectoral cooperation. WHO has estimated that, if all countries in the WHO European Region equalled the interpersonal violence mortality rates of the country with the lowest rate, nearly 90% of deaths from this cause could be averted.<sup>251</sup>

The experience of several countries in the Region shows that public policy and sustained approaches that address the underlying causes of violence can make countries safer.

WHO Europe also supports Member States by:

- Providing data on the burden of injuries and evidence of what works for prevention
- Helping them improve their capacity to strengthen prevention; and
- Facilitating the sharing of knowledge about prevention strategies that have proven effective

A European inventory of national policies for the prevention of violence and injuries has been compiled by WHO Europe to help facilitate monitoring and reporting of national policies for the prevention of violence and injuries.<sup>252</sup>

### WHO training programmes

---

The WHO have developed TEACH-VIP,<sup>253</sup> a modular training curriculum on violence and injury prevention and control, and MENTOR-VIP,<sup>254</sup> a global mentoring programme.

### Evidence base resources

---

At both international and European levels, WHO has worked with the WHO Collaborating Centre for Violence Prevention at the Centre for Public Health, Liverpool John Moores University, to increase

access to the evidence base on effective violence prevention strategies. This work programme has produced a series of reports (e.g. youth and knife violence,<sup>251</sup> elder maltreatment<sup>255</sup>) and evidence briefings (e.g. *Prevent violence: the evidence*,<sup>256</sup> *Preventing and reducing armed violence*<sup>257</sup>).

The WHO Collaborating Centre also hosts a website, [www.preventviolence.info](http://www.preventviolence.info), which contains an Evidence Base of abstracts for studies on the effectiveness of primary violence prevention interventions, and a Trials Register providing details of studies underway to evaluate the effectiveness of primary violence prevention interventions.

### International conventions

---

A range of international conventions have been adopted with the aims of preventing violence,

mostly focusing on women and children. The *UN Convention on the Rights of the Child* is an international human rights treaty setting out the civil, political, economic, social and cultural rights of children. It defines standards for the treatment and status of children, including their right to be protected from abuse or exploitation. The *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) focuses on ending sex-based discrimination, prejudices and customs based on the idea of the inferiority of one sex. Within Europe, key treaties include the *Convention on preventing and combating violence against women and domestic violence*, adopted by the Council of Europe in 2011. This provides a legal framework to prevent violence and protect victims, and criminalises various forms of violence against women including female genital mutilation, forced marriage, stalking and sexual violence.

# 7. Conclusions

## Why now is the time to act on violence prevention

---

Since the publication of the World Health Organization's *World report on violence and health*<sup>11</sup> in 2002, there has been a growing understanding in public health and partner organisations that violence is preventable, and that health services have a major role to play in prevention (see chapter 6). Over the last decade, an increasing body of research, intelligence and experience has developed our understanding of the wide range of risk factors that can contribute to violence (chapter 4) and what can be done to prevent it (chapter 5). We now have a sound knowledge of how violence affects us and which groups are most at risk, as well as strong evidence from around the world of the effectiveness and cost-effectiveness of a range of violence prevention strategies. England has robust national and local infrastructures that include universal health care and strong social support systems. These can play a major part in the prevention of violence. The results will be of benefit to individuals and public services and importantly, in times of limited resources, they can not only protect health but also save money (see chapter 5).

The potential for public health bodies to ensure local services miss no opportunity to reduce violence have never been greater. Directors of Public Health are moving into local authorities, which control and influence a range of key services including children's services, adult social care, education services, community safety and alcohol licensing. Connections must be made with and between these services to ensure that they: recognise connections between early life experiences and propensity for violence in later life; exploit all opportunities to prevent violence; and understand the benefits such prevention brings for educational achievement, employment prospects and long-term health.

Differences between the low levels of many types of violence experienced in the most affluent neighbourhoods and almost epidemic levels seen in the poorest communities are some of the starkest contrasts seen for any health related condition.<sup>258</sup> In fact, violence prevention needs to be seen as a key part of tackling inequalities. For some interventions such as nurse family partnership, parenting programmes and life skills training, there is robust international evidence of their effectiveness in violence prevention (see chapter 5). Targeting such interventions at deprived communities will help reduce inequalities as well as reduce violence and anti-social behaviour. At the same time, we need to strengthen our national evidence base on the violence prevention impact of internationally-proven measures. Much of our knowledge of what works to prevent violence comes from research undertaken in the USA, and the scarcity of home-grown knowledge is a gap that needs to be addressed. Implementing violence prevention activity within an evaluative framework will help address this gap, providing valuable information on what interventions work with which groups and what features of implementation help them succeed.

Tackling violence effectively requires action on a multi-agency basis. A number of assets are already available to facilitate such action and others will soon be in place. For example, Joint Strategic Needs Assessments enable public health teams in local authorities to work directly with clinical commissioning groups to analyse the health needs of the population and set local health, wellbeing and social care commissioning priorities. Here, public health teams should support clinical services to both play their role in violence prevention and recognise the benefits this can have to reducing

pressures on their services. Such benefits include reductions in pressures on emergency services and in the chronic morbidity associated with violence and abuse, such as poor mental health, substance use, cancer and heart disease.

Joined up approaches to violence prevention are also facilitated by Community Safety Partnerships that provide a forum for driving a public health approach to violence prevention with local criminal justice organisations. Elected police commissioners will have a key role in strengthening such local partnership working and supporting partner agencies, including health, in fulfilling their commitments to preventing crime, including violence. Further, local health bodies have been made responsible authorities under the Licensing Act 2003, enabling them to influence local licensing issues. For example, it is critical that licensing bodies have access to relevant data on violence prevention issues linked to the sale of alcohol.

Through Public Health England, we now have a national public health body capable of working pan-departmentally to implement joined up approaches to violence prevention with the Home Office, the Department for Education and other key

government departments. The inclusion of three specific violence-related indicators in the Public Health Outcomes Framework provides a consistent mechanism for measuring local progress on tackling violence. Access to additional local level data on violence is also increasing through work to meet the government's commitment to emergency department data sharing, and through the development of online intelligence tools including the Violence Indicator Profiles for England Resource (VIPER) (chapter 2). In addition to data, this tool will provide summaries of the effectiveness of different violence prevention strategies.

