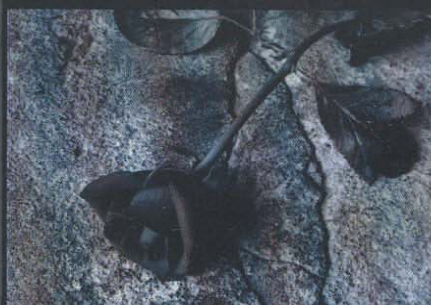


Violent Britain

People, Prevention and Public Health



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EXECUTIVE SUMMARY

Violence is one of the leading causes of ill health and premature death globally. Viewed internationally, it is easy to believe Britain is relatively unaffected by violence, yet every year millions of our citizens are victims of violence taking place within homes, schools, institutions and communities (see Table A). From threatening behaviour through to murder, violence has devastating effects on victims, their families and friends, witnesses and entire communities. There are an estimated 2.7 million incidents of violence every year in England and Wales (Upson et al., 2004), the consequences of which can include physical, mental or sexual injury for victims, whilst the wider community suffers through fear of crime, financial burden and overstretched public services. Taking the cost to services, the economy and that to individuals into account, a conservative estimate of annual costs of violent crime in England and Wales is £21 billion. However, a more recent investigation into the costs of domestic violence found these alone to exceed £22 billion (Walby, 2004; see Table B).

The World Health Assembly has declared violence a major and increasing public health problem across the globe and urged member states to prioritise violence within their borders. *Violent Britain – People, Prevention and Public Health* aims to support a public health approach to violence in Britain by moving the focus from dealing with the consequences of violence to preventing its occurrence; an

approach endorsed by the World Health Organization (See Chapter 1, Box 1.1). This report focuses on interpersonal violence; violence between individuals which takes many different forms and here is addressed in five categories:

- Youth violence (Chapter 2)
- Intimate partner violence (Chapter 3)
- Child maltreatment (Chapter 4)
- Elder abuse (Chapter 5)
- Sexual violence (Chapter 6)

Each chapter describes the extent and impacts of such violence in Britain today, and identifies those most at risk of becoming either victims or perpetrators. However, there is an increasing recognition that many risk factors (for being both a victim or perpetrator) are shared between different types of violence. For example, truancy and poor academic achievement can increase a young person's vulnerability to youth violence as both a victim and a perpetrator, whilst ensuing problems such as reduced earning potential can also increase their risk of perpetrating intimate partner violence and elder abuse in later life (see Section 7.2). Hence, Chapter 7 brings together all forms of violence and identifies violence prevention interventions that have been found to be effective at addressing individual or shared risk factors. These are discussed in light of current UK policy including both that designed to tackle violence and that which could include violence prevention.

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Table A: Estimated prevalence of different forms of violence

Type of Violence	Level ⁱ	Coverage ⁱⁱ (reference)
Homicides in the year 2003/4 (number)	601 males, 232 females	E&W, 2003/04 (Povey, 2005)
Youth Violence		
12-30 year olds involved in a fight in the last year (percentage and estimated number)	5.2% 654,934	E&W, 1998/9 (Flood-Page et al., 2000)
16-24 year olds having been victims of violent crime in the last year (percentage and estimated number)	15.5% males, 7.6% females 442,152 males, 213,985 females	E&W, 2003/4 (Dodd et al., 2004)
Under 21 year olds cautioned or found guilty in court of violent offences in the year 2002 (number)	25,800	E&W, 2002 (Home Office, 2003)
10-25 year olds carrying a weapon in the last year (percentage and estimated number)	6% 623,034	E&W, 2005 (Hayward and Norrie, 2005)
10-14 year olds having been bullied at school (percentage and estimated number)	43% boys, 46% girls 754,260 boys, 768,652 girls	England, 1997 (Smith, 2000)
Intimate Partner Violence		
Victims of non-sexual intimate partner violence since age 16 (16-59 year olds) (percentage and estimated number)	16.6% men, 25.9% women 2,524,089 men, 4,009,455 women	E&W, 2001 (Walby and Allen, 2004)
Victims of non-sexual intimate partner violence in the last year (16-59 year olds) (percentage and estimated number)	4.5% men, 6% women 684,241 men, 928,831 women	E&W, 2001 (Walby and Allen, 2004)
Victims of non-sexual intimate partner violence involving severe force in the last year (16-59 year olds) (percentage and estimated number)	1.2% men, 1.6% women 182,464 men, 247,688 women	E&W, 2001 (Walby and Allen, 2004)
Intimate partner homicides in the year 2003/4 (number)	115	E&W, 2003/4 (Povey, 2005)
Child Maltreatment		
Child homicides in the year 2003/4 (number)	Approx. 70	E&W (Povey, 2005)
Children on child protection registers in the UK (number)	32,700	UK, 2004 (Breslin and Evans, 2004)
18-24 year olds who experienced some form of serious maltreatment by parents during childhood (percentage and estimated number)	16% 793,759	UK, 1999 (Cawson et al., 2000)
18-24 year olds who experienced serious physical abuse by adults during childhood (percentage and estimated number)	7% 347,269	UK, 1999 (Cawson, 2002)
18-24 year olds who experienced some form of sexual abuse during childhood (percentage and estimated number)	16% 793,759	UK, 1999 (Cawson et al., 2000)

ⁱ Figures in blue have been calculated for this report using survey prevalence applied to 2001 Census population data. Although these calculations are approximate, they are intended to provide a crude estimate of the numbers of individuals being affected by interpersonal violence today.

ⁱⁱ E&W = England and Wales

Table A: Estimated prevalence of different forms of violence (...continued).

Type of Violence	Level ⁱ	Coverage ⁱⁱ (reference)
Elder Abuse		
Older people being abused at any one time (estimated number)	500,000 (excluding those living in institutional settings)	E&W, 1999 (House of Commons Health Committee 2004, based on Ogg and Bennett, 1992)
Older people in nursing homes receiving neuroleptic drugs - percentage for which drugs are inappropriately prescribed (percentage)	82%	(Osborne, 2002)
Average number of elder homicides per year	Approx. 50	E&W (Povey, 2004)
Sexual Violence		
Victims of actual or attempted sexual assault during lifetime (16-59 year olds) (percentage and estimated number)	4.7% men, 24.1% women 714,652 men, 3,730,806 women	E&W, 2001 (Walby and Allen, 2004)
Victims of actual or attempted sexual assault in the last year (16-59 year olds) (percentage and estimated number)	0.2% men, 2.1% women 30,411 men, 325,091 women	E&W, 2001 (Walby and Allen, 2004)
Victims of rape in the last year (16-59 year olds) (percentage and estimated number)	<0.1% men, 0.2% women 25,000 women ⁱⁱⁱ	E&W, 2001 (Walby and Allen, 2004)
Recorded sexual offences in the year 2003/4 (number)	52,070	E&W, 2003/4 (Dodd et al., 2004)
Recorded rape offences in the year 2003/4 (number)	13,247	E&W, 2003/4 (Dodd et al., 2004)

ⁱ Figures in blue have been calculated for this report using survey prevalence applied to 2001 Census population data. Although these calculations are approximate, they intend to provide a crude estimate of the numbers of individuals being affected by interpersonal violence today.

ⁱⁱ E&W = England and Wales

ⁱⁱⁱ Male prevalence was too low to generate estimates (Walby and Allen, 2004).

Youth Violence (Chapter 2)

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 (Home Office, 2003). 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. Nearly three quarters of firearms offences (71%) and incidents of

alcohol-related violence (72%) are committed by youths under the age of 30 (Povey, 2004; Maguire and Nettleton, 2003), with youth homicide in the UK increasing by 37.5% between 1985 and 1994 (although figures have since declined and stabilised; Povey, 2004). Over 5% of all 12-30 year olds report fighting in the previous year, yet just 12% of these received sanctions for the offence (Flood-Page

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Table B: Estimated annual costs of different forms of violenceⁱ

Violence type	Estimated annual cost	Costs included in Estimate	Reference	Area
Intimate partner violence ⁱⁱ	£22.9 billion	Health, Criminal Justice, Social Services, Housing, Civil Legal Services, Economic Output, Human and Emotional Costs	Walby, 2004	England and Wales
Homicide	£1.2 billion	Health, Criminal Justice, Emotional and Physical Impact, Lost Output, Support Services,	Brand and Price, 2000	England and Wales
Assault ⁱⁱⁱ	£17.2 billion	Health, Criminal Justice, Emotional and Physical Impact, Lost Output, Victim Services, Security Expenditure	Brand and Price, 2000	England and Wales
Sexual offences	£2.5 billion	Health, Criminal Justice, Emotional and Physical Impact, Lost Output, Victim Services, Security Expenditure	Brand and Price, 2000	England and Wales
Youth violence	£12.6 billion	Health, Criminal Justice, Emotional and Physical Impact, Lost Output, Victim Services, Security Expenditure	Brand and Price, 2000 ^{iv}	England and Wales
Child maltreatment	£1 billion	Statutory and Voluntary Services	NCIPA, 1996,	UK

ⁱ Figures have been collated from various sources and hence there will be some crossover between categories. This means it is not possible to add all figures to calculate the total cost of violence.

ⁱⁱ The costs of intimate partner violence have been calculated by Walby (2004) based on the methodology used by Brand and Price (2000), but developing this to include specific costs of domestic violence. Hence costs are wider than those included in other forms of violence provided here. The calculations include those for physical force, sexual violence and threats that cause fear and distress (including stalking) between intimate partners.

ⁱⁱⁱ Assault here includes calculations for serious wounding (£14.1bn), other wounding (£1.5bn) and common assault (£1.7bn)

^{iv} Estimated as 60% of all violent crime costs as calculated by Brand and Price, 2000

et al., 2000). Furthermore, almost half of 10-14 year olds have been bullied at school at some time with around 4% reporting this occurring several times per week (Smith, 2000).

The impacts of youth violence can be huge, including physical injury (sometimes lethal), mental health problems and suicide, with wider costs to society including fear of crime, destruction of property and disruption to essential services. Youth violence places a heavy burden on criminal justice and health services in particular. For example, assault is the second leading cause of hospital admission for males aged 15 to 24 years in England (Hospital Episode Statistics 2002-3; Table C). A

crude estimate of the total costs of youth violence is £12.6 billion annually (see Table B).

Those most likely to be involved in youth violence are males between the ages of 14 and 17. Other risk factors include having delinquent friends, substance use, displaying aggression in childhood, parental conflict, poor parental discipline, having a teenage mother and maternal postnatal depression. Whilst youth violence has been associated with deprivation, socio-economic differences in offenders are less pronounced in self-reported surveys than in police data, suggesting that youth violence committed in higher socio-economic groups is less well detected.

Table C: Ten leading causes of hospital admissions for males aged 10-34 years, England, 2002-2003

Rank	10-14 years (no. of admissions)	15-24 years (no. of admissions)	25-34 years (no. of admissions)
1	Unintentional Injuries 8,122	Unintentional Injuries 19,977	Unintentional Injuries 15,738
2	Malignant Neoplasm 5,320	Assault 13,867	Malignant Neoplasm 10,545
3	Congenital Anomalies 4,982	Malignant Neoplasm 10,541	Assault 9,400
4	Diseases of Appendix 3,351	Intentional Self Harm 6,920	Intentional Self Harm 8,501
5	Bronchitis, Emphysema, Asthma 2,501	Diseases of Appendix 5,308	Benign Neoplasm 7,400
6	Benign Neoplasm 2,099	Benign Neoplasm 4,403	Hernia 7,274
7	Assault 1,892	Hernia 3,713	Heart Disease 3,887
8	Diabetes Mellitus 1,443	Anaemia 3,645	Anaemia 3,779
9	Anaemia 1,154	Congenital Anomalies 3,454	Diseases of Appendix 3,463
10	Hernia 775	Diabetes Mellitus 2,238	Nephritis 2,923

Data from Hospital Episode Statistics

* Hospital Episode Statistics exclude Accident and Emergency cases that do not result in admittance to hospital. Accident and Emergency studies have found 6% of all attendances to be a result of assaults (Anderson, 2004)

Intimate Partner Violence (Chapter 3)

Intimate partner 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 (Walby and Allen, 2004). A quarter (25.9%) of women and 16.6% of men in England and Wales have experienced some form of intimate partner violence since the age of 16, with an estimated 931,000 women and 672,000 men experiencing abuse, threats or force in the last year. Female victims experience more frequent incidents of intimate partner violence than male victims (Walby and Allen, 2004), and are also more likely to suffer injury as a consequence (Archer, 2000). Females are also three times more likely than males to be

victims of intimate partner homicide, with over a third of all female homicides in England and Wales being committed by existing or ex partners (Povey, 2005). Just 21% of female victims of intimate partner violence report incidents to police, with reporting being even lower amongst male victims at 7%.

A fifth of intimate partner violence results in the victim requiring medical attention, not only for physical injury but also for problems related to sexual and reproductive health and mental health. For example, 72% of females and 51% of males who experienced intimate partner violence in the last year received some form of injury as a result, and 31% of females and 9% of males suffered mental or

emotional problems. Children who witness intimate partner violence also suffer emotional and behavioural problems and are at risk of suffering violence themselves as well as being perpetrators of violence later in life. A recent examination of the cost of intimate partner violence in England and Wales estimated total costs to exceed £22 billion per year, including both costs to services such as health and criminal justice, and human and emotional costs.

Young women aged 16-34 years are most at risk of intimate partner violence, with both prevalence and gender differences decreasing with age. Women living in low income households are three and a half times more likely to be victims. Pregnancy is a further risk for women, with 40% of intimate partner violence thought to begin during pregnancy and 30% of pregnant victims suffering miscarriage (Chung et al, 2002). Alcohol is a key risk factor for perpetrators of intimate partner violence, with a third of perpetrators being under the influence of alcohol at the time of assault (Mirlees-Black, 1999). Alcohol abuse may also be a consequence of intimate partner violence for victims (Finney, 2004).

Child Maltreatment (Chapter 4)

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. Almost a fifth (16%) of 18-24 year olds report some serious maltreatment by parents during their childhood, with 7% reporting serious physical abuse (Cawson, 2002). A reported 16% have suffered some form of sexual abuse by an adult during childhood, with 4% reporting this by parents, carers or other relatives. Over a third of children have experienced absence of care at some period, whilst 3% were frequently left to fend for themselves due to parental problems with substance use. Three quarters of abused children tell no one about their

experiences at the time of abuse. There are currently an estimated 32,700 children on child protection registers in the UK (Breslin and Evans, 2004), whilst the NSPCC received over 24,000 requests for help in 2003/4.

The impacts of child maltreatment extend from physical and mental injury, and in the worst case death, to educational difficulties and increased risk of adopting unhealthy behaviours in adulthood, such as smoking and high alcohol intake (Krug et al, 2002). Over half of children suffering physical child abuse receive physical injuries such as bruising, with around 5% sustaining head injuries and fractures. Children who suffer abuse during childhood are also at greater risk of developing aggressive and violent behaviour themselves. The cost of child abuse in the UK to statutory and voluntary agencies alone has been estimated at £1 billion per year (NCIPCA, 1996).

In the UK, boys are most at risk of physical abuse whilst girls are most at risk of emotional and sexual abuse. Premature infants, twins, and mentally/physically handicapped babies are all at increased likelihood of suffering maltreatment, with such characteristics potentially presenting extra problems to new mothers and placing them under increased stress. Similarly, children born as a result of unplanned pregnancies are at greater risk of abuse (Black et al., 1999). Other risk factors include low family income, overcrowded households and parental conflict.

Elder Abuse (Chapter 5)

Elder abuse is any act that causes harm or distress to an older person, including physical violence, emotional abuse, neglect and financial abuse. It has been estimated that half a million older people in the UK are experiencing elder abuse at any one time (Ogg and Bennett, 1992), although this excludes older people living in institutional settings. For example, it is estimated that

82% of older people in institutional receiving neuroleptic drugs receive inappropriate therapy (Osborne, 2002), whilst 88% of community and district nurses have observed elder abuse at work (House of Commons Health Committee, 2004). On average there are around fifty elder homicides annually in England and Wales. However, it can be difficult to determine whether elder deaths are due to natural causes or abuse, a problem exemplified by the 172 murders committed by Harold Shipman between 1975 and 1998.

Although little research has been conducted on the impacts of elder abuse, consequences can include depression, psychological distress, fear and physical injury. Older people suffering physical abuse are more likely to suffer serious injury due to degenerative conditions such as osteoporosis, whilst healing and convalescence can also take longer among older victims of violence (Krug et al., 2002). Furthermore, survival rates have been found to be lower amongst abused elders than those who do not suffer abuse (Lachs, 1998). There is no current estimate available of the cost of elder abuse in Britain.

Whilst female victims of elder abuse outnumber male victims, there is actually little difference in rates between the sexes as females have a longer lifespan than males. Risk of elder abuse increases with age, whilst other risk factors vary depending upon the type of abuse suffered. For example, those living alone are more vulnerable to financial abuse whilst those in institutional settings may be more vulnerable to physical abuse such as restraint and inappropriate administration of drugs. Risk factors for committing elder abuse include being male, having a controlling or depressive personality, substance use and having financial problems. Although the burden of caring for older people has often been considered a causal factor in elder abuse, in most cases perpetrators are actually dependent on the elderly victim (frequently a relative) for housing and finance.

Sexual violence (Chapter 6)

Sexual violence incorporates a wide range of different sexual acts from sexual harassment to rape. A quarter (24.1%) of women and 4.7% of men have experienced some form of sexual violence during their lifetime, with one in twenty women and one in a hundred men having been raped (Walby and Allen, 2004). The 2001 British Crime Survey estimated that 79,000 women in England and Wales had suffered an actual or attempted serious sexual assault in the previous year, with 25,000 being raped. Just 5-25% of incidents of rape are reported to police, of which only one in five reach trial and no more than half result in a conviction (Home Office, Court Service and Crown Prosecution Service, 2002). Serious sexual violence is most likely to be committed by perpetrators known to the victim, and in almost half (47%) of cases the offender is an intimate partner (current or ex husband or partner). Two thirds of women who had experienced sexual violence since the age of 16 had also been subject to intimate partner violence.

Sexual violence can have devastating impacts on victims, including physical and mental injury and sexual and reproductive health problems. For example, half of female victims of serious sexual assault suffer depression and emotional problems as a result, whilst one in twenty attempt suicide (Walby and Allen, 2004). Forced sex can also lead to a range of gynaecological problems, such as genital irritation, pelvic pain and decreased sexual desire, as well as sexually transmitted infections and unwanted pregnancy. The financial costs of sexual violence can be particularly high due to the significant emotional and physical consequences. The total annual cost of sexual violence has been estimated at nearly £2.5 billion in England and Wales, £156 million of which is borne by health services (Brand and Price, 2000).

Young women are at greatest risk of sexual violence, with women who are single or separated, living in private rented accommodation, and living in inner city areas also more likely to be victims. Sex workers are at particular risk of sexual violence, with a quarter of prostitutes working outdoors in England and Scotland having been raped by clients (Church et al, 2001). Other risk factors include substance use (alcohol and other drugs) and having many sexual partners. However whilst both these factors can increase a person's risk of experiencing sexual violence, they can also be consequences of having experienced sexual violence earlier in life. For example, experiencing sexual assault in childhood can increase the future risk of being both a victim and perpetrator of sexual assault in adulthood.

Violence Prevention (Chapter 7)

Many incidents of violence could be prevented, yet in order to implement prevention interventions effectively, information is required on those that have proven or shown promise of success, as well as how such measures can be adopted within existing policy. Chapter 7 outlines violence prevention measures shown to be effective in the UK and elsewhere. For example, Academic Enrichment Programmes in the form of homework clubs and other after school activities promote academic success, improve self-esteem and prevent children from becoming disaffected from school. This has been shown to reduce the likelihood of violent offending in later years (see Section 7.2.5). On a relationship level, targeted parenting programmes encourage consistency of discipline and improve emotional bonds, thus decreasing the likelihood of child abuse and future violent offending (Sutton et al., 2004). On a societal level, strategies which empower older people by encouraging them to serve on advisory committees for services for the elderly have shown promise in reducing levels of elder abuse (Section 7.5.4).

Here we also highlight the strong links between risk factors for different forms of violence and the need for integrated working between agencies to accomplish violence prevention. For example, children resulting from unwanted teenage pregnancies are at risk of being victims of child maltreatment and youth violence, and also of becoming perpetrators of youth violence, intimate partner violence and child maltreatment themselves in later life. Hence, teenage pregnancy strategies should consider how they contribute to violence prevention and how this role could be strengthened. The same principles apply to mentoring services for young people (Section 7.3.3) and support services for the unemployed (Section 7.5.1). Equally, the effects of violence impact on the clients and workload of many public sector and voluntary agencies, including not just those who provide treatment and support for victims or deal with perpetrators, but also those responsible for tackling the associated consequences. For example, domestic violence demands resources not only from police, health services, housing agencies and other organisations that deal with victims and perpetrators, but also on schools and the wider community through its impacts on children (for example, through increasing behavioural problems or substance use). Developing common approaches to tackling violence requires agencies have a better understanding of the shared causes and consequences of the different forms of violence, and also of the policy areas that enable them to influence the causes of violence.

Chapter 7 (see Tables 7.2-7.5) summarises both the evidence for effective violence prevention and those policy areas best placed to utilise such information. In addition however, it identifies how prevention interventions in one population can reduce levels of many types of violence. Thus, at a societal level, efforts to reduce inequalities and strengthen legal systems can reduce all types of interpersonal violence (Table 7.5) whilst home visiting, anti-bullying and parenting programmes

can reduce individuals' chances of becoming both victims and perpetrators of many types of violence (Table 7.3).

Violence in Britain

Britain continues to pay an enormous health, economic and social cost as a result of violence within homes, schools, throughout nightlife and even within our public and private sector organisations. Undoubtedly, tackling such violence is a substantial task. However, the information provided in this report shows that

measures for prevention are available and a combination of raising the awareness of where violence occurs and what effects levels as well as better inter-agency co-operation can lead to reductions in violent behaviours. By bringing information on all types of interpersonal violence together we hope that this report helps individuals and agencies to recognise how they can impact on violence not just in their own area of operation but also in those of their partners.

* * * * *



1

Introduction

I: INTRODUCTION

On almost any day, a cursory glance at international news reveals countries overtly ravaged by violence, with militia, youth gangs and other criminals terrorising and often killing each other and defenceless citizens. With few such incidents in the UK, it is easy to believe that we have escaped from an international epidemic of violence. However, in people's homes, around pubs and bars, in schools and even within health and social care establishments, UK citizens experience millions of violent acts each year. The results include living in a chronic state of fear, developing mental health problems, physical trauma and even death in the form of homicide or suicide. From threatening behaviour to murder, violence has devastating effects on victims, their family and friends, witnesses and entire communities. Violence also places a huge burden on public services, with domestic violence alone estimated to cost the NHS £1.4 billion and the criminal justice system £1 billion per year (Walby, 2004). Furthermore, health staff and police who tackle and treat violence are frequently the victims of violent behaviour themselves. This report describes the extent of violence in Britain today. It identifies those most at risk of becoming either victims or perpetrators of violence. It also outlines the policies (and sometimes lack of policies) in place to tackle violence and describes what measures can be effective in violence prevention.

An estimated 2.7 million incidents of violence, excluding violence towards and between children, occur in England and Wales annually (Upson et al., 2004). The consequences of such violence are sometimes highly visible to both the authorities and the public. For example, alcohol-related violence in and around pubs and clubs and the development of a gun culture among inner city youth are the subject of widespread media attention. Such attention is justified. Crimes involving firearms have doubled in the last five years (Povey, 2005) and



half of all violence in the UK is now related to alcohol with a fifth occurring in and around pubs and clubs (Budd, 2003).

On a daily basis however, less visible forms of violence take place in homes, schools, workplaces, military institutes and communities, much of which is never brought to the attention of either the authorities or the public. For victims, the impacts of such violence can be greater than that inflicted by a stranger during a night out. Over half the victims of serious sexual assault experience depression or emotional problems as a result, with one in twenty attempting suicide (Walby and Allen, 2004). Just 12% of the worst cases of serious sexual assault are reported to police, and two in five are reported to no-one. Fear, shame, lack of knowledge of services or inability to report or even recognise violence

can prevent victims coming forward, meaning it is often only a fraction of cases that reach public attention. Therefore, although tragedies such as the Harold Shipman murders and the deaths of Victoria Climbié, Damilola Taylor and Stephen Lawrence are exposed, they represent only the most extreme examples of incidents of elder abuse, child abuse and youth violence that occur every day in this country.

By identifying and addressing the root causes of violence (see Chapters 2-6), many violent incidents can be prevented. Although no single factor causes violence, individual attitudes and behaviours, family upbringing, community factors and social environments can all contribute. For example, young males who have experienced parental conflict, poor parental supervision, problems at school and substance use are most likely to be involved in violence (see Chapter 2). Moreover, there is an increasing recognition that the different types of violence share common risk factors (see Chapter 7, Tables 7.2-7.5). Inconsistent parental discipline for example, makes young people vulnerable to becoming victims of child maltreatment, being involved in youth violence, and also being perpetrators of intimate partner violence or child maltreatment themselves in later life.

Despite the links between the different forms of violence, each has been frequently treated in isolation and often addressed by agencies in a segregated manner. Such an approach is increasingly untenable as the consequences of different forms of violence for multiple agencies become more apparent. Domestic violence for example, demands resources from criminal justice agencies, health services, housing agencies, and a wide range of other organisations that provide treatment and support for victims. In addition it also has related impacts on agencies such as education authorities and social services that are responsible for the well being of children. However, developing common approaches to tackling violence requires agencies better

understanding not only of the shared causes and consequences of violent behaviours but also each others' agendas (see Chapter 7). This report aims to further that process.

Whilst victims of all types of violence must receive the assistance, support and protection they need, prevention of violence should be a key objective for all agencies. Considerable evidence already exists that preventative approaches can be effective (see Chapter 7). Such approaches require integrated working between agencies responsible for supporting victims, dealing with perpetrators of violence and controlling the environmental and social factors that contribute to development of violent behaviour. This list is substantial and includes health and criminal justice services, local authorities, schools, social services, community groups, employers and the media.



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Internationally, the 49th World Health Assembly (1996) declared violence a major and increasing public health problem across the globe, and urged member states to prioritise violence within their territories. The World Health Organization recommends that member states adopt a public health approach to violence prevention, as outlined in Box 1.1. This report aims to help the adoption of such an approach in Britain.

Violent Britain deals specifically with interpersonal violence, which includes:

- Family and intimate partner violence
Violence occurring largely between family members and intimate partners, usually, though not exclusively, taking place within the home.
- Community violence
Violence occurring between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home (Krug et al., 2002).

However, such interpersonal violence comes in many different forms and for the purposes of this report is addressed in five categories:

- Youth violence (Chapter 2)
- Intimate partner violence (Chapter 3)
- Child maltreatment (Chapter 4)
- Elder abuse (Chapter 5)
- Sexual violence (Chapter 6)

However, there are many subtypes of violence that cut across these categories. For example, violence in the workplace can include forms of sexual violence with individuals being threatened and abused by co-workers. Sometimes youth violence can infringe on the workplace if, for example, transport workers or healthcare workers are intimidated or assaulted by young people. Hate crimes in the forms of racism sometimes occurs as a subset of youth violence if the perpetrators are individuals under the age of thirty. Racism can

also be a factor in elder abuse if an older person in an institutional setting is persecuted on the grounds of his or her ethnicity. This report therefore, should be regarded as a general overview of the most common forms of violence in Britain today.

Each chapter of this report describes the extent, impact and associated risk factors of a different form of interpersonal violence, and identifies links between different types of violence where appropriate. Taking a macro rather than micro approach, the focus is on the wider underlying risk factors for experiencing violence as a victim or perpetrator rather than the incidental triggers associated with a specific violent event. Chapter 7 outlines prevention interventions that have been found to be effective in reducing violence, and identifies where such interventions fit into current national policy as well as where gaps in policy exist. Risk factors, prevention interventions and policy measures for all forms of violence are summarised in an *at a glance* format in Tables 7.2-7.5. These tables are designed to help agencies identify the links between violence types, and where joint working to reduce violence could be most beneficial.

Britain is paying an enormous health, economic and social price as a result of violence within homes, schools, throughout nightlife and even within our public and private sector organisations. Although tackling such violence is a substantial task, information provided in this report shows that measures for prevention are available, and with better inter-agency co-operation could be effectively implemented. We hope that this report is a first step towards adopting a co-ordinated and integrated public health approach towards violence in Britain, in which different types of violence are not seen as the domain of individual agencies and groups but as a collective challenge requiring urgent and cooperative action.

Box I.1: A public health approach to violence prevention

The World Health Organization 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” (Krug et al., 2002).

Within this, it identifies three major types of violence:

- Self-directed violence (suicidal behaviour and self harm)
- Interpersonal violence (violence between individuals)
- Collective violence (social, political and economic violence).

In response to the World Health Assembly’s call for the prioritisation of violence prevention, the World Health Organization published the World Report on Violence and Health (Krug et al., 2002), which aims to raise awareness of the problem of violence at a global level and promote a public health approach to violence prevention. A public health approach to violence prevention involves four key steps, being:

- Identifying as much knowledge as possible on violence through the systematic collection of data on the extent, type, characteristics and consequences of violence
- Researching why violence occurs, the risk factors for involvement in violence and which factors can be changed to reduce violence
- Exploring what works to prevent violence, through the implementation, monitoring and evaluation of interventions, and
- Implementing successful interventions in a range of settings, widely disseminating information and establishing cost effectiveness.

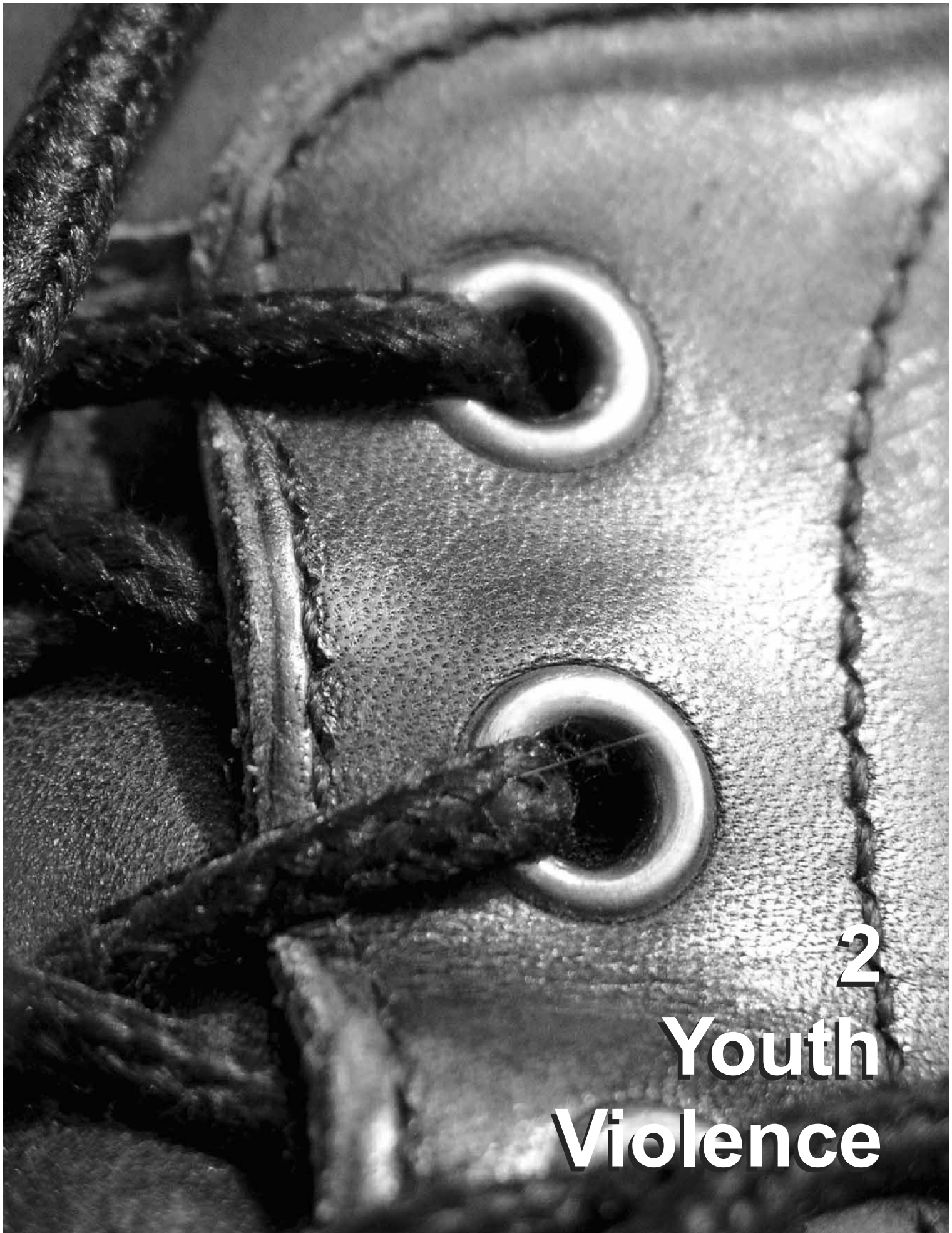
The report identifies the global extent of violence, highlights key risk factors for involvement in violence and identifies policy responses and interventions in place internationally to address violence. The report sets the following recommendations for preventing violence:

- Create, implement and monitor a national action plan for violence prevention
- Enhance capacity for collecting data on violence
- Define priorities for, and support research on, the causes, consequences, costs and prevention of violence
- Promote primary prevention responses
- Strengthen responses for victims of violence
- Integrate violence prevention into social and educational policies, and thereby promote gender and social equality
- Increase collaboration and exchange of information on violence prevention
- Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights
- Seek practical, internationally agreed responses to the global drugs trade and the global arms trade.

Krug et al., 2002

* * * * *

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2

**Youth
Violence**

2: YOUTH VIOLENCE

2.1: Introduction

Youth violence is violence committed by or against young people and has been cited as the most visible form of violence in most countries (Krug et al., 2002). This is not only because the majority of victims and perpetrators are adolescents and young adults, but also because this type of violence frequently occurs in public places, thus receiving extensive media coverage. Unless otherwise stated this report defines youth violence as acts of violence committed by or against individuals between the ages of 10 and 30 years of age*.

Youth violence takes many forms. It can be instigated by lone perpetrators or by groups. It can be directed against strangers, acquaintances, family members, classmates, or close friends. The perpetrators can be children as young as 10 years old or young adults as mature as 30. Victims on the other hand range from children being bullied at school to older people who are afraid to leave their homes for fear of attack by youths.

Perpetrators of youth violence can be divided into two broad categories. The first, *adolescence limited offenders*, comprises individuals with little childhood history of violent behaviour. These individuals behave violently during adolescence but do not progress to become violent adults. Individuals in the second category, *life-course persistent offenders*, display violent behaviour that can be traced back to early childhood and will continue long into adulthood (Moffit, 1993). International research has shown that life-course persistent offenders account for 20-45% of male perpetrators, and 47-69% of female perpetrators (Tolan, 1987). These figures suggest that, of those involved in violence, males are more likely to undergo a

temporary violent phase during adolescence than females, whose violent behaviour is more likely to be long lasting.

Because youth violence covers such a wide range of behaviour, information regarding its extent, impact and risk factors comes from a wide range of sources. This makes comparisons problematic due to the differing methodologies and definitions used in studies.



*Excluded from this section are violent acts committed by young people in domestic settings and acts of sexual violence. These types of violence are covered in other sections of this report. Although acts of violence can be perpetrated by children under the age of ten, the majority of cases fall within the 10-30 age range.

2.2: Extent of Youth Violence

2.2.1: Global data

International comparisons of non-lethal youth violence are problematic due to different definitions and data collection methodologies. An examination of youth homicides however gives some idea of the comparative magnitude of the problem posed by youth violence in various countries (Box 2.1).

Box 2.1: Global rates of youth homicide: 2000

Country	Rate (per 100,000)
Colombia	84.4
El Salvador	50.2
Puerto Rico	41.8
Albania	28.2
Russia	18.0
USA	11.0
United Kingdom	0.9
Germany	0.8
France	0.6
Global	9.2

Data from Krug et al., 2002

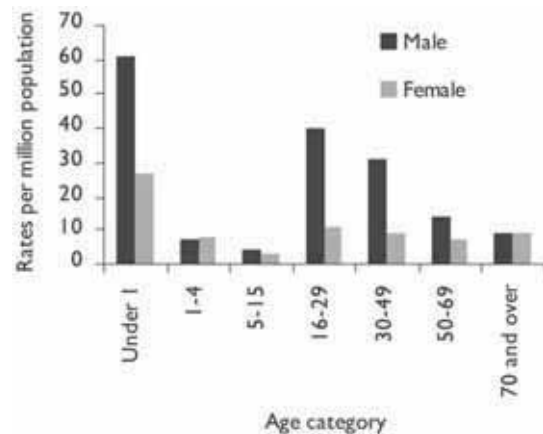
There are on average 199,000 youth homicides every year throughout the world (a rate of 9.2 per 100,000), the vast majority of which are perpetrated by males against other males (Krug et al., 2002). Furthermore, for every youth homicide there are 20-40 non-lethal incidents of youth violence that are serious enough to require hospital treatment.

2.2.2: National homicide rates

An examination of trends in youth homicide between 1985 and 1994 shows an increase in

most counties (Krug et al., 2002). Here in the UK there was a dramatic increase of 37.5% during this period. More recently, however, the rate has dropped and re-stabilised (Povey, 2004). Figure 2.1 illustrates the age and sex distribution of homicide victims in England and Wales. While infants are at the greatest risk of becoming victims of homicide, the next greatest at-risk group are young adults. This risk is greater for males than females (Povey, 2005).

Figure 2.1: Offences currently recorded as homicide by age and sex of victim, England and Wales, 2003/2004



Data from Povey, 2005

Although there are many different motives for homicide, the majority are violent assaults that end unintentionally in death (Harries, 1990). Furthermore, Gottfredson and Hirschi argue that,

“The difference between homicide and assault may simply be the intervention of a bystander, the accuracy of a gun, the weight of a frying pan, the speed of an ambulance or the availability of a trauma centre.”

