



KEY messages:

- *Young males [aged 15-24 years] are most at risk of experiencing violence either as victims or perpetrators, but children, the elderly and women are also high risk groups*
- *Violence has a significant impact on the health of individuals and communities in many ways: from fear of violence, health consequences for victims, witnesses, family and friends, to the burden on NHS services and criminal justice agencies*
- *Assault is a leading cause of hospital admissions for young men in all three Strategic Health Authorities in the North West, with a five fold higher rate in Oldham and Liverpool [1,000/100,000] compared with South Lakeland [200/100,000]*
- *A Public Health and multi-agency approach is required to tackle the problem of violence, building upon the traditional criminal justice view and bringing together data and evidence from a wide range of sources*
- *Although violence involving guns and knives is well publicised, "bodily force" alone is implicated in the majority of violent incidents that result in serious injury*
- *Alcohol is a key factor across all types of interpersonal violence. 50% of all violence in England and Wales is related to alcohol*

1 Introduction

The World Health Organization¹ defines violence as:

“ The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. ”

This report specifically examines interpersonal violence [violence between individuals]. This type of violence takes many forms [see Box 1]. Violence has traditionally been viewed as a problem to be dealt with by the Criminal Justice System. More recently, however, the importance of looking at violence from a public health perspective has been realised on an international scale. In 2002, the World Health Organization launched the Global Campaign for Violence Prevention¹ to highlight the need for a public health lead in a multi-agency approach to violence prevention. The Violent Britain report² was published in 2005 to raise awareness of the problem of violence nationally and promote the World Health Organization approach to violence prevention.

Initially, a public health approach can tackle the problem of violence by gathering data from different sources in order to assess the magnitude and patterning of violence. A public health approach can then be used to identify both risk and protective factors. This will facilitate the development and implementation of interventions tailored to the appropriate demographic and socio-economic groups. The monitoring and ultimate evaluation of such interventions, however, can only be achieved if the initial baseline data are reliable and accurate.

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Box I - Typology of Interpersonal Violence

Youth Violence

- Youth violence committed by or against young people [aged 10 to 30 years] accounts for an estimated 60% of all violence committed in England and Wales. With many incidents of youth violence occurring in public places, it is one of the most visible forms of violence and also one that receives most media attention.

Intimate Partner Violence

- Intimate partner violence [sometimes referred to as domestic violence] is violence between present or ex intimate partners. It can occur within same sex relationships, or against men by women, but the majority of victims are women within heterosexual relationships.

Child Maltreatment

- Child maltreatment is committed by adults towards children and covers physical, emotional and psychological abuse as well as adults failing to provide the care and supervision necessary to ensure a child's healthy development.

Elder Abuse

- Elder abuse is any act, single or repeated, that causes harm or distress to an older person, including physical violence, emotional abuse, neglect and financial abuse. Such acts can occur within any relationship where there is an expectation of trust. Such abuse can therefore occur in both domestic and institutional settings.

Sexual Violence

- Sexual violence incorporates a wide range of different sexual acts from sexual harassment to rape. This includes not only unwanted actual sexual acts, but also unwanted sexual comments or advances. These acts can be committed by strangers, acquaintances or intimate partners. They can occur in a variety of settings including the home and workplace.

2 Overview of violence in England, Wales and the North West

Data Sources

The true extent of violence is difficult to assess with sources often revealing conflicting data. According to police statistics, violence has increased since 1997² [Figure 1]. By contrast, figures from the British Crime Survey³, based on a questionnaire conducted in 40,000 households about experiences of crime, shows a decrease in violence for the same period [Figure 1].

Figure 1: Comparison of trends in violence in England and Wales: Police Recorded Crime [PRC] and British Crime Survey [BCS]³.