With the new public health system emerging, we have a unique opportunity to ensure that approaches to tackling violence move from a historically punitive system based within criminal justice to a preventative approach that utilises all the assets of government and civil society. This move has already been embarked upon by other government sectors that recognise the need for a life course approach to primary violence prevention.<sup>19</sup> This report identifies why we need this approach, how it can be implemented and the successes already realised where organisations and communities have taken such action.

# References

1. Scarborough P, Bhatnagar P, Wickramasinghe KK, et al. The economic burden of ill health due to diet, physical inactivity, smoking, alcohol and obesity in the UK: an updated to 2006-07 NHS costs. *Journal of Public Health* 2011;33:527-35.
2. Office for National Statistics. Crime in England and Wales, quarterly first release to March 2012. London: Office for National Statistics, 2012.
3. Sivarajasingam V, Wells JP, Moore S, et al. Violence in England and Wales in 2011: an accident and emergency perspective. Cardiff: Violence and Society Research Group, Cardiff University, 2012.
4. Bellis MA, Hughes K, Wood S, et al. National five-year examination of inequalities and trends in emergency hospital admission for violence across England. *Injury Prevention* 2011;17:319-25.
5. NHS Confederation. The joint strategic needs assessment: a vital tool to guide commissioning. London: NHS Confederation, 2011.
6. HM Government. Ending gang and youth violence: a cross-government report including further evidence and good practice case studies. Norwich: The Stationery Office, 2012.
7. Taylor P, Bond S. Crimes detected in England and Wales 2011/12. London: Home Office, 2012.
8. Smith K, Osborne S, Lau I, et al. Homicide, firearm offences and intimate violence 2010/11: supplementary volume 2 to Crime in England and Wales 2010/11. London: Home Office, 2012.
9. Bellis MA, Hughes K, Anderson Z, et al. Contribution of violence to health inequalities in England: demographics and trends in emergency hospital admissions for assault. *Journal of Epidemiology and Community Health* 2008;62:1064-71.
10. Quigg Z, Hughes K, Bellis MA. Data sharing for prevention: a case study in the development of a comprehensive emergency department injury surveillance system and its use in preventing violence and alcohol-related harms. *Injury Prevention* 2012;doi:10.1136/injuryprev-2011-040159.
11. Krug EG, Dahlberg LL, Mercy JA, et al. World report on violence and health. Geneva: World Health Organization, 2002.
12. NSPCC. Child cruelty in the UK 2011: the facts. London: NSPCC, 2011.
13. Radford L, Corral S, Bradley C, et al. Child abuse and neglect in the UK today. London: NSPCC, 2011.
14. Cawson P, Wattam C, Brooker S, et al. Child maltreatment in the United Kingdom. London: NSPCC, 2000.
15. Woods R. Helpline highlights: why people contact the NSPCC Helpline and how we can help. London: NSPCC, 2011.
16. Department for Education. Referrals, assessments and children who were the subject of a child protection plan (Children in Need Census - provisional) year ending 31 March 2011. London: Department for Education, 2011.
17. Chaplin R, Flatley J, Smith K. Crime in England and Wales 2010/11. London: Home Office, 2011.
18. Chamberlain T, George N, Golden S, et al. Tellus4 national report. London: Department for Children, Schools and Families, 2010.
19. HM Government. Ending gang and youth violence: a cross-government report including further evidence and good practice case studies. London: The Stationery Office, 2011.
20. Peirce BH, Boyle AA. How has the Licensing Act (2003) changed the epidemiology of assaults presenting to a Cambridgeshire emergency department? Before and after study. *European Journal of Emergency Medicine* 2011;18:351-56.
21. Smith K, Coleman K, Eder S, et al. Homicides, firearm offences and intimate violence 2009/10: Supplementary volume 2 to Crime in England and Wales 2009/10. London: Home Office, 2011.
22. Smith K, Flatley J, Coleman K, et al. Homicides, firearm offences and intimate violence 2008/09: supplementary volume 2 to Crime in England and Wales (3rd ed). London: Home Office, 2010.
23. Kazimirski A, Keogh P, Kumari V, et al. Forced marriage - prevalence and service response. London: Department for Children, Schools and Families, 2009.
24. HM Government. Multi-agency practice guidelines: handling cases of forced marriage. London: Forced Marriage Unit, 2009.
25. Creighton S, Sharma S. Report from the harmful traditional practices and human trafficking subgroup. Responding to violence against women and children - the role of the NHS. London: Department of Health, 2010.
26. Shannon K, Kerr T, Strathdee SA, et al. Prevalence and structural correlates of gender based violence among a prospective cohort of female sex workers. *BMJ* 2009;b2939).
27. Peterson ZD, Voller EK, Polusny MA, et al. Prevalence and consequences of adult sexual assault of men: review of empirical findings and state of the literature. *Clinical Psychology Review* 2011;31:1-24.
28. Brown J, Horvath M, Kelly L, et al. Connections and disconnections: assessing evidence, knowledge and practice in responses to rape. London: Government Equalities Office, 2010.
29. Jackson K, Jeffery J, Adamson G. The trafficking of migrant women in the England and Wales off-street prostitution sector: Association of Chief Police Officers, 2010.
30. Dorkenoo E, Morison L, Macfarlane A. A statistical study to estimate the prevalence of female genital mutilation in England and Wales. London: Forward, 2007.
31. Biggs S, Manthorpe J, Tinker A, et al. Mistreatment of older people in the United Kingdom: findings from the first national prevalence study. *Journal of Elder Abuse & Neglect* 2009;21:1-14.
32. Cooper C, Selwood A, Blanchard M, et al. Abuse of people with dementia by family carers: representative cross sectional survey. *BMJ* 2009;338:b155.
33. Equality and Human Rights Commission. An inquiry into older people and human rights in home care. Manchester: Equality and Human Rights Commission, 2011.