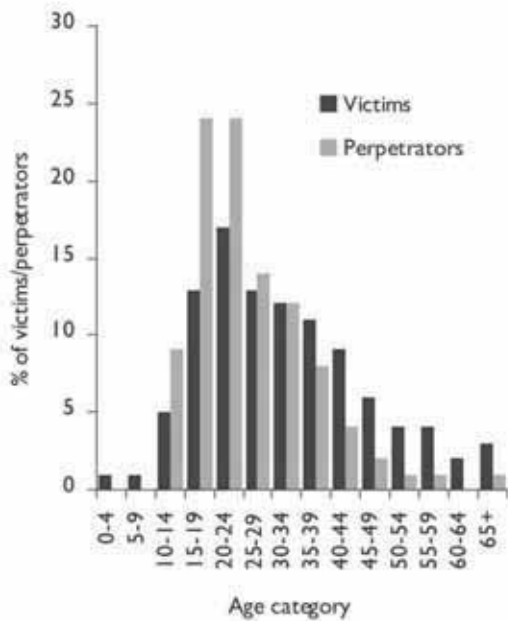
(Gottfredson and Hirschi, 1990).

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Taking this into consideration, homicide rates do not necessarily give a true indication of the extent of violence within a society. For example, US homicide rates are consistently ten times higher than those in the UK (see Krug et al., 2002). This difference, however, is likely due to the availability of firearms which accounts for the lethal outcome of a higher proportion of assaults. Figure 2.2 shows the age distribution of victims and perpetrators of offences involving firearms in England and Wales (Povey, 2004). Although the vast majority of such incidents in the UK are non-lethal, the link between violence and youth is clearly illustrated, with 48% of victims and 71% of perpetrators falling into the youth category.



Figure 2.2: Age distribution of those who have been a victim or perpetrator of offences involving firearms, 8 police force areas* 2002/2003



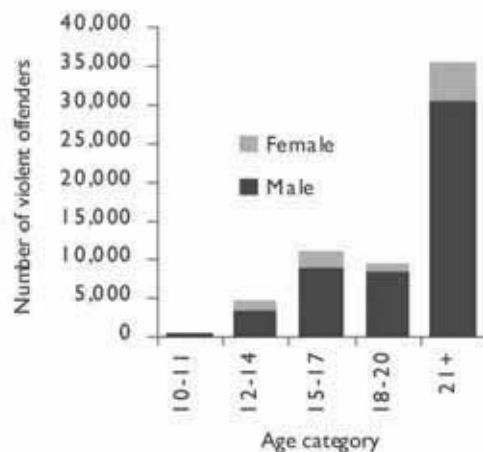
Data from Povey, 2004

* Metropolitan, West Midlands, Greater Manchester, West Yorkshire, Merseyside, Thames Valley, South Yorkshire Valley, South Yorkshire, Avon & Somerset

2.2.3: Non-lethal violence

There are many types of violence committed by young offenders ranging from minor incidents of fighting and bullying to the type of serious assault which can result in severe injury. Figure 2.3 illustrates the number of violent offenders cautioned or found guilty in England and Wales during 2002 (Home Office, 2003). The number of such offences committed by individuals under the age of 21 totals 25,800, accounting for nearly half of all violent offenders.

Figure 2.3: Individuals found guilty of violent offences in all courts or cautioned by sex and age group, England and Wales, 2002



Data from Home Office, 2003

2.2.4: Under-reporting

Information relating to those either cautioned or convicted in court excludes incidents either not reported to, or not detected by, the police. Since a large number of violent incidents are un-reported, results from self-reporting questionnaires can supply useful supplementary information. The 2003/04 British Crime Survey, for example, found 15.5% of males and 7.6% of females aged 16-24 had been victims of violent crime in the last year (Upson et al., 2004). The following information is taken from the Youth Lifestyles Survey (Flood-Page et al, 2000; see Box 2.2).

**Box 2.2:
The Youth Lifestyles Survey**

The most recent Youth Lifestyles Survey was conducted in 1998/99. The survey was based on a nationally representative sample of 4,848 young people aged between 12 and 30 years, living in private households in England and Wales. Its purpose was to measure the extent of offending amongst young people. This included information regarding the use of violence and bullying and experience of sanctions.

Flood-Page et al, 2000

Table 2.1 shows a comparison of the percentage of young people (age 12-30) who admitted to committing violent offences with the percentage sanctioned and recorded by the criminal justice system. Nearly three quarters (73%) of violent offenders received no sanction by the criminal justice system in 1998/99. This indicates that the majority of violent offences are either not reported or not detected by the police.

2.2.5: Anti-social behaviour

Many incidents of violence are not regarded as criminal, particularly when the events do not result in physical injury or when the perpetrators are juveniles (Campbell, 2002). For this reason, Anti-Social Behavior Orders (ASBOs) can provide a good indication of patterns of youth violence as they can be granted against individuals as young as 10 years of age. Furthermore, they include acts of harassment and threat that place people in fear of physical violence (See Box 2.3).

Over half of all ASBOs (52%) issued from 1999-2002 were granted against individuals engaged in violent behaviour. Acts in this category include harassment, threats and assault.

Table 2.1: Comparison of violent offences and sanctions in the previous 12 months, England and Wales, 1998/99

Offence	% of all 12-30 year olds admitting offence in last 12 months	% of all 12-30 year olds cautioned or taken to court in last 12 months
Fighting	5.2	0.8
Assault	1.2	0.4
Snatch theft	0.2	0.3
Hurt someone with a weapon	1.1	0.2
Threatened someone with a weapon	0.1	0.1

Base = 4,848

Data from Flood-Page et al., 2000

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The vast majority of ASBOs given since 1999 have been granted against young people, with 85% of offenders falling within the 11-30 year age category (Figure 2.4). The peak ages for engaging in anti-social behaviour are the 15-18 year age categories. Since the majority of this behaviour is violence-related and occurs in public spaces, it is easy to see how youth violence is responsible for much of the fear experienced by the public (Campbell, 2002). This is compounded by the fact that, in the majority of cases, anti-social behaviour is conducted not by solitary perpetrators, but as part of a larger group or gang (Figure 2.5).

Box 2.3: Anti-Social Behaviour Orders

An anti-social manner is defined as “a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household”. This includes behaviour that puts people in fear of crime.

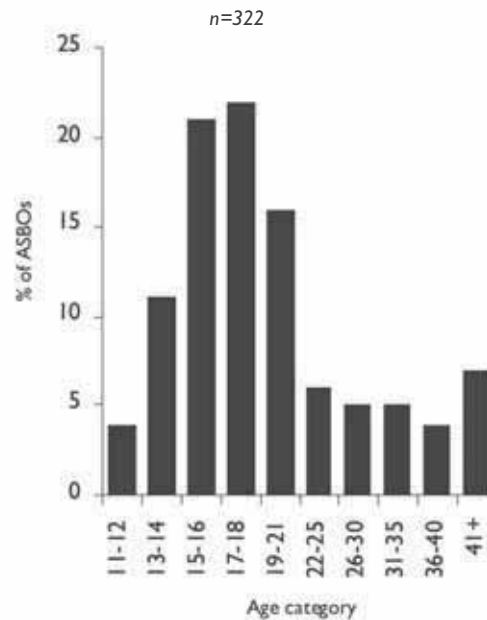
Anti-Social Behaviour Orders (ASBOs) were introduced under the Crime and Disorder Act of 1998 and have been in use since April 1999. Although injunctions and evictions were available prior to this, many individuals engaged in anti-social behaviour slipped through the net; particularly juveniles who were responsible for much of this type of conduct.

ASBOs can be given to anyone over the age of 10 years. Furthermore, since the orders are civil rather than criminal, they are granted based on a balance of probability. These factors mean that a wider range of behaviour, circumstances and individuals can be dealt with than was previously possible.

The orders are prohibitions, meaning they must require the offender to not do something. They do not have the power to impel the offender to take any kind of positive action.

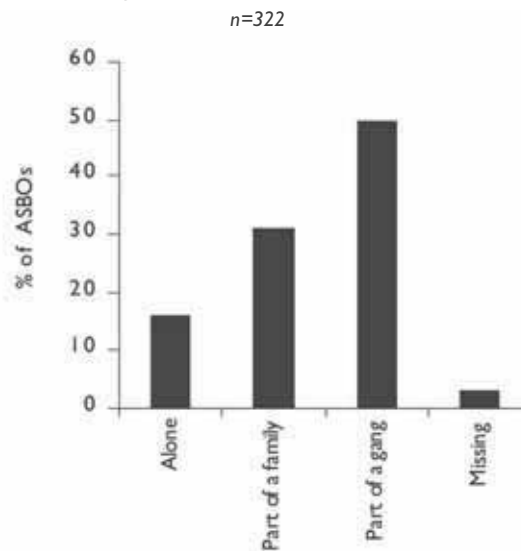
Campbell, 2002

Figure 2.4: Percentage of ASBOs given by age, England and Wales, 1999-2002



Data from Campbell, 2002

Figure 2.5: Percentage of ASBOs granted for offences committed alone or as part of a group, England and Wales, 1999-2002



Data from Campbell, 2002

The 2003 Crime and Justice Survey provides self-reporting information regarding offending. The survey asked 4,574 youths aged 10-25 about their involvement in anti-social behaviour (Budd et al., 2005). The survey found that 29% of 10-25 year olds had committed at least one type of anti-social behaviour during the previous 12 months. Types of anti-social behaviour included participating in public disturbances, racial harassment and carrying weapons (Hayward and Sharp, 2005). The age distribution of these behaviours is summarised in Table 2.2.

2.2.6: Bullying

Much of the violence perpetrated by young people is directed against peers in the form of bullying (Smith, 2000). While the majority of incidents do not cause visible, physical injury, bullying can cause long-term psychological damage to its victims (see Box 2.4).

A survey of 2,308 pupils between the ages of 10 and 14 years in England showed that nearly half (43% of boys and 46% of girls) had been bullied at some time (Smith, 2000). Although the majority of pupils reported only one or two incidents, 13% stated that they experienced bullying as a regular occurrence (Table 2.3).

Although experience of bullying others is not as prevalent, over a quarter of both boys and girls between the ages of 10 and 14 admitted to engaging in this type of behaviour (Table 2.3). Furthermore, a survey of secondary schools in Scotland showed that 34.1% of males and 8.5% of females had carried weapons to school at least once (McKeganey and Norrie, 2000).

Box 2.4: Bullying

Bullying can be defined as behaviour that is:

- Deliberately hurtful (including aggression)
- Repeated over a period of time
- Difficult for victims to defend themselves against

Three main types of bullying occur in school contexts:

- Physical: hitting, kicking, taking belongings
- Verbal: name calling, insulting, making offensive remarks
- Indirect: exclusion from social groups, spreading malicious rumours, sending malicious e-mails or text messages

From Smith, 2000

Table 2.2: Prevalence of antisocial behaviour in the previous 12 months by age. England and Wales, 2003

Age Group	Public disturbances %	Racial harassment %	Carrying weapons %	Any anti-social behaviour (excluding fare evasion) %	Base number
10-11	9	1	3	22	585
12-13	18	1	5	29	707
14-16	26	3	9	41	971
17-19	18	3	9	35	787
20-25	9	1	4	22	1,342
All	15	2	6	29	4,392

Data from Hayward and Sharp, 2005

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Table 2.3: Prevalence of being a victim or a perpetrator of bullying in schools, 10-14 year olds, England, 1997

Frequency of bullying	Victim of bullying		Perpetrator of bullying	
	Male %	Female %	Male %	Female %
Several times per week	3.8	4.5	0.8	0.4
Once per week	4.0	3.6	1.5	0.5
2-3 times per month	4.9	3.7	1.7	0.9
Once or twice	30.5	34.3	24.1	23.1
Not at all	56.8	53.9	71.9	75.1

Data from Smith, 2000

2.3: Impact of Youth Violence

When youth violence results in serious injury or death, the impacts are obvious. Less obvious, however, are the long-term, negative consequences suffered by the victim's family, friends, and community (see Box 2.5).

Box 2.5: Universal Impacts of Youth Violence

- Causes psychological harm to the families and friends of victims
- Causes death and chronic illness
- Reduces quality of life
- Adds costs to health and welfare services
- Reduces productivity
- Decreases value of property
- Disrupts essential services

from Krug et al., 2002

2.3.1: Economic impact

A conservative estimate places 60% of all violent incidents occurring in England and Wales within the youth category (Home Office, 2003). If this figure is then used to calculate the economic impact of youth violence, a crude estimate of the annual total would amount to over £12.6 billion* (see Table 2.4; Brand and Price, 2000). This excludes costs inflicted by

fear of violent crime in the form of negative health due to immobility (Department of Health, 2004). Indirect economic impacts can also be suffered by entire communities if high rates of violent crime cause businesses to fail and reduce local investment (Brand and Price, 2000).

2.3.2: Impact on health services

Youth violence has a significant impact on health services for several reasons. In terms of direct expenditure, health services must treat the traumatic injuries incurred as a result of assaults on and by young people. 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 (Anderson, 2004). Much youth violence is alcohol-related (Figure 2.6), with much of this type of violence occurring in and around pubs and nightclubs (Hughes and Bellis, 2003). When assaults in such settings result in injury, they are frequently facial (Finney, 2004). Furthermore, many youth assaults in nightlife settings involve the use of glasses and bottles

*Assuming youth and adult costs of equivalent violent acts are equal.

CHAPTER 2. YOUTH VIOLENCE • 15

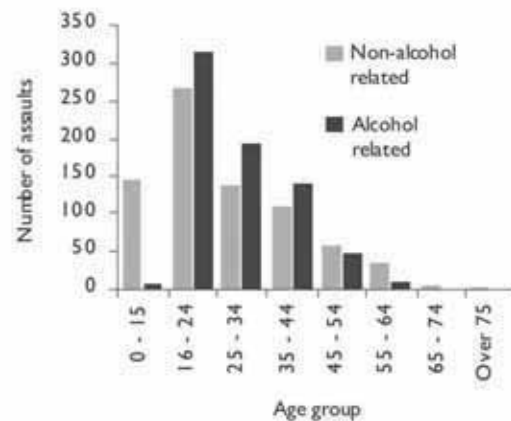
Table 2.4: Average cost estimates for violent crime, England and Wales

Offence category	All violence							Youth violence*		
	Emotional/physical impact on victim (£)	Lost Output (£)	Victim services (£)	Health services (£)	Criminal justice system cost (£)	Average cost per Incident (£)	Number of incidents (000s)	Total Cost (£ billions)	Number of incidents (000s)	Total Cost (£ billions)
Homicide	700,000	370,000	4,700	630	22,000	1,100,000	1.1	1.2	0.66	0.72
Serious wounding	97,000	14,000	6	8,500	13,000	130,000	110	14.1	66	8.46
Other wounding	120	400	6	200	1,300	2,000	780	1.5	468	0.9
Common assault	240	20	6	0	270	540	3,200	1.7	1,920	1.02
Sexual offences	12,000	2,000	20	1,200	3,900	19,000	130	2.5	78	1.5
<i>All offences</i>								21.0		12.6

(*Modified from Brand and Price, 2000)



Figure 2.6: Alcohol related assaults by age: Arwe Park Accident and Emergency department, April-September, 2004



From Anderson, 2004

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as weapons (Luke et al., 2002), and resultant injuries can have devastating consequences including long-term facial disfigurement that victims have to live with for the rest of their lives. Such facial injuries frequently lead to post-traumatic stress disorder and other psychological problems (Magennis et al., 1998).

Greater expenses are incurred when patients require admittance to hospital for further treatment, including surgery. Table 2.5 shows the top ten causes of hospital admissions in England for the year 2002-2003 (Hospital Episode Statistics). For males between the ages of 15 and 24 years, assault was the second leading cause of hospital admission.

Across all ages, 36,433 males were admitted to hospital for treatment of injuries incurred as a result of assault, ranking it the 13th leading



cause of hospital admissions for males in England, malignant neoplasms (cancer) being the leading cause. Hospital Episode Statistics show that more males require hospital beds for assault related injuries than for appendicitis and hypertension combined.

Table 2.5: Ten leading causes of hospital admissions for males aged 10-34 years, England, 2002-2003

Rank	10-14 years (no. of admissions)	15-24 years (no. of admissions)	25-34 years (no. of admissions)
1	Unintentional Injuries 8,122	Unintentional Injuries 19,977	Unintentional Injuries 15,738
2	Malignant Neoplasm 5,320	Assault 13,867	Malignant Neoplasm 10,545
3	Congenital Anomalies 4,982	Malignant Neoplasm 10,541	Assault 9,400
4	Diseases of Appendix 3,351	Intentional Self Harm 6,920	Intentional Self Harm 8,501
5	Bronchitis, Emphysema, Asthma 2,501	Diseases of Appendix 5,308	Benign Neoplasm 7,400
6	Benign Neoplasm 2,099	Benign Neoplasm 4,403	Hernia 7,274
7	Assault 1,892	Hernia 3,713	Heart Disease 3,887
8	Diabetes Mellitus 1,443	Anaemia 3,645	Anaemia 3,779
9	Anaemia 1,154	Congenital Anomalies 3,454	Diseases of Appendix 3,463
10	Hernia 775	Diabetes Mellitus 2,238	Nephritis 2,923

Data from Hospital Episode Statistics

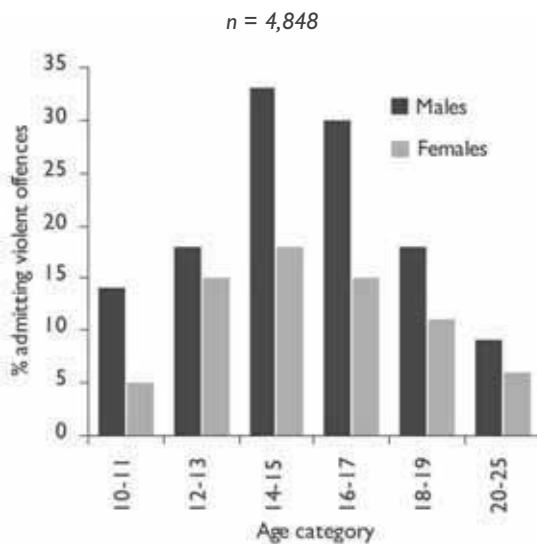
2.4: Risk Factors for Youth Violence

2.4.1: Sex and age

Figure 2.7 shows the percentage of young people in England and Wales admitting to committing violent offences during the previous year (Crime and Justice Survey. Budd et al., 2005). There is a substantial gender gap, with male offenders outnumbering female offenders. The difference is, however, less than that documented by police data. This tends to be the norm for self-reported surveys (Jenson and Eve, 1976; Hindelang et al., 1981), suggesting that violence perpetrated by females is under-reported to a greater degree than that perpetrated by males.

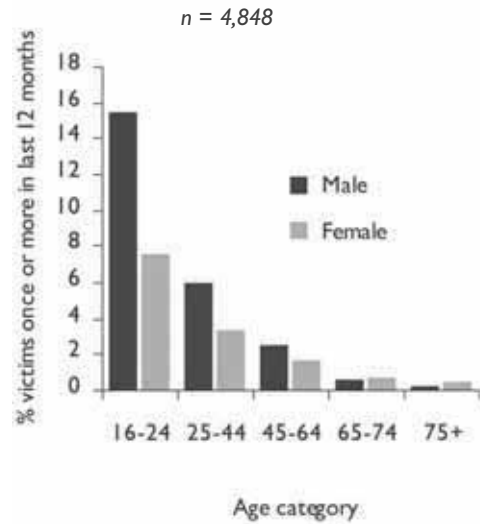
An examination of data relating to experiences of violence across all ages shows that the risk of victimisation decreases with age (Figure 2.8). This is true for both sexes, with male victims outnumbering female for all but the oldest age category.

Figure 2.7: Percentage of young people admitting violent offences once or more in last 12 months, England and Wales, 2003



Data from Budd et al., 2005

Figure 2.8: Percentage of males and females reporting being victims of violence once or more during the previous 12 months by age, England and Wales, 2003



Data from Dodd et al., 2004

2.4.2: Early behaviour

Longitudinal studies have shown that childhood aggression is a good predictor of adult violence (Krug et al., 2002; Farrington, 2001) and that self reporting at an early age can predict adult convictions for assault and other forms of violent crime (Farrington, 1998). One UK study found that 15% of children under the age of seven displayed aggressive behaviour and that half of these children were still behaving anti-socially at age 17 (Werner and Smith, 1992). Moffit (1993) defined a “life-course persistent pathway” of violence, suggesting that individuals following this path exhibited aggressive behaviour during childhood and became violent offenders in adulthood. One US study found that 20-45% of males and 47-69% of females who commit violence have a history of aggressive and anti-social behaviour dating back to childhood (Tolan, 1987). Furthermore, a study conducted in Cambridge found that 33% of males convicted of violent offences as teenagers were convicted again

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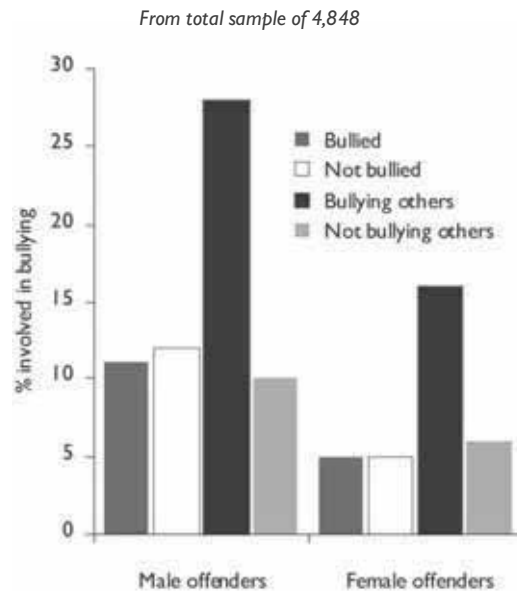
before the age of 40 compared to only 8% of those who were not convicted as teenagers (Farrington, 2001). These results must be treated with caution, since re-conviction may be partly due to the fact that obtaining a criminal record early in life makes individuals known to the police and hence more likely to be apprehended by authorities when they re-offend than those with no prior record.

Thomas and Chess (1977) identified three groups of personality types in children. One category, which is classified as “difficult,” is characterised by tense, irritable behaviour and intense, negative reactions to situations. While there is no robust evidence that these apparently inborn characteristics persist throughout life, there is evidence that if combined with other risk factors, such as poor parenting and a deprived environment, such children will go on to exhibit anti-social behaviour later in life (Sutton, 2004). Conversely, easy going, adaptable children have personalities that buffer them from pressure and stress.

The Youth Lifestyles Survey found an association between bullying and violent offending (Flood-Page et al., 2000). Of those who had committed violent offences, three times as many had engaged in bullying at school than those who had not (Figures 2.9 and 2.10)

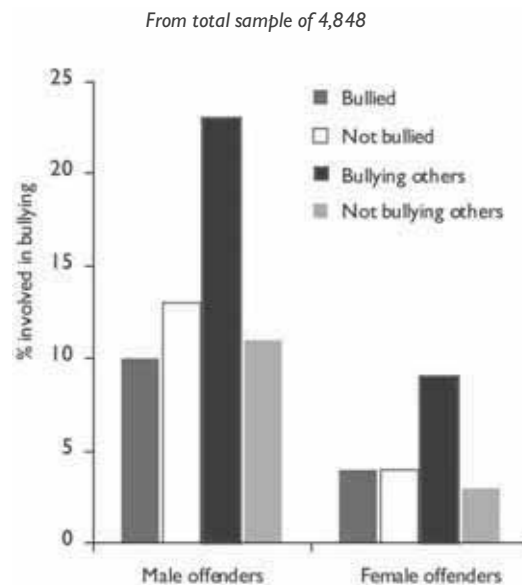


Figure 2.9: Relationship between bullying and offending, 12-16 year olds, England and Wales, 1998/99



Data from Flood-Page et al., 2000

Figure 2.10: Relationship between bullying and offending, 17-30 year olds, England and Wales,



Data from Flood-Page et al., 2000

2.4.3: Biological risk factors

Several studies have linked neural damage to violent behaviour (see Box 2.6). Furthermore, low heart rates have been associated with sensation seeking and risk taking behaviour, both of which predispose towards violence (Wadsworth, 1976; Farrington, 1997).

Maternal stress during pregnancy leads to behavioural problems in infancy, childhood and adolescence. The Avon longitudinal study of 7,500 pregnant women followed their children through the first decade of life (O'Connor et al., 2002). Anxiety at 32 weeks gestation doubled the chance of children exhibiting aggression and other behavioural problems. Experiments conducted on non-human primates concur with these findings (Schneider et al., 2001). It is not possible, however, to determine if this is due to genetic factors predisposing offspring towards anxiety, or due to developmental changes to the foetus (Weinstock, 2001).

An individual's genetic makeup can influence behaviour to a certain extent. For example,

60% of the variance in hyperactivity can be accounted for by genetics (Sutton et al., 2004). Furthermore, hyperactivity can result in behavioural problems such as impulsiveness, lack of persistence, poor behavioural control and attention problems; all of which have been cited as risk factors for violence (Henry et al., 1996). Other studies have found that although hyperactivity alone cannot cause violence, if it is combined with other risk factors it can lead to future offending (Rutter et al., 1998).

Genetic makeup can provide protective as well as risk factors. This probably accounts for much of the individual variation in reactions to similar situations. For example the enzyme MAO A is found in high levels in non-violent/non-aggressive children who have been exposed to a range of risk factors during their early years of development. They remain confident and outgoing, whereas others from similar circumstances become aggressive and violent since they have nothing to buffer them from the risk factors to which they are exposed (Werner and Smith, 1992).

Box 2.6: The brain and violent behaviour

Neurological damage during delivery has been linked to violence later in life, and can be used to predict violent behaviour up to age 22 (Kandel and Mednick, 1991). In particular, damage to the frontal lobe (either during delivery or soon after birth) has been implicated, since this area of the brain carries out important executive functions.

(Moffit and Henry, 1991)

Changes in neural functioning and associated aggressive behaviour have been linked to nicotine. These findings are based on a study of 4,000 male children with mothers who smoked more than six cigarettes a day during pregnancy.

(Smith, 2000)

Children who experience domestic violence can grow up to be "over prepared" to respond with aggression due to reactivation of the brainstem. Put simply, witnessing traumatic events in infancy and early childhood stimulates the brain stem (the part of the brain responsible for primitive functions), causing violent over-reactions. Furthermore, if the complex cerebral cortex has not been stimulated in order to develop a sufficient moderating capacity, the individual will develop into a violent, impulsive individual with little control over aggressive impulses.

(Perry, 1997)

2.4.4: Parental/family risk factors

Parental conflict

Parental conflict has been cited as a major cause of youth violence (Krug et al., 2002). Experiencing or merely witnessing violence at an early age not only causes brainstem reactivation (see Box 2.6) but also results in children seeing aggression as a normal mechanism for solving conflict (Widom, 1989). Furthermore, having a parent with a criminal record for violence is cited as the best predictor that a boy aged 10 will have an aggressive, anti-social personality by age 32 (Farrington, 2000). Again, this could be either genetic, or a result of an unstable household. Alternatively, it could be caused by children modelling their behaviour on that of a parent (Sutton, 2004). Further research needs to be undertaken to determine if this association still exists in families where the violent offender is not the aggressive child's biological father.

Maternal depression

Postnatal depression has been linked to violent and aggressive behaviour in children. Furthermore, this situation is compounded if the depression is caused by adverse living conditions rather than hormonal imbalance (Murray et al., 2003). Depression can damage bonding between mother and infant causing long lasting effects. These include poor attention skills, lack of control over emotions (Campbell, 1995), maldevelopment of personal interactions, and aggression (Lyons-Ruth and Jacobwitz, 1999). Impaired bonding can result in a lack of the early stimulation that is necessary for the development of language and cognitive skills. If these two skills are lacking by the time the child reaches school age, physiological stress, poor educational achievement and impaired socialisation are likely to occur as a result (Stattin and Klackenber-Larsson, 1993).



Discipline

Poor monitoring and parental supervision have been linked to violent offending in adolescence and early childhood (Krug et al., 2002; Farrington, 1996, 2000). A study of 9-13 year olds in Birmingham showed that families with lax discipline in the form of poor supervision of peer interaction produce two and a half times more offending children than families which are vigilant in this regard (Wilson, 1987). This result held true regardless of socio-economic status.

2.7: Teenage Mothers

Teenage mothers are frequently in situations that expose their infants to an array of risk factors:

- Low educational achievement
- Low income/low economic status
- Mental health problems
- Lack of support from family, friends and neighbours
- Unsupportive partners (Kiernan, 1985)
- Subsequently large families with four or more children (Farrington and West, 1993; Krug et al., 2002)
- Single parent households (Krug et al., 2002)
- Impaired bonding

Children of teenage mothers are more likely to:

- Have low educational achievement
- Exhibit emotional and behavioural problems
- Suffer from maltreatment

Having a teenage mother can predict anti-social behaviour up to age 23. Furthermore, the Social Exclusion Unit (1997) found that children with teenage mothers are more likely to offend and become teenage parents themselves.

(Botting et al., 1998).

Assessing the effects of sanctions is more complex. Some researchers have linked harsh discipline to future violent offending (for example McCord, 1979). Another study revealed that harsh, physical sanctions for negative behaviour could predict intimate partner abuse and other forms of violent offending up to age 30 (Eron et al., 1991). Baumrind (1991) defined three styles of parental discipline:

- a) Permissive: lacking in discipline
- b) Authoritative: firm clear boundaries and sanctions
- c) Authoritarian: Unclear guidelines with harsh and inconsistent punishment.

While style b) was found to be the most effective, style c) produced hostile child-parent relationships which resulted in avoidance of the parent. There was also an increased likelihood of later imitation of this style of physical punishment in the form of violence directed against peers. Inconsistent discipline

has also been cited as a major risk factor for violent offending (Gardner, 1989).

Several studies have found that having a teenage mother increases an individual's chance of becoming a violent offender. The reasons for this are outlined in Box 2.7.

2.4.5: Peer relationships

Delay in language and cognitive development can result in problematic interactions with peers once a child reaches school age. Failure in school and feelings of isolation can spark aggressive behaviour and violence (Sutton, 2004), whilst negative academic and social experiences in school can exacerbate existing problems and lead to isolation from peers (Kazdin, 1995). These factors put children at risk of either becoming a victim of bullying (Smith, 2000), or an aggressor. Some socially isolated individuals will respond aggressively to benign situations and be driven into groups of other anti-social children (Dishion, 1991).

Box 2.8: Factors that Encourage Young People to Join Gangs

- Lack of opportunity for social or economic mobility within a society that aggressively promotes consumption
- A decline in local enforcement of law and order
- Interrupted schooling combined with low rates of pay for unskilled labour
- Lack of guidance, supervision and support from parents and other family members
- Harsh physical punishment or victimisation at home
- Having peers already involved in a gang

From Krug et al., 2002

As children approach adolescence their social network becomes wider and more complex. As children reach this developmental stage, peers exert at least as much influence as family (Reid and Patterson, 1989). Anti-social behaviour can be reinforced by this widening social network (Sutton, 2004), particularly if peer interactions are inadequately supervised (Wilson, 1987). Having delinquent friends has been cited as a risk factor for violent offending (Reiss and Farrington, 1991). It is, however, difficult to determine if this is a cause or an effect of aggressive behaviour.

Table 2.6 illustrates risk factors for serious offending for 12-17 year old males as recorded by the 1998/99 Youth Lifestyle Survey (Flood-Page et al., 2000). It is apparent that having delinquent friends, hanging around in public places, illicit activities such as drug use, lack of parental supervision and disaffection from school all contribute to serious anti-social, and in many cases criminal, behaviour. The environment in which peer interaction occurs is also important. Depressed neighbourhoods where youths have little to occupy their time are more likely to produce violent individuals who run the risk of joining gangs (see Box 2.8). This is particularly true for individuals in the younger age range, who are more likely to be motivated by the search for excitement (LeBlanc and Frechette, 1989). Schools can act as a protective factor against violent behaviour if they have strong leadership from the head teacher, good staff morale and clear policies on

bullying and other anti-social behaviour. Conversely, if expectations of student behaviour are low, if rules are poorly defined and sanctions inconsistent, then schools can provide a disorganised environment which can actually exacerbate pre-existing problems (Anderson et al., 2001).

Table 2.6: Risk factors predicting serious offending, 12-17 year old males, England and Wales, 1998/99

From total sample of 4,848 12-30 year olds

Risk factor	% reporting risk factor	
	Serious offenders	All males (aged 12-17)
Drug user	52	18
Disaffected from school	36	15
Hanging around in public places	80	52
Delinquent friends or acquaintances	64	37
Poor parental supervision	47	22
Persistent truant	16	6

Data from Flood-Page et al., 2000



For the older age range in particular (18-30 year olds), regular drinking can be added as a major risk factor (Table 2.7). Individuals who continue to behave violently at the age of 18 are also more likely to engage in ‘utilitarian’ violence, for example during theft or when protecting territory where illegal activities such as drug dealing are conducted (Agnew, 1990). This type of violence often requires forward planning and involves weapons. Furthermore, it is more likely to result in serious injury (Farrington, 1998).

2.4.6: Community factors

There is a cyclical relationship between violence and destruction of social capital, which is characterised by a reduction of investment in the community and lack of opportunity for local residents (Krug et al., 2002). Although deprived neighbourhoods do not impact directly on infants, an indirect impact is caused by the stress and lack of support experienced by parents (Sampson, 1997). Consequently, poverty, unemployment,

Table 2.7: Risk factors predicting serious offending, 18-30 year old males, England and Wales, 1998/99

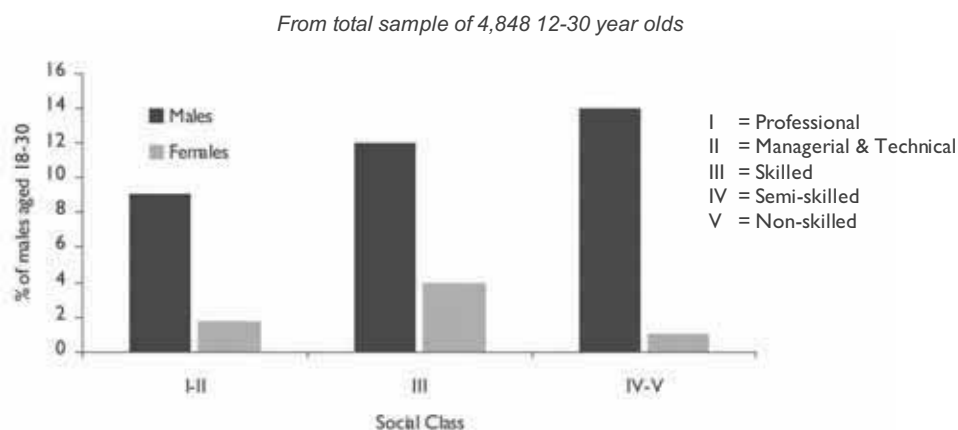
From total sample of 4,848 12-30 year olds

Risk factor	% reporting risk factor	
	Serious offenders	All males (aged 18-30)
Drug user	45	22
Leaving school with no qualifications	19	8
Delinquent friends or acquaintances	77	52
Drinking at least 5 times a week	22	13
Being temporarily or permanently excluded from school	22	13

Data from Flood-Page et al., 2000

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Figure 2.11: Violent offending by social class, males aged 18-30, England and Wales, 1998/99



Data from Flood-Page et al., 2000

overcrowding and illness all have a negative impact on parenting and are associated with conduct disorders in children (Rutter, 1978; Ghate and Hazel, 2002).

A longitudinal study of 400 delinquent boys from South London found that violence was correlated with low socio-economic group (Farrington and West, 1993). The Youth Lifestyles Survey of self-reported violence found an inverse relationship between socio-economic status and frequency of offending in males. Socio-economic differences in offenders, however, tend to be less apparent in self-reported surveys than in police data (Gold, 1970; Riley and Shaw, 1985). This suggests that violent crime committed by individuals in higher socio-economic groups is more likely to remain undetected.

When community violence occurs, fear of crime reduces physical mobility and raises unemployment. This helps cause inequalities in both health and socio-economic status (Department of Health, 2004). Furthermore, it has been suggested that inequality plays a greater role in the proliferation of violence than poverty alone (Krug et al., 2002; Unnithan and Whitt, 1992). Studies of bullying support this notion since there is no link between bullying and low socio-economic status.

Instead, disparity in wealth and the display of expensive possessions and accessories are more likely to trigger violence (Smith, 2002).

2.4.7: Alcohol

Alcohol plays a major role in youth violence, particularly in incidents involving older youths in nightlife settings. A national survey found that 18-24 year olds who binge drink (defined as drinking enough to feel very drunk at least once a month) are four times more likely to have committed violent criminal acts and five times more likely to have been involved in a group fight in public than 'regular' drinkers (those who drink frequently but rarely feel very drunk) (Richardson and Budd, 2003).

A fifth of all violence in the UK occurs in or around pubs and clubs (Allen et al., 2003), with 80% of incidents being related to alcohol (Budd, 2003). A recent study in Cardiff (Maguire and Nettleton, 2003) found that almost half of all incidents of violence and disorder in the city centre occurred at weekend nights, and that the vast majority of both offenders and victims were male (88% arrestees, 83% victims) and under the age of 30 (72% arrestees, 75% victims).

Whilst alcohol consumption is known to increase a person's risk of being both a

perpetrator and a victim of aggression and violence (Rossow, 1996; McClelland and Teplin, 2001), the relationship between alcohol and violence in nightlife settings is complex (Bellis et al., 2004). For example, the effects of alcohol may make drinkers more aggressive and less afraid of the consequences of their aggression (Graham et al., 2000), and can also render people less capable of preventing an attack and interpreting warning signs (Krug et al., 2002).

An important factor in levels of violence in nightlife, however, is the drinking environment within pubs and clubs and conditions within the wider night time environment (Bellis et al., 2004). For example, crowded pubs and clubs with poor ventilation, bad management, atmospheres of permissiveness towards anti-social behaviour and poorly trained staff have been associated with higher levels of violence and disorder (e.g. Homel et al., 2004). Similarly, lack of late night transport and security in nightlife areas can contribute to violence and

anti-social behaviour outside pubs and clubs and on routes home (Marsh and Kibby, 1992; Bellis et al., 2004).