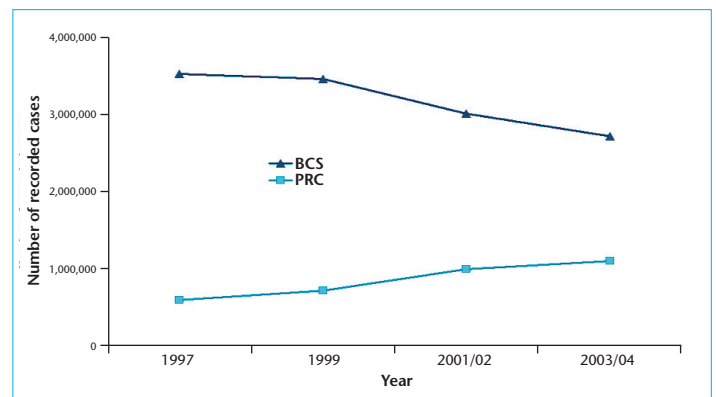
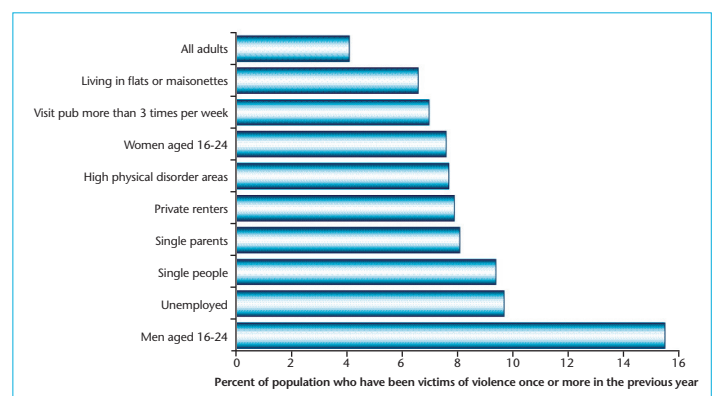


Table 1 lists some potential data sources and their limitations. While most resources have flaws, using them in combination still provides a valuable overview.

There is consensus, however, regarding those who are at highest risk of becoming victims of violence [Figure 2]. These individuals are likely to come into contact with healthcare providers for other reasons, since they also fall into other high-risk categories. This means that health service providers are in a good position to take the lead in gathering information, and in implementing and evaluating prevention initiatives.

Figure 2: British Crime Survey 2003/2004: people at highest risk of violence³.



Impact of Violence on health, communities and services

Table 1: Examples of data sources.

Data Category	Source	Information	Limitations
Mortality	Office for National Statistics	Date and cause of death, victim demographics	<ul style="list-style-type: none"> Many suicides are classified as "open verdict" Homicides are often not included until months or even years after the event No perpetrator information
Morbidity and health related	Hospital Episode Statistics	Cause, type of injury, victim demographics, length of hospital stay, date of admission	<ul style="list-style-type: none"> Only the most serious cases requiring hospital stay No perpetrator information
	A&E data	Variable	<ul style="list-style-type: none"> Not standardised
	Ambulance data		
Criminal justice	Police Recorded Crime	Date, time and location, perpetrator demographics	<ul style="list-style-type: none"> Under reporting of violent crime
	Crown Prosecution Service		
	Anti Social Behaviour Orders		
Self reported	British Crime Survey	Date, location, victim demographics, type of violence, perpetrator information, circumstances	<ul style="list-style-type: none"> Perpetrator and circumstances information based on victims perception, so subjective
	Charities and focus groups	Variable	

Table 2: Ten leading causes of hospital admissions for males aged 15-24 years, 2003/04 (number of admissions).

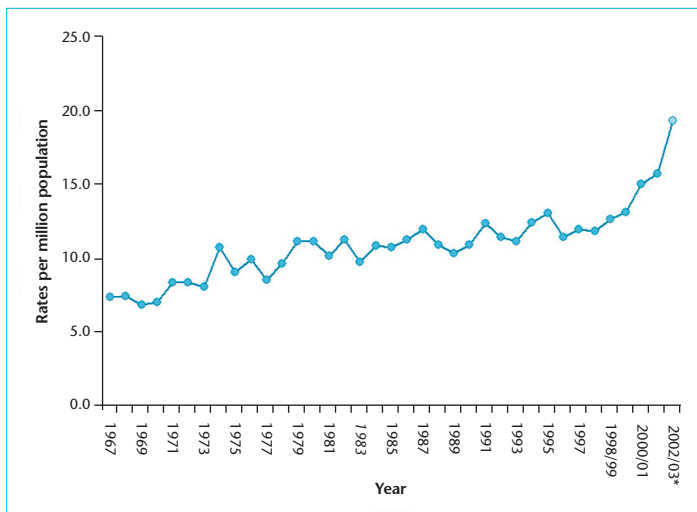
Rank	England & Wales	North West	Greater Manchester	Cumbria & Lancashire	Cheshire & Merseyside
1	Unintentional Injuries 19,734	Assaults 2,950	Assaults 1,153	Unintentional Injuries 742	Assaults 1,138
2	Assaults 13,743	Unintentional Injuries 2,570	Malignant Neoplasms 869	Assaults 659	Unintentional Injuries 1,005
3	Malignant Neoplasms 10,395	Malignant Neoplasms 1,674	Unintentional Injuries 823	Malignant Neoplasms 504	Intentional Self-Harm 386
4	Intentional Self-Harm 6,753	Intentional Self-Harm 1,147	Intentional Self-Harm 433	Intentional Self-Harm 328	Malignant Neoplasms 301
5	Diseases of Appendix 5,300	Benign Neoplasms 750	Benign Neoplasms 300	Diseases of Appendix 204	Diseases of Appendix 277
6	In Situ Neoplasm 4,379	Diseases of Appendix 744	Diseases of Appendix 263	Benign Neoplasms 186	Benign Neoplasms 264
7	Hernia 3,735	Hernia 560	Hernia 234	Hernia 138	Nephritis 257
8	Anaemia 3,609	Nephritis 519	Nephritis 225	Congenital Anomalies 129	Hernia 187
9	Congenital Anomalies 3,368	Congenital Anomalies 493	Congenital Anomalies 211	Bronchitis, Emphysema, Asthma 101	Congenital Anomalies 153
10	Diabetes Mellitus 2,230	Diabetes Mellitus 339	Anaemia 211	Diabetes Mellitus 78	Bronchitis, Emphysema, Asthma 113