34. Office for National Statistics. Population ageing in the United Kingdom, its constituent countries and the European Union. Newport: Office for National Statistics, 2012.
35. Department of Health. Briefing note: issues highlighted by the 2011 NHS Staff Survey in England. London: Department of Health.
36. Ipsos MORI. Violence against frontline NHS staff: research study conducted for COI on behalf of the NHS Security Management Service: Ipsos MORI, 2010.
37. McDonnell A, Wilkinson A. RCN lone working survey 2011. London: Royal College of Nursing, 2012.
38. NHS Security Management Services. Cost of violence against NHS staff. London: NHS Counter Fraud Service, 2010.
39. HM Government. The Coalition: our programme for government. London: Cabinet Office, 2010.
40. Violence & Society Research Group. <http://www.cardiff.ac.uk/dent/research/themes/appliedclinicalresearch/violenceandsociety/index.html>.
41. Quigg Z, Rooney J, Perkins C. Violence-related ambulance call outs in the North West of England 2010-2011. Liverpool: Centre for Public Health, Liverpool John Moores University, 2012.
42. Winsper C, Lereya T, Zanarini M, et al. Involvement in bullying and suicide-related behavior at 11 years: a prospective birth cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry* 2012;5:271-82.
43. Fowler PJ, Tompsett CJ, Braciszewski JM, et al. Community violence: a meta-analysis on the effect of exposure and mental health outcomes of children and adolescents. *Development and Psychopathology* 2009;21:227-59.
44. Gates DM, Gillespie GL, Succop P. Violence against nurses and its impact on stress and productivity. *Nursing Economics* 2011;29:59-66.
45. Mencap. Bullying wrecks lives: the experiences of children and young people with a learning disability. London: Mencap, 2007.
46. Disability Rights Commission. Hate crime against disabled people in Scotland: a survey report. Stratford Upon Avon: Disability Rights Commission, 2004.
47. Equality and Human Rights Commission. Hidden in plain sight: inquiry into disability-related harassment. Manchester: Equality and Human Rights Commission, 2011.
48. Topper LR, Castellanos-Ryan N, Mackie C, et al. Adolescent bullying victimisation and alcohol-related problems mediated by coping drinking motives over a 12 month period. *Addictive Behaviors* 2011;36:6-13.
49. Miles R. Neighborhood disorder, perceived safety, and readiness to encourage use of local playgrounds. *American Journal of Preventive Medicine* 2008;34:275-81.
50. Weir LA, Etelson D, Brand DA. Parents' perceptions of neighborhood safety and children's physical activity. *Preventive Medicine* 2006;43:212-17.
51. Quilgars D, Johnsen S, Pleace N. Youth homelessness in the UK: a decade of progress? London: Joseph Rowntree Foundation, 2008.
52. Gilbert R, Spatz Widom C, Browne K, et al. Burden and consequences of child maltreatment in high-income countries. *The Lancet* 2009;9657:68-81.
53. Rothon C, Head J, Klineberg E, et al. Can social support protect bullied adolescents from adverse outcomes? A prospective study on the effects of bullying on the educational achievement and mental health of adolescents at secondary schools in East London. *Journal of Adolescence* 2011;34:579-88.
54. Boden JM, Horwood LJ, Fergusson DM. Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. *Child Abuse & Neglect* 2007;31:1101-14.
55. Currie J, Widom CS. Long-term consequences of child abuse and neglect on adult economic well-being. *Child Maltreatment* 2010;15:111-20.
56. Fergusson DM, Boden JM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect* 2008;32:607-19.
57. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience* 2006;256:174-86.
58. Simpson TL, Miller WR. Concomitance between childhood sexual and physical abuse and substance use problems. A review. *Clinical Psychology Review* 2002;22:27-77.
59. Bebbington P, Jonas S, Kuipers E, et al. Childhood sexual abuse and psychosis: data from a cross-sectional national psychiatric survey in England. *British Journal of Psychiatry* 2011;199:29-37.
60. Felitti VJ, Anda RF, Nordenburg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: the adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine* 1998;14:245-58.
61. Jonas S, Bebbington P, McManus S, et al. Sexual abuse and psychiatric disorder in England: results from the 2007 Adult Psychiatric Morbidity Survey. *Psychological Medicine* 2011;41:709-19.
62. Chartier MJ, Walker JR, Naimark B. Childhood abuse, adult health, and health care utilization: results from a representative community sample. *American Journal of Epidemiology* 2007;465:1031-38.
63. Duke NN, Pettingell SL, McMorris BJ, et al. Adolescent violence perpetration: association with multiple types of adverse childhood experiences. *Pediatrics* 2010;125:e778-e86.
64. Whitfield CL, Anda RF, Dube SR, et al. Violent childhood experiences and the risk of intimate partner violence in adults: assessment in a large health maintenance organization. *Journal of Interpersonal Violence* 2003;18:166-85.
65. Dubourg R, Hamed J. Estimates of the economic and social costs of crime in England and Wales: costs of crime against individuals and households, 2003/04. London: Home Office, 2005.
66. Walby S. The cost of domestic violence: up-date 2009. Lancaster: Lancaster University, 2009.