2.4.8: Media

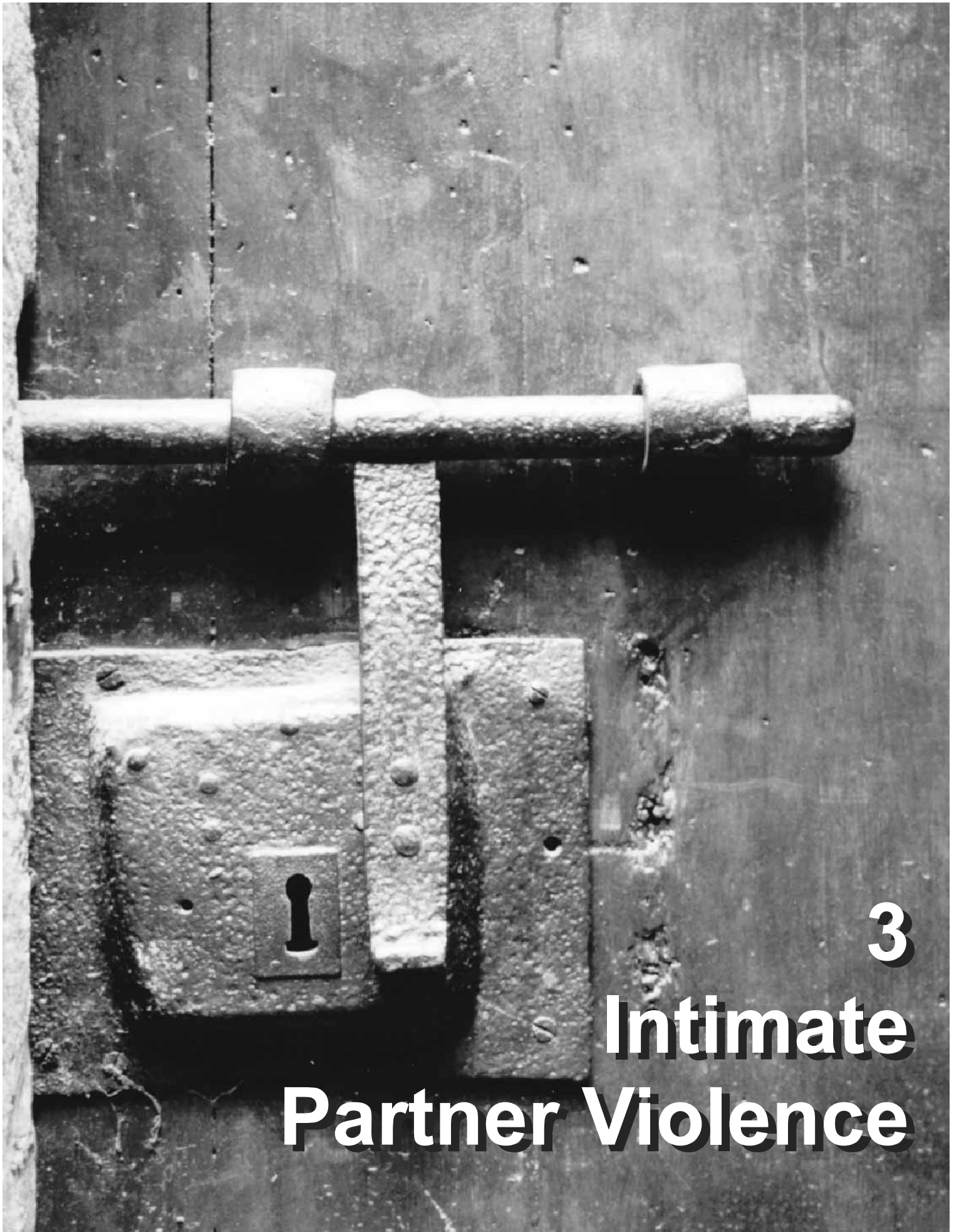
Increasing portrayal of violence in the media has resulted in growing concerns about its effects on young people. It is, however, difficult to isolate media violence as a causal factor in youth violence as apparent links could merely be a reflection of a pre-existing fascination with violence.

While media violence has been found to have a short term increase in aggressive behaviour in young children (Paik and Comstock, 1994), there have been no longitudinal studies into the long term effects of media violence on violent offending in adolescents and adults. This is because it is not possible to conduct robust experimental studies with effective control groups in order to isolate long term effects (Krug et al., 2002).



Key Points

- In England and Wales 25,800 violent offenders under the age of 21 were cautioned or found guilty of violent offences during 2002.
- Youths account for 48% of victims and 71% of perpetrators of offences involving firearms.
- 73% of violent offenders under the age of 30 escape all sanctions by the criminal justice system.
- 52% of Anti Social Behaviour Orders (ASBOs) are granted for violent behaviour.
- 85% of ASBOs are granted to young people (under the age of 30).
- 43% of boys and 46% of girls are bullied at some time during their school careers.
- Over a quarter of both boys and girls between the ages of 10 and 14 admit to having bullied others at some point.
- A Scottish survey showed that 34% of boys had carried weapons in secondary school at least once.
- Assault is the second leading cause of hospital admission for males between the ages of 15 and 24.
- Children who do not receive adequate parental supervision of their peer interactions are two and a half times more likely to commit violent offences.
- Children who have teenage mothers are more likely to commit violent offences than those who have older mothers.
- 18-24 year olds who binge drink are four times more likely to commit violent acts than other regular drinkers.



3

Intimate Partner Violence

3: INTIMATE PARTNER VIOLENCE

3.1: Introduction

The terms domestic violence and intimate partner violence are often used interchangeably. This is due to differing definitions of the term 'domestic violence', since this term can be applied to violence perpetrated by any former or present family member towards another. For the purpose of the British Crime Survey, domestic violence is defined as:

“All violent incidents, except mugging, which involve partners, ex-partners, household members or other relatives” (Dodd et al., 2004).

However, in the Home Office guidance paper “Safety and Justice, The Government’s Proposals on Domestic Violence” the definition used is:

“Any violence between current or former partners in an intimate relationship, wherever or whenever the violence occurs. The violence may include physical, sexual, emotional and financial abuse” (Douglas et al., 2003).

Used in this way, the term 'domestic violence' is the same as the term 'intimate partner

violence' as defined by the World Health Organization:

“Any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationships” (Krug et al., 2002).

For the purpose of this report, intimate partner violence is used to describe violence between present or ex intimate partners. Other types of domestic violence such as child or elder abuse are dealt with in other sections.

Definitions of the different sub-types of intimate partner violence are provided in Box 3.1.

Intimate partner violence can occur within same sex relationships, or against men by women, but the majority of victims are women within heterosexual relationships (Walby and Allen, 2004). This type of violence is the most common form of violence suffered by women in contrast to men who are more likely to be the victims of violence perpetrated by acquaintances or strangers (Krug et al., 2002; Dodd et al., 2004).

Box 3.1: Typology of Intimate Partner Violence

- **Physical aggression**
Can range from minor trauma which can be hidden from everyone and for which medical attention is never sought, to homicide at its most severe
- **Psychological abuse**
Can result in depression or have as severe effects as suicide
- **Controlling behaviour**
Can be emotional or financial
- **Sexual coercion**
Includes forced prostitution and/or rape (this type of violence is dealt with in Chapter 6: Sexual Violence)

From Krug et al., 2002

3.2: Extent of Intimate Partner Violence

Some of the statistics relating to intimate partner violence have been highly publicised. This section places these well known statistics in context and also explores some of the issues surrounding less well known data relating to violence inflicted on men by women, and also violence in same-sex relationships.

3.2.1: Gender symmetry

The majority of studies relating to intimate partner violence have focused on female victims and male perpetrators (see Box 3.2).

Krug and colleagues (2002) define two main patterns of intimate partner violence. The first, “battering” is characterised by severe violence which escalates over time, and comprises multiple forms of abuse. The second pattern, “common couple violence” is more moderate, tending to stem from continuing frustration and anger which occasionally erupts into violence. Men engage as perpetrators in both patterns, while female perpetrators tend to engage only in common couple violence. Victims of “battering” are thought to be more difficult to detect in surveys (Krug et al., 2002).

Box 3.2: Gender Symmetry in Intimate Partner Violence

‘Gender symmetry’ is the term applied to situations in which an equal number of men and women are victims of intimate partner violence. The emphasis placed on female victims has resulted in some criticism of a dominant “feminist” perspective and a lack of concern for male victims since some studies have found gender symmetry in intimate partner violence (Straus and Gelles, 1990). Such studies, however, use the Conflict Tactics Scale which has been criticised for failing to measure outcomes and impact, and which ignores sexual violence (Dobash et al., 1992). Some activists claim that males suffer as greatly as females, citing Archer’s metastudy of comparative gender rates of violence within heterosexual relationships (Archer, 2000). Archer’s study found that women were more likely to be perpetrators of aggression than males but were also more likely to be injured as a result of male aggression. The vast majority of the studies included in Archer’s meta analysis involved small samples of US high school and university students (under 22 years old) and thus cannot be considered a representative sample for the UK. The high-risk categories in England and Wales are slightly older women from low-income households, either unemployed or from non-professional/managerial backgrounds (See Section 3.4). Another limitation stems from the fact that many of the studies used in the meta analysis utilised confidential questionnaires asking if subjects had behaved aggressively towards an intimate partner. It could be argued that males are more likely to deny such behaviour due to the social stigma attached to it in western society whereas young females feel that such behaviour is a desirable form of assertiveness. Furthermore, aggression amongst females is becoming a serious concern in the UK. While Archer’s study makes a valuable contribution to the debates on the biological basis for aggression, and aggression as an evolutionary adaptation, it is less appropriate for supplying epidemiological information on intimate partner violence. Most of the data and studies cited in this chapter, therefore, are British-based studies.

3.2.2: Global comparisons

The pooling of international data can be problematic due to different methods of data collection and analysis. For example, when calculating rates of intimate partner violence, some countries exclude individuals who have never had an intimate relationship, while others do not, therefore altering prevalence rates. This obviously negates the validity of many international comparisons. Table 3.1 illustrates comparisons of prevalence of intimate partner violence towards women. In all instances the samples include individuals who have never had an intimate relationship.

3.2.3: National data - the British Crime Survey

The annual British Crime Survey is concerned with experience of crime, and is based on face to face interviews with respondents residing in private households in England and Wales. Since 1996, research into subjects deemed sensitive (such as experience of drug use, sexual assault and domestic violence) have been conducted via detailed, self completion questionnaires. The British Crime Survey supplement “Domestic violence, sexual assault and stalking” (Walby and Allen, 2004) presents the findings of 22,463 confidential self completed questionnaires relating to subjects including intimate partner violence. The sample contains comparable numbers of males and females



aged 16-59 and is representative of the population of England and Wales. The information from the study can be divided into two main categories: lifetime experience (incidents occurring since age 16) and experience during the past 12 months.

Table 3.1: Proportion of women who have ever been physically assaulted by a partner according to selected international studies

Country	Year of Study	Sample	Percent
Nigeria	1993	Not stated	31
Barbados	1990	National	30
Canada	1991-1992	Toronto	27
United States	1995-1995	National	22
Netherlands	1986	National	21
United Kingdom	1993	London	30

Data from Krug et al., 2002

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Figure 3.1 shows comparative percentages of victimisation for males and females. Females outnumber males as victims for all forms of non-sexual intimate partner violence, with 26% of females and 16.5% of males having experienced some form of intimate partner violence since age 16. Over the previous 12 month period, 6% of females and 4% of males reported experiencing some form of intimate partner violence (Figure 3.2).

Figure 3.1: Prevalence of non-sexual intimate partner violence since age 16, England and Wales, 2001

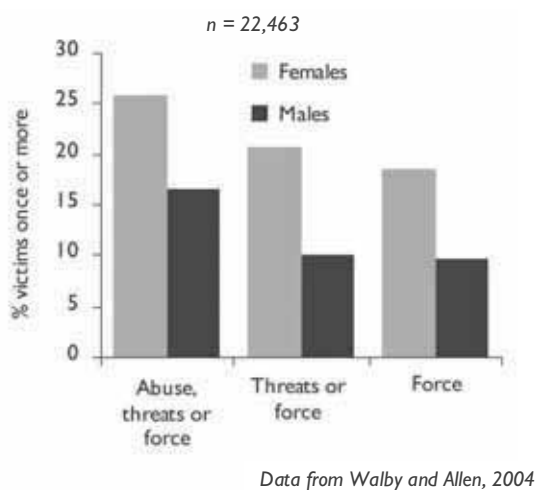


Figure 3.2: Prevalence of non-sexual intimate partner violence in 12 months prior to interview, England and Wales, 2001

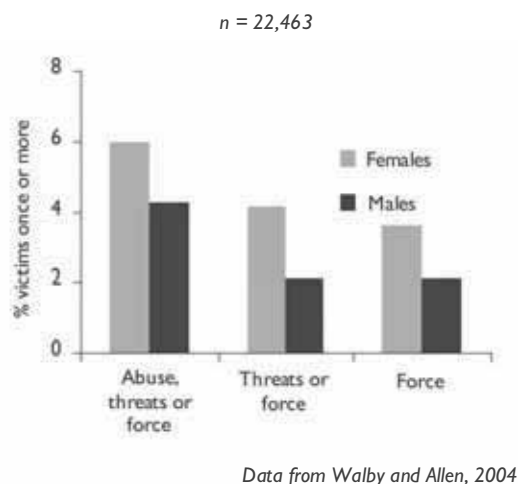


Figure 3.3: Mean number of incidents of non-sexual intimate partner violence per victim in the previous 12 months, England and Wales, 2001

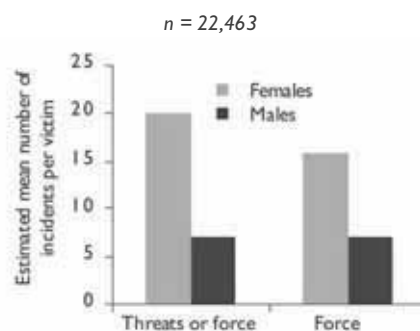


Table 3.2: Estimated number of victims of non-sexual intimate partner violence in the last 12 months: England and Wales, 2001.

Type of intimate partner violence	Females	Males
Abuse, threat or force	931,000	672,000
Threat or force	657,000	356,000
Force	529,000	338,000

Data from Walby and Allen, 2004

A comparison of the different categories of intimate partner violence shows very little difference between use of force, and threats combined with force. This suggests that threats of violence are usually carried through with physical violence.

Females also outnumber males when numbers of incidents per victim are compared (Figure 3.3 and Table 3.2). It is also apparent that although female victims suffer more frequent incidents of violence at the hands of males than vice versa, female perpetrators are less likely to make idle threats. This could be because females are more afraid and therefore make more attempts to resolve the situation before the situation escalates to physical assault.

3.2.4: Under-reporting

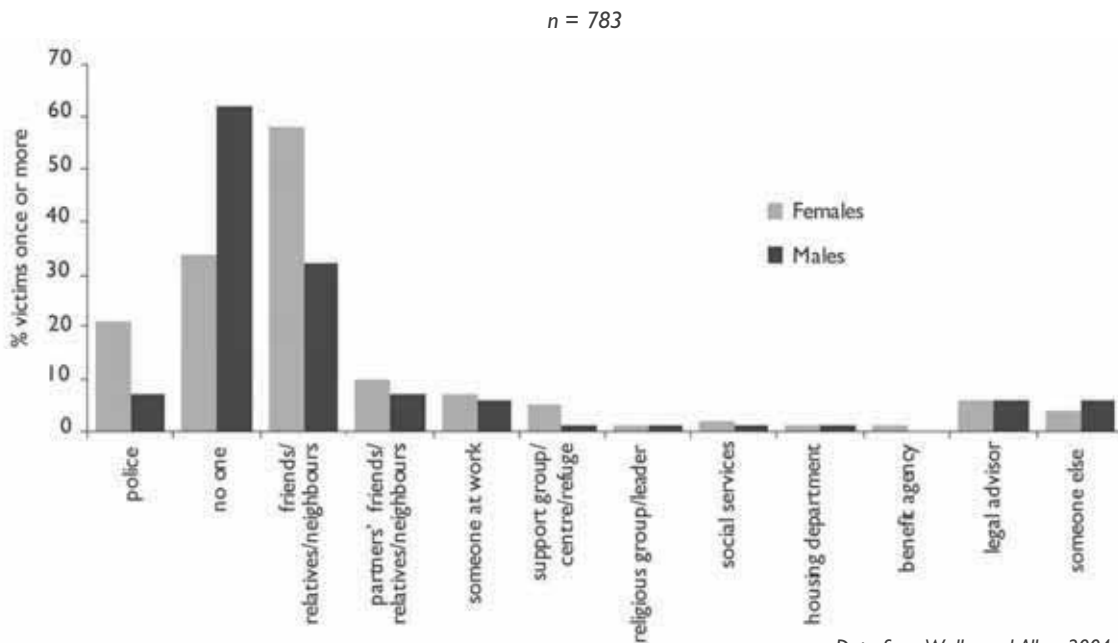
An important factor in intimate partner violence is under-reporting. The British Crime Survey figures differ from Police recorded crime figures for all forms of crime, but victims of intimate partner violence are particularly reluctant to involve the criminal justice system. Only 21% of women report the violence they experienced to the police (Figure 3.4; Walby and Allen, 2004). Many reasons have been suggested for this including fear of partner retribution, feelings of shame and isolation and fear of losing custody of children.

Males are even less likely than females to report incidents of intimate partner violence to the authorities, with only 7% contacting the police. This could be because they do not take the incidents as seriously (as discussed further in section 3.3) or because they feel more shame. For this reason, males should be considered a “hard to reach” group in this regard and more sensitive research needs to be undertaken to assess the harm caused to males and male-headed households.

There are other groups for whom further research needs to be undertaken, since under-reporting is a particular problem (Box 3.3). There is a paucity of data on intimate partner violence within gay, lesbian, bisexual and transgender relationships, since studies tend to be small scale and use non-randomised samples. It has been suggested that fear of homophobia and threats of “outing” add another dimension of abuse to these relationships (Gadd et al., 2002).

Many minority ethnic groups are also reluctant to report incidents of intimate partner abuse to the authorities due to suspicion and fear of racism. Asian women may fear breaking family honour (Choundry, 1996), while refugees and asylum seekers may avoid contact with the criminal justice system due to language barriers and fear of deportation (Erez, 2002). Other groups which present a particular problem in this regard are victims who work in healthcare (Mezey, 1997) and the criminal justice system (Paradine and Wilkinson, 2004),

Figure 3.4: Who was told about the worst incident of non-sexual intimate partner violence? England and Wales, 2001



Data from Walby and Allen, 2004

Box 3.3: Summary of “hard to reach” groups in respect to the reporting of intimate partner violence

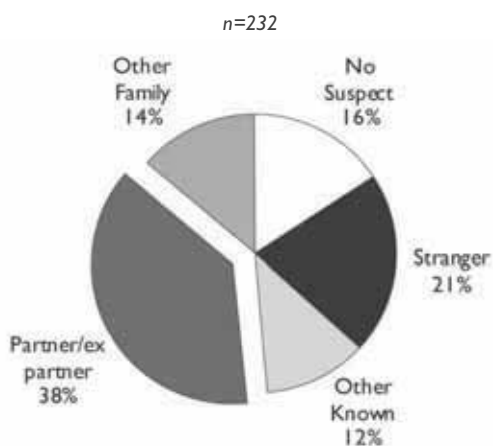
- Men
- Minority ethnic groups
- Refugees and asylum seekers
- Gay, lesbian, bisexual and transgender couples
- Disabled individuals
- People suffering from mental illness
- Older people
- Travellers
- Substance misusers
- Victims and perpetrators working in healthcare or the criminal justice system

since fear of exposure to colleagues adds a further disincentive to reporting. Box 3.3 summarises groups that are considered ‘hard to reach’ with regards to intimate partner violence.

3.2.5: Intimate partner homicide

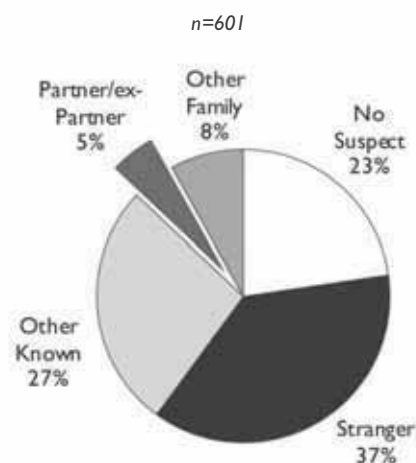
Some researchers have suggested that homicide rates provide a better indicator of gender differences in intimate partner victimisation since reporting is not an issue in this regard. There were 115 intimate partner homicides in England and Wales in 2003/2004.

Figure 3.5: All homicide victims by relationship of victim to principal suspect: females, England and Wales, 2003/2004



Data from Povey, 2005

Figure 3.6: All homicide victims by relationship of victim to principal suspect: males, England and Wales, 2003/2004



Data from Povey, 2005

Figures 3.5 and 3.6 present a comparison of perpetrator patterns for homicides of males and females, revealing that females are over three times more likely to become the victims of homicide by present or former intimate partners than males (Povey, 2005). These figures however, cannot be used as reliable indicators of the ratio of male to female perpetrated violence; in general men have greater physical strength than women, so assaults by males are more likely to be lethal.

3.3: Impact of Intimate Partner Violence

3.3.1: Health impact

When intimate partner violence results in serious physical trauma the health consequences are obvious; 18% of intimate partner assaults result in a doctor's visit in comparison to 8% for stranger violence (Paradine and Wilkinson, 2004). However, in addition to the acute conditions requiring

urgent care, intimate partner violence frequently results in chronic conditions which require long-term treatment. A summary of common acute and chronic health problems occurring as a consequence of intimate partner violence are provided in Table 3.3.

Table 3.3: Health consequences of intimate partner violence

Physical	Sexual & Reproductive	Psychological & Behavioural	Fatal
Abdominal/thoracic injuries	Gynaecological disorders	Alcohol and drug and tobacco use	AIDS related mortality
Bruises and welts	Infertility	Depression and anxiety	Maternal mortality
Chronic pain syndrome	Pelvic inflammatory disease	Eating and sleep disorders	Homicide
Disability	Pregnancy complications/ miscarriage	Feelings of shame and guilt	Suicide
Fibromyalgia	Sexual dysfunction	Phobias and panic disorder	
Fractures	Sexually transmitted infections including HIV/AIDS	Physical inactivity	
Gastrointestinal disorders	Unsafe abortion	Poor self-esteem	
Irritable bowel syndrome	Unwanted pregnancy	Post traumatic stress disorder	
Lacerations and abrasions		Psychosomatic disorders	
Ocular damage		Unsafe sexual behaviour	
Reduced physical functioning		Suicide and self harm	

Adapted from Krug et al., 2002

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A study of assault victims at Epsom and St Helier Accident and Emergency department in London showed an association between victimisation and other health disorders (Stevens, 2002), with the majority of women suffering from other complaints not directly associated with the assault. Furthermore, patients with a history of abuse made up a significant portion of the total number of patients presenting for chronic medical conditions (Table 3.4).

Table 3.4: Association between victimisation and selected medical conditions, Epsom and St Helier Accident and Emergency department, London

Other health problems reported by individuals with a history of intimate partner abuse		Contribution of individuals with history of intimate partner abuse to selected medical conditions	
Irritable Bowel Syndrome	82%	Chronic headaches	9%
Gastrointestinal reflux	92%	Fainting attacks	14%
Non-specific chest pains	27%	Chest pain	11%
		Hyper-ventilation	8%

Data from Stevens, 2002

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 admissions. Furthermore, 64% of all female psychiatric inpatients have a history of abuse by intimate partners (Stevens, 2002). A breakdown of the disorders experienced by these patients is presented in Table 3.5.

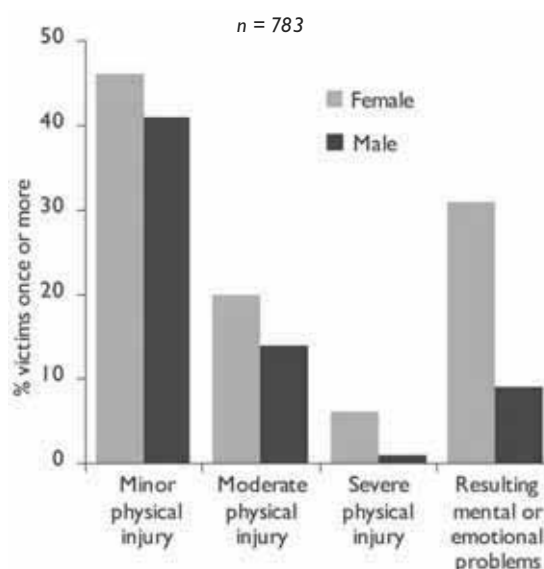
Table 3.5: Psychiatric disorders experienced by victims of intimate partner violence presenting at Epsom and St Helier Accident and Emergency department, London

Psychiatric disorder	Percent
Clinical depression	33%
Suicide & parasuicide	26%
Alcohol abuse	16%
Eating disorders	16%
Drug abuse	10%
Sleep disorders	8%

Data from Stevens, 2002

These findings concur with those of the British Crime Survey (Walby and Allen, 2004), which also discovered that a high proportion of female victims suffer psychological harm as a result of intimate partner violence (Figure 3.7).

Figure 3.7: Injuries sustained as a result of non-sexual intimate partner violence during the worst incident experienced in the last year, England and Wales, 2001



Data from Walby and Allen, 2004

3.3.2: Economic Impact

Estimates of the economic impact of intimate partner violence vary according to the measure of prevalence used and type of costs included. The costs incurred by the individual include: missing paid work, negative influences on earnings and reduced ability to keep a job. (Waters et al., 2002). Furthermore, costs to society are borne by the government, employers, and the health, legal, criminal justice, financial, housing, and social welfare sectors (Waters et al., 2002).



In the UK, there are an average of 150 murders a year due to intimate partner violence, costing a total of £165 million (Brand and Price, 2000). It is estimated that £60 million of this total is due to lost output and public service expenditures, including police investigations. The cost of emotional impact makes up the remaining £105 million. The cost of homicide, however, constitutes only a small proportion of the overall economic impact of intimate partner violence. A recent study

estimated the total cost of intimate partner violence in the UK to victims, employers and the state at £23 billion (Walby, 2004).

3.3.3: Homelessness

Intimate partner violence has been cited as one of the chief causes of homelessness. One study in Birmingham indicated that 69% of families in a homeless shelter were there as a result of intimate partner violence, while an investigation of Shelter's "Homeless to Home" project revealed that 38% of families using the service have lost their homes as a consequence of escaping violent partners (Jones et al., 2002). Between 1997 and 2002, 54,000 households were re-housed by housing associations as a result of intimate partner violence; an average of 11,000 per year. Over 95% of these households were headed by females, while a further 61% included children (Housing Corporation, 2003).

In a "snapshot" survey of intimate partner violence it was reported that, in a single day, 110 women and 102 children were housed in London's refuges alone (Stanko, 2000). A further 36 individuals could not be accommodated due to lack of space. Shortage of refuge places is not limited to London. Furthermore, this form of shelter is usually provided by the voluntary sector and therefore receives no secure funding (Jones et al., 2002).

3.3.4: Impact on children

Many children from households experiencing intimate partner violence are at risk, with 40% of child abuse cases correlating with abuse of the mother (Stevens, 2002). Furthermore, 75% of children on the at-risk register live in households where intimate partner violence exists (Bossy and Coleman, 2000). This has resulted in tension between child protection services and services for women victims. Consequently, there are many reported incidents of women failing to seek help for fear of losing their children (Department of Health, 2002). Children who do not experience direct

physical abuse in such households may suffer indirect harm as a result of witnessing violence. The subsequent short and long term behavioural problems displayed by such children are well documented (Box 3.4).

Box 3.4: Behavioural problems displayed by children who witness intimate partner violence

- Failure to thrive
- Bedwetting
- Bad behaviour at school (including bullying)
- Lying
- Stealing
- Illegal substance misuse

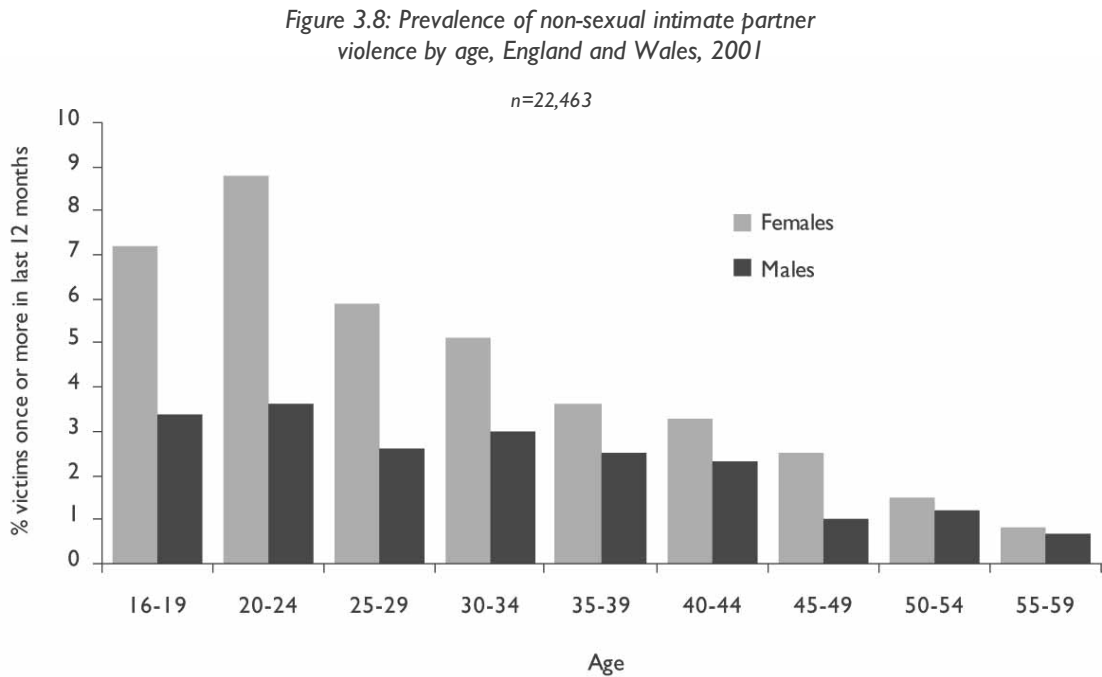
(from Stevens, 2002)



3.4: Risk Factors for Intimate Partner Violence

3.4.1: Age and sex

Figure 3.8 shows how the gender differences discussed in Section 3.2 relate to age. Although female victims outnumber male victims in all age cohorts, the gap narrows with age. Whilst youth is a risk factor for both sexes, it is more apparent for females.



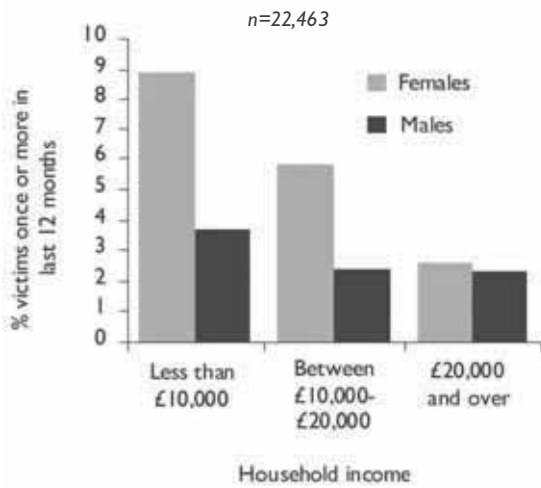
Data from Walby and Allen, 2004

The magnitude of this problem is substantial since it is estimated that children are in the same or an adjacent room in 90% of incidents of intimate partner violence (NCH Action for Children, 1994). For further discussion of the long term consequences of witnessing violence see Chapter 2.

3.4.2: Socio-economic group

Socio-economic status can be assessed in several ways. Figure 3.9 illustrates victimisation by household income. For females there is an obvious increased risk for those living in low income households. This is less apparent for males, which concurs with global findings (see Krug et al., 2002).

Figure 3.9: Prevalence of non-sexual intimate partner violence by household income, England and Wales, 2001



Data from Walby and Allen, 2004

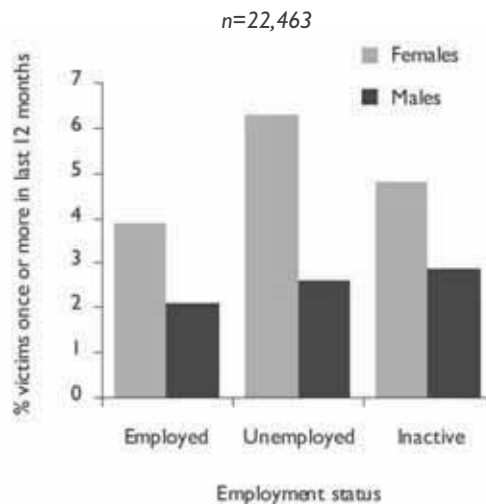
There could be several reasons for this. Females are more likely to be financially dependant on their partners than males, and therefore find it more difficult to leave an abusive relationship. It has also been suggested that men in poverty show power through violence in the home (Walby and Allen, 2004). Both these factors could contribute to the correlation between low income and female victimisation.

The stresses and pressures induced by poverty can lead to conflict, which in turn can trigger common couple violence. Since this affects both sexes, it could account for the differences in male victimisation rates. There is also an argument that intimate partner violence results in poverty. Since women in households with an



income below £10,000 are three and a half times more likely to have been victims in the last 12 months, this could be because they have fled the family home. Similarly, it is not possible to determine if unemployment is a cause or a result of intimate partner violence (Figure 3.10).

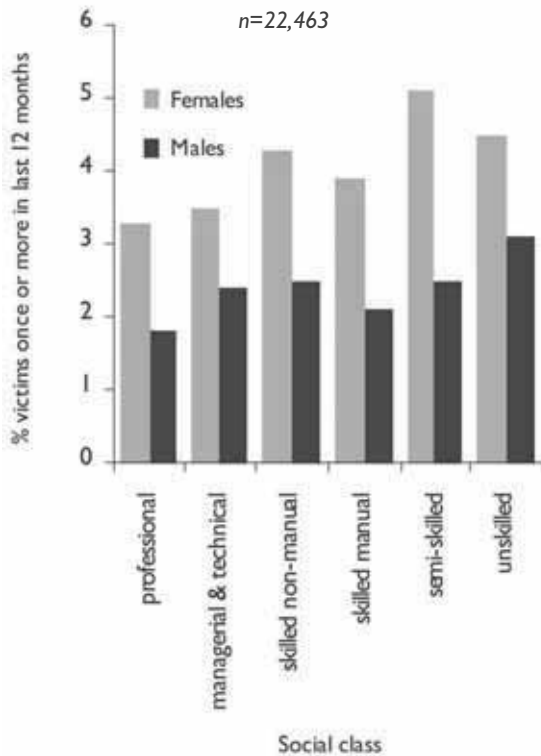
Figure 3.10: Prevalence of non-sexual intimate partner violence by employment status, England and Wales, 2001



Data from Walby and Allen, 2004

While the relationship between low income and the experience of intimate partner violence is clear, the situation regarding socio-economic status is more complex and shows no clear pattern (Figure 3.11).

Figure 3.11: Prevalence of non-sexual intimate partner violence by social class, England and Wales, 2001



Data from Walby and Allen, 2004

3.4.3: Pregnancy

One study found intimate partner homicide to be the leading cause of death amongst pregnant women (Metropolitan Police Service, 2002). Sub-lethal violence during pregnancy is even more widespread. One study of women attending primary care in East London found that 40% of violence starts during pregnancy. Furthermore, the study found that 30% of cases involving pregnant women as victims resulted in miscarriage (Chung et al., 2002).

Other reported negative health consequences include foetal distress, poor pregnancy outcomes, low birth weight and pre-term labour (Adam, 2002).

3.4.4: Alcohol

There is a clear link between alcohol consumption and intimate partner violence with 32% of perpetrators reported as being under the influence of alcohol at the time of assault (Mirlees-Black, 1999). Furthermore, alcohol abuse has been found to be 2-7 times higher for perpetrators of intimate partner abuse than for other offenders (Finney, 2004). In contrast to other types of violence, for example youth violence, offender-only drinking is common (Martin and Bachman, 1997). One study, however, reported that 52% of female victims of intimate partner violence reported being “frequently drunk”, with a further 22% reported being engaged in “episodes of heavy drinking.” (Mirlees-Black, 1999). This cannot be seen as a cause of violence, but rather as a consequence of it, since alcohol dependency is



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a widely documented symptom of post-traumatic stress and associated psychiatric disorders (see Finney, 2004). Box 3.5 summarises the relationship between alcohol and intimate partner violence.

In the case of perpetrators, the relationship between violence and alcohol is also complex. Many researchers emphasise that alcohol should be considered a contributing factor

rather than a cause of violent behaviour. For example, Krug et al., 2002; Finney, 2004). White and Chen (2002) emphasise the role of alcohol in the escalation and severity of violence, and explain how disparate drinking can cause conflict and trigger arguments between partners. Since arguments can trigger further drinking, a cycle of violence and alcohol misuse frequently characterises intimate partner violence.