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Extent of Violence

In the most extreme cases interpersonal violence results in homicide. Figure 3 illustrates the steady increase in homicide rates over the last 25 years. In comparison to many countries, homicide rates in England and Wales are still relatively low.⁴ However, thousands of incidents of non-fatal violence occur every day throughout England and Wales and the North West, with interpersonal violence in the form of assault accounting for a high proportion of hospital admissions. For the highest risk group, males between the ages of 15 and 24, assault is a leading cause of hospital admission in all Strategic Health Authorities in the North West [Table 2]. Facts and figures for all types of interpersonal violence in England and Wales highlight the extent of the problem [Box 2].

Figure 3: Homicide Rates in England and Wales: 1967 - 2002/03⁴.



*172 murder victims of Dr Harold Shipman were recorded for this year

Box 2 - Epidemiology of Violence in England and Wales²

Youth Violence

- 73% of violent offenders under the age of 30 escape all sanctions by the criminal justice system.
- An estimated 654,934 12-30 year olds [5.2%] were involved in a fight during the last year.
- Youths account for 48% of victims and 71% of perpetrators of offences involving firearms.

Intimate Partner Violence

- 26% of females and 16.5% of males have experienced some form of intimate partner violence since age 16.
- Three quarters of abused mothers say that their children have witnessed intimate partner violence
- 115 people were murdered by their intimate partners in 2003/2004.

Child Maltreatment

- On average, 80 child homicides are recorded in England and Wales each year. Over 90% of these deaths are inflicted by a parent, caregiver, or person known to the child.
- 16% of children experience some form of sexual abuse.
- It is estimated that 35% of individuals experience absence of care at some point during their childhood, 6% of whom suffer severe hardship through neglect.

Sexual Violence

- In 2003/4, 52,070 sexual offences were recorded in England and Wales, including 12,354 rapes towards females and 893 rapes towards males.
- One in twenty women and one in a hundred men have been raped.
- 24% of women and 5% of men have experienced some form of sexual assault during their lifetime.

Elder Abuse

- Half a million older people in the UK are experiencing abuse at any one time.
- An estimated 82% of older people in institutions receiving neuroleptic drugs are receiving inappropriate therapy.
- Only 5% of people over the age of 65 live in institutional settings, yet 31% of abuse occurs at these locations.

3 Impact of Violence on Health [Communities and Health Services]

Violence has a significant impact on health in many ways. In the wider community, high levels of violence not only have devastating consequences for victims, their family and friends and witnesses but also place huge strains on the Criminal Justice System, education, Local Authorities and other agencies. For example, fear of violence reduces community cohesion and can prevent people visiting certain areas associated with violence, such as parks or towns and city centres at night. This in turn can hamper efforts to promote healthy lifestyles, to diversify late night leisure options and to regenerate urban centres. While the total costs of such losses are difficult to measure, the economic costs of violence in England and Wales, including health costs, criminal justice, lost economic output and the social and emotional costs to victims, have been estimated at £24.4 billion annually.⁵