67. Jarvinen J, Kail A, Miller I. Hard knock life: violence against women. A guide for donors. London: New Philanthropy Capital, 2008.
68. World Health Organization. Preventing violence: a guide to implementing the recommendations of the World report on violence and health. Geneva: World Health Organization, 2004.
69. Shonkoff JP. Building a new biodevelopmental framework to guide the future of early childhood policy. *Child Development* 2010;81:357-67.
70. Whitaker DJ, Le B, Hanson RK, et al. Risk factors for the perpetration of child sexual abuse: a review and meta-analysis. *Child Abuse & Neglect* 2008;32:529-48.
71. Jespersen AF, Lalumiere ML, Seto MC. Sexual abuse history among adult sex offenders and non-sex offenders: a meta-analysis. *Child Abuse & Neglect* 2009;33:179-92.
72. Salter D, McMillan D, Richards M, et al. Development of sexually abusive behaviour in sexually victimised males: a longitudinal study. *Lancet* 2003;361:471-76.
73. Hemphill SA, Smith BH, Toumbourou JW, et al. Modifiable determinants of youth violence in Australia and the United States: a longitudinal study. *Australia and New Zealand Journal of Criminology* 2009;42:289-309.
74. Lacourse E, Nagin D, Tremblay RE, et al. Developmental trajectories of boys' delinquent group membership and facilitation of violent behaviours during adolescence. *Development and Psychopathology* 2003;15:183-97.
75. Moffitt TE. Adolescence-limited and life-course-persistent antisocial behaviour: a developmental taxonomy. *Psychological Review* 1993;100:674-701.
76. World Health Organization. Adverse Childhood Experiences International Questionnaire (ACE-IQ), 2012.
77. Antrobus S. Dying to belong: an in-depth review of street gangs in Britain. London: The Centre for Social Justice, 2009.
78. Elgar FJ, Aitken N. Income inequality, trust and homicide in 33 countries. *European Journal of Public Health* 2010;21:241-46.
79. Hughes K, Bellis MA, Hughes S. Youth violence and alcohol. Geneva: World Health Organization, 2006.
80. Taylor B, Irving HM, Kanteres F, et al. The more you drink the harder you fall: a systematic review and meta-analysis of how acute alcohol consumption and injury or collision risk increase together. *Drug and Alcohol Dependence* 2010;110:108-16.
81. Hutchison IL, Magennis P, Shepherd JP, et al. The BAOMS United Kingdom survey of facial injuries part 1: aetiology and the association with alcohol consumption. *British Journal of Oral and Maxillofacial Surgery* 1998;36:3-13.
82. Abbey A, Clinton-Sherrod AM, McAuslan P, et al. The relationship between the quantity of alcohol consumed and the severity of sexual assaults committed by college men. *Journal of Interpersonal Violence* 2003;18:813-33.
83. Rossow I, Norstrom T. The impact of small changes in bar closing hours on violence. The Norwegian experience from 18 cities. *Addiction* 2011;107:530-37.
84. Livingston M. A longitudinal analysis of alcohol outlet density and domestic violence. *Addiction* 2011;106: 919-25.
85. Atkinson AM, Anderson Z, Hughes K, et al. Interpersonal violence and illicit drugs. Liverpool: Centre for Public Health, Liverpool John Moores University, 2009.
86. Lupton R, Wilson A, May T, et al. A rock and a hard place: drug markets in deprived neighbourhoods. London: Home Office, 2002.
87. Centre for Public Health, Liverpool John Moores University, and World Health Organization. Changing cultural and social norms that support violence. Geneva: World Health Organization, 2009.
88. House of Commons Home Affairs Committee. Domestic violence, forced marriage and 'honour'-based violence: sixth report of session 2007-08. London: House of Commons, 2008.
89. Brandon J, Hafez S. Crimes of the community: honour-based violence in the UK. London: Centre for Social Cohesion, 2008.
90. Hughes K, Bellis MA, Jones L, et al. Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies. *Lancet* 2012;379:1621-9.
91. Jones L, Bellis MA, Wood S, et al. Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. *Lancet* 2012;380:899-907.
92. World Health Organization and World Bank. World report on disability. Geneva: World Health Organization, 2011.
93. Barrett KA, O'Day B, Roche A, et al. Intimate partner violence, health status, and health care access among women with disabilities. *Women's Health Issues* 2009;19:94-100.
94. Smith DL, Strauser DR. Examining the impact of physical and sexual abuse on the employment of women with disabilities in the United States: an exploratory analysis. *Disability and Rehabilitation* 2008;30:1039-46.
95. Fazel S, Gulati G, Linsell L, et al. Schizophrenia and violence: a systematic review and meta-analysis. *PLoS Medicine* 2009;6:e1000120.
96. Freestone M, Howard R, Coid JW, et al. Adult antisocial syndrome co-morbid with borderline personality disorder is associated with severe conduct disorder, substance dependence and violent antisociality. *Personality and Mental Health* 2012. doi:10.1002/pmh.1203.
97. Blackburn R, Coid JW. Empirical clusters of DSM-III personality disorders in violent offenders. *Journal of Personality Disorders* 1999;13:18-34.
98. Hodgins S, Cree A, Alderton J, et al. From conduct disorder to severe mental illness: associations with aggressive behaviour, crime and victimization. *Psychological Medicine* 2008;38:975-987.
99. Hodgins S. Persistent violent offending: what do we know? *British Journal of Psychiatry* 2007;190:s12-s14.
100. Olds DL, Eckenrode J, Henderson CR, et al. Long-term effects of home visitation on maternal life course and child abuse and neglect. *Journal of the American Medical Association* 1997;278:637-43.
101. Olds D, Henderson CR, Cole R, et al. Long-term effects of nurse home visitation on children's criminal and antisocial behavior. *Journal of the American Medical Association* 1998;280:1238-44.