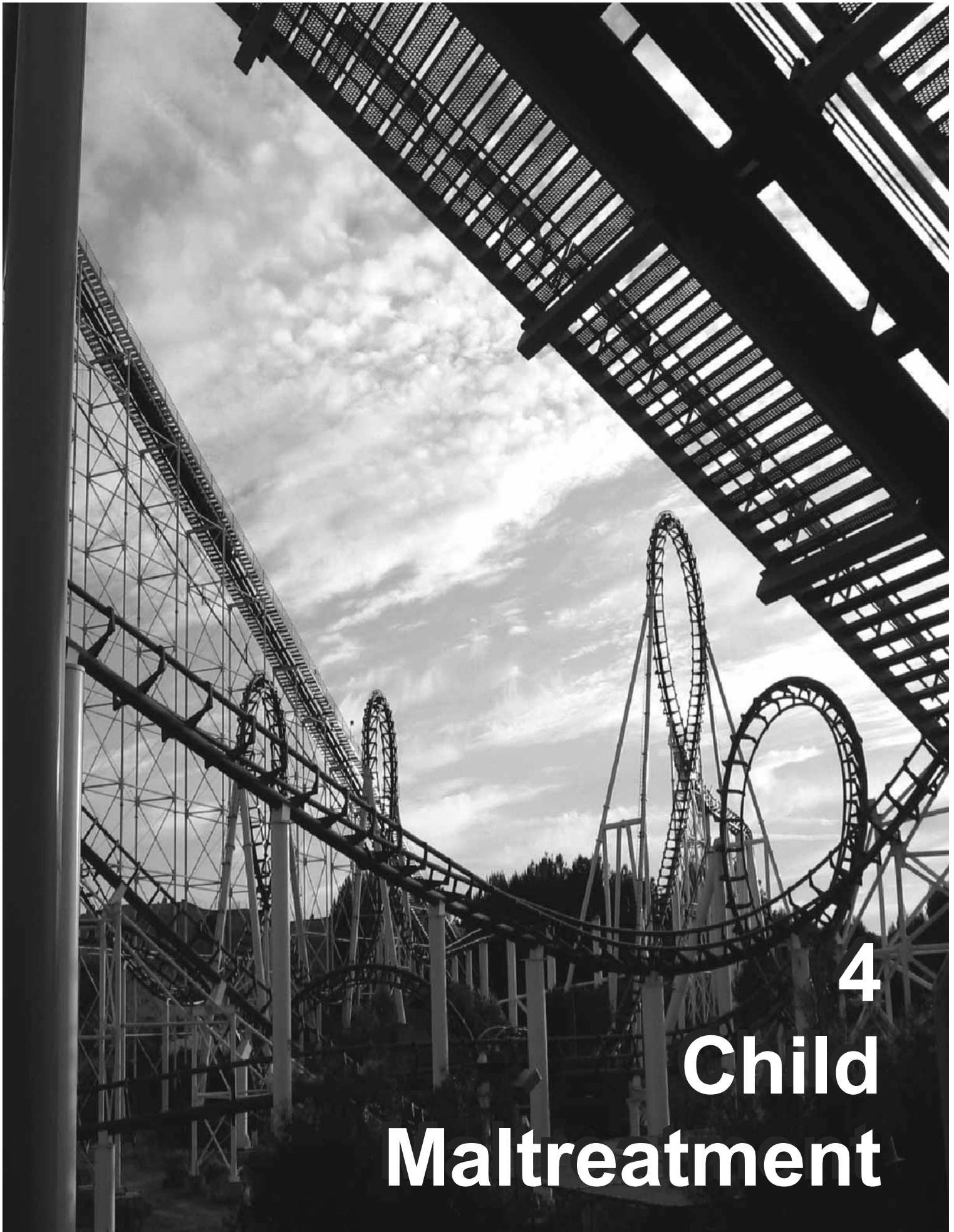
Box 3.5: Alcohol related factors that contribute to intimate partner violence

- **Cultural factors**
How alcohol and its relationship to violence are understood by society (this is culturally variable)
- **Personal factors**
Individual responses, expectations and beliefs about alcohol (alcohol is sometimes used as an excuse for intimate partner violence)
- **Pharmacological factors**
Escalation of violence can occur due to alcohol's psychopharmacological properties as a disinhibitor (it can exacerbate problems where conflict already exists and intensify negative emotions)
- **Contextual factors**
Physical and social circumstances under which alcohol is consumed

* * * * *

Key Points

- Females outnumber males as victims for all forms of non-sexual intimate partner violence, with 26% of females and 16.5% of males having experienced some form of intimate partner violence since age 16.
- Only 21% of women report the violence they experience to the police. Males are even less likely than females to report incidents of intimate partner violence to the authorities, with only 7% contacting the police.
- Victims of intimate partner abuse are 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 admissions.
- Over 64% of all female psychiatric inpatients have a history of abuse by intimate partners.
- In the UK, there are an average of 150 murders a year due to intimate partner violence, costing a total of £165 million.
- The total cost of intimate partner violence in the UK to victims, employers and the state is £23 billion.
- Between 1997 and 2002, 54,000 households were re-housed by housing associations as a result of intimate partner violence; an average of 11,000 per year. Over 95% of these households were headed by females.
- Over 40% of child abuse cases correlate with abuse of the mother.
- Children are in the same or an adjacent room in 90% of incidents of intimate partner violence.
- Women in households with an income below £10,000 are three and a half times more likely to be victims.
- A study of women attending primary care in East London found that 40% of violence starts during pregnancy.
- Miscarriages occur in 30% of cases involving pregnant women victims of intimate partner violence.



4
Child
Maltreatment

4: CHILD MALTREATMENT

4.1: Introduction

Child maltreatment can be divided into two broad categories. The first type, acts of commission, occur when an adult actively behaves in a way that is damaging to the child. This type of maltreatment includes physical abuse, emotional abuse and psychological abuse. The second category, acts of omission, includes any behaviour whereby an adult in a position of responsibility and trust fails to provide the care and supervision necessary to ensure the healthy development and safety of the child (see Box 4.1). Although the household is the primary context for maltreatment and parents are the most likely perpetrators (Cawson et al., 2000), children are also at risk of abuse and neglect in the homes of family friends, neighbours and foster parents. Abuse can also occur in institutional settings, churches, youth clubs, and sports clubs (Ghate and Daniels, 1997).

Although different cultures tend to have different rules about what are considered to be acceptable parenting practices, there is a general consensus that child abuse should not be tolerated (Bross et al., 2000). Creighton and Russell (1995) found a 90% consensus in defining harsh physical and sexual abuse. This is probably because the immediate and long term consequences of such abuse have been well documented and are therefore universally acknowledged (Cawson et al., 2000). Problems of consensus do occur, however, in situations concerning less serious abuse, particularly if the behaviour is not covered by any penal code or if the consequences are less well known. Such grey areas include: exposure to sexually explicit material, failure to provide a healthy diet, and allowing children to witness domestic violence. Another grey area concerns acceptable levels of discipline, for example: depriving a child of a meal, spanking, face slapping, shaking, or pinching.

Cawson and colleagues (2000) stress that child maltreatment is a continuum and that borderline areas of uncertainty are based upon

Box 4.1: Typology of child maltreatment

- **Physical**
Acts that cause, or have the potential to cause, physical harm
- **Sexual**
Acts for the sexual gratification of the perpetrator
- **Emotional**
Acts that fail to provide an appropriate and supportive emotional environment
- **Neglect**
Failure to provide for the development of the child (when otherwise able to do so) in: health, education, emotional development, nutrition, shelter and safe living conditions.

From Krug et al., 2002



individual perceptions of acceptable behaviour. They argue that if definitions are to have credibility they need to be based on a social consensus of acceptable behaviour. They point to the particular difficulties of establishing boundaries between child maltreatment and other forms of harm that arise from poverty and its consequences for parenting. Controversy, however, extends further than establishing boundaries. There are debates regarding whether measures of abuse should be based on behaviour and intent, or if the emphasis should be placed on impact, outcome and harm (Cawson et al., 2000). These issues, along with more detailed definitions and measures, are discussed further in the following sections.

4.2: Extent of Child Maltreatment

4.2.1: Measuring the extent of child maltreatment

Official statistics reveal little about the patterns and levels of maltreatment since only the most severe cases are recorded. This is because agencies involved in child protection are concerned primarily with preventing future harm rather than recording past incidents. Similarly, children who seek help represent a very small minority of the overall number of children experiencing abuse and neglect. The reasons for the considerable levels of under-reporting and under-recording are highlighted in Box 4.2.

Box 4.2: Factors impeding accurate estimates of the prevalence of child maltreatment

Under-reporting due to:

- Some children may feel that the abuse or neglect was deserved and therefore do not perceive it as abusive (Bower and Knutson, 1996)
- Some may compare their own situation to that of those worse off than themselves, and so feel that their own treatment is acceptable in comparison (Bifulco and Moran, 1998)
- A child may be aware of the problems experienced by the abuser, and accept their situation due to empathy (Cawson et al., 2000)

Under-recording due to:

- UK child protection registers are based on the likelihood of future significant harm, so much past maltreatment is not recorded (Cawson et al., 2000)
- Younger children are more likely to be on the child protection register, so the number of maltreated adolescents is underestimated (Rees and Stein, 1999)
- Low income families are more likely to come to the attention of authorities, so official registers cannot be regarded as a true reflection of levels of harm for different sections of the population (Department of Health, 1995)
- There are often no legal or social systems for recording or responding to low levels of abuse, for example exposure to sexually explicit material or milder forms of physical discipline (Bross et al., 2000)



4.2.2: Global data

Globally, there are over 57,000 homicides of children under the age of 15 every year, the greatest risk being for children less than one year old (Krug et al., 2002). The lowest rates tend to be in high-income countries. However, problems with the classification of deaths due to ambiguous causes such as domestic accidents and Sudden Infant Death Syndrome (SIDS) has almost certainly resulted in the underestimation of infant homicides in the developed world (Kirschner and Wilson, 2001; Reece and Krous 2001). There is, therefore, a general consensus that homicides of young children in most countries are more frequent than suggested by official statistics (Krug et al., 2002; Adinkrah, 2000; Kotch et al., 1993).

4.2.3: National data – child homicides

There are, on average, 80 child homicides recorded in England and Wales each year. Approximately 90% of these deaths are inflicted by a parent, caregiver, or person known to the child (Povey, 2005). The true number of homicides is probably considerably higher due to difficulties in diagnosis, recording and assessment (Stangler et al., 1991). The individuals at most risk, in common with most countries, are babies under the age of one year.

4.2.4: Physical abuse

The latest available figures show that there are 32,700 children on child protection registers in the UK (Breslin and Evans, 2004). Furthermore, the National Society for the Prevention of Cruelty to Children (NSPCC) teams and helplines accepted over 24,000 requests for help over the last year (NSPCC, 2004). These figures, however, cannot be used to estimate the prevalence of child maltreatment with any degree of reliability.

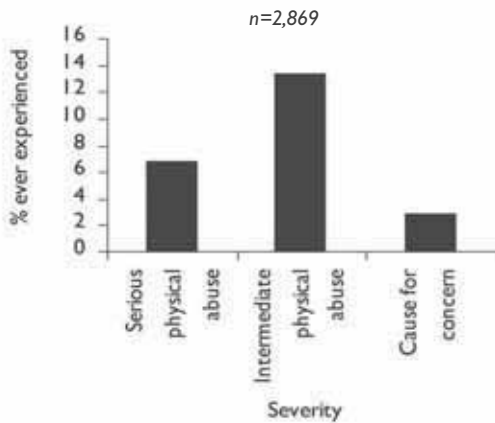
An NSPCC population based report of childhood experiences surveyed 1,235 men and 1,634 women aged 18-24 years in the UK (Cawson et al., 2000). Since all individuals in

this representative sample were questioned about their childhood experiences up to age 16, the results provide the most accurate picture of the extent of child maltreatment in the UK to date. Although nine out of ten children considered themselves to have come from a warm and loving family background, detailed questions revealed that 16% of children had experienced serious maltreatment by their parents, of whom one third had experienced more than one type of maltreatment (Cawson, 2002). This is because definitions of maltreatment vary; many individuals deny abuse even though the harm they suffered may have been severe.



Since overall figures mask the severity and frequency of maltreatment (Dingwall, 1989) a more detailed account of different levels and types of maltreatment is presented below. The NSPCC study divided physical abuse into three categories based on levels of severity (Box 4.3). It was found that 7% of respondents had experienced serious physical abuse during childhood, the majority of which had occurred at the hands of parents or carers. Over twice this amount had experienced physical abuse at lesser levels of severity (Figure 4.1).

Figure 4.1: Past experience of physical abuse during childhood: severity of physical abuse, UK, 1999 : 18-24 year olds



Data from Cawson et al., 2000

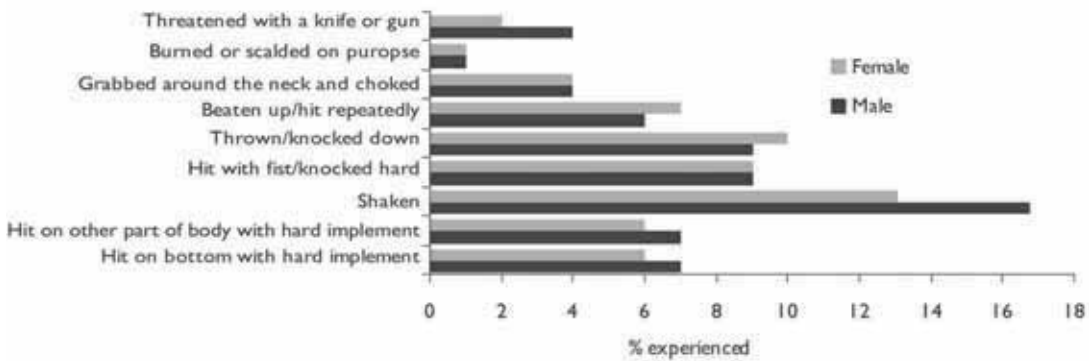
Box 4.3: Levels of physical abuse

- **Serious:**
Where violent treatment either caused injury or carried a high risk of injury if continued over time
- **Intermediate:**
Where violent treatment occurred occasionally but caused no injury, or where other physical treatment/discipline was used regularly over the years and/or led to physical effects such as pain, soreness or marks lasting at least until the next day
- **Cause for concern:**
Where injury or potential harm was not immediately serious, but where less serious physical treatment/discipline occurred regularly and indicated problems in parenting or the quality of care which could escalate or lead to continued distress for a child

From Cawson et al., 2000

Figure 4.2 illustrates the distribution of incidents classified as types of serious physical abuse. Being “shaken” was the most commonly reported abuse experienced, reported by 17% of males and 13% of females. It must be remembered however, that these data only represent incidents remembered from childhood, so violence experienced in the first years of life will be un-reported.

Figure 4.2: Past experience of physical abuse during childhood: Distribution of incidents experienced by those reporting having experienced serious physical abuse before age 16, 18-24 year olds: UK, 1999



Data from Cawson et al., 2000

4.2.5: Sexual abuse

Child sexual abuse can be defined as:

“The involvement of dependent children under the age of 16 in sexual activity which they do not fully understand and to which they are not in a position to give informed consent – the activity being intended to gratify or satisfy the needs of the other person”

(Creighton and Russell, 1995).

This broad definition includes a wide range of behaviours from rape to the exposure of children to sexually explicit material. Although serious forms of contact abuse are universally accepted as harmful, boundaries between normal and less serious abusive behaviour can be difficult to define. Furthermore, since it is estimated that half of the female population have undergone some form of unwanted sexual experience, many victims and perpetrators view such incidents as “normal” (Lamb and Coakely, 1993).

Cawson and colleagues (2002) argue that this accounts for much of the variation reported in different UK studies. Box 4.4 outlines the range of behaviours that can be classed as contact or non-contact abuse.

The most serious form of sexual abuse is the rape of children. Although over a quarter of all rapes recorded by the police are committed against children under 16 (Harris and Grace, 1999) the majority of cases remain unreported to the authorities (Leventhal, 1998). The NSPCC childhood experiences study found that three-quarters of sexually abused children did not tell anyone about the abuse at the time, and around a third still had not told anyone about their experiences by early adulthood (Cawson et al., 2002).

Some studies estimate that between a third and a quarter of abusive sexual acts are perpetrated by other juveniles (see Glasgow et al., 1994). This makes it difficult to distinguish between normal sexual experimentation between peers and actual abuse. The NSPCC

Box 4.4: Classification of sexual abuse of children under age 16 years

Non-contact:

- Pornographic photographs or videos taken of a child
- Pornographic photographs or videos shown to a child
- Making a child watch real people engaging in sexual activities
- Someone exposing their genitals to a child to shock them or to arouse themselves

Contact

- Unwanted sexual hugging or kissing of a child
- Touching or fondling a child’s sex organs
- Making a child touch an adult’s sex organs
- Attempting to have oral sex with a child
- Attempting to have sexual intercourse with a child
- Attempting to have anal intercourse with a child
- Having full sexual intercourse with a child
- Having anal intercourse with a child
- Having oral sex with a child
- Inserting a finger, tongue or object into a child’s vagina or anus

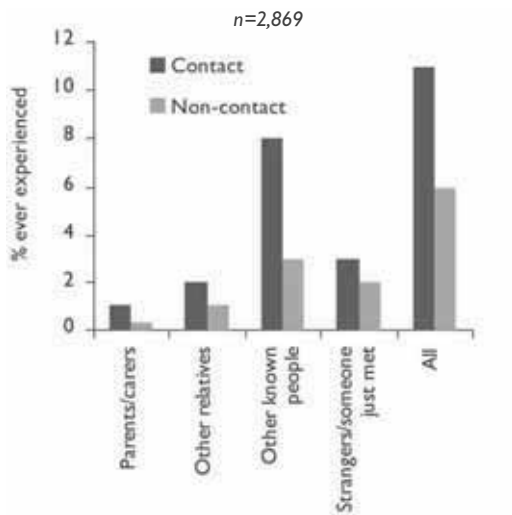
From Cawson et al., 2000

survey, therefore, only includes acts where the perpetrator is at least five years older than the victim.



Figure 4.3 shows that 16% of respondents reported some form of sexual abuse during childhood, with the experience of contact abuse twice as common as non-contact (Cawson et al., 2000). Similarly, Russell (1984) found that serious sexual abuse (intercourse, oral sex and digital penetration) was more common than non-serious abuse (sexual touching over clothes). Such results must be treated with caution, since children may be more reluctant to report behaviour they consider to be ambiguous.

Figure 4.3: Past experience of childhood abuse: summary of all child sexual abuse by relationship of abuser. UK 1999:18-24 year olds



Data from Cawson et al., 2000

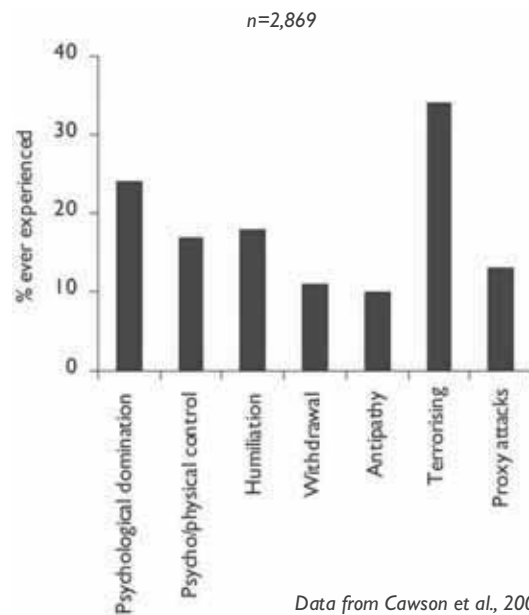
This may also indicate that under-reporting is a more serious problem for abuse perpetrated by family and friends, since children may have more difficulty defining the boundaries of appropriate behaviour than they would with strangers or professionals. This may account for the fact that only 4% of respondents in the NSPCC survey reported sexual abuse by a parent, carers and other relatives, while 11% reported sexual abuse by people known but unrelated to them.

4.2.6: Emotional abuse

Emotional abuse is the most difficult category of child maltreatment to define, not only due to varying cultural and societal perceptions, but also due to the significant degree of overlap with other forms of abuse. Furthermore, some forms of emotional abuse are commonly regarded by many as reasonable disciplinary sanctions, for example threatening abandonment (Krug et al., 2002). Box 4.5 presents definitions of the different dimensions of emotional abuse. Behaviour in each category can vary in severity based on frequency, duration and extent (Cawson et al., 2002).

Figure 4.4 indicates that terrorising is the most common form of emotional abuse. This is probably because some parents find that threatening a child with acts such as abandonment is an effective form of behaviour control. The NSPCC survey found that emotional abuse was widespread and prolonged with 6% of children experiencing frequent and severe levels during childhood (Cawson et al., 2000).

Figure 4.4: Past experience of childhood abuse: emotionally abusive experiences by sub-type. UK, 1999: 18-24 year olds



Data from Cawson et al., 2000

Box 4.5: Dimensions of emotional abuse

- **Psychological control and domination:**
Attempts to control the child's thinking and isolation from other sources of support and development
- **Psychophysical control and domination:**
Physical acts which exert control and domination but cause distress rather than pain and injury
- **Humiliation/degradation:**
Psychological attacks on a person's worth and self esteem. This can be verbal or non-verbal
- **Withdrawal:**
Withholding affection and care, exclusion from family (including showing preference to siblings and excluding the child from benefits given to other children in the family)
- **Antipathy:**
Showing marked dislike of the child by word and deed
- **Terrorising:**
Threats to harm the child or someone/something the child loves: threatening with fear figures, threats to have the child sent away, making the child do something that frightens them
- **Proxy attacks:**
Harming someone/something the child loves or values (includes deliberate attacks on pets and violence between carers)

From Cawson et al., 2000



4.2.7: Neglect

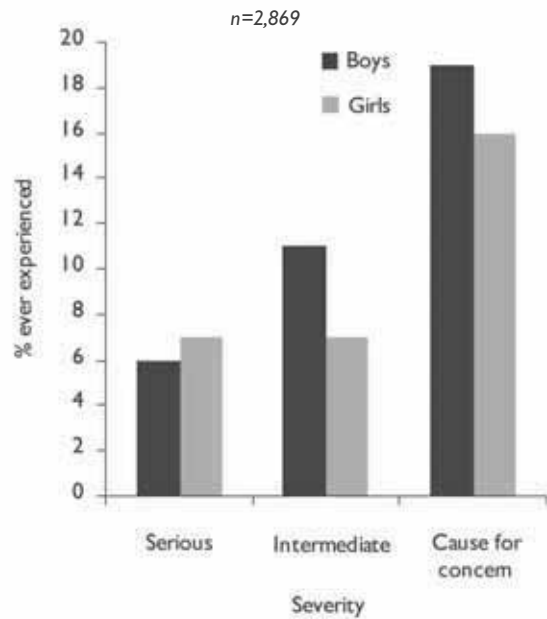
There is no universally agreed definition of child neglect. Although it is acknowledged that failure to provide for the development of a child in the form of healthcare, education, emotional development, nutrition, shelter and safe living conditions is harmful, many families are financially unable to provide all of these resources (Krug et al., 2002). Because it is difficult to separate neglect from poverty, any definition must take into account the ability and resources of the parents involved. Further problems with defining neglect arise from differing class perceptions. When asked to define neglect, working class mothers emphasised lack of physical care such as food and clothing, whereas middle class mothers emphasised psychological and emotional criteria (Dubowitz et al., 1998).

Child neglect can be divided into two broad categories: absence of care where the parent or caregiver denies the child basic physical care and nurturing, and lack of supervision where there is failure to provide age appropriate safeguards to protect the child from external harm.

Absence of parental care

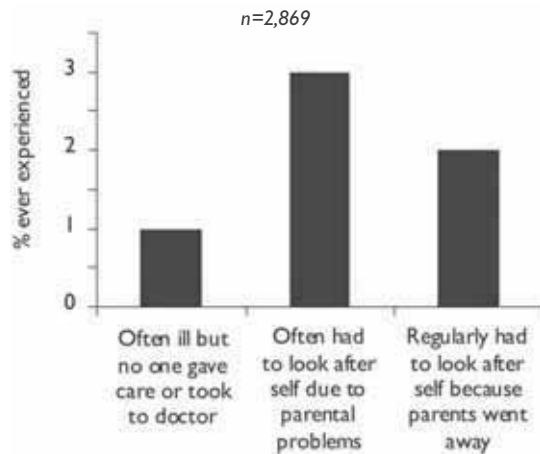
This category of neglect includes behaviour that varies in severity, duration and frequency. It is estimated that 35% of individuals experience absence of care at some point during their childhood, 6% of whom will have suffered severe hardship through neglect (Figure 4.5; Cawson et al., 2000). The most common form of absence of care experienced by respondents in the NSPCC childhood experiences survey was being frequently left to care for oneself due to incapacity of the parent as a consequence of substance misuse (Figure 4.6; Cawson et al., 2000). Over one in ten neglected children fell into this category. Frequent/regular hunger and dirty living conditions were experienced by less than 1% of neglected children.

Figure 4.5: Past experience of childhood abuse: prevalence of absence of care by level of severity. UK 1999: 18-24 year olds



Data from Cawson et al., 2000

Figure 4.6: Past experience of childhood abuse: serious absence of care: three most frequently reported measures. UK 1999: 18-24 year olds

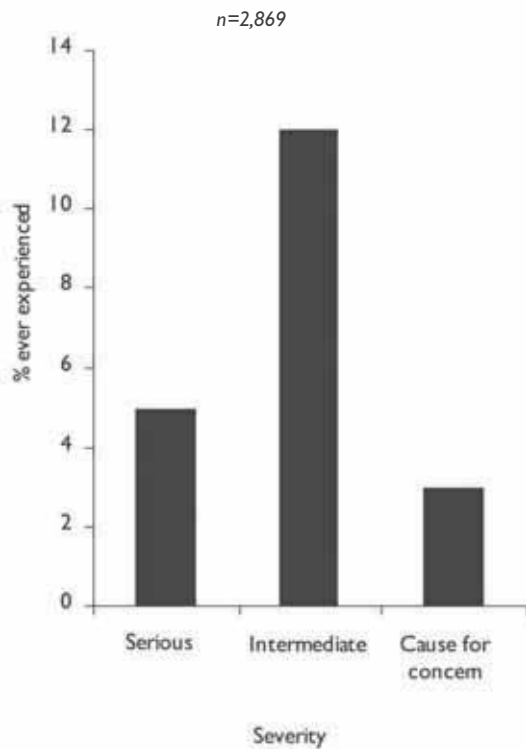


Data from Cawson et al., 2000

Lack of supervision

Failure to safeguard children through supervision appropriate to their age and living situation is a form of child neglect that is both commonplace and dangerous. Negligence of this sort leaves children exposed to harm through accidents or at the hands of others. The NSPCC survey measured lack of supervision by the frequency a child under the age of ten was left at home with no supervision or allowed to stay out at night (Cawson et al., 2000). One in five neglected children had experienced such lack of supervision. In 5% of cases the episodes were considered to be regular occurrences of long duration (Figure 4.7).

Figure 4.7: Past experience of childhood abuse: lack of supervision under age ten. UK 1999: 18-24 year olds



Data from Cawson et al., 2000



4.3: Impact of Child Maltreatment

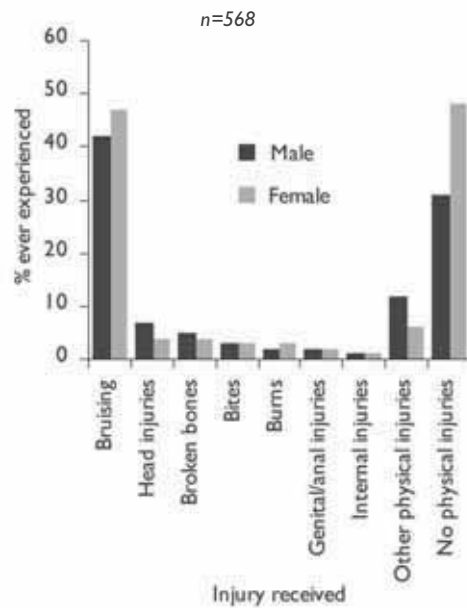
The impacts of child maltreatment are far-reaching. They can range from severe impacts, with the worst cases resulting in death, to more minor but nevertheless widespread impacts such as increased likelihood of adopting unhealthy behaviours during adulthood, for example smoking and high alcohol intake (Krug et al., 2002). Whilst the most severe forms of abuse receive greater attention and cause most public concern, other widely prevalent behaviours can cause more damage on a societal level. Widespread behaviours which have small, individual effects (for example physical punishment) can have a greater impact on public health than a risk factor with a large individual effect but low prevalence, such as child homicide (Rose, 1985).

4.3.1: Health impact

Negative impacts on health place a significant burden on healthcare services. These can be acute in the form of trauma requiring immediate treatment. For example, “battered child syndrome” is characterised by devastating skin injuries, damage to skeletal and nervous tissue, and trauma to the head and viscera (Krug et al., 2002). Other forms of physical abuse such as the violent shaking of infants have both short and long term effects (Box 4.6).

Health services need to cope not only with the physical manifestations of abuse, but also with psychological effects which can be equally as devastating.

Figure 4.8: Past experience of childhood abuse: injuries sustained as a consequence of physical child abuse. UK 1999: 18-24 year olds



Data from Cawson et al., 2000

Box 4.6: The Shaken Infant: International Findings

Victims

- Very young children, the majority of whom are less than 9 months old

Perpetrators

- The majority are male
- Whether this is because they are more prone to this behaviour or because they cause more damage due to greater strength is not known

Short-term consequences

Injuries from shaking or shaking-and-head-hitting-surface:

- Intercranial haemorrhages
- Retinal haemorrhages
- Small “chip” fractures at the major joints of the child’s extremities.
- Death (in one third of cases)

Long-term consequences

- Mental retardation
- Cerebral Palsy
- Blindness

From Krug et al., 2002

Figure 4.8 illustrates the distribution of injuries suffered by children subject to physical abuse. Over 52% of female and 69% of male victims were physically harmed, with 5.5% receiving injuries to the head and 4.5% sustaining fractures (Cawson et al., 2000).



Table 4.1 outlines the physical, sexual/reproductive, and psychological health impacts of child maltreatment along with other long-term negative consequences. Some such consequences are indirect but nevertheless serious. For example, several studies have linked child maltreatment with the adoption of negative behaviours that increase the risk of cancer, irritable bowel syndrome and other chronic adult disorders.



Table 4.1: Health consequences of child maltreatment

Physical	Sexual and reproductive	Psychological	Other longer-term health consequences
<ul style="list-style-type: none"> • Abdominal/thoracic injuries • Brain injuries • Bruises and welts • Burns and scalds • Central nervous system injuries • Disability • Fractures • Lacerations and abrasions • Ocular damage • Hearing damage 	<ul style="list-style-type: none"> • Reproductive health problems • Sexual dysfunction • Sexually transmitted diseases, including HIV/AIDS • Unwanted pregnancy • Infertility 	<ul style="list-style-type: none"> • Alcohol and drug abuse • Cognitive impairment • Delinquent, violent and other risk-taking behaviours • Depression and anxiety • Developmental delays • Eating and sleep disorders • Feelings of shame and guilt • Hyperactivity • Poor relationships • Poor school performance • Poor self-esteem • Post-traumatic stress disorder • Psychosomatic disorders • Suicidal behaviour and self-harm 	<ul style="list-style-type: none"> • Cancer • Chronic lung disease • Fibromyalgia • Irritable bowel syndrome • Ischaemic heart disease • Liver disease

From Krug et al., 2002

Behaviour-related impact

Child maltreatment can be considered a significant factor in the development of aggressive behaviour and violent offending (see Section 2.4). Furthermore, severe neglect has been shown to impair a child's intellectual development and concentration skills. Cognitive impairment resulting from lack of stimulation is usually characterised by disruptive behaviour in the classroom. This can impede academic progress throughout the child's school career (Krug et al., 2002). Later in life this will contribute to lack of self-esteem and problems of integration into the workforce (see Box 4.7).

An individual who has suffered severe maltreatment as a child may also grow up to experience difficulties in establishing close adult relationships and in bonding with their own children (Department of Health, Home Office and Department for Education and Skills, 1999).

Box 4.7: Summary of behaviour-related consequences of child maltreatment

- Development of aggressive/violent behaviour
- Impairment of intellectual development and concentration skills
- Impaired educational progress
- Poor social functioning
- Problematic adult relationships
- Poor self-image and low self-esteem
- Difficulties of establishment in the workforce
- Failure to develop effective parenting skills
- Substance misuse
- Increased likelihood of inappropriate sexual behaviour

DoH, Home Office and DfES, 1999



4.3.2: Economic impact

Direct financial costs related to child maltreatment include treatment for both physical and mental trauma that require medical treatment. A considerable financial burden is also placed on the criminal justice system and welfare services (Krug et al., 2002). The National Commission of Inquiry into the Prevention of Child Abuse estimated the cost of child abuse to statutory and voluntary agencies at £1 billion per year in the UK (NCIPCA 1996). Other indirect costs are summarised in Box 4.8.

4.4: Risk Factors for Child Maltreatment

4.4.1: Age

Victims

The inverse relationship between serious physical abuse and age has been well documented (Krug et al., 2002). In fatal cases, infants are at the greatest risk of any age category (Adinkrah, 2000; Kirschner et al., 2001). Infants under one year old account for over a third of all homicides in England and Wales (Povey, 2004). Victimisation in the form of sexual abuse, however, follows a different

pattern. The onset of puberty is a trigger in many instances, with rates of abuse continuing to rise throughout adolescence (Sedlak and Broadhurst 1996; Vissing et al., 1991).

Perpetrators

While there is no clear link between severe abuse and age of perpetrator (Chaffin et al., 1996; Wolfner and Gelles, 1993) numerous studies have found that perpetrator age is inversely associated with less serious forms of abuse (for example Straus et al., 1998). More specifically, mothers who are in their teens at the onset of motherhood have been found to face a high risk of maltreating their children (Connelly and Straus, 1992). Teenagers are also more likely than adults to sexual abuse children (Boney-McCoy and Finkelhor, 1995).

4.4.2: Sex

Victims

In most countries girls are at a higher risk of infanticide, neglect, emotional and sexual abuse (Krug et al., 2002). The situation is reversed for harsh physical punishment, with boys facing the greatest risk in this regard (National Research Council, 1993).

Box 4.8: Indirect costs of child maltreatment

- Lost productivity
- Disability
- Decreased quality of life
- Premature death
- Apprehending and prosecuting offenders
- Investigation by social welfare organisation of child abuse reports
- Foster care
- Costs to education system
- Costs to employment sector due to absenteeism and low productivity

From Krug et al., 2002

In the UK, however, boys are victimised in greater numbers for physical abuse and neglect at all levels of severity with the exception of the “most severe” category where girls are at greater risk (see Table 4.2). For emotional and sexual abuse, however, the UK follows the global pattern with girls being at the greatest risk for all levels of severity (Figures 4.9 and Table 4.3).

Table 4.2: Past experience of childhood abuse: level of severity of physical abuse, absence of care and lack of supervision. UK, 1999: 18-24 year olds

Level of Severity	Serious %	Intermediate %	Cause for concern %
Physical abuse			
Boys	6	15	4
Girls	8	12	2
Absence of care			
Boys	6	11	19
Girls	7	7	16
Lack of supervision			
Boys	6	14	3
Girls	7	10	3

Data from Cawson et al., 2000

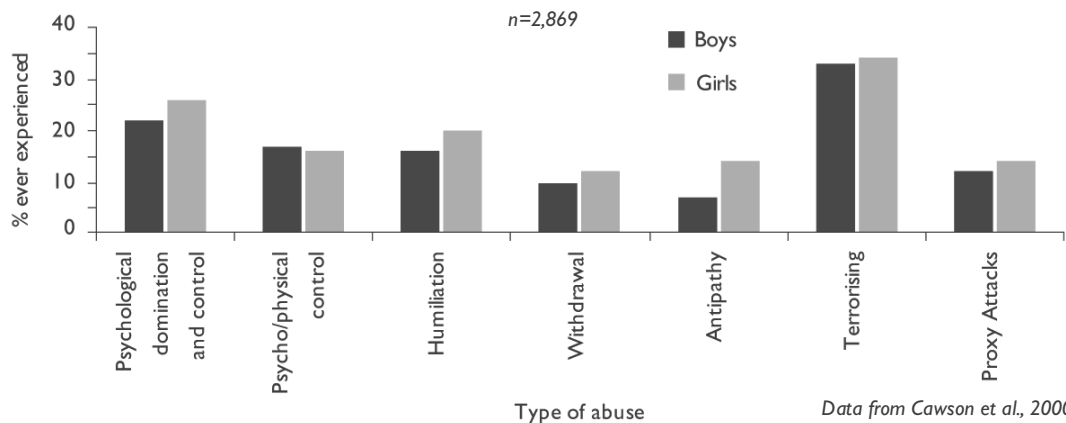
Table 4.3: Past experience of childhood abuse: Sexual abuse by sex of victim UK, 1999: 18-24 year olds

	Contact sexual Abuse %	Non-contact sexual abuse %
Boys	7	4
Girls	4	8

Data from Cawson et al., 2000



Figure 4.9: Past experience of childhood abuse: emotional abuse by type and sex of victim. UK 1999: 18-24 year olds



Data from Cawson et al., 2000

Perpetrators

Research conducted in western, industrialised countries shows that although women are more likely to use more physical discipline (Hunter et al., 2000) men are more likely to cause life-threatening, physical damage in the form of head injuries, internal injuries and serious fractures (Starling and Holden, 2000). This could, however, be due to greater physical strength rather than the fact that men are more prone to extreme forms of aggression.

Sexual abuse is more likely to be perpetrated by male offenders (Levesque, 1999). For girls, 90% of this form of abuse is by males whether relatives, friends, acquaintances or strangers. For boys this applies to approximately three-quarters of cases (see Black et al., 1999)

4.4.3: Individual characteristics

Victims

Many individual characteristics are correlated with child victimisation (Box 4.9). Several such characteristics exist at birth or even precede it. For example premature infants, twins, and mentally/physically handicapped babies are all at increased likelihood of suffering maltreatment (Krug et al., 2002). All these characteristics can present extra problems to new mothers and place them under increased stress. Similarly, children born as a result of unplanned pregnancies experience maltreatment in greater numbers than those who are planned (Black et al., 1999).

Another set of risk factors occur later in childhood and relate to the victim's behaviour. (Box 4.9). However, it is not possible to determine if such factors are antecedents of maltreatment or consequences of emotional distress (Boney-McCoy and Finkelhor, 1995).

Perpetrators

Parents more likely to maltreat their children have been reported to exhibit the characteristics outlined in Box 4.10. Another

Box 4.9: Individual risk factors for maltreated children

- Premature infants
- Twins
- Handicapped children
- Mental retardation
- Result of unplanned pregnancy
(Krug et al., 2002)
- Aggression, delinquency and inter-personal problems
(Vissing et al., 1991)
- Poor academic achievement.
- Score lower in intelligence tests
(Manion et al., 1996)
- Behavioural problems in school
(Paradise et al., 1994)

frequently cited factor relates to the perpetrator's own experience of maltreatment during childhood. However, most researchers argue that the importance of this as a risk factor may have been over-estimated, and the complexity of the relationship has not been fully explored (Krug et al., 2002). Other factors such as overcrowded housing, substance abuse and poverty are thought to be more predictive (National Research Council, 1993).



Box 4.10: Individual risk factors for perpetrators of child maltreatment

Sexual abuse

- Distress
- Loneliness
- Inflexibility
- Unhappiness

(Black et al., 1999)

Other types of maltreatment

- Low self-esteem
- Poor impulse control
- Mental health problems (including depression)
- Antisocial behaviour
- Unrealistic expectations about children
- Show greater irritation and annoyance in response to their child's moods and behaviour
- Are less supportive, affectionate, playful and responsive to their children
- Are more controlling and hostile

(National Research Council, 1993)

environment play a substantial role in the development of violent and abusive behaviour towards children.

Family size

Size of family may increase the risk of maltreatment. Larrain and colleagues found that parents with more than four children were more likely to be perpetrators of all forms of child abuse and neglect (Larrain et al., 1997). Another study found family size was correlated with lesser forms of physical abuse, but not with severe physical abuse (Straus, 1994); although other research has produced inconclusive results (see Black et al., 1999; Chaffin et al., 1996). More recent studies, however, suggest that overcrowding rather than family size increases stress and tension within the family, thus triggering maltreatment (see Dubowitz and Black, 2001).

Violence in the home

Households where intimate partner violence occurs are more likely to experience other forms of domestic violence including child maltreatment (Krug et al., 2002). A study by Lesnik-Oberstein (1995) found heightened levels of physical and emotional abuse in households where verbal and physical aggression between parents occurred. Witnessing intimate partner aggression and violence as a child has also been cited as a predictor of future abuse (Straus, 1994).