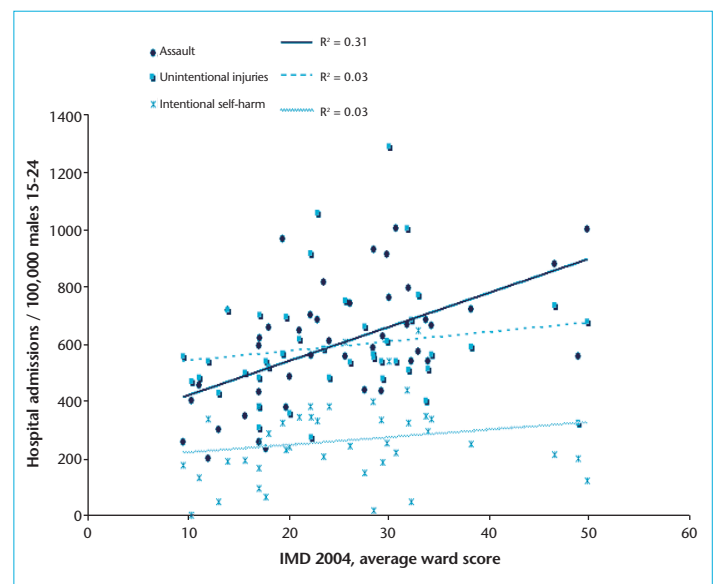
In terms of direct economic expenditure, health services must treat the traumatic injuries incurred as a result of violence. Hospital Episode Statistics show that hospital admissions due to violence cost the NHS between £1.1-1.3 billion annually.⁶ Since this figure only includes inpatients, the overall cost will be significantly higher. If this financial burden is reduced, then access to services will improve, and targets will be more easily reached.

Violence also has an indirect impact on health services due to attacks and fear of attacks on personnel [Box 3]. Between 2002-2003, 116,000 NHS staff were victims of violence. Apart from having a detrimental effect on morale, violence and aggression to staff costs the NHS £300-678 million per year.⁷

Youth Violence

The impact of youth violence on Accident and Emergency departments has been well documented. For example, in one study, 76% of all assault victims attending an Accident and Emergency department on Merseyside fell into the youth age category.⁸ Youth violence is often alcohol-related, with much of this type of violence occurring in and around pubs and nightclubs. Many youth assaults in nightlife settings involve the use of glasses and bottles as weapons and resultant injuries can have devastating consequences including long-term facial

Figure 4: Relationship between deprivation [Index of Multiple Deprivation 2004] and leading causes of violence-related hospital admissions of young men for Local Authorities in the North West, 2003/04.



disfigurement and ensuing psychological problems.⁹ Greater expenses are incurred when patients require admittance to hospital for further treatment, including surgery. Across the North West, rates of admissions to hospital for assault, for men aged 15-24 increase with local area deprivation [Figure 4]. Rates of hospital admissions for assault in males aged 15-24 vary considerably between Local Authorities from 200-300 per 100,000 population in more rural areas such as South Lakeland, Wyre and Vale Royal to over 1000/100,000 in the urban areas of Liverpool and Oldham [Figure 5 and Appendix 1]. These figures represent the residence of the assault victim and not necessarily the Local Authority of where the assault took place.

Box 3 - Violence: Indirect negative impacts on health

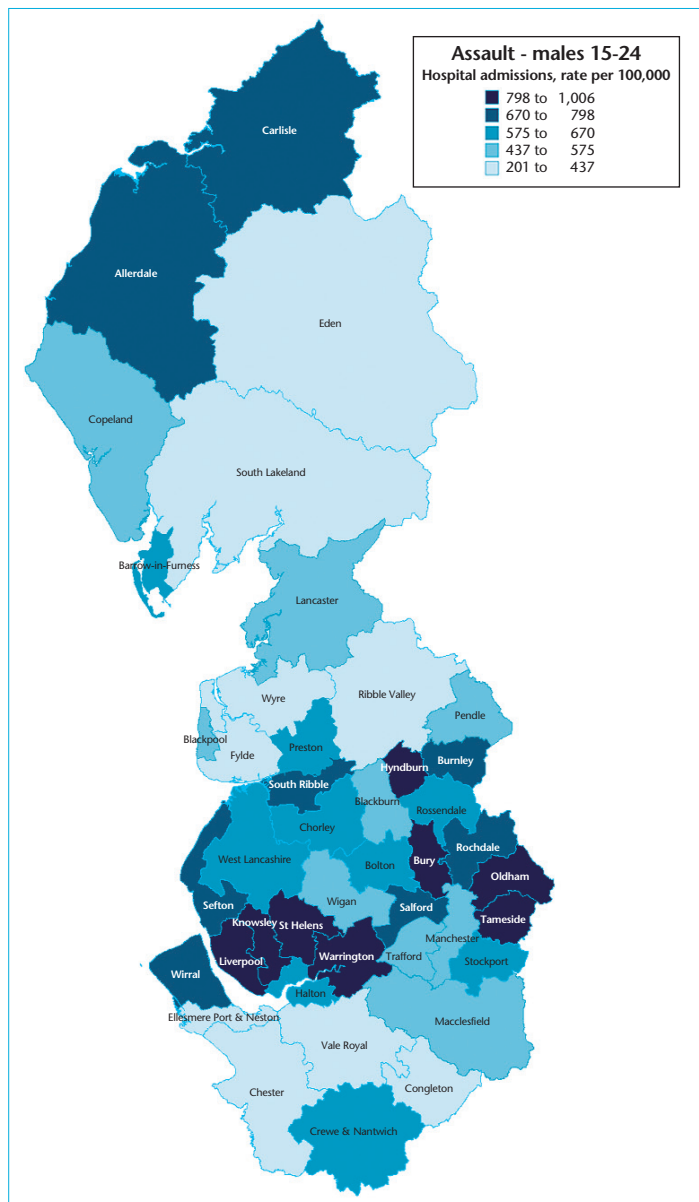
- Fear of violence can produce stress and also result in reduced mobility.
- Domestic violence has long-term health consequences for women and for their children who often witness it.
- Child abuse can cause mental health impairment long into adulthood. This often creates a cycle of abuse.
- Elder abuse that takes place in health care settings, impedes the recovery of the patient.
- Access to health services is reduced due to the financial burden of violence.