102. Eckenrode J, Campa M, Luckey DW, et al. Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Archives of Pediatric and Adolescent Medicine* 2010;164:9-15.
103. Aos S, Lieb R, Mayfield J, et al. Benefits and costs of prevention and early intervention programs for youth. *Olympia* 2004; Washington State Institute for Public Policy.
104. Aos S, Miller M, Drake E. Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates. Olympia: Washington State Institute for Public Policy, 2006.
105. Department of Health. The Family Nurse Partnership Programme, 2012.
106. Department of Health. Health visitor implementation plan 2011-2015: a call to action. London: Department of Health, 2011.
107. Fergusson DM, Grant H, Horwood J, et al. Randomized trial of the Early Start program of home visitation. *Pediatrics* 2005;116:e803-e09.
108. Prinz RJ, Sanders MR, Shapiro CJ, et al. Population-based prevention of child maltreatment: the U.S. Triple P System population trial. *Prevention Science* 2009;10:1-12.
109. Joachim S, Sanders MR, Turner KMT. Reducing preschoolers' disruptive behaviour in public with a brief parent discussion group. *Child Psychiatry and Human Development* 2010;41:47-60.
110. Zubrick SR, Ward KA, Silburn SR, et al. Prevention of child behavior problems through universal implementation of a group behavioral family intervention. *Prevention Science* 2005;6:287-304.
111. Edwards RT, O'Ceilleachair A, Bywater T, et al. Parenting programme for parents of children at risk of developing conduct disorder: cost effectiveness analysis. *BMJ* 2007;334:682.
112. Hutchings J, Bywater T, Daley D, et al. Parenting intervention in Sure Start services for children at risk of developing conduct disorder: pragmatic randomised controlled trial. *BMJ* 2007;334:678.
113. Lindsay G, Strand S, Cullen MA, et al. Parenting early intervention programme evaluation. London: Department for Education, 2011.
114. Dretzke J, Davenport C, Frew E, et al. The clinical effectiveness of different parenting programmes for children with conduct problems: a systematic review of randomised controlled trials. *Child and Adolescent Psychiatry and Mental Health* 2009;3:7.
115. Knapp M, McDaid D, Parsonage E. Mental health promotion and mental illness prevention: the economic case. London: Department of Health, 2011.
116. Dubowitz H, Feigelman S, Lane W, et al. Pediatric primary care to help prevent child maltreatment: the Safe Environment for Every Kid (SEEK) model. *Pediatrics* 2009;123:858-864.
117. Morrell CJ, Warner R, Slade P, et al. Psychological interventions for postnatal depression: cluster randomised trial and economic evaluation. The PoNDER trial. *Health Technology Assessment* 2009;13(30).
118. Schweinhart LJ, Montie J, Xiang Z, et al. Life time effects: the High/Scope Perry Preschool Study through age 40. Ypsilanti, MI: High/Scope Press, 2005.
119. Reynolds AJ, Robertson DL. School-based early intervention and later child maltreatment in the Chicago Longitudinal Study. *Child Development* 2003;74:3-26.
120. Reynolds AJ, Ou SR, Topitzes JW. Paths of effects of early childhood intervention on educational attainment and delinquency: a confirmatory analysis of the Chicago Child-Parent Centers. *Child Development* 2004;75:1299-328.
121. Reynolds AJ, Temple JA, Ou SR, et al. Effects of a school-based, early childhood intervention on adult health and well-being. *Archives of Pediatric and Adolescent Medicine* 2007;161:730-39.
122. Reynolds AJ, Temple JA, Robertson DL. Age 21 cost benefit analysis of the Title I Chicago Child-Parent Centers. *Educational Evaluation and Policy Analysis* 2002;24:267-303.
123. Melhuish E, Belsky J, Leyland AH, et al. Effects of fully-established Sure Start Local Programmes on 3-year-old children and their families living in England: a quasi-experimental observational study. *Lancet* 2008;372:1641-47.
124. Conduct Problems Prevention Research Group. Initial impact of the Fast Track prevention trial for conduct problems: II. Classroom effects. *Consulting and Clinical Psychology* 1999;67:648-57.
125. Curtis C, Norgate R. An evaluation of the Promoting Alternative Thinking Strategies curriculum at key stage 1. *Educational psychology in practice: theory, research and practice in educational psychology* 2007;23:33-44.
126. Grossman DC, Neckerman HJ, Koepsell TD, et al. Effectiveness of a violence prevention curriculum among children in elementary school. *Journal of the American Medical Association* 1997;277:1605-11.
127. Holson I, Smith BH, Frey KS. Outcomes of the social competence program "Second Step" in Norwegian elementary schools. *School Psychology International* 2008;29:71-88.
128. Hawkins JD, Catalano RF, Kosterman R, et al. Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatric and Adolescent Medicine* 1999;153:226-234.
129. Hawkins JD, Kosterman R, Catalano RF, et al. Effects of social development intervention in childhood 15 years later. *Archives of Pediatric and Adolescent Medicine* 2008;162:1133-41.
130. Foshee VA, Bauman KE, Ennett ST, et al. Assessing the effects of the dating violence prevention program "safe dates" using random coefficient regression modeling. *Prevention Science* 2005;6:245-58.
131. James-Burdumy S, Dynarski M, Moore M, et al. When schools stay open late: the national evaluation of the 21st century community learning centers program: final report: US Department of Education, 2005.
132. MacBeth J, Kirwan T, Myers K. The impact of study support: a report of a longitudinal study into the impact of participation in out-of-school hours learning on academic attainment, attitudes and school attendance of secondary school students. London: Department for Education and Skills, 2001.

133. Cummings C, Dyson A, Muijs D, et al. Evaluation of the Full Service Extended Schools initiative: final report. London: Department for Education and Skills, 2007.
134. Olweus D, Limber SP. Bullying in school: evaluation and dissemination of the Olweus Bullying Prevention Program. *American Journal of Orthopsychiatry* 2010;80:124-34.
135. Sebba J, Robinson C. Evaluation of UNICEF UK's Rights Respecting Schools Award. London: UNICEF UK, 2010.
136. Koegl CJ, Farrington DP, Augimeri LK, et al. Evaluation of a targeted cognitive-behavioral program for children with conduct problems - the SNAP Under 12 Outreach Project: service intensity, age and gender effects on short- and long- term outcomes. *Clinical Child Psychology and Psychiatry* 2008;13:419-34.
137. Nickel MK, Krawczyk J, Nickel C, et al. Anger, interpersonal relationship, and health-related quality of life in bullying boys who are treated with outpatient family therapy: a randomized, prospective, controlled trial with 1 year of follow-up. *Pediatrics* 2005;116:247-54.
138. Santisteban DA, Vidal-Perez A, Coatsworth JD, et al. Efficacy of brief strategic family therapy in modifying hispanic adolescent behavior problems and substance use. *Journal of Family Psychology* 2003;17:121-33.
139. Sawyer AM, Borduin CM. Effects of multisystemic therapy through midlife: a 21.9 year follow-up to a randomized clinical trial with serious and violent juvenile offenders. *Journal of Clinical and Consulting Psychology* 2011;79:643-52.
140. Butler S, Baruch G, Hickey N, et al. A randomized controlled trial of multisystemic therapy and a statutory therapeutic intervention for young offenders. *Journal of the American Academy of Child and Adolescent Psychiatry* 2011;50:1220-1235.
141. Lloyd C, Wollny I, White C, et al. Monitoring and evaluation of family intervention services and projects between February 2007 and March 2011. London: Department for Education, 2011.
142. Fisher H, Montgomery P, Gardner FE. Opportunities provision for preventing youth gang involvement for children and young people (7-16). *Cochrane Database of Systematic Reviews* 2008;16:CD007002.
143. Braga AA. Pulling levers focused deterrence strategies and the prevention of gun homicide. *Journal of Criminal Justice* 2008;36:332-43.
144. King KA, Vidourek RA, Davis B, et al. Increasing self-esteem and school connectedness through a multidimensional mentoring program. *Journal of School Health* 2009;72:294-299.
145. Snider C, Lee J. Youth violence secondary prevention initiatives in emergency departments: a systematic review. *Canadian Journal of Emergency Medicine* 2009;11:161-68.
146. Cheng TL, Haynie D, Brenner R, et al. Effectiveness of a mentor-implemented, violence prevention intervention for assault-injured youths presenting to the emergency department: results of a randomized trial. *Pediatrics* 2008;122:938-46.
147. Walton MA, Chermack ST, Shope JT, et al. Effects of a brief intervention for reducing violence and alcohol misuse among adolescents: a randomized controlled trial. *Journal of the American Medical Association* 2010;304:527-35.
148. Holdsworth G, Criddle J, Mohiddin A, et al. Maximizing the role of emergency departments in the prevention of violence: developing an approach in South London. *Public Health* 2012;5:394-396.
149. Zlotowitz SA, Alcock C, Barker C. Grime not crime: the psychological impact of a community-based music intervention for gang-involved young people. *In prep.*
150. Connor JL, Kypri K, Bell ML, et al. Alcohol outlet density, levels of drinking and alcohol-related harm in New Zealand. *Journal of Epidemiology and Community Health* 2011;65:841-6.
151. Liverpool John Moores University, World Health Organization. Preventing violence by reducing the availability and harmful use of alcohol. Geneva: World Health Organization, 2009.
152. Markowitz S, Grossman M. Alcohol regulation and domestic violence towards children. *Contemporary Economic Policy* 1998;16:309-20.
153. Yu Q, Scribner R, Carlin B, et al. Multilevel spatio-temporal dual changepoint models for relating alcohol outlet destruction and changes in neighbourhood rates of assaultive violence. *Geospatial Health* 2008;2:161-172.
154. National Institute of Health and Clinical Excellence. NICE public health guidance 24: alcohol-use disorders: preventing harmful drinking. London: National Institute of Health and Clinical Excellence, 2010.
155. Jackson R, Johnson M, Campbell F, et al. Interventions on control of alcohol price, promotion and availability for prevention of alcohol use disorders in adults and young people. Sheffield: University of Sheffield, 2010.
156. Stockwell T, Chikritzhs T. Do relaxed trading hours for bars and clubs mean more relaxed drinking? A review of international research on the impacts of changes to permitted hours of drinking. *Crime Prevention and Community Safety* 2009;11:153-70.
157. Hough M, Hunter G, Jacobson J, et al. The impact of the Licensing Act 2003 on levels of crime and disorder: an evaluation. London: Home Office, 2008.
158. Department for Culture, Media and Sport. Evaluation of the impact of the Licensing Act 2003. London: Department for Culture, Media and Sport, 2008.
159. Bellis MA, Hughes K. Getting drunk safely? Nightlife policy in the UK and its public health consequences. *Drug and Alcohol Review* 2011;30:536-45.
160. Chikritzhs T, Stockwell T. The impact of later trading hours for Australian public houses (hotels) on levels of violence. *Journal of Studies on Alcohol* 2002;63:591-99.
161. Kypri K, Jones C, McElduff P, Barker D. Effects of restricting pub closing times on night-time assaults in an Australian city. *Addiction* 2011;106:303-10.
162. Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: a meta-analysis of 1003 estimates from 112 studies. *Addiction* 2009;104:179-90.