4.4.4: Family characteristics

Parents and other family members are most likely to be the perpetrators of all forms of child maltreatment with the exception of sexual abuse (see Section 4.2). It is, therefore, not surprising that family structure and



Unhappy marriages can create high-risk environments, even if there is no aggression between partners. Mothers reporting unsatisfactory marriages may be seven times more likely to parent children who will experience sexual abuse by a family member before their 16th birthday (Paveza, 1988).

4.4.5: Socio-economic factors

There is a strong association between poverty and child maltreatment in most countries (Krug et al., 2002). UK studies show that inadequate family income is strongly associated with violence towards children (for example Sidebotham et al., 2001). Since approximately one third of children in this country live in households that earn less than half the national average income, poverty has been cited as a major causal factor in child maltreatment (Cawson et al., 2000). The negative impacts of poverty and its contribution to child maltreatment are highlighted in Box 4.11.

Box 4.11: Contribution of poverty to child maltreatment

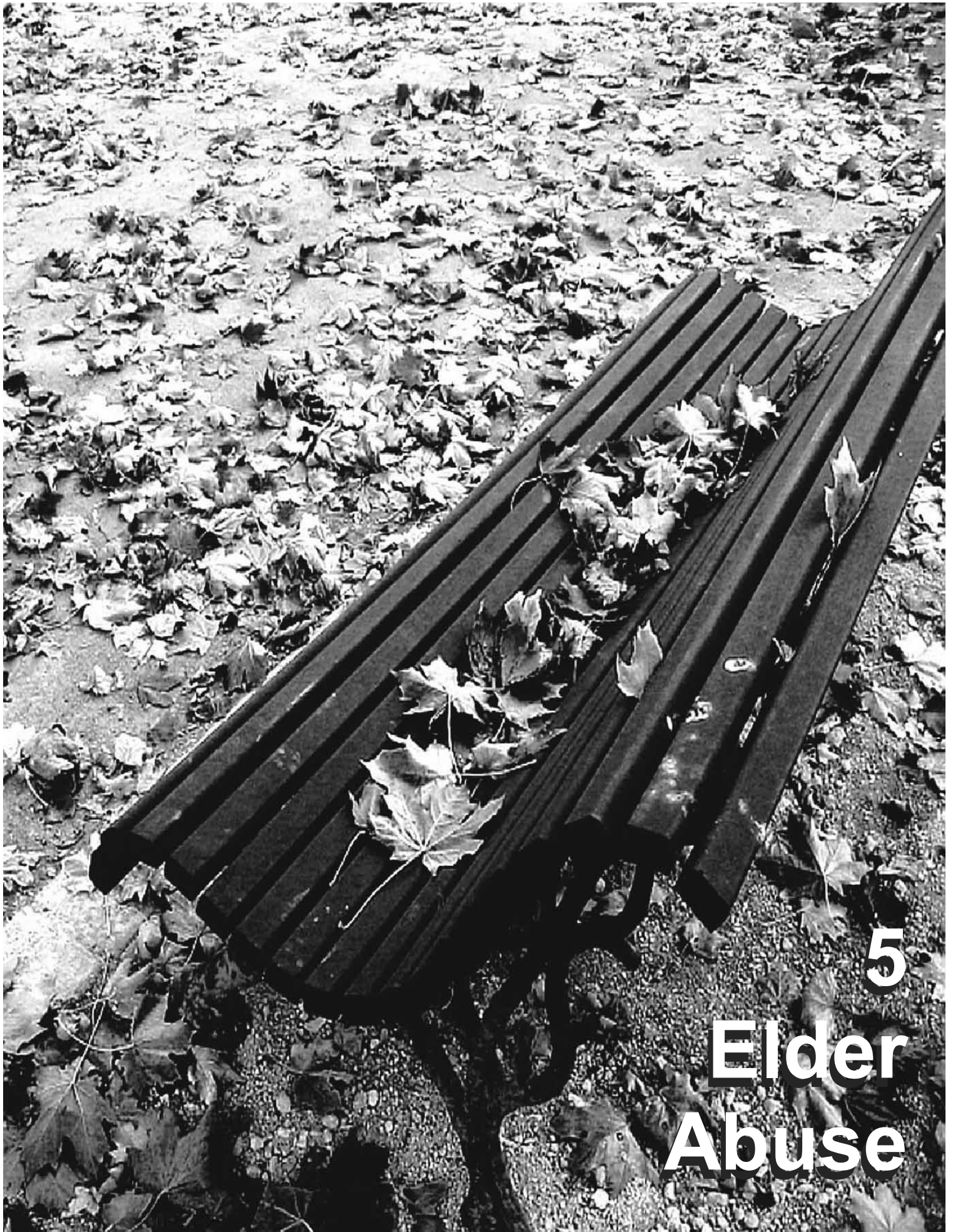
Poverty reduces the coping capacity of parents due to:

- Feelings of helplessness
- Social exclusion
- Susceptibility to physical and mental illness
- Neglect of emotional needs of the child in favour of procuring basic necessities such as food and clothing
- Reduced availability of community resources
- Lack of protective factors such as social networks
- Children from economically deprived homes are more likely to exhibit behavioural problems and are thus more difficult to cope with



Key Points

- There are, on average, 80 child homicides recorded in England and Wales each year. Over 90% of these deaths are inflicted by a parent, caregiver, or person known to the child.
- 7% of children experience serious physical abuse during childhood, the majority of which occurs at the hands of parents or carers.
- Although over a quarter of all rapes recorded by the police are committed against children under 16, the majority of cases remain unreported to the authorities.
- Three-quarters of sexually abused children do not tell anyone about the abuse at the time, and around a third still have not told anyone about their experiences by early adulthood.
- Between a third and a quarter of abusive sexual acts are perpetrated by other juveniles.
- 16% of children experience some form of sexual abuse.
- Emotional abuse is widespread and prolonged with 6% of children experiencing frequent and severe levels.
- 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.
- Over 2% of children have to care for themselves due to numerous parental absences, while 1% are regularly not cared for while ill.
- Mothers who are in their teens at the onset of motherhood face a higher risk of maltreating their children.
- Teenagers are more likely than adults to sexually abuse children.
- Premature infants, twins, and mentally/physically handicapped babies are all at increased likelihood of suffering maltreatment.
- Parents with more than four children are more likely to be perpetrators of all forms of child abuse and neglect.
- Inadequate family income is strongly associated with violence towards children.



5
Elder
Abuse

5: ELDER ABUSE

5.1: Introduction

“Elder” is a comparative term, therefore its use is subjective and culturally variable. In western society the term is usually applied to those over retirement age. However chronological age (age in years) is different from social or biological age; some 65 year olds are healthy and independent so cannot be regarded as vulnerable adults, whereas others have undergone a serious physical decline and can no longer continue to function in their former social or economic role. Both the Department of Health and the Home Office regard elders as a subset of vulnerable adults; a term applying to any individual over the age of 18 who, due to physical or mental capacity, can not be independent (Department of Health, 1999). Since different studies use different age boundaries to define elder abuse, details will be given where relevant throughout this chapter.

The term “abuse” includes a whole suite of acts of both commission and omission (Box 5.1). The acts can be intentional or unintentional if they arise through ignorance or thoughtlessness by those in positions of trust, responsibility and power (Garner and Evans, 2000).



Box 5.1: Typology of Elder Abuse

- **Physical abuse**
The infliction of pain or injury, physical coercion, or physical or drug induced restraint
- **Psychological or emotional abuse**
The infliction of mental anguish
- **Financial or material abuse**
The illegal or improper exploitation or use of funds and resources of the elder
- **Sexual abuse**
Non-consensual sexual contact of any kind
- **Neglect**
Refusal or failure to fulfil a care-giving obligation. May or may not involve conscious or intentional attempt to inflict physical or emotional distress

(from Krug et al., 2002)

The definition of abuse used in this report is that used by the International Network for the Prevention of Elder Abuse; a definition adopted from Action on Elder Abuse.

“A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” (Action on Elder Abuse, 1995).

Clearly, this definition only applies to those who are abused by friends, neighbours, family and professional carers, and excludes violence by strangers, such as muggings. These types of violence are covered in other sections of this report.

5.2: Extent of Elder Abuse

5.2.1: Global data

Elder abuse is a global problem. It is predicted that this will worsen since the global population of over 60 year olds will have approximately doubled by 2025 to 1.2 billion (Krug et al., 2002). The extent of the problem is difficult to assess due to a paucity of data, particularly with regard to developing countries. Worldwide estimates of prevalence (4-6%) are extrapolated from five surveys conducted in developed countries (Box 5.2). However, it is not possible to compare rates between countries due to different methodologies and time frames.

Box 5.2: Prevalence of Elder Abuse in Five Developed Countries

- **USA:** 3.2% (Pillemer and Finkeihor, 1988)
- **Canada:** 4.0% (Podnieks, 1992)
- **Finland:** 5.4% (Kivelä et al., 1992)
- **UK:** 5% (Ogg and Bennett, 1992)
- **Netherlands:** 5.6% (Comijs, 1998)

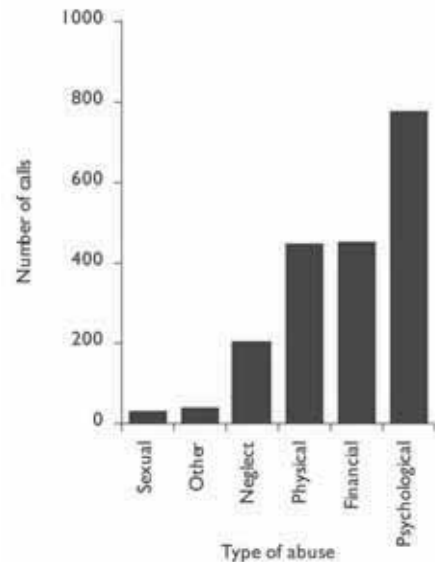
5.2.2: National data

The most commonly quoted statistic regarding the prevalence of elder abuse is that half a million older people are experiencing abuse at any one time in the UK. This figure is derived from a representative survey of 2,000 individuals over the age of 60 (Ogg and Bennett, 1992). This figure, however, must be treated with caution since all individuals in the survey were living in the community, and therefore individuals residing in institutional settings were omitted. Furthermore, robust evidence of abuse is hard to obtain due to under-reporting. This is true for all violence, but is particularly pertinent in the case of older

people due to the relatively high proportion of individuals in this category being physically and mentally frail and therefore unable to acknowledge victimisation (House of Commons Health Committee, 2004). Figure 5.1 illustrates the relative proportions of different types of abuse suffered by elders, based on self-reporting to the Action on Elder Abuse helpline between 1997 and 1999 (Jenkins et al., 2000).

The helpline received a total of 1,421 calls regarding abuse during this time. Furthermore the average number of calls increased from 53 calls per month at the beginning of the survey to 78 per month by the end. It cannot be determined, however, if this is reflecting an increase in prevalence of elder abuse or an increasing awareness of the helpline by members of the public.

Figure 5.1: Number of calls regarding abuse made to the Action on Elder Abuse Helpline, 1997-1999



Data from Jenkins et al., 2000

5.2.3: Physical abuse

Physical abuse is more likely to occur in institutional rather than home settings (Bromley Adult Protection Committee, 2004). This type of elder abuse comes in many forms, with the most obvious being assault. However, more subtle types of abuse such as medical and physical restraint must also be considered. Many older people in institutional settings are unnecessarily sedated with anti-psychotic drugs. Based on a study of 935 nursing home residents, it is estimated that 82% of older people in institutions receiving neuroleptic drugs receive inappropriate therapy (Osborne, 2002). Although the negative effects of these drugs are acknowledged, their use is often inadequately documented. This results in many older people, particularly those with diminished mental capacity, being sedated for convenience rather than for medical reasons (Garner and Evans, 2000).

Box 5.3: Elder Abuse and Health Care Professionals

- The Nursing and Midwifery Council receives 1,000 allegations of elder abuse per year
- In 1998, 84 nurses lost their registrations due to elder abuse
- The National Care Standards Committee found that only 50% of care homes met or exceeded minimum acceptable standards
- 88% of community and district nurses had encountered elder abuse at work

Data from the House of Commons Health Committee, 2004

Restraint can occur in the form of physical confinement by the use of furniture and appliances such as bedrails and Buxton chairs. Apart from being abusive in terms of false

imprisonment, some apparatus can actually cause physical injury and restrict breathing (House of Commons Health Committee, 2004).

5.2.4: Financial abuse

In contrast to physical abuse, financial abuse is more commonly experienced by older people who live alone (Bromley Adult Protection Committee, 2004). Furthermore, financial abuse is usually accompanied by psychological abuse in the form of threats and bullying. This can be particularly distressing since the abuser is likely to be a close relative and, in situations where the elder lives alone, may be the individual's only social contact (Krug et al., 2002). Research undertaken by Oxfordshire Social and Health Care Directorate revealed that financial abuse was identified in 88% of reported cases of multiple abuse inflicted by family members, but only in 8% of cases inflicted by paid staff (House of Commons Health Committee, 2004).

Action on Elder Abuse state:

“of all calls to the helpline regarding financial abuse, the misuse of unregistered powers of attorney continues to be one of the greatest concerns expressed”

(Jenkins et al., 2000).

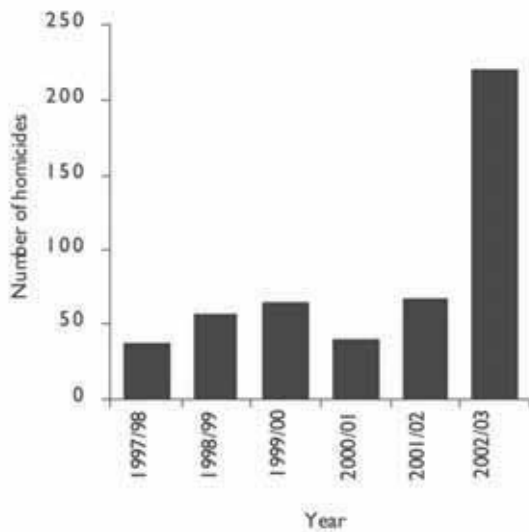
The number of reported cases is probably underestimated, since those at greatest risk are individuals suffering from dementia (House of Commons Health Committee, 2004).

5.2.5: Homicide

The average annual number of elder homicides is usually slightly over 50 (Povey, 2004). However, it can be difficult to determine if deaths are due to natural causes or the result of abuse. This problem is exemplified by the murders committed by Dr. Harold Shipman between 1975 and 1998. Figure 5.2 illustrates the number of elder homicides from 1997 to

2003. Data for 2002/03 includes 172 murders committed by Shipman. These deaths actually occurred over a period of 23 years and had initially been recorded as deaths by natural causes (Smith, 2002b).

Figure 5.2: Offences currently recorded as homicide of older people, England and Wales, 1997/98-2002/03



Data from Povey, 2004

5.3: Impact of Elder Abuse

5.3.1: Health impact

Very little research has been undertaken to investigate either the short or long term impacts of elder abuse. One US study compared survival rates of 2,812 abused and non-abused elders. Regardless of age, sex and socio-economic factors, after a period of 13 years 40% of the non-abused sample were still alive compared to only 9% of the abused sample (Lachs, 1998). Depression and psychological distress often occur as a consequence of elder abuse (Krug et al., 2002). While these factors may trigger physiological stress, there are no longitudinal studies on which to base an evaluation of cause and effect and how these translate to physical conditions.

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 (Krug et al., 2002).

5.3.2: Economic impact

To date, there has been no assessment of the economic impact of elder abuse and more information regarding the nature of injuries and resources required for treatment and convalescence needs to be obtained. Furthermore, the economic consequences of financial abuse also need considering. Elderly individuals who lose resources due to extortion or fraud are unlikely to be able to replace them. The effect of losing resources on an individual's life socially, physically and psychologically, and the resulting cost to public services, all require further study.



5.4: Risk Factors for Elder Abuse

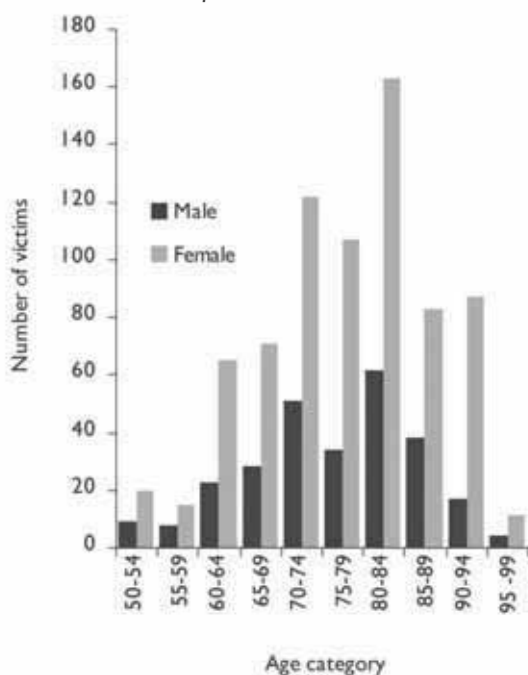
5.4.1: Sex

Victims

Sex differences in victimisation suggests that females face a higher risk since both global and national data show far greater numbers of older female victims. However, when the underlying demographic structures of the contributing populations are considered, there is no significant difference. This is because females have a longer lifespan than males in all countries, although the gap is smaller in developing countries (Krug et al., 2002). In the UK, 71% of callers to the Action on Elder Abuse helpline were female (Jenkins et al., 2000).



Figure 5.3: Victims of elder abuse by age, based on calls to Action on Elder Abuse Helpline, 1997-1999



Data from Jenkins et al., 2000

Perpetrators

In contrast to victims, in the UK male perpetrators outnumber female perpetrators, although the difference is only slight. However these differences may be greater in care settings. Over half of all complaints against staff in care facilities for the elderly cite males as the abuser, even though males make up only 9% of nurses and less than 3% of other care workers (UKCC, 1996).

5.4.2: Age

Data from Action on Elder Abuse and other studies indicate an increasing risk of victimisation with age (Jenkins et al., 2000; Aiken and Griffen, 1996; Krug et al., 2002). Degenerative diseases in older patients (aged over 70) result in fewer therapeutic rewards to carers. Consequently older people can be more vulnerable than their younger counterparts if their carers suffer from low morale (House of Commons Health Committee, 2004). To date, there have been no studies relating to the age profile of perpetrators of elder abuse.

5.4.3: Health status

Although there appears to be no correlation between cognitive and physical impairment and likelihood of abuse (Pillemer, 1989; Paveza et al., 1992) detection is more problematic in the severely impaired, leading to under-representation of this group (Jenkins et al., 2000).

Although there has been no link between Alzheimer's disease and increased prevalence of elder abuse (Pavesa et al., 1992), US studies of abuse in nursing homes found that mental disorders that are manifest by aggressive behaviour can trigger abuse in return (Pillemer and Moore, 1989; Pillemer and Sutor, 1992; O'Loughlin and Duggan, 1998).

5.4.4: Socio-economic status

Economic status of the older person is not related to the likelihood of victimisation. However, economic factors play a part in the profile of the abuser. Individuals with financial difficulties are more likely to commit elder abuse in both domestic and institutional settings, with feelings of resentment fuelling pre-existing feelings of aggression (Garner and Evans, 2000; Krug et al., 2002). In domestic settings a large proportion of perpetrators are suffering from economic stress as a result of substance misuse (Homer and Gilleard, 1990).

5.4.5: Location

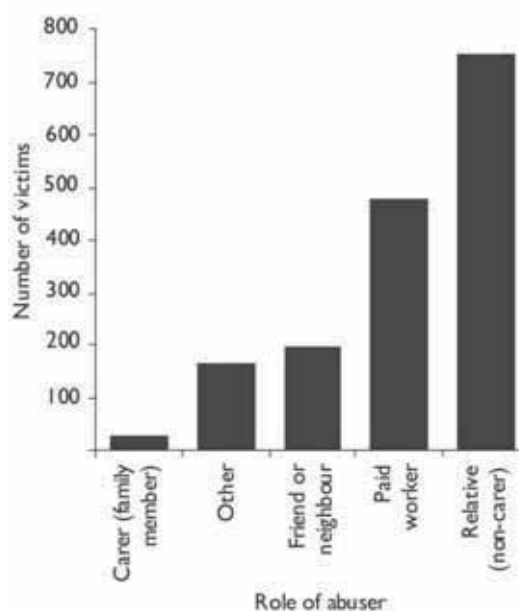
Although the data on location of abuse show that only 31% of abuse occurs in institutional settings, this is actually an over-representation since less than 5% of people over the age of 65 live in institutional settings. The apparent under-representation of domestic elder abuse could be due to under-reporting since victims may be reluctant to report family members particularly if the abuser is the person on which they rely for care and companionship (Jenkins et al., 2002). However, institutional abuse may also be under represented since telephones may be more difficult to access for private use and the elderly in institutional

settings are more likely to be physically and/or mentally impaired, again inhibiting reporting (Glennendenning, 1997).

5.4.6: Domestic settings

Early studies have cited carer burnout as the major cause of domestic elder abuse (reviewed in Krug et al., 2002). However this has been over-stated as a causal factor, and details of the long-term history of the relationship between the victim and perpetrator must be considered (Jenkins et al., 2000). The most commonly reported abuse role in calls to the Action on Elder Abuse helpline was that of relatives (734 calls). However, the relative was the carer in only 31 of these calls (Figure 5.4). In fact, in most cases the perpetrator of elder abuse is dependent on the elderly relative for housing and finance (Pillemer, 1989).

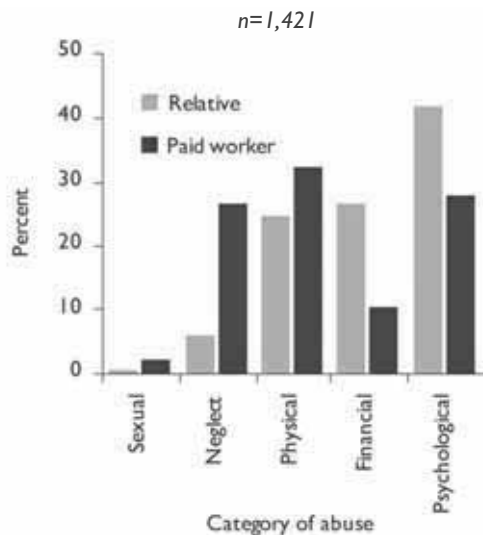
Figure 5.4: Number of victims of elder abuse by role of abuser, based on calls to the Action on Elder Abuse Helpline, 1997-1999



Data from Jenkins et al., 2002

A breakdown of the types of abuse perpetrated by relatives and paid workers supports the suggestion that economically dependent relatives are most likely to victimise elders. Figure 5.5 illustrates how relatives are more likely to commit financial or emotional abuse, while paid workers are more likely to commit physical or sexual abuse, or be guilty of neglect.

Figure 5.5: Type of elder abuse by role of abuser, based on calls to the Action on Elder Abuse Helpline, 1997-1999



Data from Jenkins et al., 2002

5.4.7: Institutional settings

In 1961 Goffman examined organisational factors that have a negative impact on staff working in institutions and thus increase the likelihood of abusive behaviour (Box 5.4). This is still relevant today since most institutions still have some of these factors in place (Garner and Evans, 2000). Many researchers have examined the role played by specific institutional cultures as a contributing factor to elder abuse. For example, the atmosphere within the ward or nursing home will be negative unless positive forces are present to counteract it (Evans, 1998). Furthermore,

institutional infantilisation of the elderly can result in a dread of dependency and death on the part of staff, which can be translated into anger and aggression in some individuals (Terry, 1998).

Box 5.4: Negative organisational factors of institutions for the elderly

- Discouragement of social intercourse
- Timetable living
- Distinction between managers and staff
- Aims of institution placed before aims of individual
- Stripping of personal identity by restricting possessions privacy and individual responsibility

(from Goffman, 1961)

Cultures of ageism within institutions are often fed by broader social influences. Negative language in official documents such as “rising tide” of elderly and “burden on taxpayers” (Health Advisory Service, 1985) can help fuel a lack of respect for, and devaluation of, the elderly. Similarly, ageist policies created by healthcare providers (for example not treating individuals over the age of 80 in Accident and Emergency departments) also



stimulate negative attitudes (Garner and Evans, 2000). Furthermore, poor working conditions can demoralise staff causing an escalation of resentment. In some individuals these strong negative feelings will be displaced and re-directed towards elderly patients, furthering a “domino effect of abuse” (Terry, 1998).

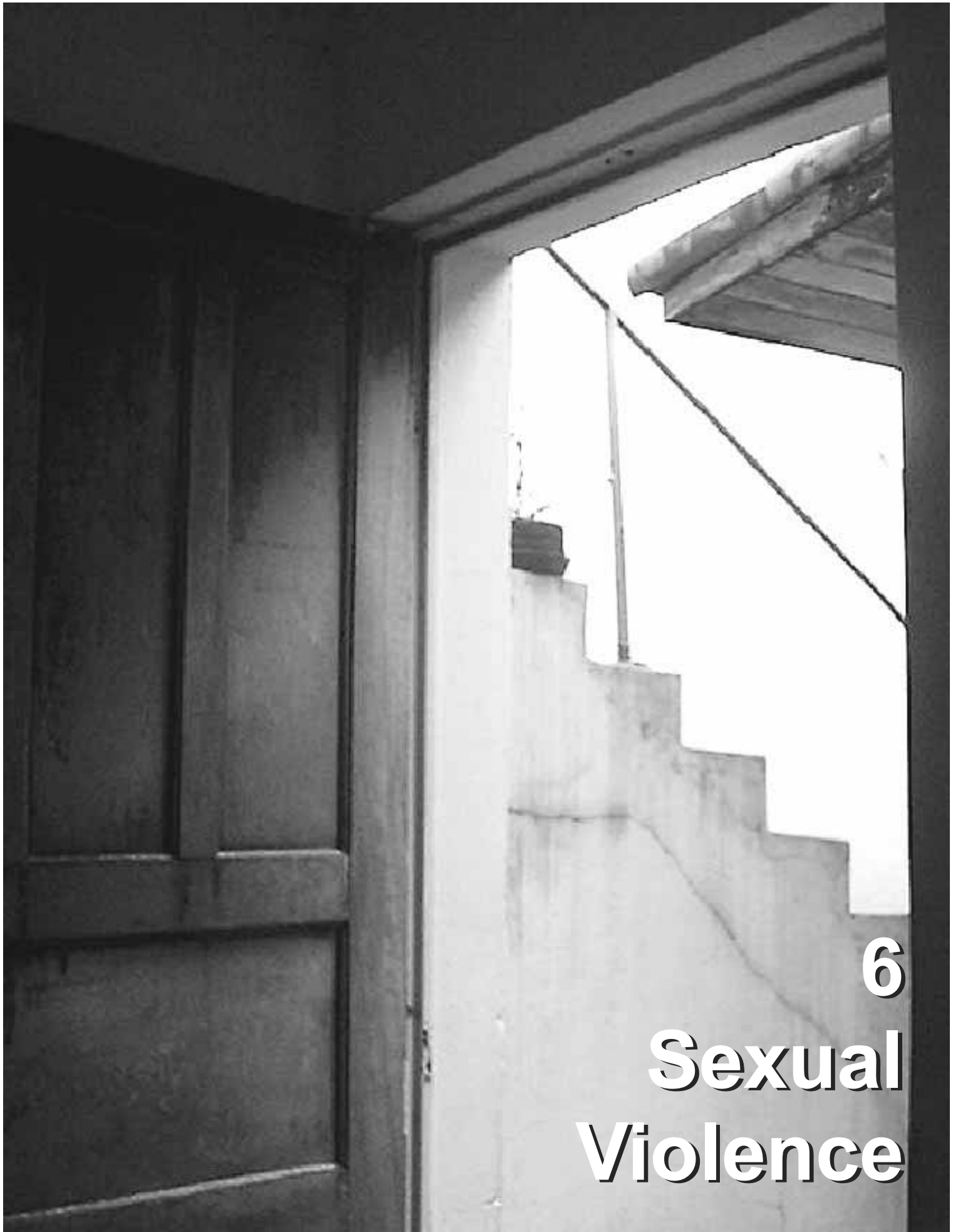
Although there is a paucity of evidence regarding abuser profiles (Bennet et al., 1997), it is clear that pre-existing personal factors come to the fore in negative institutional settings. Such factors may include a propensity

for bullying (Davenhill, 1998), misuse of drugs and alcohol, relationship difficulties (Pillemer and Moore, 1990), controlling or depressive personality, and poor work ethics (Royal College of Nursing, 1996). Since the majority of perpetrators abuse individuals of the same sex, there is identification with the victim. Furthermore, patients may come to represent parents or an unwelcome self-projected image (i.e. how they themselves may be in old age) triggering feelings of resentment (Garner and Evans, 2000).



Key Points

- Half a million older people in the UK are experiencing abuse at any one time.
- Many older people in institutional settings are unnecessarily sedated with anti-psychotic drugs. Based on a study of 935 nursing home residents, it is estimated that 82% of older people in institutions receiving neuroleptic drugs are receiving inappropriate therapy.
- The Nursing and Midwifery Council receives 1,000 allegations of elder abuse per year.
- In 1998, 84 nurses lost their registrations due to elder abuse.
- The National Care Standards Committee found that only 50% of care homes met or exceeded minimum acceptable standards.
- 88% of community and district nurses have encountered elder abuse at work.
- Financial abuse is identified in 88% of reported cases of multiple abuse inflicted by family members, but only in 8% of cases inflicted by paid staff.
- The average annual number of elder homicides is usually slightly over 50.
- A study of 2,812 abused and non-abused elders found that after a period of 13 years, 40% of the non-abused sample were still alive compared to only 9% of the abused sample (regardless of age, sex and socio-economic status).
- Over half of all complaints against staff in care facilities for the elderly cite males as the abuser, even though males make up only 9% of nurses and less than 3% of other care workers.
- Individuals with financial difficulties are more likely to commit elder abuse in both domestic and institutional settings.
- Only 5% of people over the age of 65 live in institutional settings, yet 31% of abuse occurs at these locations.
- Although the Action on Elder Abuse helpline received 734 calls regarding abuse by relatives, the relative was the carer in only 31 calls.
- In most cases the perpetrator of elder abuse is dependent on the elderly relative for housing and finance, not vice versa.



6
**Sexual
Violence**

6: SEXUAL VIOLENCE

6.1: Introduction

The World Health Organization defines sexual violence as

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work”

(Krug et al., 2002).

Hence sexual violence incorporates a wide range of different sexual acts from sexual harassment to rape, which can occur in a variety of settings including at home, in the street, in institutional settings such as schools, health services and the military, and in sports and recreational pursuits. Types of sexual violence as defined by the World Health Organization are provided in Box 6.1.

In the UK, the Sexual Offences Act 2003 has updated definitions of sexual assault and created a range of new laws for addressing sexual violence to better protect both children and adults from sexual harm. Under the Act, rape is defined as penetration by the penis of somebody’s vagina, anus or mouth, without their consent. Hence, by definition, rape can only be committed by men yet can be committed against both men and women. A woman forcing a man to have sex against his consent would be an offence under the law of *Causing a person to engage in a sexual activity without consent*. A new offence, *Assault by penetration*, covers penetration of the anus or vagina with any part of the body or with an object, if the penetration is sexual and the person does not consent. Other new offences include: *Administering a substance with intent* (e.g. drink spiking), *Trespass with intent*, and *Voyeurism*.

Box 6.1: Types of sexual violence

- Rape within marriage or dating relationships
- Rape by strangers
- Systematic rape during armed conflict
- Unwanted sexual advances or sexual harassment, including demanding sex in return for favours
- Sexual abuse of mentally or physically disabled people
- Sexual abuse of children
- Forced marriage or cohabitation, including the marriage of children
- Denial of the right to use contraception or to adopt other measures to protect against sexually transmitted infections
- Forced abortion
- Violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity
- Forced prostitution and trafficking of people for the purpose of sexual exploitation

(Krug et al., 2002)

Sexual violence has a particularly damaging effect on both physical and mental health. Whilst immediate physical injuries may heal, sexual, reproductive and mental health problems are often sustained long after the assault, and may even be fatal (e.g. suicide, HIV; Krug et al., 2002). Accordingly, the British Crime Survey finds that women fear rape above any other crime (Walby and Allen, 2004).

Whilst both women and men are victims of sexual violence, victimisation is far higher amongst women and hence more research has been conducted into male on female sexual violence. This chapter, therefore, focuses largely on sexual violence directed at females although data are provided for males where available (see Box 6.4). Whilst over a quarter of recorded rapes in the UK are against children (Harris and Grace, 1999), sexual violence towards children has been included in Chapter 4.

6.2: Extent of Sexual Violence

6.2.1: Global data

Available data on sexual violence include that from police, from health services treating the physical or emotional consequences of sexual violence, and from survey research. However, sexual violence is vastly under-reported, with many victims being unwilling to report incidents to police or other agencies through, for instance, shame, fear of not being believed or fear of being blamed. Furthermore, health services are only likely to treat the victims of more serious incidents of sexual violence (Krug et al., 2002).

Global estimates of sexual violence are taken from national surveys of crime victims. The percentage of women reporting sexual assault in the last five years ranges from 0.3% of women (aged 16 and over) in the Philippines to 8.0% in Brazil. However, research focusing specifically on sexual assault committed by



Box 6.2: The 2001 British Crime Survey

The 2001 British Crime Survey included a self-completion component on interpersonal violence, which gathered information on domestic violence, sexual assault and stalking. The survey utilised a scale to distinguish between different types of sexual assault based on their seriousness. Serious sexual assaults group various forms of penetration of the body, including but not exclusive to, rape, whilst less serious sexual assaults are classed as those which did not involve penetration but caused fear, alarm or distress such as flashing and sexual threats. The survey also enquired about sexual assaults on men.

(Walby and Allen, 2004)

intimate partners finds lifetime prevalence among women to range from 5.9% in Finland to 46.7% in Cusco, Peru (compared with 14.2% across England, Scotland and Wales) (Krug et al., 2002).

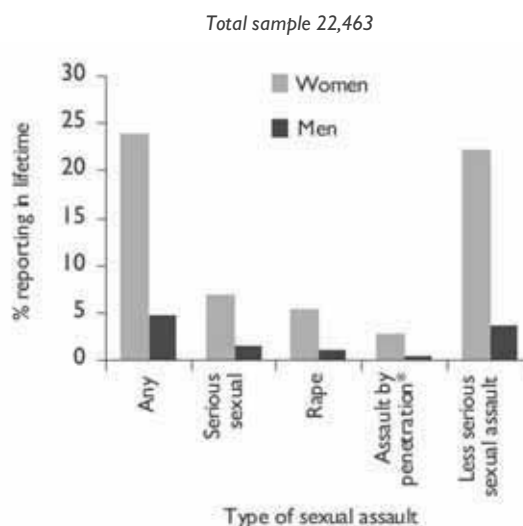
6.2.2: National data

Sexual violence is thought to be vastly under-reported in England and Wales. A research review into the investigation and prosecution of cases involving alleged rape, for example, found that only 5-25% of cases were reported to police, of which only one in five reached trial and no more than half resulted in a conviction (Home Office, Court Service and Crown Prosecution Service, 2002). However, in 2001 the British Crime Survey, an annual crime survey conducted among private households in England and Wales, included a self-completion module incorporating questions on experience of sexual violence (See Box 6.2). This survey covers individuals aged 16–59 living in private households in the UK, and hence does not include sexual violence towards children. Information on sexual violence committed against children is included in Chapter 4.

The 2001 British Crime Survey estimated that 24.1% of women and 4.7% of men had experienced some form of sexual assault (or attempted assault) in their lifetime (16.6% of women and 2.1% of men since the age of 16; Walby and Allen, 2004). Lifetime prevalence of serious sexual assault was 7% among women

and 1.5% among men, with one in twenty women and one in a hundred men having been raped (see Figure 6.1).

Figure 6.1: Lifetime prevalence of sexual assault (including attempts) by gender, England and Wales, 2001



*Assault by penetration is non-consensual penetration of the vagina or anus by an object or part of the body other than the penis, introduced as a new legal offence in 2003.

Data from Walby and Allen, 2004

In the 12 months prior to interview, 0.2% of women had been raped, 0.3% had suffered serious sexual assault and 2.1% less serious sexual assault. Amongst men, 0.2% had experienced any sexual assault in the 12 months prior to interview. Estimates of the

CHAPTER 6. SEXUAL VIOLENCE • 77

numbers of female sexual assault victims in the last year are provided in Table 6.1. Prevalence of sexual violence towards males was too low to permit estimates or further analyses.

Approximately half of female victims of sexual assault reported more than one incident in the previous 12 months, with the mean number of incidents per victim being two. In total there were an estimated 190,000 incidents of serious sexual assault (including attempts), 80,000 incidents of rape and 450,000 incidents of less serious sexual assault involving female victims in England and Wales in the last year.

Of serious sexual assaults, the majority (62%) involved physical force, whilst 37% were achieved through threats, 12% through threats with a weapon, and 27% occurred while the victim was drugged, unconscious or otherwise unable to give consent (Walby and Allen, 2004). Incidents of drug rape reported to the British Charity 'The Roofie Foundation', have increased dramatically over the last decade, from 39 in 1990 to 935 in 2002 (The Roofie Foundation, 2004). However, it is not known if this is due to an increase in incidence or to greater awareness of drug rape and the drug rape helpline. International research has found

that alcohol is the most common behaviour altering substance found in the system of sexual assault victims (EISOhly and Salamone, 1999).



Table 6.1: Estimated number of female victims of sexual assault in the 12 months prior to survey, England and Wales, 2001

	Best estimate	Lowest estimate	Highest estimate
Serious sexual assault (including attempts)	79,000	54,000	104,000
Rape* (including attempts)	47,000	28,000	67,000
Rape* (excluding attempts)	25,000	11,000	39,000
Less serious sexual assault	293,000	245,000	340,000

Data from Walby and Allen, 2004

* Figures for rape provided here utilise the extended 1994 definition of rape (non consensual sex involving a penis and vagina or anus). Use of the further extended 2003 definition (including penetration of the mouth by a penis without consent) would slightly increase the estimated number of victims of rape. These cases are included here in the serious sexual assault category.

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The British Crime Survey found that serious sexual assaults on females were most likely to be committed by perpetrators known to the victim (82%) (Figure 6.2). In almost half (47%) of the worst cases in the last 12 months, the perpetrator was an intimate partner (14% husband, 22% partner, 10% ex-husband or partner). For incidents of rape only this increased to over half (54%). Other perpetrators of serious sexual assault known to victims included friends (8%), dates (6%), colleagues (6%) and acquaintances (6%).