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Intimate Partner Violence

Over 18% of intimate partner assaults result in a doctor's visit in comparison to 8% for stranger violence.¹⁰ In addition to acute conditions requiring urgent care, intimate partner violence frequently results in chronic conditions that require long-term treatment. Victims of intimate partner abuse were likely to require treatment for a number of psychiatric disorders, with victims of intimate partner violence accounting for 25% of all female emergency psychiatric inpatient admissions¹¹. Furthermore, 64% of all female psychiatric inpatients have a history of abuse by intimate partners.¹¹

Figure 5: Geographic distribution of hospital admissions for assault in young men in the North West, 2003/04.



Child Maltreatment

Child maltreatment can result in the form of trauma requiring immediate treatment. For example, “battered child syndrome” is characterised by serious skin injuries, damage to skeletal and nervous tissue, and trauma to the head and viscera. Other forms of physical abuse such as the violent shaking of infants have both acute and chronic effects. There are many indirect, long-term consequences of all forms of child maltreatment; these can be physical, sexual/reproductive, or psychological. Several studies have linked child maltreatment with the adoption of negative behaviours that increase the risk of cancer, irritable bowel syndrome, sexually transmitted diseases and other chronic disorders during adulthood.

Elder Abuse

Although there has been very little research into the health impacts of this type of violence, one US study found a reduction in life expectancy in those who experienced elder abuse. The study, which compared survival rates of 2,812 abused and non-abused elders, found that only 9% of the abused sample were still alive after a period of 13 years, compared to 40% of the non-abused sample.¹² Older people are more likely to suffer serious injury as a consequence of violence than their younger counterparts due to degenerative conditions such as osteoporosis. Furthermore, healing and convalescence take considerably longer; this can be exacerbated by the depression and psychological distress that occurs as a consequence of abuse.

Sexual Violence

The British Crime Survey investigated the physical and mental health consequences of sexual violence. Among female victims, half [52%] reported depression and emotional problems, a third [38%] stopped trusting people, and a fifth [21%] had difficulty sleeping. Physical injuries included minor bruising and scratches [18%], substantial bruising [10%] and bleeding from cuts [7%]. One in twenty victims reported having attempted suicide as a result of the assault.¹³ Another British study found women admitted to hospital following deliberate self-poisoning [overdose] were 12 to 15 times more likely to have suffered sexual abuse than those admitted for other purposes.¹⁴

4 Effective Interventions and Policy

The World Health Organization World Report on Violence and Health¹ provides a range of guidance to assist violence prevention at all levels, much of which is based on the growing evidence that risk factors for violence can be reduced through effective intervention [Box 4 summarises the risk factors for victimisation and perpetrators for different types of violence].²

In the North West and the UK as a whole, a large amount of work is being undertaken to prevent and address violence, particularly the more visible and widespread forms such as alcohol-related and domestic violence.²

The following sections identify interventions that have proven to be effective in a variety of countries and highlight the role health care professionals can play as part of a multi-agency approach to reducing violence. However, this synthesis report is not able to provide a comprehensive overview of all policy and action in place across Britain aimed at tackling violence but, it focuses on examples of policies that are being or could be used to address specific risk factors and successful interventions. Hence it identifies policies that may not normally be directly associated with violence, but in doing so intends to provide a broader view of violence prevention and identify the wide range of agencies that can and should contribute to the violence prevention agenda.