163. Wagenaar AC, Tobler AL, Komro KA. Effects of alcohol tax and price policies on morbidity and mortality: a systematic review. *American Journal of Public Health* 2010;100:2270-78.
164. Grossman M, Markowitz S. Alcohol regulation and violence on college campuses. In: Grossman M, Hsieh CR, editors. *Economic analysis of substance use and abuse: the experience of developed countries and lessons for developing countries*. Cheltenham: Edward Elgar, 2001.
165. Markowitz S. The price of alcohol, wife abuse, and husband abuse. *Southern Economic Journal* 2000;67:279-304.
166. Purshouse R, Brennan A, Latimer N, et al. Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0: report to the NICE Public Health Programme Development Group. Sheffield: University of Sheffield, 2009.
167. HM Government. The Government's Alcohol Strategy. Norwich: The Stationery Office, 2012.
168. Stockwell T, Auld MC, Zhao J, et al. Does minimum pricing reduce alcohol consumption? The experience of a Canadian province. *Addiction* 2012;107:912-20.
169. HM Government. The Government's Alcohol Strategy. Norwich: The Stationery Office, 2012.
170. Fleming MF, Barry KL, Manwell LB, et al. Brief physician advice for problem alcohol drinkers. *Journal of the American Medical Association* 1997;277:1039-45.
171. Sitharthan T, Sitharthan G, Hough MJ, et al. Cue exposure in moderation drinking: a comparison with cognitive behavior therapy. *Journal of Consulting and Clinical Psychology* 1997;65:878-82.
172. Barber J, Crisp BR. The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction* 1995;90:269-76.
173. Hawkins JD, Oesterle S, Brown EC, et al. Sustained decreases in risk exposure and youth problem behaviors after installation of the Communities that Care prevention system in a randomized trial. *Archives of Pediatric and Adolescent Medicine* 2012;166:141-48.
174. Hughes K, Quigg Z, Eckley L, et al. Environmental factors in drinking venues and alcohol-related harm: the evidence base for European intervention. *Addiction* 2011;106 (Supp 1):37-46.
175. Wiggers J, Jauncey M, Considine R, et al. Strategies and outcomes in translating alcohol harm reduction research into practice: the Alcohol Linking Program. *Drug and Alcohol Review* 2004;23:355-64.
176. Warburton AL, Shepherd JP. Tackling alcohol related violence in city centres: effect of emergency medicine and police intervention. *Emergency Medical Journal* 2006;23:12-17.
177. Graham K, Osgood D, Zibrowski E, et al. The effect of the Safer Bars programme on physical aggression in bars: results of a randomized controlled trial. *Drug and Alcohol Review* 2004;23:31-41.
178. Homel R, Carvolth R, Hauritz M, et al. Making licensed venues safer for patrons: what environmental factors should be the focus of interventions? *Drug and Alcohol Review* 2004;23:19-29.
179. Pointing S, Hayes-Jonkers C, Bohanna I, et al. The role of an open-space CCTV system in limiting alcohol-related assault injuries in a late-night entertainment precinct in a tropical Queensland city, Australia. *Injury Prevention* 2012;18:58-61.
180. Jones L, Hughes K, Atkinson AM, et al. Reducing harm in drinking environments: a systematic review of effective approaches. *Health and Place* 2011;17:508-18.
181. Wallin E, Norstrom T, Andreasson S. Alcohol prevention targeting licensed premises: a study of effects on violence. *Journal of Studies on Alcohol* 2003;64:270-77.
182. Mansdotter AM, Rydberg MK, Wallin E, et al. A cost-effectiveness analysis of alcohol prevention targeting licensed premises. *European Journal of Public Health* 2007;17:618-23.
183. Warpenius K, Holmila M, Mustonen H. Effects of a community intervention to reduce the serving of alcohol to intoxicated patrons. *Addiction* 2010;105:1032-40.
184. Miller P, Sonderlund A, Coomber K, et al. Do community interventions targeting licensed premises reduce alcohol-related emergency department interventions? *Drug and Alcohol Review* 2011;30:546-53.
185. Dines C. Using A&E data to prevent violence in communities. *Nursing Times* 2011;107:16-18.
186. Florence C, Shepherd J, Brennan I, et al. Effectiveness of anonymised information sharing and use in health service, police, and local government partnership for preventing violence related injury: experimental study and time series analysis. *BMJ* 2011;342:d3313.
187. Farrington DP, Welsh BC. Effects of improved street lighting on crime: a systematic review. London: Home Office, 2002.
188. Cerda M, Morenoff JD, Hansen BB, et al. Reducing violence by transforming neighborhoods: a natural experiment in Medellin, Colombia. *American Journal of Epidemiology* 2012;175:1045-1053.
189. Kuo FE, Sullivan WC. Aggression and violence in the inner city: effects of environment via mental fatigue. *Environment and Behavior* 2001;33:543-571.
190. Sullivan WC, Kuo FE, DePooter SF. The fruit of urban nature: vital neighborhood spaces. *Environment and Behavior* 2004;36:678-700.
191. World Health Organization and Liverpool John Moores University. Changing social and cultural norms that support violence. Geneva: World Health Organization, 2009.
192. Wellings K, Macdowal W. Evaluating mass media approaches to health promotion: a review of methods. *Health Education* 2000;100:23-32.
193. Durrant JE. Evaluating the success of Sweden's corporal punishment ban. *Child Abuse and Neglect* 1999;23:435-48.
194. Durrant JE, Janson S. Law reform, corporal punishment and child abuse: the case of Sweden. *International Review of Victimology* 2005;12:139-58.