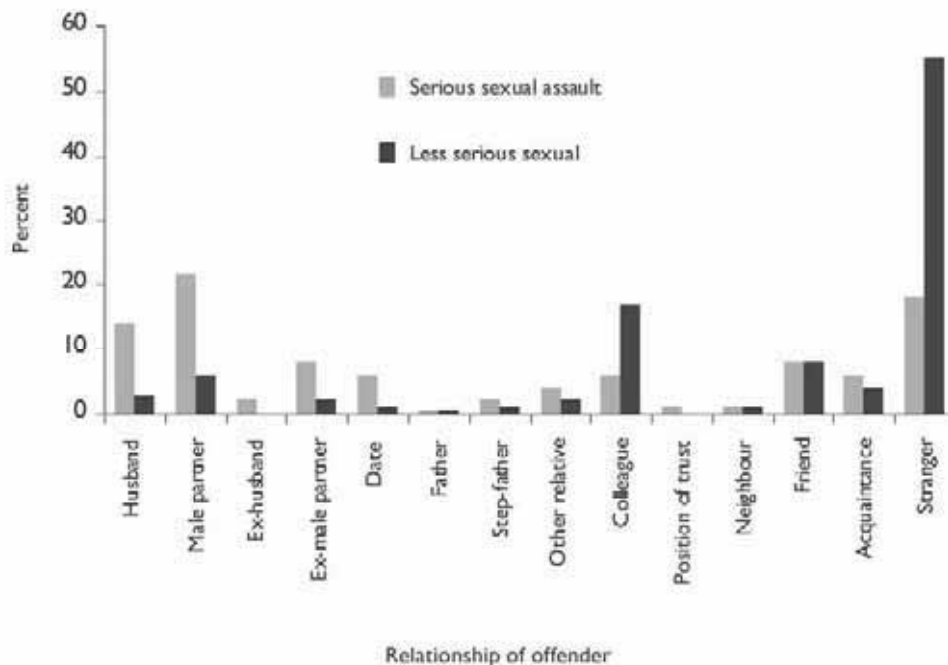
Perpetrators of less serious assaults were more likely to be strangers (55%), however when flashing is excluded 57% were committed by people known to the victim. Of perpetrators that were known to the victim, the most commonly reported category was colleague (17%).

Reporting of sexual violence to the police is very low. Just 12% of the worst incidents of serious sexual assault (since age 16) and 13% of

less serious sexual assaults reported in the British Crime Survey came to be known to police. Two in five victims of serious sexual assault and one in five victims of less serious sexual assault told no-one about their worst incident. Of those who did tell someone about the incident, the most likely confidants were



Figure 6.2: Relationship of offender to victim at worst incident of serious and less serious sexual assault in the last year, female victims, England and Wales, 2001



Data from Walby and Allen, 2004

friends, relatives or neighbours (49% of all serious sexual assault victims and 72% of less serious sexual assault victims).

Given the very low reporting rate of sexual violence, recorded police data vastly underestimate the number of sexual offences actually committed. However, in the year 2003/4, 52,070 sexual offences were recorded in England and Wales, accounting for 5% of all recorded crime (see Box 6.3) (Dodd et al., 2004). Within this figure were 26,709 indecent assaults and 12,354 rapes towards females, 4,070 indecent assaults and 893 rapes towards males, and 1,942 offences of gross indecency towards children (Figure 6.3). Between the quarters July-Sept 2003 and July-Sept 2004, sexual offences recorded by police increased by 22%. However, changes to sexual offences brought about through the Sexual Offences

Box 6.3: Recorded sexual offences

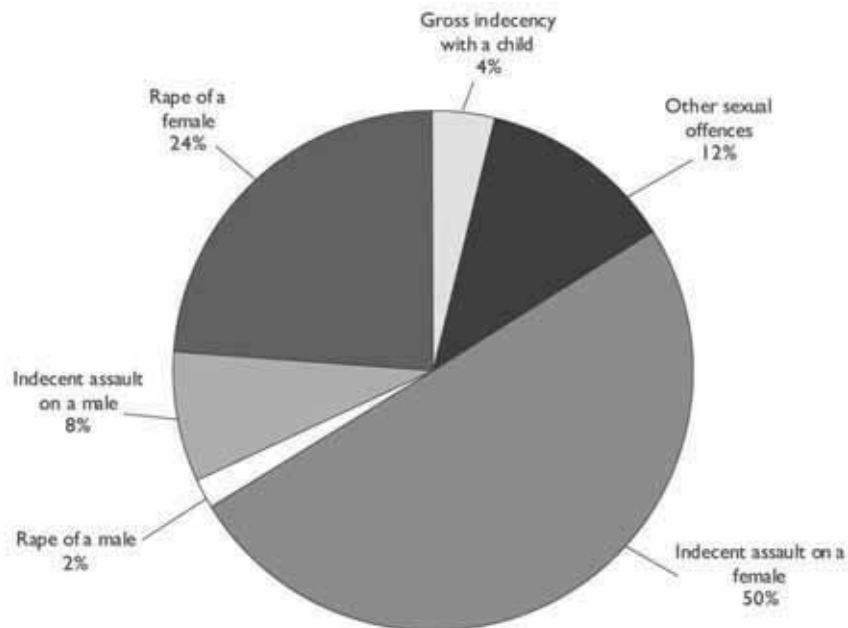
The sexual offences category of recorded crime covers most unlawful sexual activity, including rape, buggery, indecent assault, incest, unlawful sexual intercourse with an under-age girl, and gross indecency with a child. It also includes kerb crawling and procuration, but excludes prostitution. Not all offences included are violent: e.g. bigamy. Indecent exposure, although recorded by the police, does not fall into the sexual offences category.

(Dodd et al., 2004)

Act 2003 may account for some of this increase (Allen et al., 2005; see Section 6.1).

Box 6.4 provides information on sexual violence towards men.

Figure 6.3: Recorded sexual offences in England and Wales, by offence type, 2003/4



Data from Dodd et al., 2004

Box 6.4: Sexual violence towards men

The 2001 British Crime Survey found that 5% of men had experienced some form of sexual violence during their life, with 1.5% experiencing an actual or attempted serious sexual assault and 1.2% suffering actual or attempted rape (Walby and Allen, 2004). Reporting of male sexual assault is thought to be particularly low with issues such as shame and prejudices around male sexuality preventing men from disclosing the assault (Krug et al., 2002). Male sexual assaults can occur in many different settings including educational institutions, prison and the military, whilst males are also victims of drink spiking and drug rape (Krug et al., 2002).

The psychological consequences of sexual assaults on males are similar to those of females, including depression, guilt, sexual dysfunction, sleep disturbances and attempted suicide (Krug et al., 2002). One study among sexually assaulted men attending general practice and genitourinary services in England found men who had experienced sexual assault in adulthood were more likely to have suffered a psychological disorder, and particularly more likely to have self-harmed, than those who had not experienced sexual assault (King et al., 2002). A different survey conducted in a Genitourinary clinic in London found 18% of attendees reported sexual molestation as an adult, with 14% of victims having contracted a sexually transmitted infection as a result of the assault. Being a male victim of sexual molestation in adulthood was associated with having male sexual partners and having been sexually abused as a child (Coxell et al., 2000). Sexual assault towards children is covered in Chapter 4.

6.3: Impact of Sexual Violence

6.3.1: Health impact

Sexual violence impacts substantially on both physical and mental health. In addition to physical injury sustained during a sexual assault (which can sometimes be fatal), sexual violence can lead to sexual and reproductive health problems and a range of emotional problems including depression, post-traumatic stress disorder, sleep difficulties, behavioural problems and suicide (Krug et al., 2002). Women who are subjected to both physical and sexual violence from intimate partners have a greater risk of experiencing health problems than those who suffer non-sexual intimate partner abuse alone (Krug et al., 2002).

The 2001 British Crime Survey enquired about physical and mental health problems resulting from the worst incident of serious sexual assault sustained since age 16 (Walby and Allen, 2004). 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. A case-control study conducted in Bath 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 (Coll et al., 2001).

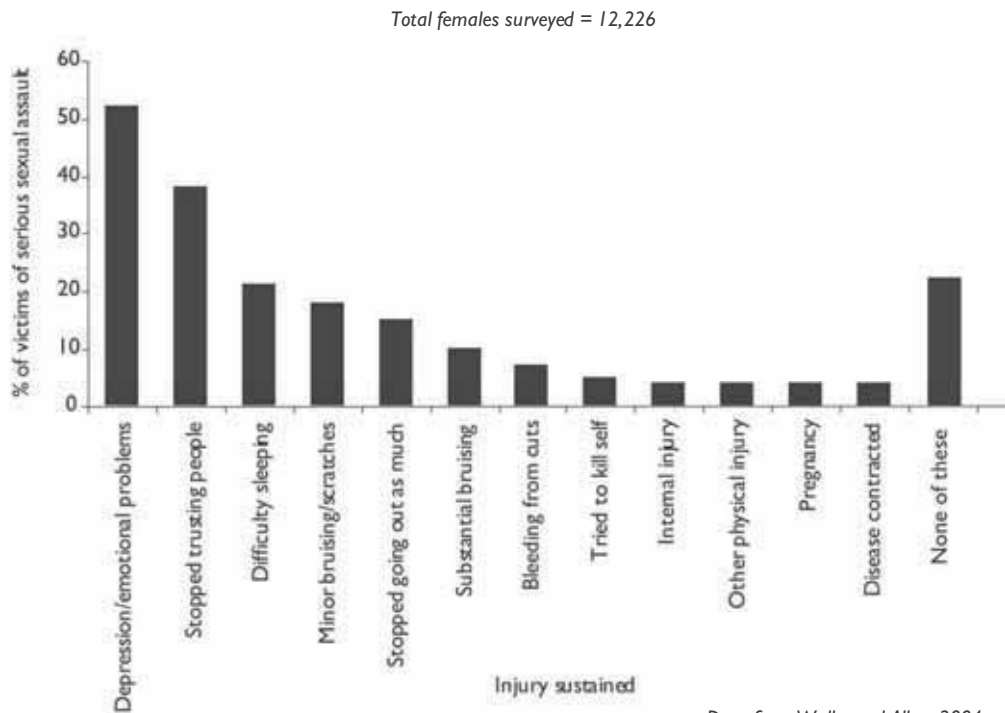
Sexual and reproductive problems

Forced sex can lead to a range of gynaecological complications including vaginal bleeding or infection, genital irritation, chronic pelvic pain, urinary tract infection, pain during intercourse and decreased sexual desire (Krug et al., 2002).

Furthermore, abrasions sustained during forced sexual intercourse can facilitate the transmission of STIs. The 2001 British Crime Survey found that 2% of female victims of serious sexual assault had contracted a disease as a result of the assault (Walby and Allen, 2004). A comprehensive service for sexual assault victims in London, however, found a much higher prevalence of sexual problems among victims of sexual assault, with 23% having sustained genital injuries and 21% of those accepting screening being diagnosed with one or more sexually transmitted infection (Bottomley et al., 1999).

The British Crime Survey also found that 4% of female victims of serious sexual assault (since age 16) had become pregnant as a result of the assault (Walby and Allen, 2004). A study of women requesting abortion in a pregnancy counselling clinic in the North West of England

Figure 6.4: Injuries sustained during the worst incident of serious sexual assault since the age of 16, female victims, England and Wales, 2001



found that 3.7% had experienced forced sexual intercourse in the last year, and in more than half of these cases the pregnancy may have been the result of the assault (Keeling et al., 2004).

Risky sexual behaviour and vulnerability to sexual violence may also be consequences of sexual assault. Research shows that females who are sexually abused at a young age are more likely to have multiple partners and unprotected sex, increasing their risk of sexually transmitted infections, and are also more likely to participate in sex work (see Box 6.6) and to use substances (see Box 6.7) (Krug et al., 2002).

6.3.2: Financial impact

Although sexual offences make up only 1% of all crimes, they account for 8% of the estimated costs of crime (Brand and Price, 2000). This is because the emotional and physical impacts are so great, costing an average of £12,000 per incident for the victim out of a total cost of £19,000 (costs are

Table 6.2: Average cost estimates for sexual offences, England and Wales

Category of cost	£ per incident
Defensive expenditure	2
Physical and emotional impact	12,000
Victim services	20
Lost output	2,000
Health services	1,200
Police activity	1,900
Prosecution	60
Magistrates court	7
Crown court	180
Jury service	20
Legal aid	200
Non legal-aid defence	50
Probation service	60
Prison service	1,200
Other CJS costs	160
Total per incident	19,059

From Brand and Price, 2000



itemised in Table 6.2). Based on an estimate of 130,000 incidents of sexual violence annually, the total cost of sexual violence is calculated at nearly £2.5 billion every year, £156 million of which is borne by health services (Brand and

6.4: Risk Factors for Sexual Violence

The World Health Organization identifies a range of risk factors that increase women’s vulnerability to sexual violence, provided in Box 6.5. Risk of violence increases along with the number of risk factors present.

6.4.1: Sex

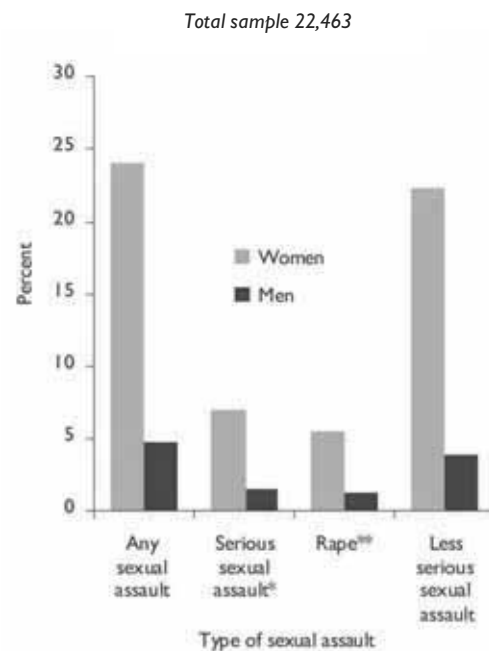
Women are more likely to be victims of all forms of sexual violence than men. The 2001 British Crime Survey (Walby and Allen, 2004) found lifetime prevalence of any sexual assault to be five times higher among females (24.1%) than males (4.7%), with lifetime prevalence of rape (including attempts) being over four times higher among females (5.5% females compared with 1.2% males). When attempted rapes were excluded, lifetime prevalence of rape was six times higher among females (4.4% compared with 0.7% for males), potentially indicating a

greater ability among males to protect themselves from sexual assault. Women were over ten times more likely to have experienced some form of sexual assault in the last year than men (2.1% compared with 0.2%) (See Figure 6.5).

6.4.2: Age

Young women are at greatest risk of sexual violence, with prevalence in the last year decreasing with age. Among 16-19 year old females, 7.2% have experienced some form of sexual assault in the last year, decreasing to 0.1% of females in the 55-59 year age group.

Figure 6.5: Lifetime prevalence of sexual assault (including attempts), by gender: 16-59 year olds, England and Wales, 2001



*Serious sexual assaults include rapes and assault by penetration – a new legal offence introduced in 2003 involving non-consensual penetration of the vagina or anus with an object or body part other than a penis

**Rape uses the 2003 legal definition of rape including penetration of the vagina, anus or mouth by a penis without consent

Data from Walby and Allen, 2004

Box 6.5: Risk factors for women becoming a victim of sexual violence: global findings

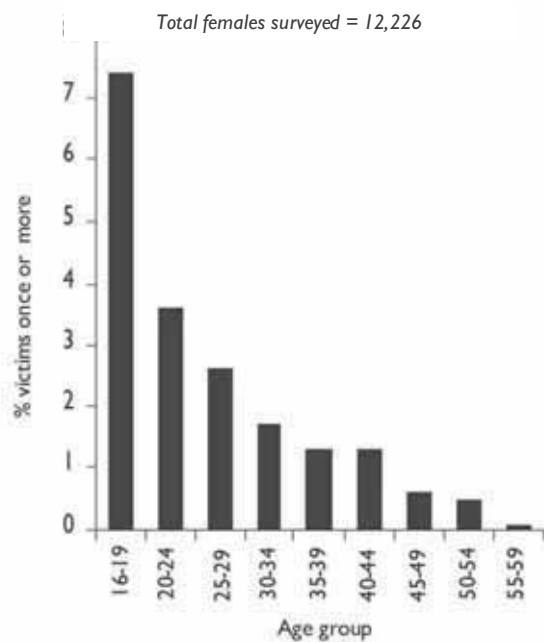
- Being married or living with a partner
- Being young
- Using alcohol or drugs
- Having many sexual partners
- Involvement in sex work
- Becoming more educated and economically empowered (for sexual violence committed by an intimate partner)
- Poverty

Krug et al., 2002

Young women may be more at risk of sexual violence due to a greater vulnerability in general, higher numbers of sexual partners, the greater likelihood of violence being committed by younger men, and also their greater likelihood of being in places where sexual violence may occur, including schools, colleges and pubs and clubs (Krug et al., 2002; Walby and Allen, 2004) (Figure 6.6).



Figure 6.6: Prevalence of sexual assault (including attempts) in the past year by age group, female victims, England and Wales, 2001



Data from Walby and Allen, 2004

6.4.3: Socio-economic status

Availability of economic resources can influence an individual's risk of sexual violence. For example, individuals with few financial resources may be forced into risky occupations such as sex work (see Box 6.6), may be vulnerable to sexual coercion from individuals who can provide them with money or employment, and may be forced to walk home from work or recreational pursuits at

night rather than using private or public transport (Krug et al., 2002).

The 2001 British Crime Survey (Walby and Allen, 2004) found that women living in low income households were more likely to be victims of sexual violence than those living in the most affluent households, with 2.7% of those with a household income of less than £10,000 having experienced sexual assault in the last year compared with 1.5% of those with household incomes greater than £20,000. However, household income does not necessarily indicate the level of resources available to women, as income may be controlled by their partner or spouse.

Enquiring how difficult it would be for women to find £100 at short notice, those who considered it would be impossible were more than twice as likely to have experienced sexual violence in the last year as those who thought it would not be a problem (3.3% compared with 1.5%). Unemployed women were almost twice as likely to have experienced sexual violence in the last year than those in employment (3.4% compared with 1.8%).

Almost 5% of women living in private rented accommodation had experienced sexual violence in the last year, twice those living in social rented accommodation and triple those living in owned homes. However, this could reflect the greater risk of sexual violence among young women who may live in private rented accommodation (Walby and Allen, 2004).

Box 6.6: Sex workers and sexual violence

Sexual violence is a known risk factor for involvement in sex work, with many prostitutes reporting sexual and physical abuse in childhood (Dalla et al., 2003). Sex workers are also particularly vulnerable to sexual violence committed by clients, pimps or traffickers. For many, initiation into sex work is itself a form of sexual violence with, for example, between half and three quarters of female prostitutes in England thought to have commenced sex work before the age of 18 (Home Office, 2004a). Furthermore, over the past decade, trafficking of women and girls for sex work has become a major concern, with rough estimates indicating that up to two million women and girls are trafficked across international borders each year for sex work purposes (see Watts and Zimmerman, 2002). An estimated 70% of indoor sex workers in London are foreign nationals, although it is not known how many of these are victims of trafficking (Home Office, 2004a). In addition to forced prostitution, trafficked women often report sexual assault by traffickers (Watts and Zimmerman, 2002).

The majority of female sex workers working outdoors have experienced some form of sexual violence whilst working (Clark et al., 2004; Church et al., 2001). Research in England and Scotland found that a quarter of female prostitutes working outdoors had been raped by clients, whilst half had experienced some form of client violence in the last six months (Church et al., 2001). Levels of violence were lower among sex workers working indoors, yet a fifth of these had experienced attempted or actual rape (2% actual rape). Just a third of all sex workers experiencing violence by clients had reported this to police.

Levels of drug use are high amongst sex workers (Church et al., 2001). In addition to the traditional ‘pimp’ figure, increasingly common in the UK is the drug-addicted boyfriend who pimps his girlfriend to raise money to support both their drug habits (Home Office, 2004a). Sex workers are thought to be particularly vulnerable where drugs are involved (Dalla et al., 2003).

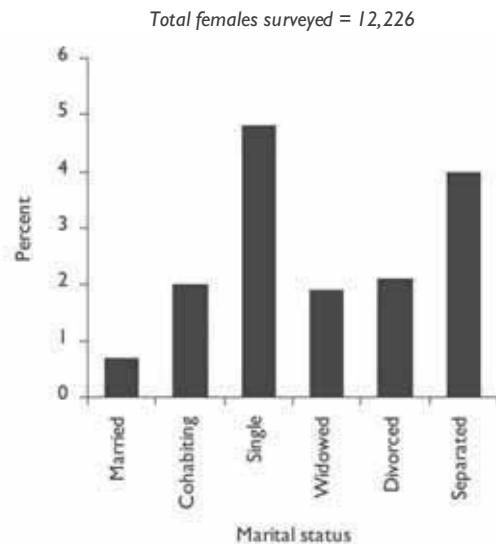
6.4.4: Ethnicity

The 2001 British Crime Survey found few differences between experiences of sexual violence and ethnicity, with 2.1% of women classified as black, 2.0% of those classified white and 1.5% of those classified as Asian having experienced sexual assault in the last year (Walby and Allen, 2004). However, sexual violence will be particularly prevalent among some non-British groups such as women who have been trafficked to the UK specifically for work in the sex trade, and asylum seekers. For example, asylum seekers attending a genitourinary clinic in Sheffield were significantly more likely to have suffered sexual violence than British patients (Rogstad and Dale, 2004).

6.4.5: Marital status

Women who are single or separated report the highest prevalence of sexual violence in the last year, at 4.8% and 4.0% respectively (Figure 6.7). For single women, this reflects the fact

Figure 6.7: Prevalence of sexual assault (including attempts) in the past year by marital status of female victims, England and Wales, 2001



Data from Walby and Allen, 2004

that young women are at greater risk of sexual assault, whilst the category 'separated' may contain women who have recently left a violent relationship (Walby and Allen, 2004). Two thirds of women who had experienced sexual violence since the age of 16 had also been subject to domestic violence.

6.4.6: Geographical location

Women living in inner city areas are more likely to have experienced sexual violence in the last year (3.0%) than those living in urban (2.2%) or rural (1.2%) areas (Walby and Allen, 2004). Figure 6.8 shows prevalence of sexual assault in the last year among women by Government Office Region. Highest prevalence is in the East Midlands region (2.8%) with lowest prevalence being in Wales (0.5%).

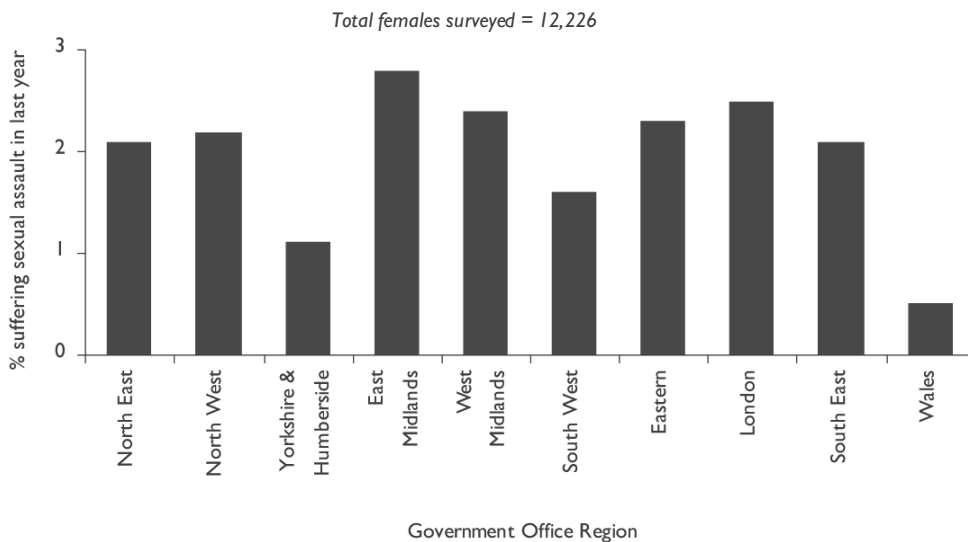
6.4.7: Health status

Unlike other forms of interpersonal violence (e.g. domestic violence), there is little association between prevalence of sexual violence and self-reported health status, with



2% of those reporting good health having experienced sexual violence in the last year compared with 3% of those reporting poor health (Walby and Allen, 2004). However, this includes all sexual assaults. Given the particularly damaging effects of serious sexual assault on both physical and mental health, health status is likely to be lower amongst victims of serious sexual violence. In addition, those with mental health problems may be particularly vulnerable, but less likely to report an incident of sexual violence.

Figure 6.8: Prevalence of sexual assault (including attempts) in the last year among women by Government Office Region, England and Wales, 2001



Data from Walby and Allen, 2004

Box 6.7: Substance use and sexual violence

Substance use can increase the risk of a person being both a victim and a perpetrator of sexual violence. Using alcohol or other drugs can reduce an individual's ability to interpret and act on warning signs and to protect themselves from assault. International research shows many victims of sexual violence are under the influence of alcohol at the time of their assault. For example, a study of college students in the US found victims of sexual victimisation were under the influence of alcohol in between 35% and 81% of incidents (Testa and Parks, 1996). In addition, being in social environments where alcohol and drugs are used, such as pubs and clubs, may increase the likelihood of coming into contact with a potential offender (Krug et al., 2002; Bellis et al., 2004).

Substance use can also be a consequence of sexual violence, with research suggesting that female survivors of sexual assault use alcohol partly to self-medicate (Miranda et al., 2002; Finney, 2004a). Research in the US has found higher alcohol consumption levels amongst both males and females with experience of sexual victimisation and rape (Corbin et al., 2001; Ratner et al., 2003).

Sexual violence also frequently involves alcohol consumption by the perpetrator. One study found over half (58%) of men imprisoned in the UK for rape had drunk alcohol within the six hours preceding the rape, whilst 37% were considered to be alcohol dependent (Grubin and Gunn, 1990). Sexual assaults in which the offender has been drinking have been associated with greater offender aggression and victim injury, yet also with less likelihood of rape completion (Testa, 2004; Brecklin and Ullman, 2001).

Alcohol and drugs can also be a means to sexual assault for perpetrators (Bellis and Hughes, 2004; Finney, 2004a). Concerns around drink spiking and drug rape have been increasing in the UK, with many incidents reportedly involving the surreptitious administration of a substance to the victim's drink in nightlife settings. International research has found that alcohol itself is one of the main substances present in victim urine analyses (ElSohly and Salamone, 1999).

6.4.8: Previous history of sexual assault

Experience of sexual abuse in childhood or adolescence can increase the risk of sexual victimisation in adulthood (Krug et al., 2002). For example, a study of women attending primary care practices in London found that those who had experienced unwanted sexual intercourse before the age of 16 were more than twice as likely to have suffered sexual assault or rape in adulthood (Cold et al., 2001).

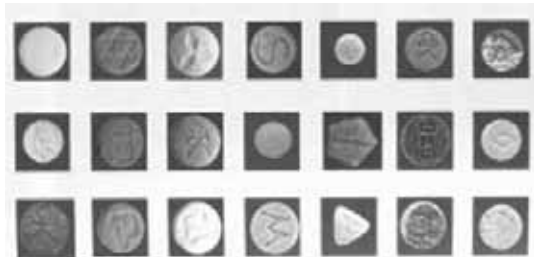
6.4.9: Sexual behaviour

Women who have many sexual partners are at greater risk of sexual violence (Krug et al., 2002). However, whilst having many sexual partners may expose women to more potential attackers, increased number of sexual partners may also be a consequence of sexual violence. For example, research in New Zealand found that young women who

experienced childhood sexual abuse had greater numbers of sexual partners in adolescence than those with no history of childhood sexual abuse (Fergusson et al., 1997).

6.4.10: Substance Use

Alcohol and drug use can increase a person's vulnerability to sexual violence. Further information is provided in Box 6.7.



6.4.11: Factors increasing men’s risk of committing sexual violence

Less data are available on the risk factors associated with committing sexual violence. Whilst most incidents of rape are committed by men known to their victims, a range of other factors related to attitudes, beliefs and social conditions can impact on sexual violence (Krug et al., 2002). Those identified by the World Health Organization are identified in Table 6.3.

Alcohol and drug consumption

Alcohol and some drugs, such as cocaine, have been shown to have a disinhibiting effect in committing sexual assault (Krug et al., 2002). The mechanisms involved in the relationship between alcohol and violence are outlined in chapter 4 (also see Box 6.7).



Table 6.3: Factors increasing men’s risk of committing rape

Individual Factors	Relationship Factors
<ul style="list-style-type: none"> • Alcohol and drug use • Coercive sexual fantasies/attitudes and beliefs supportive of sexual violence • Impulsive and anti-social tendencies • Preference for impersonal sex • Hostility towards women • History of sexual abuse as a child • Witnessed family violence as a child 	<ul style="list-style-type: none"> • Associate with sexually aggressive and delinquent peers • Family environment characterised by physical violence and few resources • Strongly patriarchal relationship or family environment • Emotionally unsupportive family environment • Family honour considered more important than the health and safety of the victim
Community Factors	Societal Factors
<ul style="list-style-type: none"> • Poverty, mediated through forms of crisis of male identity • Lack of employment opportunities • Lack of institutional support from police/ judicial system • General tolerance of sexual assault within the community • Weak community sanctions against perpetrators of sexual violence 	<ul style="list-style-type: none"> • Societal norms supportive of sexual violence • Societal norms supportive of male superiority and sexual entitlement • Weak laws and policies relating to sexual violence • Weak laws and policies relating to gender equality • High levels of crime and other forms of violence

Krug et al., 2002

Psychological factors

The psychological factors that predispose men to commit rape and other sexual offences are both variable and complex. Many sex offenders have a preference for impersonal sexual relationships and may therefore lack experience and knowledge about women and their feelings. The fact that rapists have less knowledge about the impact of rape than other men supports this. The ultimate lack of empathy for their female victims is also exemplified by the tendency for male sex offenders to consider victims responsible for the offence. Furthermore, since they may have only had superficial sexual relationships, their ignorance is likely to be manifest in the misreading of cues in social situations.

Male sex offenders have also been found to have more hostile feelings towards women than their non-offending counterparts. Some men tend to see women as opponents to be challenged and may fuel these feelings by engaging in coercive sexual fantasies. If these tendencies are combined with other negative personality traits such as impulsivity, anti-social behaviour and an exaggerated sense of masculinity, the individual will be at a heightened risk of sexual offending (Krug et al., 2002).

Peer pressure

For some young offenders, the impetus to commit this type of crime may come from peer pressure, particularly if the individual is a gang member and has delinquent friends. Such pressures however, will be more powerful if the individual has already been exposed to risk factors during early childhood.

Family gender roles

Children whose parents engage in intimate partner violence and fail to provide emotional support, face an enhanced risk of perpetrating sexual offences later in life. If the household

environment is also characterised by competition for scarce resources, the problems will be compounded. Furthermore, boys who are raised by families with strongly patriarchal structures are also more likely to become violent, to rape and to use sexual coercion against partners than men raised in homes that are more egalitarian. Consequently, the ethos of such families is more likely to dictate that women be blamed for incidents of sexual violence. Specifically, if such assaults are viewed primarily in terms of damage to family honour and purity, then male children are at an even greater risk of becoming sexual offenders (Salter et al., 2003).

Community and societal factors

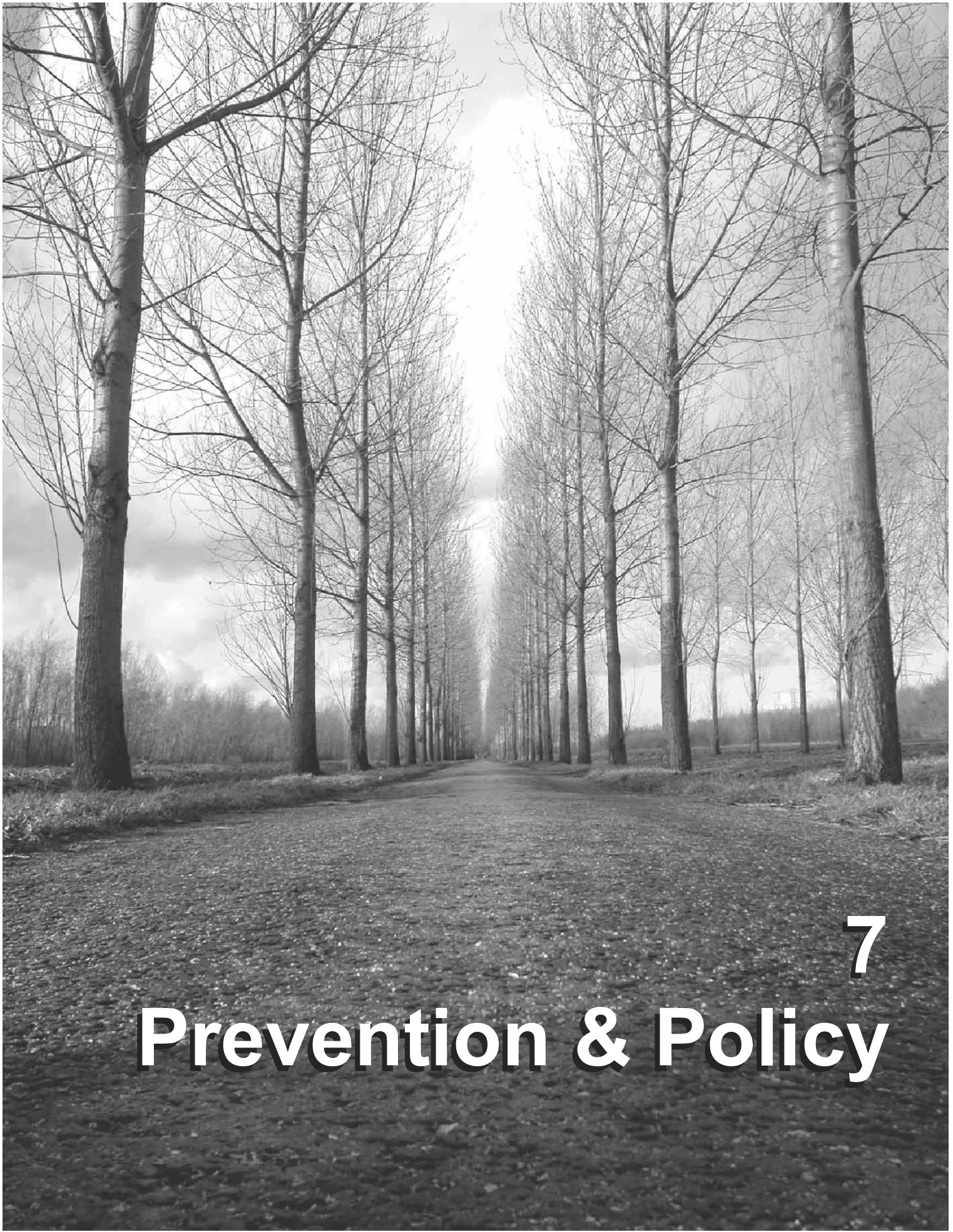
While most incidents of sexual violence occur within the home of either the abuser or victim, factors that influence sexual aggression come from a much broader context. Societal pressures which encourage unrealistic models of 'successful' masculinity can cause feelings of anger and resentment. Some individuals externalise their anger which then manifests in the form of sexual aggression directed against women they feel they can no longer control (Krug et al., 2002).



* * * * *

Key Points

- In 2003/4, 52,070 sexual offences were recorded in England and Wales, including 12,354 rapes towards females and 893 rapes towards males
- Only 5-25% of rapes are reported to police, of which only one in five reach court and no more than half result in a conviction
- 24% of women and 5% of men have experienced some form of sexual assault during their lifetime
- One in twenty women and one in a hundred men have been raped
- In the last year, an estimated 25,000 women were raped, 79,000 suffered attempted or actual serious sexual assault and 293,000 experienced less serious sexual assault
- Approximately half of female victims of sexual assault in the previous 12 months reported more than one incident during that time
- In total there were an estimated 80,000 incidents of rape, 190,000 incidents of serious sexual assault and 450,000 incidents of less serious sexual assaults on women in the previous year
- 62% of serious sexual assaults on women involve physical force, 37% involve threats, 12% involve threats with weapons and 27% occur when the victim is drugged, unconscious or otherwise unable to give consent
- 82% of serious sexual assaults, 54% of rapes and 57% of less serious sexual assaults are committed by a perpetrator known to the victim
- Just 12% of the worst cases of serious sexual assault are reported to police
- 52% of female victims of serious sexual assault report depression and emotional problems as a consequence
- One in twenty victims of serious sexual assault have attempted suicide
- 21% of victims attending a sexual assault service in London, who accepted screening, were diagnosed with at least one sexually transmitted infection
- 4% of female victims of serious sexual assault became pregnant as a result
- The total cost of sexual violence in England and Wales is estimated at £2.5 billion every year, with £156 million being borne by health services
- Women are over ten times more likely to have experienced some form of sexual assault in the last year than men
- Young women are most at risk of sexual violence – 7.2% of 16-19 year olds have experienced sexual assault in the last year
- A quarter of female prostitutes working outdoors have been raped by clients
- Asylum seekers visiting a genitourinary clinic were significantly more likely to have suffered sexual violence than British patients



7

Prevention & Policy

7: PREVENTION AND POLICY

7.1: Introduction

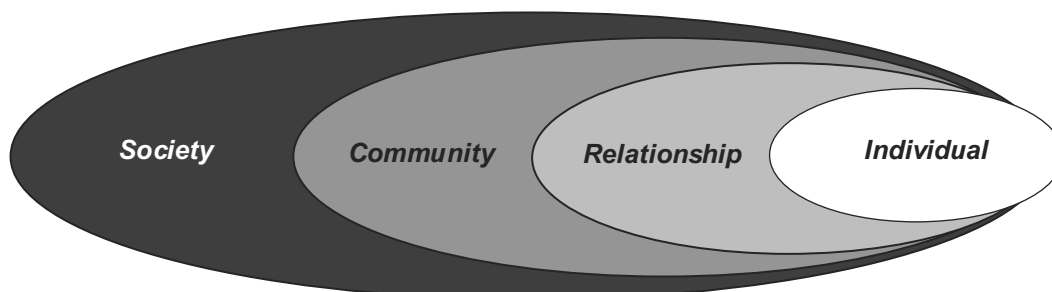
The previous chapters have identified the extent of interpersonal violence in Britain, its impacts on individuals, communities, public services and the economy, and the risk factors that make people vulnerable to becoming victims or perpetrators of violence. The information provided shows the huge burden interpersonal violence is placing on British society, yet much of this violence is preventable. There is a growing evidence base on what works to prevent the risk factors associated with violence, and knowledge of successful and promising interventions is essential in ensuring appropriate and effective measures to prevent violence are adopted where they are needed most. Both nationally and internationally, much work has been done to provide information and guidance on violence prevention. Internationally, the World Health Organization's World Report on Violence and Health (Krug et al., 2002) highlighted the global problem of violence and has been accompanied by a range of material and guidance to assist violence prevention at international, national and local levels (http://www.who.int/violence_injury_prevention/en/). The Council of Europe have also prioritised violence and have produced a range of reports and materials to assist member states in reducing and responding to violence (http://coe.int/T/E/Integrated_Projects/violence/).