Box 4 - Risk Factors for Violence²

Youth Violence	Victim	Perpetrator	Child Maltreatment	Victim	Perpetrator
Aggressive and anti-social behaviour during childhood	✓	✓	Having more than three siblings	✓	✗
Maternal stress during pregnancy	✓	✓	Being a teenage mother	✗	✓
Maternal postnatal depression	✓	✓	Living in a low income household	✓	✓
Having a teenage mother	✓	✓	Living in a household where intimate partner violence occurs	✓	✓
Witnessing intimate partner violence during childhood	✓	✓	Elder Abuse		
Lack of parental supervision	✓	✓	Being aged over 80	✓	✗
Delay in language and cognitive development	✓	✓	Suffering from a mental disorder	✓	✗
Drug use	✓	✓	Having dependent relatives	✓	✗
Alcohol misuse	✓	✓	Living in an institutional setting	✓	✗
Disaffection from school	✓	✓	Drug and alcohol misuse	✓	✓
Living in a deprived neighbourhood	✓	✓	Low income	✗	✓
Being male	✓	✓	Sexual Abuse		
Intimate Partner Violence			Being married or living with a partner	✓	✓
Living in a low income household	✓	✓	Being young	✓	✗
Pregnancy	✓	✗	Drug or alcohol misuse	✓	✓
Alcohol misuse	✓	✓	Involvement in sex work	✓	✗
Being female	✓	✗	Poverty	✓	✓
Being male	✗	✓	Being female	✓	✗
			Being male	✗	✓

Reducing unintended pregnancies

Children born as a result of unwanted pregnancies, particularly to teenage mothers, face a higher risk of becoming either victims or perpetrators of violence. Research in the UK shows that unwanted teenage pregnancies can be prevented most effectively if interventions are initiated early, before risky sexual behaviour has been established.¹⁵ Evidence from other European countries shows that co-ordinated programmes involving policy reforms in addition to work by contraceptive services, schools and hospitals result in major reductions in the teenage conception rate.¹⁶

Policies:

The Teenage Pregnancy Unit [a cross Government Unit located within the Children and Families Directorate in the Department of Education and Skills] implements the Government's teenage pregnancy strategy by coordinating activity at national level while providing support for local activity. This includes the education of parents and teenagers on the availability of contraceptive and sexual health services. It also provides appropriate referral guidance for professionals who come into contact with teenagers.

www.teenagepregnancyunit.gov.uk

The national *Teenage Pregnancy Strategy*¹⁷ sets out to halve the under 18 conception rate in England by 2010. The teenage conception reduction target is also one of the NHS Performance Indicators for Primary Care Trusts [PCTs] and is a national Public Service Agreement [PSA] for Local Government.

www.audit-commission.gov.uk/index.asp

*Choosing Health: Making Healthier Choices Easier*¹⁸ [the Public Health White Paper published in November 2004] outlines a new national campaign to raise awareness of the risks of unprotected sex and to avoid the risk of unwanted pregnancies in young people.

www.dh.gov.uk

Increasing access to pre and postnatal services

Postnatal depression has been shown to increase the likelihood of child maltreatment and future offending during adulthood. Eight weekly home visits from healthcare professionals during the postnatal period have been found to be as effective as antidepressants in reducing maternal anxiety and associated risk factors for violence.¹⁹ Although such long-term programmes are too cost-prohibitive to serve as primary interventions, targeting mothers who lack protective factors could be feasible as a secondary intervention, particularly if incorporated into existing programmes such as Sure Start.

Extending the duration of home visiting following birth has also proven beneficial. Such programmes provide support for women who lack a support network within their own community.²⁰ By screening for early language development problems, consequential later violent offending can be reduced. Longitudinal studies in the US have found a substantial reduction in child aggression by age three²¹ as a result of screening and speech therapy.

Policies:

*The National Service Framework [NSF] for Children, Young People and Maternity Services*²² requires PCTs and NHS maternity service providers to ensure all pregnant women have two visits with midwives early in their pregnancy and are able to access the support of a named midwife thereafter. It is also a requirement that maternity services have a policy to identify pregnant women with mental illnesses and ensure that they receive support. www.dh.gov.uk

There is provision for further support under *Sure Start Plus* programmes that are aimed at teenage parents both before and after pregnancy. Services include healthcare, practical advice and training in parenting skills. Teenage mothers experiencing postnatal depression are given particular attention. www.teenagepregnancyunit.gov.uk. *Every Child Matters*²³ also makes provision for home visiting programmes. www.rcu.gov.uk/articles/news/everychildmatters.pdf

Train health care professionals to screen, identify and refer victims of violence

Healthcare professionals frequently come into contact with victims of all types of violence, and are therefore ideally situated to identify victims of violence and refer them to appropriate local services. Although the majority of work undertaken in this area involves victims of child maltreatment and female victims of intimate partner violence, the protocols can be adapted for screening and referring victims of elder abuse.