195. Association of Chief Police Officers, Crown Prosecution Service and NHS Protect. Tackling violence and antisocial behaviour in the NHS. London, 2011.
196. Foubert J, Newberry JT. Effects of two versions of an empathy-based rape prevention program on fraternity men's survivor empathy, attitudes, and behavioral intent to commit rape or sexual assault. *Journal of College Student Development* 2006;47:133-48.
197. Olive P. Care for emergency department patients who have experienced domestic violence: a review of the evidence base. *Journal of Clinical Nursing* 2007;16:1736-48.
198. O'Campo P, Kirst M, Tsamis C, et al. Implementing successful intimate partner violence screening programs in health care settings: evidence generated from a realist-informed systematic review. *Social Science and Medicine* 2011;72:855-66.
199. Feder G, Ramsay J, Dunne D, et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment* 2009;13(16).
200. Feder G, Long C. Report from the domestic violence sub-group: responding to violence against women and children - the role of the NHS. London: Taskforce on the Health Aspects of Violence Against Women and Children, 2010.
201. Sherin KM, Sinacore JM, Li XQ, et al. HITS: a short domestic violence screening tool for use in a family practice setting. *Family Medicine* 1998;30:508-12.
202. Chen P, Rovi S, Vega M, et al. Screening for domestic violence in a predominantly Hispanic clinical setting. *Family Practice* 2005;22:617-23.
203. Cohn F, Salmon ME, Stobo JD. Confronting chronic neglect: the education and training needs of health professionals to respond to family violence. Washington DC: National Academy Press, 2002.
204. Harwell TS, Casten RJ, Armstrong KA, et al. Results of a domestic violence training program offered to the staff of urban community health centers. Evaluation Committee of the Philadelphia Family Violence Working Group. *American Journal of Preventive Medicine* 1998;15:235-42.
205. Feder G, Davies RA, Baird K, et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence with a primary care training and support programme: a cluster randomised controlled trial. *Lancet* 2011;378:1788-95.
206. Department of Health. Domestic violence: a resource manual for health care professionals. London: Department of Health, 2000.
207. McFarlane JM, Groff JY, O'Brien JA, et al. Secondary prevention of intimate partner violence: a randomized controlled trial. *Nursing Research* 2006;55:52-61.
208. Ramsay J, Carter Y, Davidson L. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews* 2009;3:CD005043.
209. Robinson A. Independent Sexual Violence Advisors: a process evaluation. London: Home Office, 2009.
210. Campbell R, Patterson D, Lichy LF. The effectiveness of Sexual Assault Nurse Examiner (SANE) programs: a review of psychological, medical, legal, and community outcomes. *Trauma, Violence, & Abuse* 2005;6:313-329.
211. Steel N, Blakeborough L, Nicholas S. Supporting high-risk victims of domestic violence: a review of Multi-Agency Risk Assessment Conferences (MARACs). London: Home Office, 2011.
212. Chaffin M, Silovsky JF, Funderburk B, et al. Parent-child interaction therapy with physically abusive parents: efficacy for reducing future abuse reports. *Journal of Clinical and Consulting Psychology* 2004;72:500-510.
213. MacMillan HL, Wathen CN, Fergusson DM, et al. Interventions to prevent child maltreatment and associated impairment. *Lancet* 2009;373:250-266.
214. Leve LD, Fisher PA, Chamberlain P. Multidimensional treatment foster care as a preventive intervention to promote resiliency among youth in the child welfare system. *Journal of Personality* 2009;77:1869-1902.
215. Roberts NP, Kitchiner NJ, Kenardy J, et al. Systematic review and meta-analysis of multiple-session early interventions following traumatic events. *The American Journal of Psychiatry* 2009;166:293-301.
216. Kornor H, Winje D, Ekeberg O, et al. Early trauma-focused cognitive-behavioral therapy to prevent chronic post-traumatic stress disorder and related symptoms: a systematic review and meta-analysis. *BMC Psychiatry* 2008;8:81.
217. Martsof DS, Draucker CB. Psychotherapy approaches for adult survivors of childhood sexual abuse: an integrative review of outcomes research. *Issues in Mental Health Nursing* 2005;26:801-25.
218. Coon DW, Thompson L, Steffen A, et al. Anger and depression management: psychoeducational skill training interventions for women caregivers of a relative with dementia. *Gerontologist* 2003;43:678-89.
219. Shaw C, McNamara R, Abrams K, et al. Systematic review of respite care in the frail elderly. *Health Technology Assessment* 2009;13.
220. Holt VL, Kernic MA, Wolf ME, et al. Do protection orders affect the likelihood of future partner violence and injury? *American Journal of Preventive Medicine* 2003;24:16-21.
221. Crown Prosecution Service. Specialist domestic violence courts review 2007-08. [http://www.cps.gov.uk/publications/equality/sdvc\\_review\\_exec\\_sum.html](http://www.cps.gov.uk/publications/equality/sdvc_review_exec_sum.html), 2008.
222. HM Government. Healthy lives, healthy people: our strategy for public health in England. London: The Stationery Office, 2010.
223. HM Government. Healthy lives, healthy people: update and way forward. London: The Stationery Office, 2011.
224. Department of Health. Public health in local government: fact sheets. London: Department of Health, 2011.
225. HM Government. The government response to the Stern Review: an independent review into how rape complaints are handled by public authorities in England and Wales. London: Cabinet Office, 2011.