A great deal of work is also underway to address violence in Britain, and particularly the more visible and widespread forms of violence such as alcohol-related and domestic violence. However, the purpose of this chapter is not to provide a comprehensive overview of all policy and action in place across Britain aimed at tackling violence. Rather, it focuses on the specific risk factors for violence, identifies what can be successful in preventing them and highlights examples of policies that are being or could be used to address them. Hence it identifies policies that may not normally be directly associated with violence prevention, 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. The chapter uses the World Health Organization's ecological model of violence as its framework (sections 7.1 and 7.2) to identify risk factors, successful prevention strategies and relevant policies.

7.1.1: The ecological model for understanding violence

The ecological model can be used to help understand violence by examining the relationships between risk factors operating in different contexts. The model regards violence as the result of many interacting behavioural

Figure 7.1: Ecological model for understanding violence



From Krug et al., 2002

influences that operate at different levels (see Figure 7.1).

Individual level

This level consists of individual factors such as age, personality, personal history and demographic profile. It focuses on the specific characteristics that increase an individual's chances of becoming either a perpetrator or victim of violence.

Relationship level

This level consists of factors arising from the interactions and influences operating in personal relationships, such as family contexts and peer groups.

Community level

Influences that operate at the community level consist of factors that arise from social relationships in broader settings, such as schools, neighbourhoods and workplaces.

Societal level

This level consists of the broader influences that operate in society as a whole. These include cultural norms, the influence of the media and social/economic policies.

7.1.2: Developmental stage

This report uses developmental life stages in order to highlight how the different levels of influences in the ecological model affect different age groups. The developmental stages used in this section are outlined in Table 7.1.

Table 7.1: Developmental stages

Life stage	Age
Infancy	Prenatal-3 years
Childhood	3-11 years
Adolescence	11-19 years
Adulthood	20 years and over



7.1.3: Addressing Risk Factors

The remainder of this chapter deals with prevention measures that have proved successful in addressing risk factors for violence and related national policy measures. Each section addresses a different ecological level (individual, relationship, community and societal) and is concluded with a summary table (Tables 7.2-7.5; for key, see Box 7.1). These tables outline the prevention strategies included in the specific ecological level, the risk factors they address, relevant policy areas and also which types of violence the strategies can reduce.

Box 7.1: Key to Tables 7.2-7.5

- Robust evidence of an increased risk of becoming a *perpetrator* of violence
- Evidence suggests an increased risk of becoming a *perpetrator* of violence
- ⊗ No evidence of an increased risk of becoming a *perpetrator* of violence
- Robust evidence of an increased risk of becoming a *victim* of violence
- Evidence suggests an increased risk of becoming a *victim* of violence
- ⊗ No evidence of an increased risk of becoming a *victim* of violence

Example: Poor academic achievement and truancy from school are individual risk factors that increase the likelihood of adolescents becoming involved in violent crime (see Section 7.2.4 and Table 7.2).

Youth violence ■ ●

Such individuals, who become disaffected from school, are likely to form negative peer relationships, and have delinquent friends. Since such relationships encourage risk taking behaviour, young people in this category are more likely to become involved in youth violence not only as perpetrators (■), but also as victims (●).

Intimate partner violence ■ ○

Adolescents who perform poorly at school will have reduced earning potential in adulthood. Reduced economic resources place stress on relationships which can lead to violence. This risk is greater for perpetrators (■) than victims (○).

Child maltreatment ■ ●

If adolescents have a problematic relationship with their parents, poor academic achievement and truancy can trigger child maltreatment in the form of harsh physical discipline (●). Furthermore, ensuing friendships with delinquents can lead to long lasting alcohol and drug problems. This increases the likelihood of them abusing their own children later in life (■).

Elder abuse □ ⊗

Reduced earning potential resulting from lack of academic qualifications slightly increases the chances of perpetration of elder abuse, as does involvement with illegal drugs and alcohol (□). There are no established links between lack of educational attainment and being a victim of elder abuse (⊗).

Sexual violence □ ○

Poor academic achievement and truancy place an individual at a slightly higher risk of becoming involved in sexual violence as either a victim (○) or perpetrator (□). Again, this can occur as a result of risk taking behaviour, economic stress, or substance misuse.

7.2: Prevention strategies to reduce individual risk factors (Table 7.2)

Influences that operate on the individual level include factors such as personality, personal history and demographic profile. Put simply, individual risk factors are the specific characteristics that increase an individual's chances of becoming a perpetrator and/or a victim of violence. The prevention strategies outlined in this section are aimed at these individual risk factors (for summary see Table 7.2).

7.2.1: Reducing unintended pregnancies

Life stage:

- Infant (prenatal-3 years)
- Child (3-11)

Risk factors:

- Having a teenage mother
- Having more than three siblings
- Being the result of unwanted pregnancy

Successful prevention strategies:

Contraceptive services help prevent violence by reducing risk factors for infants and children born as a result of unwanted pregnancies, particularly to teenage mothers. Furthermore, by limiting family size, the number of infants and children exposed to risk factors associated with poverty are also reduced.

Programmes to prevent unwanted pregnancy vary in timing, intensity and duration. The results of research in the UK indicate that risk-reduction interventions are most successful if initiated early, prior to the establishment of sexual behaviour patterns (Oakley et al., 1995). Evidence from other European countries shows that co-ordinated programmes in which contraceptive services, schools and policy reforms work together can result in major reductions in the teenage conception rate (Kane and Wellings, 1999).

Policy:

The national *Teenage Pregnancy Strategy* (Social Exclusion Unit, 1999) sets out two national targets: to halve the under 18 conception rate in England by 2010 and to increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long term social exclusion. The teenage conception reduction target is one of the NHS Performance Indicators for Primary Care Trusts and is a national Public Service Agreement (PSA) for Local Government. It is also one of two cross-cutting indicators in the Local Government Best Value Performance Indicator Set. Each local authority in England has its own locally developed Teenage Pregnancy Strategy.

The Teenage Pregnancy Unit is a cross Government Unit located within the Children and Families Directorate in the Department of Education and Skills. The objectives of the Teenage Pregnancy Unit are to oversee the implementation of the Government's teenage pregnancy strategy, co-ordinate activity at national level and provide support for local activity. The Unit provides information for parents and teenagers on the availability of contraceptive and sexual health services. It also provides guidance for professionals who are in a position to refer teenagers to such services.

www.teenagepregnancyunit.gov.uk
<http://www.audit-commission.gov.uk/index.asp>

Choosing Health: Making Healthier Choices Easier, the Public Health White Paper published in November 2004, reinforces the objective of reducing unwanted teenage pregnancy. The paper describes a new national campaign, targeted primarily at young men and women, which aims to raise awareness of the risks of unprotected sex and to encourage the greater use of condoms to avoid the risk of unwanted pregnancies.

www.dh.gov.uk

7.2.2: Increasing access to pre and postnatal services

Life stage:

- Infant (prenatal-3 years)

Risk factors:

- Neural damage
- Having a mother with pre-postnatal stress

Successful prevention strategies:

Prenatal and postnatal health services can play a vital role in preventing violence by averting risks to the unborn child and providing support to new mothers (Krug et al., 2002). Home visiting during pregnancy can be effective in reducing maternal anxiety and associated risk factors (Glover and O'Connor, 2002). Social support can be delivered alongside prenatal care in the form of nurse-family partnerships. These programmes target high-risk mothers and involve regular home visits during pregnancy. This strategy has proven successful in reducing maternal anxiety and consequent health problems in newborns (Sutton et al., 2004).

International studies show that professional support during the pre and postnatal period reduces both child maltreatment and the risk of violent offending later in life (Widom, 1989), and that a reduction in violent behaviour can be observed until mid adolescence (Olds et al., 1998). 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 (Sutton et al., 2004; see Section 7.2.4). Reductions in postnatal depression and its consequences for child maltreatment and future offending have been found to result from eight weekly home visits from healthcare professionals during the postnatal period. These visits can be conducted by either



purpose trained health visitors or psychotherapists (Cooper and Murray, 2003), and have been found to be as effective as antidepressants in reducing maternal anxiety and associated risk factors for violence (Appleby et al., 1997).

Policy:

The National Service Framework (NSF) for Children, Young People and Maternity Services (Department of Health, 2004) is a 10-year programme that aims to improve children's health and which sets standards for the delivery of health and social services for children, young people and mothers. It requires primary care trusts 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 at any time during their pregnancy. NHS maternity

services are also required to have a policy to identify and support pregnant women who are suffering or at risk of developing serious mental illnesses, and ensure all pregnant women are provided with information on mental health problems and available help. Following birth, the NSF states that all women should receive midwifery support for at least a month and longer if required. Additional support pre and post birth can help parents cope with new babies and hence help reduce the risk of child maltreatment.

<http://www.dh.gov.uk/>

Sure Start Plus, which aims to reduce the risk of long-term social exclusion resulting from teenage pregnancy, forms part of the Government's Teenage Pregnancy Strategy. *Sure Start Plus* programmes intend to provide a range of services specially tailored to meet the needs of teenage parents both before and after pregnancy, including healthcare, practical advice and training in parenting skills, and information on available benefits. The

programme also includes a target to identify and support teenage mothers experiencing postnatal depression.

www.teenagepregnancyunit.gov.uk

7.2.3: Child maltreatment victim treatment programmes

Life stage:

- Infant (prenatal-3 years)

Risk factor:

- Recognised victim of child maltreatment

Successful prevention strategies:

Maltreated children face a heightened risk of developing behavioural problems later in life, including aggressive and violent behaviour (Krug et al., 2002). Maltreated, severely withdrawn children can be placed in playgroups with better functioning children who then act as role models. Such programmes have produced an improvement in social behaviour



in the short term (Oates and Bross, 1995) although the long-term effects have yet to be evaluated.

Policy:

In response to the Victoria Climbié inquiry, the *Every Child Matters Green Paper* set out a range of measures intended to improve services for children and safeguard their well-being. The *Children Act 2004* provides the legal framework for change, placing a duty on all key agencies to protect children and promote their welfare, and a duty on every Local Authority to establish a statutory Local Safeguarding Children Board. These boards comprise representatives from a range of agencies including local authorities, NHS organisations, police, probation services and Connexions services (see Section 7.3.4), and are responsible for co-ordinating and ensuring the effectiveness of local services to safeguard children. *Every Child Matters: Change for Children* provides information on the measures being taken to reform children's services.

www.everychildmatters.gov.uk

Choosing Health, the public health White Paper, recognises the negative impacts physical, emotional and sexual abuse towards children has on children's physical and mental health. It highlights cross-government working to address these issues between the Department of Health, the Department for Education and



Skills and Home Office, through the Inter-ministerial Group on Domestic Violence and Sexual Offending.

www.dh.gov.uk

7.2.4: Social development training

Life stage:

- Child (3-11 years)
- Adolescent (12-19 years)

Risk factors:

- Hyperactivity
- Displaying aggressive behaviour
- Bullying others

Successful prevention strategies:

Social development programmes aim to prevent anti-social and aggressive behaviour and focus on learning the following skills (from Krug et al., 2002).

- Managing anger
- Modifying behaviour
- Adopting a social perspective
- Moral development
- Building social skills
- Solving social problems
- Resolving conflicts

These techniques can be cost effectively taught in the classroom by incorporating them into other life skills training (Sutton et al., 2004). Social development programmes are most effective when targeted at pre-school or primary school children. However when integrated into the curriculum of secondary schools, such programmes can be used to promote out of school activities. This allows the application of social skills to generalised settings (Greenberg et al., 1998). A UK evaluation of the social development programme Promoting Alternative Thinking Strategies (PATHS) showed social development training to be effective in five out

of six West Lothian schools where peer aggression, hyperactivity and disruptive behaviour were all reduced (Davids, 2003).

Policy:

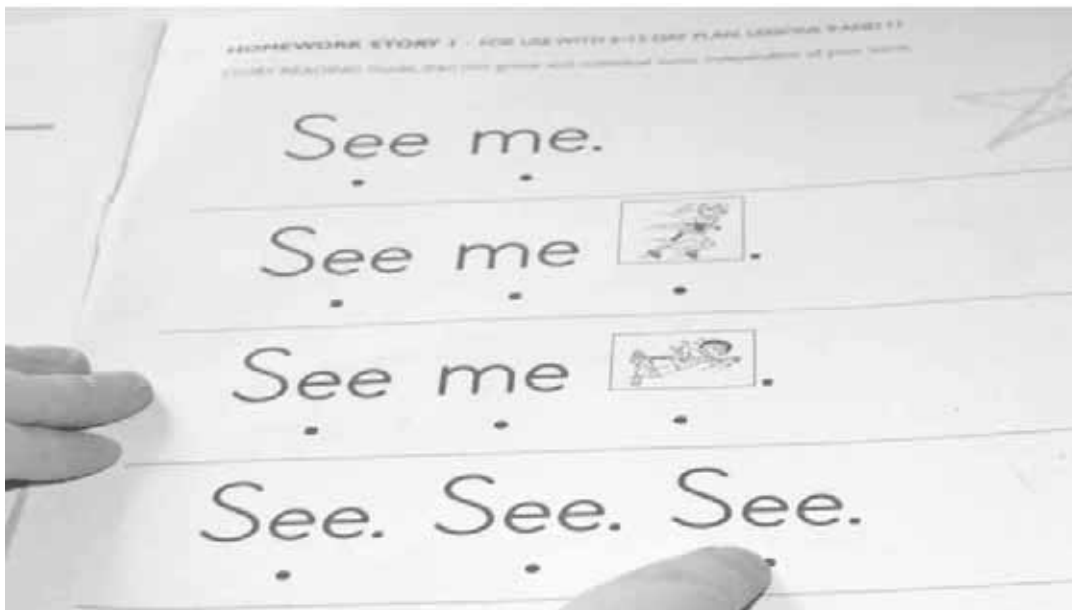
In recent years there has been increased Government interest in children's behaviour and *Social and Emotional Development* has become a priority area in both childcare and education. The Government's *Sure Start* programme aims to improve outcomes for children, families and communities through improving health and social development for young children, increasing the availability of childcare and providing support to parents. The *Sure Start* target to increase the proportion of children with normal levels of social and economic development aims to prevent the negative impacts poor social and emotional development have on social functioning in childhood and later in life, and hence should help reduce violence associated with these factors. These include poor relationships with peers, academic problems and involvement in crime. *Sure Start* Local Programmes, targeting 0-5 year olds, currently provide services to over 400,000 children in England, focusing on the most disadvantaged families.

Within the education system, *Personal, Social and Emotional Development (PSED)* forms one of the six areas of learning within the Foundation Stage curriculum (age 3-5 years; Qualifications and Curriculum Authority, 2000). PSED focuses on issues such as children's relationships, self-perceptions, cultural identity and development of a positive disposition to learning. This emphasis during early education is intended to help encourage positive attitudes towards life including the promotion of emotional resilience and good behaviour.

http://www.qca.org.uk/downloads/cg_foundation_stage.pdf

Through the *National Behaviour and Attendance Strategy*, the *Primary Behaviour and Attendance* programme is currently being piloted in primary schools in 25 Local Education Authority areas to help address poor behaviour and attendance in schools for which these are key issues. The pilot provides participating schools with curriculum materials specifically designed to promote children's social, emotional and behavioural skills (SEBS) along with continuing professional development opportunities for school staff.

<http://www.standards.dfes.gov.uk/primary/wholeschools/banda/>



7.2.5: Academic enrichment programmes

Life stage:

- Adolescent (12-19 years)

Risk factors:

- Poor academic achievement
- Truancy

Successful prevention strategies:

Anti-social behaviour and aggression in children and adolescents have been associated with low academic achievement, poor literacy and disaffection from school. Enrichment in the form of study support has proved successful in improving numeracy and literacy skills in children and adolescents from disadvantaged backgrounds (Sharp et al., 1999). Furthermore, curriculum extension activities in the form of homework clubs and revision centres can not only improve attitudes towards school, but also improve attendance, self esteem, and peer relationships, while reducing anti-social behaviour and aggression (DfES, 1999).

Policy:

The *National Healthy School Standard (NHSS)* is part of the Healthy Schools Programme, jointly funded by the Department for Education and Skills and the Department of Health. The NHSS was introduced as a vehicle to support the delivery of Personal, Social and Health Education (PSHE) and Citizenship in schools. It aims to contribute to reducing health inequalities, raising pupil achievement and promoting social inclusion, and hence can help contribute to violence prevention. The NHSS focuses on several themes including local and school priorities, citizenship, drug education, emotional health and well-being (including bullying), safety, healthy eating and sex education.

www.wiredforhealth.gov.uk

The *Extended Schools* programme aims to encourage schools to provide a range of activities and services in addition to traditional

learning for pupils, families and the wider community both during and after the school day. These can include study support, adult learning, access to information and communication technology (ICT) facilities, community sports programmes and health and social care services. Such activities are intended to cater for the needs of pupils and the wider community and are considered to bring a range of benefits that can reduce risk factors for current and future involvement in violence including:

- increased pupil motivation and self-esteem
- increased child behaviour and social skills
- increased child supervision outside of school hours

Many schools are already offering extended services and the Government intends all schools to become Extended Schools over time.

<http://www.surestart.gov.uk/surestartservices/extendedschools/>

The Department for Education and Skills' *Behaviour Improvement Programme (BIP)* originated under the Government's Street Crime Initiative and forms part of the *National Behaviour and Attendance Strategy* and the *Excellence in Cities Initiative*. The programme aims to ensure full time education for all excluded pupils, and improve behaviour and decrease truancy in schools where these are key issues. Measures included in the programme include the provision of learning mentors for pupils considered at risk of exclusion, truancy and criminal behaviour (see Section 7.3.4), and the development of multi-agency Behaviour and Education Support teams to work with individual pupils and groups of children to address emotional and behavioural problems.

<http://www.dfes.gov.uk/behaviourimprovement/>

Table 7.2: Prevention measures effective at combating risk factors that operate on the individual level.

Response		Risk Factors						
Prevention measure	Some related policy areas	Type of violence						
		Youth violence	Intimate partner violence	Child maltreatment	Elder abuse	Sexual violence		
		Risk factors for violence addressed by prevention measure						
		- Having a teenage mother - Having more than 3 siblings - Being the result of unwanted pregnancy	■ ●	■ ●	■ ●	■ ●	■ ●	■ ●
		- Neural damage - Having a mother with prenatal/postnatal stress	■ ●	■ ●	■ ●	■ ●	■ ●	■ ●
		- Recognised victim of child maltreatment	■ ●	■ ●	■ ●	■ ●	■ ●	■ ●
		- Hyperactivity - Displaying aggressive behaviour	■ ●	■ ●	■ ●	■ ●	■ ●	■ ●
		- Hyperactivity - Displaying aggressive behaviour - Bullying others	■ ●	■ ●	■ ●	■ ●	■ ●	■ ●
		- Poor academic achievement - Truancy	■ ●	■ ●	■ ●	■ ●	■ ●	■ ●
			■ ●	■ ●	■ ●	■ ●	■ ●	■ ●

Life Stage	Prevention measure	Some related policy areas
Infant	Develop services to reduce unwanted pregnancies (Section 7.2.1)	- The National Teenage Pregnancy Strategy - Choosing Health White Paper
	Increase access to prenatal/postnatal services (Section 7.2.2)	- The National Service Framework for Children, Young People and Maternity Services - Sure Start Plus
	Provide child maltreatment victim treatment programmes (Section 7.2.3)	- Every Child Matters - Choosing Health White Paper
Child	Provide social development training (Section 7.2.4)	- Social and Emotional Development - Sure Start - National Behaviour and Attendance Strategy
Adolescent	Provide social development training (Section 7.2.4)	- Social and Emotional Development - Sure Start - National Behaviour and Attendance Strategy
	Provide academic enrichment programmes (Section 7.2.4)	- Healthy Schools - Extended Schools - Behaviour Improvement Programme

■	Robust evidence of an increased risk of becoming a perpetrator of violence
□	Evidence suggests an increased risk of becoming a perpetrator of violence
⊗	No evidence of an increased risk of becoming a perpetrator of violence
●	Robust evidence of an increased risk of becoming a victim of violence
○	Evidence suggests an increased risk of becoming a victim of violence
⊗	No evidence of an increased risk of becoming a victim of violence

7.3: Prevention strategies to reduce relationship risk factors (Table 7.3)

Influences that operate at the relationship level include risk factors associated with interactions within the family and between peers, and are therefore often concentrated in home and school settings (for summary see Table 7.3)

7.3.1: Home Visiting

Life stage:

- Infant (prenatal-3 years)

Risk factors:

- Parental conflict
- Maternal depression
- Impaired bonding
- Lack of maternal support network

Successful prevention strategies:

Maternal anxiety and postnatal depression can increase a mother's risk of maltreating her child. Home visiting by healthcare workers has proved valuable in helping mothers cope with new babies. Consequently, this reduces maternal depression, lessens the likelihood of



conflict within the family and improves bonding between mother and infant. Although this role has been played by midwives with success, there are benefits in extending the duration of home visits following birth. After the initial postnatal period, home visits can be made by nurses or trained volunteers as part of a 'community mothers programme'. Such programmes provide support for women who lack a support network within their own community (Farrington and Welsh, 1999). Child development programmes in which trained health visitors make monthly home visits throughout the first year of an infant's life have also proved effective in helping reduce problematic behaviour in infants, which can act as a barrier to effective mother/infant bonding (Barker et al., 2002). Since the long duration of these programmes proves expensive, home-visiting programmes should be targeted at high-risk households. A study conducted in disadvantaged areas of London showed a reduction in maternal anxiety and depression due to improvements in infant behaviour (Davis and Spurr, 1998).

Screening for early language development problems has also shown promise in counteracting problems associated with later violent offending. For example, the Wilstaar Programme involves the screening of babies from 10 months onwards for slow language development. This is followed by monthly home visits by trained therapists. Evaluations in the US showed a substantial reduction in child aggression by age three (Ward, 1999).

Policy:

Every Child Matters (HM Treasury, 2003) aims to provide a range of support to parents and carers, including home visiting programmes. Frequent visits to parents in the pre and postnatal period are seen as important to help support parenting and identify postnatal

depression, which is recognised in the Every Child Matters Green Paper as a risk factor for child abuse, neglect and injury.

The *Teenage Pregnancy Strategy* (Social Exclusion Unit, 1999) makes provision for improving services for young parents, including postnatal support in the form of home visiting. This is important as children of teenage mothers are at particular risk of maltreatment. Home visiting and outreach are also considered important in engaging disadvantaged young parents with other services.

<http://www.dfes.gov.uk/teenagepregnancy/>

7.3.2: Parenting Programmes

Life stage:

- Infant (prenatal–3 years)
- Child (3–11 years)

Risk factors:

- Lack of stimulation
- Inconsistent discipline
- Harsh, physical discipline
- Parental conflict

Successful prevention strategies:

Parenting programmes help reduce violent behaviour by encouraging consistency of discipline, improving emotional bonds within the family, and helping parents develop self-control (Thornton et al., 2002). Such schemes have proved effective in the long term, and also cost effective since group work and telephone advising prove as effective as home visiting (Sutton et al., 2004).

Webster Stratton's 'incredible years' programme involves parent training, teacher training and child social skills training. The programme was originally designed for homes and clinics through the use of self administered manuals and videos, but can be transferred elsewhere. It has been evaluated in the UK in a variety of contexts including NHS settings, the voluntary sector and inner city primary schools.

It has proved effective for reducing aggression in children from a variety of backgrounds including low-income families and ethnic minorities (Gross et al., 2003). The Living with Children programme uses a cognitive behavioural approach, targeting specific high risk children such as those with Attention Deficit Hyperactivity Disorder (ADHD). It has been evaluated in the UK and proved effective in reducing anti-social and aggressive conduct in children with serious behavioural problems (Sutton et al., 2004).

Policy:

Every Child Matters (HM Treasury, 2003) includes parent education programmes targeted towards the parents of 5-8 year olds, with programmes considered to have the largest impact on children's behaviour at this developmental stage. The Every Child Matters Green Paper suggests such programmes can involve parental training in behavioural techniques over at least six weekly sessions.

<http://www.rcu.gov.uk/articles/news/everychildmatters.pdf>

7.3.3: Anti-Bullying Programmes

Life stage:

- Child (3–11 years)
- Adolescent (11–19 years)

Risk factors:

- Bullying others

Successful prevention strategies:

Numerous strategies have been devised to combat bullying in schools. The most successful programmes use 'whole school' approaches to change the school ethos (Sutton et al., 2004). For example, the Norwegian Bullying Prevention Programme uses a multi-level approach in which all students participate at the lower levels of the programme by means of in-class discussions mediated by trained school staff. Perpetrators and victims of bullying receive additional, individual attention. Extensive evaluations show a reduction in

bullying of 50% (Olweus et al., 1999). This programme has also proved successful in the UK, with reductions ranging from 5% to 17%. However, when combined with additional playground measures this was improved to 40% (Smith and Sharp, 1994).

Policy:

There is a legal requirement on head teachers to have a policy in place to prevent bullying amongst pupils in their schools. The Department of Education and Skills has produced an anti-bullying pack, *Bullying: Don't suffer in silence*, to assist schools in developing their anti-bullying policies. This outlines measures for implementing a whole school approach to bullying including awareness raising, measures for addressing incidents of bullying and bullying prevention strategies. An Anti-Bullying Charter for Action for schools was launched in November 2003. A UK evaluation of the 'Don't Suffer in Silence' whole school approach found the programme proved popular with both teachers and students and showed promise in reducing bullying and fear of victimisation (Smith and Samara, 2003). However, no longitudinal study has yet been undertaken to assess the long-term effects of this strategy.

<http://www.dfes.gov.uk/bullying/>

The Public Health White Paper *Choosing Health* (Department of Health, 2004) points to the national Key Stage 3 (age 11-14) Behaviour and Attendance programme as a mechanism for schools to tackle bullying. The paper also identifies the Department of Health's ongoing partnership work with the Anti-Bullying Alliance (launched June 2004), Parentline Plus, Childline in Partnership with Schools and the Diana Award.

www.dh.gov.uk

7.3.4: Mentoring

Life stage:

- Child (3-11 years)
- Adolescent (11-19 years)

Risk factors:

- Having delinquent friends
- Bullying others

Successful prevention strategies:

Although peer mentoring and peer counselling have proved ineffective in reducing violent behaviour in young people, having an adult role model outside the family has been found to act as a strong protective factor against both perpetration and victimisation (Krug et al., 2002). Such mentors can be teachers, counsellors, police officers or other respected members of the community (Thornton et al., 2002). Adult mentoring programmes have been found to be successful in improving school attendance and personal relationships, while reducing anti-social behaviour and drug use (Grossman and Garry, 1997).

The Big Brother/Big Sister programme has undergone extensive evaluation in the US. Following weekly four hour meetings with mentors, adolescents have been found to be 46% less likely to use drugs, 27% less likely to use alcohol, and 52% less likely to play truant from school (Tierney and Grossman, 1998), all of which are risk factors for involvement in violence. The Big Brother/Big Sister programme has been delivered in some areas of the UK for the past decade, and has proved promising in reducing anti-social and delinquent behaviour when targeted at troubled children with lone parents (Sutton, 2004).

Policy:

Through the *Excellence in Cities Initiative* 800 learning mentors are being placed in inner city secondary schools in six conurbations in England (inner London, Birmingham, Manchester/Salford, Liverpool/Knowsley, Leeds/Bradford and Sheffield/Rotherham). Learning mentors work on a one-to-one basis with pupils to help identify and overcome barriers to learning both inside and outside of school, including behavioural problems, problems at home and poor study skills. They

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intend to provide an additional and supportive service to school staff and external agencies such as Social and Youth Services, Probation, the Educational Welfare Service and Careers Service and act as a single point of contact with such services. The intention is for all pupils entering or returning to secondary school to be assessed to identify those that require additional help and the ongoing support of a learning mentor. Targeting pupils in deprived areas, the objectives of learning mentors are to help improve academic achievement and reduce truancy and exclusion, which can increase a child's risk for involvement in violence.

<http://www.standards.dfes.gov.uk/sie/eic/eiclearningmentors/>

The Department for Education and Skills' *Behaviour Improvement Programme* (see Section

7.2.4) also includes measures to provide learning mentors for pupils identified as being at risk of exclusion, truancy or criminal behaviour.

Connexions, the government's support service for adolescents, joins up the work of six government departments with private and voluntary groups that cater to the needs of young people aged 13 to 19 years. The *connexions* service provides personal advisors to young people. For adolescents with aggression and delinquency problems, such advisors can offer in-depth, substantial, one to one support. This can take the form of advice on personal issues, identification of barriers to learning, and referrals to specialist services for substance misuse problems and other violence related risk factors.

<http://www.connexions.gov.uk/>



Table 7.3: Prevention measures effective at combating risk factors that operate on the Relationship level.

Response		Risk Factors					
Life Stage	Prevention measure	Some related policy areas	Type of violence				
			Youth violence	Intimate partner violence	Child maltreatment	Elder abuse	Sexual violence
Infant	Provide home visiting services (Section 7.3.1)	- Every Child Matters - The National Teenage Pregnancy Strategy	■ ●	■ ○	■ ●	■ ⊗	■ ○
	Provide parenting programmes (Section 7.3.2)	- Every Child Matters	■ ●	■ ○	■ ●	■ ⊗	■ ○
Child	Provide anti-bullying programmes (Section 7.3.3)	- Bullying: Don't Suffer in Silence - Choosing Health White Paper	■ ●	■ ○	■ ⊗	■ ⊗	■ ●
	Provide mentoring services (Section 7.3.4)	- Excellence in Cities Initiative - National Behaviour and Attendance Strategy/ The Behaviour Improvement Programme	■ ●	■ ○	■ ⊗	■ ⊗	■ ●
	Provide parenting programmes (Section 7.3.2)	- Every Child Matters	■ ●	■ ○	■ ●	■ ⊗	■ ○
Adolescent	Provide anti-bullying programmes (Section 7.3.3)	- Bullying: Don't Suffer in Silence - Choosing Health White Paper	■ ●	■ ○	■ ⊗	■ ⊗	■ ●
	Provide mentoring services (Section 7.3.4)	- Excellence in Cities Initiative - National Behaviour and Attendance Strategy/ The Behaviour Improvement Programme - Connexions Services	■ ●	■ ○	■ ⊗	■ ⊗	■ ●

■ Robust evidence of an increased risk of becoming a perpetrator of violence
 □ Evidence suggests an increased risk of becoming a perpetrator of violence
 ⊗ No evidence of an increased risk of becoming a perpetrator of violence
 ● Robust evidence of an increased risk of becoming a victim of violence
 ○ Evidence suggests an increased risk of becoming a victim of violence
 ⊗ No evidence of an increased risk of becoming a victim of violence

7.4: Prevention strategies to reduce community risk factors (Table 7.4)

Influences that operate at the community level consist of risk factors that arise from relationships in a broad, social context, such as schools, neighbourhoods and workplaces (for summary see Table 7.4)

7.4.1: Change school culture

Life stage:

- Child (3-11 years)

Risk factors:

- Low expectations at school
- Poorly defined school rules

Successful prevention strategies:

Schools can act as protective factors against violence by providing a safe and supportive learning environment to children. However, if teachers and pupils perceive the school as a dangerous place the influence will be negative rather than positive. Initially, steps can be taken to improve school security by taking measures such as community policing, establishing 'safe routes' for children travelling to and from the school, and installing metal detectors (Krug et al., 2002). Citizenship classes can include prevention and education campaigns to increase awareness and understanding about violence and its consequences. Such lessons, however, must form part of an integrated 'whole school' approach, which also includes improving the inter-personal skills of pupils, the advanced training of teachers in classroom management, and the expansion of parenting programmes for use in the classroom. Schools that have achieved a change in ethos through such approaches have shown a significant reduction in levels of violence and aggression (Berthet and Jacobs, 2002).

Policy:

Citizenship Education is now part of the national curriculum across all Key Stages. It intends to assist pupils' social and moral development, encourage them to play an active and useful role in society and promote respect for different ethnic groups and religions. This part of the curriculum can be used to raise awareness about all types of violence and their consequences, and to reduce conflict by promoting tolerance and encouraging discussion about issues such as hate crime and anti-social behaviour.

The Department for Education and Skills sees a whole school approach as vital for the successful implementation of citizenship education; classes should be taught in a coordinated manner, with specially trained teachers and involvement of parents playing a key role in relating citizenship to everyday experience both at home and at school.

<http://www.dfes.gov.uk/citizenship/>

The Department for Education and Skills' *Five Year Strategy for Children and Learners* (Department for Education and Skills, 2004e) outlines measures being taken by the Government in order to improve school environments and performance. These include the *Building Schools for the Future* programme, which aims to ensure all secondary schools are rebuilt or refurbished over the next 10 to 15 years to provide each school with the buildings, facilities and information technology to help pupils fulfil their academic potential and prepare them for the modern workplace. If successful, this will help reduce violent offending by engaging children in school life, increasing self-esteem, and improving future job prospects. The programme also aims to achieve these improvements by expanding popular schools, closing failing schools, and

establishing new schools and sixth form colleges. In this way, schools which help discourage violence by counteracting negative influences are rewarded.

<http://www.bsf.gov.uk/>

Foundation Partnerships were established to enable schools to group together for the purpose of raising standards and improving effectiveness in fulfilling wider responsibilities such as provision for special educational needs or hard-to-place pupils. The system should encourage inclusion and raise expectations of children with special needs. Such an inclusive approach can help counteract risk factors for violence such children may be experiencing at both school and home.

<http://www.standards.dfes.gov.uk/sie/si/foundationpartnerships/>

7.4.2: Alcohol and drug reduction strategies

Life stage:

- Adolescent (11-19 years)
- Adult (20 years and over)

Risk factors:

- Misuse of alcohol
- Illegal substance use

Successful prevention strategies:

The links between alcohol and violence have been well documented (Bellis et al., 2004). Consequently there have been many programmes devised to limit the availability of alcohol and reduce alcohol-related harms (Krug et al., 2002). Evaluated alcohol reduction strategies implemented in a variety of settings have been reviewed elsewhere (see Hughes et al., 2004). Programmes that have shown success at the community level include: strict enforcement of age restrictions in on- and off-licensed premises (Jeffs and Saunders, 1983), preventing the sale of alcohol to intoxicated individuals (Waller et al., 2002) and street drinking bans (Webb and Marriot Lloyd, 2004).

There is less evidence available for the effectiveness of interventions to reduce drug use in preventing violence, yet reducing the availability and use of drugs in such settings would help prevent people becoming vulnerable to violence, help reduce aggression, and reduce violence associated with drug dealing. In addition to alcohol and drug use, the environment in and around licensed premises can itself contribute to levels of violence in numerous ways. For example, overcrowded, noisy and poorly designed pubs and clubs can increase levels of frustration and potential for confrontation between customers; discarded glasses and bottles can be used as weapons, increasing the severity of injuries in fights, and lack of late night transport can cause large crowds of intoxicated individuals to congregate on the streets, again increasing potential for violent incidents (Bellis et al., 2004).

Integrated community approaches towards violence that involve a range of interventions addressing both the availability of alcohol and drugs and modification of the nightlife environment are considered most successful at reducing alcohol-related violence. In Australia, for example, the North Queensland Action Plans aimed to reduce anti-social behaviour in nightlife areas in three major towns. The plans involved a range of measures including working with local communities to set up task forces and community forums, working with licensees to develop codes of good practice in pubs and clubs, and strict enforcement of licensing laws. Over the course of the projects, levels of visible male drunkenness, arguments, verbal abuse and confrontations in pubs and clubs all decreased. Analysis of findings revealed that those measures that had the most impact on behaviour were: increased levels of comfort within licensed premises (e.g. greater provision of seating), improved bar staff practice, reduced tolerance of anti-social behaviour by venue management and increased provision of late night transport (Hemel et al., 2004).

In the UK, the Tasc project is a police-led multi-agency scheme that aims to reduce alcohol-related violence and anti-social

behaviour in Cardiff, particularly in and around pubs and clubs. The programme includes the identification of hotspots of violence (through police and Accident and Emergency department data), targeted police operations, bar staff training, a licensees forum, support for victims of violence attending Accident and Emergency services and campaigns to raise awareness of alcohol-related violence. Evaluation of the scheme found alcohol-related violence to have decreased by 8%, with an associated increase in recorded incidents of alcohol-related disorder of 54% (Maguire and Nettleton, 2003). However, much of this increase is likely to be due to greater reporting and recording of offences rather than increasing incidents.

For a fuller review of interventions to address both drug and alcohol related violence in nightlife settings see Bellis et al., 2004.

Policy:

The *Alcohol Harm Reduction Strategy for England* was published by the Strategy Unit in March 2004. The strategy aims to address the range of harms caused by alcohol misuse in England, with alcohol-related crime and disorder being a key issue. Measures covered in the strategy include encouraging wider use of Fixed Penalty Notices by police to tackle low-level alcohol-related crime and also wider use of the police accreditation scheme introduced under the *Police Reform Act 2002* to provide accredited individuals (e.g. community support officers, door supervisors) with limited police powers. The strategy also intends to work with the licensed trade to develop a voluntary code of good practice for licensed premises including such commitments as selling alcohol responsibly and seeking age identification from customers.

www.strategy.gov.uk

Choosing Health (Department of Health, 2004) intends to build on the commitments within the *Alcohol Harm Reduction Strategy for England* by providing guidance to ensure all health professionals are able to identify alcohol

problems early, to pilot approaches to targeted screening and brief intervention in both primary care and hospital settings, to develop initiatives in the criminal justice settings to reduce repeat offending and to develop a programme of improvement for alcohol treatment services.

www.dh.gov.uk

The consultation paper *Drinking Responsibly: The Government's Proposals* (Department for Culture, Media and Sport, 2005) sets out the Government's plan to address alcohol misuse. The proposals include the designation of alcohol disorder zones in areas experiencing particular problems with anti-social drinking – whereby licensees operating within these zones would be required to implement measures to reduce alcohol-related disorder and if failing to do so may be required to pay towards the costs of dealing with alcohol-related problems, such as policing. Other proposals include steps towards changing the drinking culture, reducing irresponsible drinks promotions and preventing underage sales of alcohol.