Training is required in all types of screening, since healthcare professionals need to be taught not only how to identify abuse, but also how to question patients about abuse safely and sensitively.²⁴ Furthermore, they must be familiar with locally available services to which they can refer individuals who have disclosed abuse.²⁵ To ensure that information is shared effectively and safely with relevant agencies, staff must also be trained in protocols for information sharing.²⁶

Policies:

A large proportion of domestic violence either starts or intensifies during pregnancy. By including routine enquiry in antenatal appointments, health professionals may be able to detect women who are at risk of, or have already experienced, intimate partner violence during their pregnancy, and ensure they receive appropriate support and advice. To this end, the Department of Health has developed a *Resource Manual for Health Care Professionals*²⁴ to provide healthcare workers with information on intimate partner violence and advice on training staff in its detection. This is particularly relevant to those working in maternity services. This is also recognised in *Choosing Health*¹⁸, which recommends that all pregnant women should be routinely screened for this form of violence by healthcare professionals during early pregnancy. www.dh.gov.uk

The England Violence and Abuse Programme on Health and Mental Health examines the role of healthcare professionals in identifying and referring victims of all forms of violence including children, adolescents and the elderly. www.dh.gov.uk

Change culture in institutions for older people

Institutions for older people should have a culture that respects dignity, privacy and choice. To achieve this, service users should be involved in the decision-making processes.²⁷ This must be accompanied by rigorous inspections of institutions to ensure that acceptable standards are met. In 2004, The National Care Standards Commission and the General Social Care Council recommended the registration and training of all care workers in institutions for older people. Follow up action after complaints, policies and practices to deal with aggression by service users, and training to ensure that complaint procedures are in place and known are also useful in reducing abuse.

Policies:

Standard Two of the NSF is relevant to changing the culture in institutions for older people, since it aims to ensure that all older people are treated as individuals and receive appropriate care that meets their personal needs. The aim of Standard Seven: Mental Health in Older People, is to promote good mental health in older people and to treat and support those with dementia and depression. This will help protect the most vulnerable older people from abuse.

www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeoplesNSFStandards

Better Government for Older People [BGOP] aims to involve older people in shaping the development of strategies and services for an ageing population by ensuring they play a key role as partners. If successful, this UK wide partnership will help achieve a societal shift in attitudes towards elders and abuse perpetrated against them.

www.bgop.org.uk/pages/index.html

Alcohol reduction strategies

Since the links between alcohol and violence have been well documented, there are many well-evaluated programmes in the field of alcohol-related violence prevention. Community level programmes that have proven successful include increased alcoholic drinks prices, strict enforcement of laws that restrict the sale of alcohol to minors, enforcement of bans that restrict the drinking of alcohol in streets and public parks, and prevention of the sale of alcohol to intoxicated individuals. Interventions to train health staff to recognise those at risk and provide advice and support have proved effective in reducing behaviours associated with alcohol-related violence.^{28, 29, 30}

Other successful strategies involve a co-ordinated approach to change the environment in and around pubs and clubs where alcohol related violence frequently occurs. For example, the reduction of overcrowding, removal of glasses and bottles that can be used as weapons, and the provision of late night transport can all reduce the potential for violent incidents.²⁹ The Tasc project, a police-led multi-agency scheme, is proving promising in reducing alcohol-related violence and anti-social behaviour in Cardiff. The success of such projects is enhanced through partnership with health services and improvements to health [e.g. Accident and Emergency] data to assist in the identification of at risk populations and locations. Healthcare providers can also play a role in campaigns to raise awareness of alcohol-related violence, and in referring both victims and perpetrators of alcohol-related violence to the relevant support agencies.