226. Alberti G. Responding to violence against women and children - the role of the NHS: Task Force on the Health Aspects of Violence Against Women and Children, 2010.
227. Crilly T, Combes G, Davidson D, et al. Feasibility of transferring budget and commissioning responsibility for forensic sexual offences examination work from the police to the NHS: evidence base to support the impact assessment. Birmingham: University of Birmingham, 2011.
228. Department of Health. Joint Strategic Needs Assessment and joint health and wellbeing strategies explained: commissioning for populations. London: Department of Health, 2011.
229. Department of Health. Improving outcomes and supporting transparency. Part 1: A public health outcomes framework for England, 2013-2016. London: Department of Health, 2012.
230. HM Government. No health without mental health: a cross-government mental health outcomes strategy for people of all ages. London: Department of Health, 2011.
231. HM Government. Drug strategy 2010. Reducing demand, restricting supply, building recovery: supporting people to live a drug free life. London Home Office, 2010.
232. Police Reform and Social Responsibility Act 2011. Norwich: The Stationery Office, 2011.
233. Department of Health. Public Health Responsibility Deal: <http://responsibilitydeal.dh.gov.uk/>.
234. HM Government. Call to end violence against women and girls. London: Home Office, 2010.
235. HM Government. Call to end violence against women and girls: action plan. London: Cabinet Office, 2011.
236. HM Government. Call to end violence against women and girls: taking action - the next chapter. London: The Stationery Office, 2012.
237. Home Office. Multi-agency statutory guidance for the conduct of domestic homicide reviews. London: Home Office.
238. Department of Health. Improving services for women and child victims of violence: the Department of Health Action Plan. London: Department of Health, 2010.
239. Department of Health. Commissioning services for women and children who experience violence or abuse - a guide for health commissioners. London: Department of Health, 2011.
240. Department of Health. Response to sexual violence needs assessments (RSVNA) toolkit: informing the commissioning and development of co-ordinated specialist services for victims of sexual violence. London: Department of Health, 2011.
241. Department of Health. The operating framework for the NHS in England 2011/12. London: Department of Health, 2010.
242. Department of Health. Healthy lives, healthy people: consultation on the funding and commissioning routes for public health. London: Department of Health, 2011.
243. Stern V. The Stern review: a report by Baroness Vivien Stern CBE of an independent review into how rape complaints are handled by public authorities in England and Wales. London: Government Equalities Office/Home Office, 2010.
244. Munro E. The Munro review of child protection: final report. London: The Stationery Office, 2011.
245. HM Government. Caring for our future: reforming care and support. London: HM Government, 2012.
246. Department of Health. Safeguarding adults: the role of health services. [http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_124882](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124882) 2011.
247. Communities and Local Government. Troubled Families: <http://www.communities.gov.uk/communities/troubledfamilies/>.
248. Department of Health. Getting it right for children, young people and families: maximising the contribution of the school nursing team: vision and call to action. London: Department of Health, 2012.
249. HM Government. The equality strategy - building a fairer Britain. London: Government Equalities Office, 2010.
250. Department of Health. Guidance on provisions to deal with nuisance or disturbance behaviour on NHS premises in England. London: Department of Health, 2009.
251. Sethi D, Hughes K, Bellis MA, et al. European report on preventing violence and knife crime among young people. Copenhagen: World Health Organization Regional Office for Europe, 2010.
252. World Health Organization Regional Office for Europe. European inventory of national policies for the prevention of violence and injuries: <http://data.euro.who.int/InjuryPrevention/?TabID=149801>
253. World Health Organization. TEACH-VIP: [http://www.who.int/violence\\_injury\\_prevention/capacitybuilding/teach\\_vip/en/](http://www.who.int/violence_injury_prevention/capacitybuilding/teach_vip/en/).
254. World Health Organization. MENTOR-VIP: [http://www.who.int/violence\\_injury\\_prevention/capacitybuilding/mentor\\_vip/en/](http://www.who.int/violence_injury_prevention/capacitybuilding/mentor_vip/en/).
255. Sethi D, Wood S, Mitis F, et al. European report on preventing elder maltreatment. Copenhagen: World Health Organization Regional Office for Europe, 2011.
256. World Health Organization and Liverpool John Moores University. Prevent violence: the evidence. Geneva: World Health Organization, 2009.
257. Bellis MA, Jones L, Hughes K, et al. Preventing and reducing armed violence: what works? New York: United Nations Development Programme, 2010.
258. Wood J, Hennell T, Jones A, et al. Where wealth means health. Liverpool: North West Public Health Observatory, 2005.

**Address for Correspondence**

North West Public Health Observatory  
@ The Centre for Public Health  
A WHO Collaborating Centre for Violence Prevention  
Liverpool John Moores University  
15-21 Webster Street  
Liverpool L3 2ET  
Tel: +44 (0)151 231 4511

Electronic copies are available at:

[www.cph.org.uk](http://www.cph.org.uk)  
[www.nwpho.org.uk](http://www.nwpho.org.uk)  
[www.preventviolence.info](http://www.preventviolence.info)

October 2012  
ISBN 978-1-908929-20-4 (web)