Policies:

The Alcohol Harm Reduction Strategy for England³¹ aims to reduce the harms caused by alcohol misuse, including alcohol-related violence and disorder. www.strategy.gov.uk. Choosing Health¹⁸ builds on this by aiming to ensure that all health professionals can identify alcohol-related problems at an early stage. It provides guidance for targeted screening and brief interventions in healthcare settings.

www.dh.gov.uk

5 Partnership working and data sharing

A successful public health approach to violence is dependent upon multi-agency partnership working between a range of agencies including health, criminal justice, Local Authorities, social services, education, trading standards, businesses and local communities, all of whom are affected by violence and able to influence it.^{1,2} Promoting partnership-working means raising awareness of the impacts of violence on society [including public service targets] as well as the risk factors for involvement in violence. Increased awareness of violence will facilitate the implementation of violence prevention interventions that require co-operation between agencies, such as community schemes addressing nightlife environments. A co-ordinated approach will also help prevent the efforts of one agency to reduce violence being negated by the efforts of another agency to tackle a different issue.

In addition to partnership working, data sharing between agencies is essential in providing a wider picture of the true extent of violence and in identifying population groups and geographic locations at risk. Much violence is not reported to police, yet many victims are in contact with a range of other agencies including health services, social services and education. Thus many different agencies have the potential to identify victims and collate information that is required for appropriate targeting of interventions. Across the North West, efforts to share data between, for example, health and criminal justice services are increasing [e.g. the Trauma and Injury Intelligence Group in Cheshire and Merseyside www.nwpho.org.uk/ait; and Greater Manchester against Crime [GMAC] www.gmpa.gov.uk/site/publications/documents/PolicingStrategy2005-08.pdf.]

Implementation of the Home Office Tackling Violent Crime Programme in the region has prompted a range of data sharing events, and data exchange is an increasing priority. Work is also underway regionally to increase partnership working to address issues such as alcohol-related violence. For example, the North West Alcohol Harm Reduction Strategic Group brings together regional leads on alcohol from the Department of Health, the Home Office and a range of other organisations to implement a regional approach to reducing alcohol-related harm and violence.

Tackling violence is a substantial task. A public health approach to violence prevention can contribute by bringing together data from a wide range of sources. This is essential if effective interventions and prevention strategies are to be implemented in a cost-effective manner.

Impact of Violence on health, communities and services

Appendix I: Numbers and rates of hospital admissions for accidents and injuries for young men aged 15-24 by Local Authority in the North West, 2003/04.

Local Authority	Unintentional Injuries		Assault		Intentional Self-Harm	
	No.	Rate/100,000	No.	Rate/100,000	No.	Rate/100,000
Allerdale	54	1059	35	687	17	334
Barrow-in-Furness	31	775	23	575	26	650
Blackburn with Darwen	66	686	52	541	5	52
Blackpool	42	516	44	541	24	295
Bolton	82	481	107	628	32	188
Burnley	57	1005	38	670	25	441
Bury	65	584	91	817	23	207
Carlisle	55	920	42	702	23	385
Chester	22	308	31	434	7	98
Chorley	43	704	38	622	16	262
Congleton	28	557	13	259	9	179
Copeland	31	755	23	560	25	609
Crewe and Nantwich	25	383	39	597	25	383
Eden	13	503	9	349	5	194
Ellesmere Port & Neston	33	697	18	380	11	232
Fylde	17	430	12	304	2	51
Halton	45	567	53	668	27	340
Hyndburn	28	556	47	933	1	20
Knowsley	75	736	90	883	22	216
Lancaster	31	276	63	561	39	347
Liverpool	253	679	374	1003	47	126
Macclesfield	36	486	34	459	10	135
Manchester	138	328	235	559	85	202
Oldham	76	542	141	1006	31	221
Pendle	39	663	26	442	9	153
Preston	57	570	59	590	40	400
Ribble Valley	14	471	12	404	0	0
Rochdale	54	404	92	688	47	351
Rossendale	19	486	24	614	15	384
Salford	96	592	117	722	41	253
Sefton	92	539	127	743	42	246
South Lakeland	27	542	10	201	17	341
South Ribble	45	721	45	721	12	192
St Helens	55	510	86	798	35	325
Stockport	83	520	105	658	46	288
Tameside	81	613	121	915	34	257
Trafford	45	361	61	489	30	241
Vale Royal	32	486	17	258	11	167
Warrington	66	570	112	968	38	328
West Lancashire	41	620	43	650	23	348
Wigan	103	542	83	437	64	337
Wirral	243	1291	144	765	102	542
Wyre	32	542	14	237	4	68

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Acknowledgments

Many thanks to the staff at the North West Public Health Observatory and the Centre for Public Health for their help and support, in particular Sacha Wyke, Jeremy Hooper, Diana Leighton and Sara Hughes.

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e-mail: info@nwpho.org.uk
website: www.nwpho.org.uk
ISBN Number: 1-902051-74-2