<http://www.crimereduction.gov.uk/alcohol03.htm>

Over the summer and Christmas period in 2004, police in many areas implemented the Home Office Alcohol Enforcement Campaigns to raise awareness of licensing regulations and identify venues that were selling alcohol to underage drinkers. During the summer campaign, almost half of on-licensed premises



and a third of off-licensed premises targeted were found to sell alcohol to underage customers. Building on these campaigns, the Home Office *Tackling Violent Crime Programme* is focusing resources on areas with particularly high levels of crime and intends to support local practitioners in implementing effective strategies to address alcohol-related violence and domestic violence.

The Home Office Crime Reduction website provides a wide range of resources to Crime and Disorder Reduction Partnerships (CDRPs) and other agencies in developing strategies to deal with alcohol-related crime and violence at the local level.

<http://www.homeoffice.gov.uk/crime/alcoholrelatedcrime/publications/index/html>

Legislation to help tackle alcohol-related crime includes *The Licensing Act 2003*, which will be fully implemented in 2005. This introduces a new licensing regime that includes a statutory objective on the prevention of crime and disorder. *Licensing Act Guidance* (Department of Culture, Media and Sport, 2004) sets out the details of the new licensing arrangements. Section 155 of the Act has been introduced in advance and allows police, in certain circumstances, to confiscate alcohol from people drinking in public places. This will help prevent alcohol-related violence committed by and against young people. *The Criminal Justice and Police Act 2001* makes it easier for local authorities to restrict public drinking where there is evidence that nuisance is alcohol-related.

Whilst much work to tackle substance use and violence focuses on alcohol, drug use is a risk factor for becoming both a victim and perpetrator of violence. The *Updated Drug Strategy* (Drugs Strategy Directorate, 2002) builds upon the Government's *Drug Strategy Tackling drugs to build a better Britain*, launched in 1998. The strategy aims to reduce drug-related crime and the harm drug use causes to society through, for example, preventing drug use among young people, reducing the

availability of drugs and providing treatment services for drug users. A national Crack Plan (Drug Strategy Directorate, 2002a) has also been developed to reduce the particular harms caused by crack cocaine use. This includes reducing the supply of crack, providing diversionary programmes to help prevent young people using crack, and providing specialist treatment services for users.

<http://www.drugs.gov.uk/NationalStrategy>

7.4.3: Disrupt illegal gun markets

Life stage:

- Adolescent (11-19 years)
- Adult (20 years and over)

Risk factors:

- Access to firearms

Successful prevention strategies:

Metropolitan Police Service (MPS) has produced promising reductions in gun crime following the implementation of an innovative gun crime strategy. Through involvement in community partnerships in high risk boroughs, the MPS strategy includes components such as a gun amnesty, the disruption of gun smuggling and transportation, disturbance of meeting



places for gun criminals, and the interruption of communication networks (including websites) (Her Majesty's Inspectorate of Constabulary, 2004). Consequently, the MPS reported a 7.8% reduction in gun crime and a 24% reduction in armed robbery (Metropolitan Police, 2004).

Policy:

There are various elements to the Home Office strategy for tackling gun crime, including an amnesty in April 2003 which resulted in 44,000 guns and more than a million rounds of ammunition being handed in. Pre-existing Firearms legislation was strengthened by the *Criminal Justice Act 2003*, which introduced a mandatory minimum sentence of five years for possession of an illegal firearm. Furthermore, the firearms provisions of the *Anti-social Behaviour Act 2003* aims to reduce the increase in crimes involving imitation firearms and air weapons, by prohibiting them in public places and raising the legal age of possession to 17 years. As of January 2004, there has been a ban on air weapons that use a self-contained gas cartridge system, since they can be converted to fire live ammunition.

Tackling the Illegal Possession and Criminal Use of Firearms outlines the Association of Chief Police Officers/HM Inspectorate of Constabulary/Home Office joint action plan to tackle illegal possession of firearms (HM Inspectorate of Constabulary, 2004).

<http://www.homeoffice.gov.uk/crime/guncrime/strategy.html>

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

Life stage:

- Infant (prenatal –3 years)
- Child (3-11 years)
- Adolescent (11-19 years)
- Adult (20 years and over)



Risk factors:

- Unrecognised/undisclosed victim of violence

Successful prevention strategies:

Since healthcare professionals frequently come into contact with victims of all types of violence, they are ideally situated to identify individuals who would benefit from local services to help prevent repeat victimisation (Henwood et al., 2000). In the UK, most ongoing work in this area involves victims of child maltreatment and female victims of intimate partner violence (Taket, 2004). However, protocols established for dealing with these situations can be applied to victims of other types of violence, and would be particularly helpful for identifying victims of elder abuse (Lachs and Pillemer, 1995).

Screening for interpersonal violence can be routine (whereby all attendees to clinical settings are asked if they have experienced abuse) or targeted (whereby healthcare

professionals question individuals they suspect have been abused). Routine screening has the advantage of not stigmatising people and also of educating the public at large. Furthermore, healthcare professionals sometimes make incorrect judgements and fail to recognise abuse when it is occurring. (Adam et al., 2000). In order to be effective, therefore, targeted screening would require extensive training to help practitioners recognise less obvious signs of abuse. This is particularly true in the case of elder abuse, since fragile skin and blood vessels can be easily damaged, making systematic abuse difficult to distinguish from accidental trauma (Garner and Evans, 2000). Due to these shortcomings the Department of Health recommends routine screening wherever possible, especially for all pregnant women (Henwood, 2000).

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 (Henwood, 2000). Furthermore, they must be familiar with locally available services to which they can refer individuals who have disclosed abuse (Taket, 2004). To ensure that information is shared effectively and safely with relevant agencies, staff must also be trained in protocols for information sharing (Douglas et al., 2003).

Policy:

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 have developed a *Resource Manual for Health Care Professionals* (Henwood, 2000) to provide healthcare workers with a better knowledge and understanding of intimate partner violence and how it may be detected amongst their

patients. The document also discusses the importance of partnership working in addressing intimate partner violence and the need for the training of healthcare professionals in this area.

Choosing Health (Department of Health, 2004) also recognises the additional risk of violence faced by pregnant women. It states that all pregnant women should be routinely questioned by doctors and midwives during appointments in early pregnancy, such as for foetal scans, about whether they have experienced domestic violence at the hands of their partner. Those who require help will be referred to appropriate services, or to the policy if it emerges that they need protection. Health service professionals play a crucial role in providing access to support mechanisms for women who are being abused.

www.dh.gov.uk

The Home Office guidance document, *Developing Domestic Violence Strategies - A Guide for Partnerships* (Home Office Violent Crime Unit, 2004) offers information and guidance for agencies and stakeholders in developing strategies to tackle, monitor and evaluate intimate partner violence. The guidance suggests possible partners for involvement in the development and delivery of strategies that cover violence prevention, early intervention, protection and justice, and victim support. The guidance also informs partnerships of strategies for raising awareness amongst their employees.

[http://www.crimereduction.gov.uk/
domesticviolence46.htm](http://www.crimereduction.gov.uk/domesticviolence46.htm)

Tackling Domestic Violence: the role of health professionals, also by the Home Office (Taket, 2004), aims to raise awareness of the scale of the health problem presented by domestic violence and provide health professionals with practical measures through which they can make a contribution to tackling this issue. These include asking women about their experience of abuse, enabling women to access specialised services and supporting them in changing their circumstances. Suggested

protocols for information sharing are also provided.

<http://www.homeoffice.gov.uk/rds/pdfs04/dpr32.pdf>

The *England Violence and Abuse Programme on Health and Mental Health* (run jointly by the Department of Health and the National Institute for Mental Health) pertains to violence in a broader context. It examines the role of health professionals and services in identifying and responding to the needs of victims and survivors of violence, including children and adolescents.

<http://www.dh.gov.uk/>

7.4.5: Coordinated community interventions for violence prevention

Life stage:

- Adolescent (11-19 years)
- Adult (20 years and over)

Risk factors:

- Depressed neighbourhood
- Poor social cohesion

Successful prevention strategies:

Community involvement in violence prevention has proved effective in many countries (Butchart et al., 2004). For example, an Australian study of a public housing estate in Sydney linked the incidence and fear of crime and violence with inequality, social exclusion and lack of opportunity for children and young people to develop their potential. A community based project, Residents in Safer Environments (RISE), was implemented that produced positive changes in the perception of crime, levels of fear and quality of life. However, examinations of definite links between the project and actual levels of crime were inconclusive (Lane and Henry, 2001).

In the UK, the Civil Renewal Unit of the Home Office undertook a review of research evidence from a number of strategies devoted to promoting community involvement in crime prevention. Evidence suggested that local

contexts are vital for involving local people and community groups in crime prevention (Larsen, 2004). Community Facilitation Programmes, set up in 34 areas throughout England and Wales to counteract violence centring on racial hatred, created and promoted new resources, new approaches and new networks (Neighbourhood Renewal Unit, 2004). They proved effective in the areas of conflict prevention, the prevention of conflict escalation and learning from conflict.

Policy:

The escalation of racial tensions to violence in Burnley, Oldham and Bradford in 2001 prompted a Government focus on community cohesion to promote respect for diverse cultures and better community relations. *Improving Opportunity, Strengthening Society*, the Government's strategy to increase race equality and community cohesion, was published by the Home Office in January 2005 (Home Office, 2005). The strategy proposes a range of measures that aim to end discriminatory practices, ensure the enforcement of appropriate policing methods and promote respect and communication between different ethnic and religious groups. The Home Office provides a range of information and guidance on community cohesion, available at:

<http://www.homeoffice.gov.uk/comrace/cohesion/index.html>

7.4.6: Change culture in institutions for older people

Life stage:

- Adult (20 years and over)

Risk factors:

- Anti-social norms in institutions for older people

Successful prevention strategies:

No robust evaluations have been undertaken regarding preventing violence against older people in institutions, but several strategies

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involving training staff to deal with complaints show promise (Krug et al., 2002). Other promising strategies include: the registration and training of care workers as recommended by the National Care Standards Commission and the General Social Care Council, rigorous inspections of institutions to ensure they meet minimum requirements, follow up action after complaints/concerns are expressed, policies and practices to deal with aggression by service users, training to ensure that complaint procedures are in place and known (House of Commons Healthcare Committee, 2004), and setting a tone that respects dignity, privacy and choice, while incorporating service users into decision making processes (Garner and Evans, 2000). However, multi-disciplinary research is needed to establish the extent of elder abuse in institutional settings if improvements are to be quantified.

Policy:

Launched in 2001, *The National Service Framework (NSF) for Older People* sets national

standards for improved health and social care services for the elderly, including those in institutional settings such as residential homes and hospitals. 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. If this standard is met, abusive practices such as physical and medical restraint of older people in institutional settings will not be tolerated. Standard Three includes the support of timely discharge from hospital and emphasises independent living. By helping older people live independent lifestyles and supporting them in their own homes, pressure on residential care homes and hospitals will be relieved. This will facilitate more timely and effective inspections of such institutions and hence help reduce elder abuse and ensure minimum standards of care.

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



Table 7.4: Prevention measures effective at combating risk factors that operate on the community level.

Response		Risk Factors					
Life Stage	Prevention measure	Some related policy areas	Type of violence				
			Youth violence	Intimate partner violence	Child maltreatment	Elder abuse	Sexual violence
Infant	Train healthcare professionals in screening, identification and referral of victims of violence (Section 7.4.4)	- Choosing Health White Paper - The England Violence and Abuse Programme on Health and Mental Health - Home Office Domestic Violence guidance	■ ●	■ ●	■ ●	■ ●	■ ●
	Change school culture (Section 7.4.1)	- Citizenship Education - Building Schools for the Future Programme - Foundation Partnerships for schools	■ ●	■ ○	■ ○	■ ●	■ ●
Child	Train healthcare professionals in screening, identification and referral of victims of violence (Section 7.4.4)	- Choosing Health White Paper - The England Violence and Abuse Programme on Health and Mental Health - Home Office Domestic Violence guidance	■ ●	■ ●	■ ●	■ ●	■ ●
	Provide coordinated community interventions for violence prevention (Section 7.4.5)	- Improving Opportunity, Strengthening Society	■ ●	■ ●	■ ●	■ ●	■ ●
Adolescent	Disrupt illegal gun markets (Section 7.4.3)	- Tackling the Illegal Possession and Criminal Use of Firearms	■ ●	☒ ☒	☒ ☒	☒ ☒	☒ ☒
	Train healthcare professionals in screening, identification and referral of victims of violence (Section 7.4.4)	- Choosing Health White Paper - The England Violence and Abuse Programme on Health and Mental Health - Home Office Domestic Violence guidance	■ ●	■ ●	■ ●	■ ●	■ ●
	Implement alcohol/illegal drug reduction strategies] (Section 7.4.2)	- Alcohol Harm Reduction Strategy for England - Home Office Tackling Violent Crime Programme - The Licensing Act 2003	■ ●	■ ●	■ ●	☐ ☒	■ ●

■ Robust evidence of an increased risk of becoming a perpetrator of violence
 ☐ Evidence suggests an increased risk of becoming a perpetrator of violence
 ☒ No evidence of an increased risk of becoming a perpetrator of violence

● Robust evidence of an increased risk of becoming a victim of violence
 ○ Evidence suggests an increased risk of becoming a victim of violence
 ☒ No evidence of an increased risk of becoming a victim of violence

Table 7.4: Prevention measures effective at combating risk factors that operate on the community level (continued)

Response		Risk Factors						
Life Stage	Prevention measure	Some related policy areas	Type of violence					
			Youth violence	Intimate partner violence	Child maltreatment	Elder abuse	Sexual violence	
Adult	Provide coordinated community interventions for violence prevention (Section 7.4.5)	- Improving Opportunity, Strengthening Society	■ ●	■ ●	■ ⊗	■ ⊗	■ ⊗	
	Disrupt illegal gun markets (Section 7.4.3)	- Tackling the Illegal Possession and Criminal Use of Firearms	■ ●	⊗ ⊗	⊗ ⊗	⊗ ⊗	⊗ ●	
	Implement alcohol/illegal drug reduction strategies (Section 7.4.2)	- Alcohol Harm Reduction Strategy for England - Home Office Tackling Violent Crime Programme - The Licensing Act 2003	■ ●	■ ⊗	■ ●	■ ⊗	■ ●	
	Train healthcare professionals in screening, identification and referral of victims of violence (Section 7.4.4)	- Choosing Health White Paper - The England Violence and Abuse Programme on Health and Mental Health - Home Office Domestic Violence guidance	■ ⊗	⊗ ●	⊗ ⊗	⊗ ●	⊗ ⊗	
	Change culture in institutions for older people (Section 7.4.6)	- The National Service Framework for Older People		⊗ ⊗	⊗ ⊗	⊗ ⊗	⊗ ●	⊗ ⊗
				⊗ ⊗	⊗ ⊗	⊗ ⊗	⊗ ●	⊗ ⊗
			- Living in a high crime area - Living in a deprived neighbourhood	- Access to firearms	- Easy access to alcohol - Illegal drug use	- Unrecognised/undisclosed victim of violence	- Anti-social culture in institutions for older people	

■ Robust evidence of an increased risk of becoming a perpetrator of violence
 □ Evidence suggests an increased risk of becoming a perpetrator of violence
 ⊗ No evidence of an increased risk of becoming a perpetrator of violence
 ● Robust evidence of an increased risk of becoming a victim of violence
 ○ Evidence suggests an increased risk of becoming a victim of violence
 ⊗ No evidence of an increased risk of becoming a victim of violence

7.5: Prevention strategies to reduce societal risk factors (Table 7.5)

The societal level consists of the broader influences that operate in society as a whole. This includes cultural norms, the influence of the media and social/economic policies.

7.5.1: De-concentrate poverty, reduce inequality

Life stage:

- Infant (prenatal-3 years)
- Child (3-11 years)
- Adolescent (11-19 years)
- Adult (20 years and over)

Risk factors:

- Social deprivation, inequalities

Successful prevention strategies:

The links between social inequality, poverty and all forms of crime have been well documented (Krug et al., 2002). Significant and lasting reductions in homicide can be best achieved by reducing poverty and social inequality (Brookman and Maguire, 2003). De-concentrating poverty and reducing inequality by the provision of safety nets (e.g. adequate unemployment benefits), education, health facilities and improved living conditions are means by which the benefits of economic growth and prosperity can be distributed (Butchart et al., 2004).

Policy:

Under the *Regional Development Agencies Act 1998*, England's Regional Development Agencies have a statutory responsibility to reduce social deprivation. Through strategies such as promoting business efficiency and training local people in skills relevant to their region, the aim of the development agencies is to achieve sustainable development to further economic development and regeneration. If

successful, this will help reduce violent crime by helping alleviate risk factors associated with poverty.

High unemployment contributes to social inequality. The Department for Work and Pensions' Five Year Strategy, *Opportunity and Security Throughout Life*, aims at an employment rate of over 80 per cent (Department for Work and Pensions, 2005). The strategy focuses on:

- Supporting children and families by helping lone parents into work
- Helping people on incapacity benefits to fulfil their employment potential
- Assisting disabled people, older workers and ethnic minorities in finding work and fully realising their ambitions in the workplace.

http://www.dwp.gov.uk/publications/dwp/2005/5_yr_strat/report.pdf

Many of the initiatives in the public health White Paper *Choosing Health* aim to target their interventions first at communities and groups where opportunities to live healthy lifestyles are least well developed and most progress is needed. There is a strong focus on building on the partnerships that already exist in communities and across government to tackle inequalities.

www.dh.gov.uk

7.5.2: Strengthen the criminal justice system

Life stage:

- Infant (prenatal-3 years)
- Child (3-11 years)
- Adolescent (11-19 years)
- Adult (20 years and over)

Risk factors:

- Weak criminal justice system

Successful prevention strategies:

Studies have found universally lower homicide rates in countries with reliable and effective criminal justice systems. Furthermore, a strong criminal justice system can be regarded as an effective form of primary prevention, since it contributes to deterrence of all types of violence (Butchart, 2004).

Mandatory arrests for perpetrators of intimate partner violence have proved effective in reducing repeat assaults in some areas of the US (Krug et al., 2002). However, arrests will only result in prosecution if evidence is good and witnesses are reliable and competent; several US studies have found that nearly half of all cases involving violence escape prosecution due to lack of evidence and witnesses being reluctant to give evidence (for example, Cross et al., 1995). This figure may be higher for elder abuse due to the reluctance of older people to prosecute. Specific legislation for elder abuse is needed (House of Commons Health Committee, 2004).



Policy:

The Home Office White Paper *Justice for All* sets out a long term strategy to modernise and improve the criminal justice system. It focuses on reducing all crime, including violent offences. One important aspect of this strategy is to improve public confidence in the criminal justice system. It is hoped that this will be achieved by delivering faster and more effective justice, better support for victims and witnesses, and improved detection rates. Furthermore, the strategy aims to improve efficiency by providing a joined up system which will engage the public and deter potential violent offenders.

www.homeoffice.gov.uk/docs3/justiceforall_whitepaper.html

7.5.3: Reduce media violence

Life stage:

- Child (3-11 years)
- Adolescent (11-19 years)

Risk factors:

- High levels of media violence

Successful prevention strategies:

Television violence has a far greater detrimental effect on children under the age of seven than any other age group, yet the most damaging portrayals of violence can be found in genres and channels aimed at these younger viewers (Federman, 1997). In the US, efforts to reduce the presumed harmful effects of media violence on youths have taken various forms, including:

- Attempting to reduce the amount of media violence and children's access to it (for example, calls for media self-regulation and violence ratings);
- Encouraging and facilitating parental monitoring of children's access to media (for example, V-chip legislation and advisory labels on music and video games);

- Educating parents and children about the potential dangers of media violence (for example, media and empathy educational programs); and
- Targeting children's views about violence to reduce the chances that they will imitate the violence they see.

Unfortunately there has been insufficient research in this area upon which to base even experimental interventions (Elliot et al., 2001).

Policy:

Section 7(1)(a) of the *Broadcasting Act 1990* requires the Independent Television Commission (now Ofcom) to provide guidance regarding the showing of violence in television programmes, particularly when the audience is likely to consist of large numbers of children and young people. Taking the freedom of programme makers into consideration, the guidance advocates the promotion of good taste and avoidance of gratuitous violence, and provides advice on decisions relating to programme content and time of day, nature of the channel and the likely audience. For example, material unsuitable for children must not be transmitted at times when large numbers of children may be expected to be watching. Based on the premise that children find violence which resembles real life more upsetting than violence in a fantasy context, it



is recommended that scenes of serious domestic conflict be treated with special caution. Further information is available from:

www.ofcom.org.uk

The Interactive Software Federation of Europe (ISFE) runs the Pan European Games Information age rating system for computer and video games. This aims to protect children from exposure to inappropriate content in games, including depictions of violence.

<http://www.pegi.info/home.jsp>

7.5.4: Empower older people

Life stage:

- Adult (20 years and over)

Risk factors:

- Social exclusion of older people

Successful prevention strategies:

There have been no robust evaluations of strategies to specifically prevent elder abuse. The World Health Organization, however, advocates primary prevention to create a society where older people can live not only with the necessities of life but also with dignity (Krug et al., 2002). This can be achieved with the help of improving awareness of elder abuse through media campaigns.

The Royal College of Psychiatrists recommend empowering older people by encouraging them to serve on advisory committees for services for the elderly (Garner and Evans, 2000). Similarly, self-help programmes and assistance in networking with peers have been cited as factors that will help engage older people as active citizens (House of Commons Health Committee, 2004).

Policy:

Better Government for Older People (BGOP) is a UK-wide partnership in which older people play a key role as partners. Its role is to ensure

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older people are engaged as citizens at all levels of decision making, and are involved in shaping the development of strategies and services for an ageing population. Involving older people in this way promotes a change in attitudes and services in order to achieve a societal shift in attitudes towards elders and abuse perpetrated against them.

<http://www.bgop.org.uk/pages/index.html>

Launched in 2001, the *National Service Framework (NSF) for Older People* sets national standards for improved and more integrated health and social care services for older people in domestic and institutional settings. 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 and is relevant to such issues as physical and medical restraint in institutional settings. The aim of Standard Eight: The Promotion of Health and Active Life in Older Age, is to extend the healthy life expectancy of older people. In order to achieve such an improvement in quality of life, fear of violent crime must be reduced to ensure that older people remain active and independent.

<http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/OlderPeoplesServices/OlderPeoplesNSFStandards/fs/en>



Table 7.5: Prevention measures effective at combating risk factors that operate on the societal level.

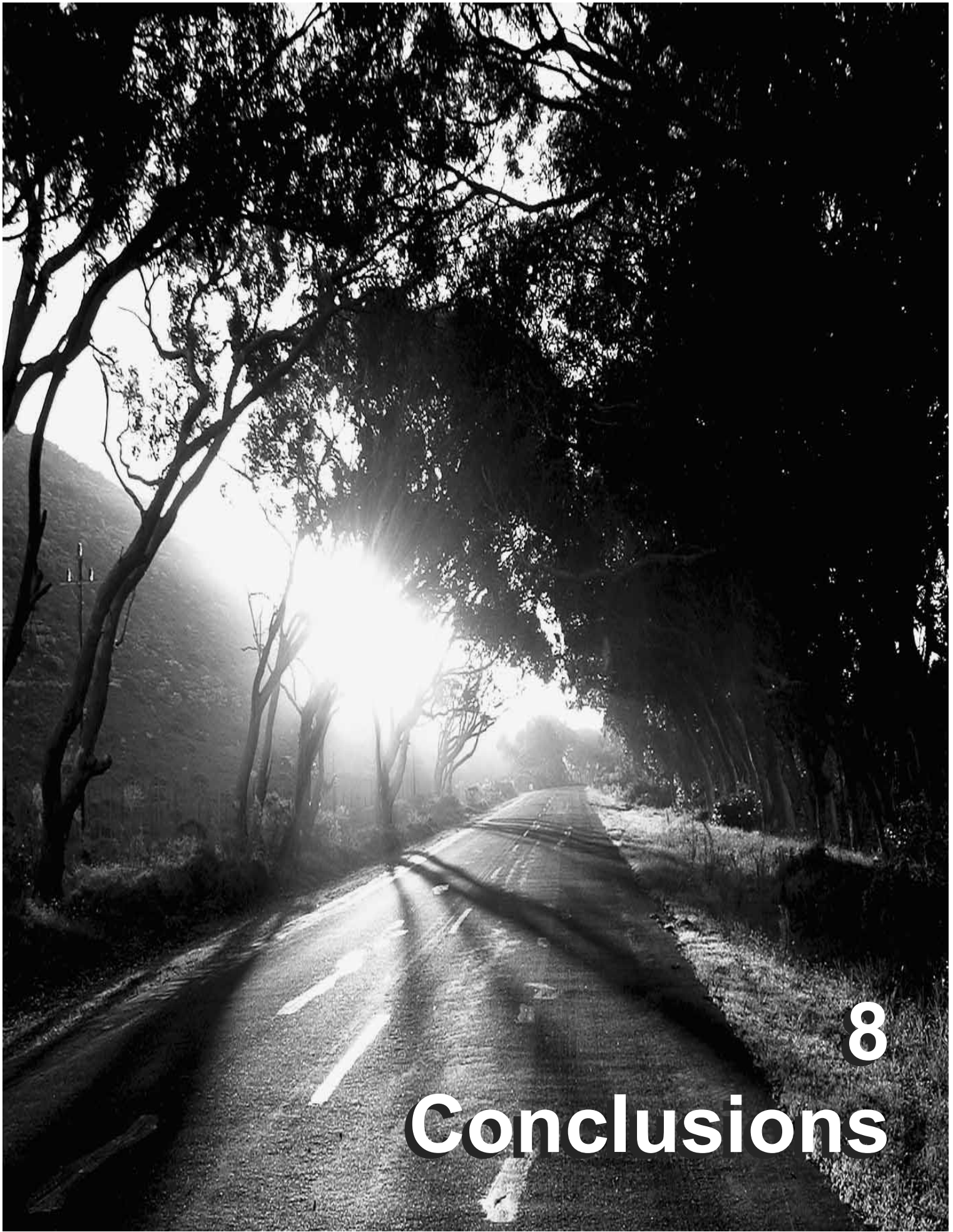
Response		Risk Factors						
Life Stage	Prevention measure	Some related policy areas	Type of violence					
			Risk factors for violence addressed by prevention measure	Youth violence	Intimate partner violence	Child maltreatment	Elder abuse	Sexual violence
Infant	De-concentrate poverty, reduce inequality (Section 7.5.1)	- Choosing Health White Paper - Regional Development Agencies - Department for Work and Pensions' Five Year Strategy, Opportunity and Security Throughout Life	- Social deprivation - Inequalities	■ ●	■ ●	■ ●	■ ●	■ ●
	Strengthen police and judicial system (Section 7.5.2)	- Justice for All White Paper	- Weak police and judicial system	■ ●	■ ●	■ ●	■ ●	■ ●
Child	De-concentrate poverty, reduce inequality (Section 7.5.1)	- Choosing Health White Paper - Regional Development Agencies - Department for Work and Pensions' Five Year Strategy, Opportunity and Security Throughout Life	- Social deprivation - Inequalities	■ ●	■ ●	■ ●	■ ●	■ ●
	Reduce media violence (Section 7.5.3)	- The Broadcasting Act 1990	- Media violence	■ ●	■ ●	■ ●	■ ●	■ ●
	Strengthen police and judicial system (Section 7.5.2)	- Justice for All White Paper	- Weak police and judicial system	■ ●	■ ●	■ ●	■ ●	■ ●

- Robust evidence of an increased risk of becoming a perpetrator of violence
- Evidence suggests an increased risk of becoming a perpetrator of violence
- ⊗ No evidence of an increased risk of becoming a perpetrator of violence
- Robust evidence of an increased risk of becoming a victim of violence
- Evidence suggests an increased risk of becoming a victim of violence
- ⊗ No evidence of an increased risk of becoming a victim of violence

Table 7.5: Prevention measures effective at combating risk factors that operate on the societal level (continued)

Life Stage	Response		Risk Factors					
	Prevention measure	Some related policy areas	Risk factors for violence addressed by prevention measure	Youth violence	Intimate partner violence	Child maltreatment	Elder abuse	Sexual violence
Adolescent	De-concentrate poverty, reduce inequality (Section 7.5.1)	- Choosing Health White Paper - Regional Development Agencies - Department for Work and Pensions' Five Year Strategy, Opportunity and Security Throughout Life	- Social deprivation - Inequalities	■ ●	■ ●	■ ●	■ ⊗	■ ●
	Reduce media violence (Section 7.4.3)	- The Broadcasting Act 1990	- Media violence	■ ●	■ ●	■ ●	■ ⊗	■ ●
	Strengthen police and judicial system (Section 7.5.2)	- Justice for All White Paper	- Weak police and judicial system	■ ●	■ ●	■ ●	■ ⊗	■ ●
Adult	De-concentrate poverty, reduce inequality (Section 7.5.1)	- Choosing Health White Paper - Regional Development Agencies - Department for Work and Pensions' Five Year Strategy, Opportunity and Security Throughout Life	- Social deprivation - Inequalities	■ ●	■ ●	■ ⊗	■ ⊗	■ ●
	Empower older people (Section 7.5.4)	- The National Service Framework for Older People	- Social exclusion of older people	☒ ⊗	☒ ⊗	☒ ⊗	☒ ●	☒ ●
	Strengthen police and judicial system (Section 7.5.2)	- Justice for All White Paper	- Weak police and judicial system	■ ●	■ ●	■ ●	■ ●	■ ●

- Robust evidence of an increased risk of becoming a perpetrator of violence
- Evidence suggests an increased risk of becoming a perpetrator of violence
- ☒ No evidence of an increased risk of becoming a perpetrator of violence
- Robust evidence of an increased risk of becoming a victim of violence
- Evidence suggests an increased risk of becoming a victim of violence
- ⊗ No evidence of an increased risk of becoming a victim of violence



8

Conclusions

8: CONCLUSIONS

8.1: Violence: A Public Health Preventative Approach

Britain has already made substantial efforts to reduce the occurrence of interpersonal violence and the effects that such incidents have on individuals and communities. However, most violence reduction initiatives are still directed through the criminal justice system and rely on judicial penalties being imposed on those who commit violent acts, with the threat of such penalties acting as the major deterrent. Other agencies, such as the health service, are frequently involved in dealing with violence but all too often this means treating the results of violent behaviour rather than preventing it. However, recent years have seen major efforts (in areas including obesity, sexual health and drug and alcohol use) to move *upstream* from treating the consequences of behaviours to tackling their causes.

For violence, such an approach requires understanding intelligence on the characteristics (e.g. age, sex, geography) of those who commit violence, the societal experiences that make them prone to becoming offenders (e.g. poverty and social inequality) and the trigger factors that can initiate violent acts (e.g. drunkenness). Equally, a public health based preventative approach to violence means understanding the demographics of victims, the conditions that increase their vulnerability (e.g. pregnancy, disaffection from school, and social exclusion) and the environments in which they are most likely to be affected (e.g. poor and overcrowded housing).

1. Key areas of interpersonal violence require better routine intelligence. Areas needing urgent attention include sexual violence, child maltreatment and elder abuse.

For interpersonal violence, this report brings together existing intelligence and importantly helps identify where information resources need further development. For example, just 12% of the worst cases of sexual violence are reported to police, with two in five being reported to no-one. Little is also known about the true extent and impact of child maltreatment and elder abuse with current understanding clouded by communication barriers, high levels of fear and even a lack of understanding or recognition of victimisation. Even in better researched areas such as nightlife violence, lack of good information from, for example, Accident and Emergency (A&E) departments, means the full costs of violence and characteristics of offenders and victims are obscured. However, sufficient information is available to begin developing a multi-agency, preventative approach to violence in Britain.

2. Accident and Emergency data should play a central role in understanding the epidemiology of violence. A national system is urgently required providing intelligence not just to the health service but to the judicial system and other key partners in violence prevention.

This report deals specifically with youth violence, intimate partner violence, child maltreatment, elder abuse and sexual violence. It does not provide detailed analyses of crosscutting settings such as workplaces where violence can include elements of bullying, sexual violence and youth violence (e.g. violence directed towards transport and health services). Moreover the report does not analyse in depth issues such as hate crimes motivated by race, religion or sexual orientation, which can materialise as youth

violence, child maltreatment and elder abuse if individuals are victimised on the grounds of their personal characteristics. However, **Violent Britain** does bring together intelligence on the most common forms of violence in Britain today and highlights the strong connections between types of violence and the costs they bring to bear on individuals and society as a whole.

Such costs are substantial. Across Britain millions of incidents of violence occur every year ruining lives, disrupting communities, demanding excessive resources from public and voluntary services and hampering efforts for social and economic development. In the last year alone, 6% of women and 4% of men have been victims of non-sexual intimate partner violence, an estimated 25,000 women have been raped, and over 15% of young males (aged 16-24) and 7% of young females have been victims of some form of violent crime. Among children, nearly half have suffered bullying during their school years whilst among 18-24 year olds more than 16% have suffered some form of parental abuse during childhood. Furthermore, an estimated half a million older people are suffering abuse at any one time (excluding those living in institutional settings). For intimate partner violence alone, the wider costs to society are estimated to be over £22 billion pounds per year, and consequently the benefits of investing in effective prevention can be equally substantial.

8.2: Common factors

In common with other countries, citizens and communities in Britain are affected by many different types of violence. However, analysis of their causes show many shared characteristics including family upbringing, economic inequalities and poverty, which contribute to an increased risk of both perpetration and victimisation. For example, inconsistent and inappropriate parental discipline (see Section 2.4.4) is associated with becoming a victim of child maltreatment, being involved in youth violence and, completing the

cycle, becoming a perpetrator of intimate partner violence and child maltreatment in later life. Hence, despite some gaps in intelligence, many areas of interpersonal violence appear to have shared roots especially in childhood and adolescence (see Section 2.4). Since intervening at these ages is likely to reduce violence (See Chapter 7), developments in children's policy should consider reducing violence as a key objective.

3. Services supporting parents and young children can play a major role in reducing violence later in children's lives. However, more work is urgently needed to educate individuals directing such services about the roles they can play.

For many types of interpersonal violence weaknesses in the judicial system can promote an increase in violent incidents, but equally poor environmental conditions and housing (see Section 2.4.6), lack of access to and support in education (see Section 2.4.5), and poor family support networks (see Section 2.4.4) are key factors in promoting violence. Furthermore, those inclined to violence (e.g. through problematic upbringing) may resort to violence after experiencing one of many triggers, such as alcohol and drug use, stress and financial hardship. However, across all areas of interpersonal violence our understanding of what experiences predispose individuals to being violent as well as what triggers individual incidents is still partial and in some areas particularly poor. Specifically, research into the causes of elder abuse is an essential step in preventing violence amongst this vulnerable group and therefore should be considered a priority.

4. Especially for elder abuse, what predisposes people to being violent and what triggers violent incidents is poorly understood. Research addressing these gaps is likely to be cost effective and of international as well as national significance.

8.3: Partnerships in Prevention

Shared risk factors for violence and the consequent health and economic impact across all public and private sector agencies require an integrated, multi-agency response. Preventing violence requires joint working between those agencies that provide support and treatment for victims, that deal with perpetrators of violence, and that can affect the environmental and social factors that contribute to the development of violent behaviour. Along with statutory health and judicial services, this means voluntary organisations, ethnic and community groups, employers, educational establishments, emergency services and the media all have vital roles (see Chapter 7).

5. Preventing violence requires investment in joint working between statutory health and judicial services, voluntary organisations, ethnic and community groups, employers, educational establishments, emergency services and the media.

Since violence prevention does not appear explicitly as a specific priority to direct many public sector organisations, we have identified policies through which violence prevention could be delivered. A shared understanding between organisations of those policies that affect violence should not only allow individual organisations to maximise their contribution to violence prevention but also allow identification of more areas for partnership working.

A key issue currently restricting partnership working on violence prevention is the lack of clarity regarding information exchange. Agencies are often unaware of what intelligence partners hold and how this can be accessed. Even when information of strategic and operational importance is identified, individuals are frequently unsure about whether it can be shared with other organisations, the level of detail that can be disclosed and the format in which data should be provided. At a local level, police, health services, educational authorities and other

6. In order to aid partnership working, clear national guidance is required on the exchange of information related to violence, especially between health and judicial systems. Such guidance should cover both anonymised and identifiable information.

service providers debate these issues repeatedly. Clear national guidance on the exchange of such information would reduce the need for such debates and allow closer partnership working. Inevitably, access to such information will expose that many public sector organisations record violence (or suspected violence) poorly and that in many cases there are no recognised national recording systems to enable better composite intelligence.

As well as information exchange on population data, clarity is also needed on information specifically about named individuals. When individuals identify a victim of violence or even a perpetrator, their responsibilities in recording that information appropriately and passing it on to the judicial services should be clear. Health agencies in particular have even greater opportunity than the police for accessing current and potential victims of violence; 70% of the population visit their GPs every year and most pregnant women contact obstetric and gynaecology services. Well trained and informed staff should be able to identify or at least make appropriate enquiries about problems relating to violence (see Section 7.4.4). Such developments require an investment in understanding and identifying violence in public sector organisations outside of the criminal justice services. Hence, nurses, doctors and other health and social care professionals should be trained to develop such expertise. Furthermore, other professionals who come into contact with victims of violence (e.g. those involved in education) should also be appropriately skilled in violence detection and prevention as well as

7. Training of health service personnel should include skills to investigate and identify violence. Other public service staff including those in education, should also be trained to identify and help prevent violence occurring.

understanding the range of support measures available to victims. Equally, with support from the public sector, private organisations should be able to access expert advice to improve their role in violence prevention. For example, such support could include the training of door staff to diffuse conflict in nightlife and the provision of advice on re-designing bars and nightclubs to create environments less conducive to violence. Such initiatives can complement other important, better established aspects of violence prevention such as police-led interventions to reduce alcohol-related violence at night. Even here however, a partnership approach often allows better targeting of resources and assessment of effectiveness. Thus, health data can supplement criminal justice data in identifying crime hotspots and independently monitoring the effectiveness of police interventions (e.g. through A&E data).

8. A national multi-disciplinary group is required in order to ensure violence prevention is properly integrated across individual departmental policies and to ensure organisations at a local level have the resource and opportunity to collaborate.

Collaborative approaches to preventing violence in young people must include other partners in information sharing and assessing the effectiveness of prevention strategies. Potential partners include educational personnel, parents, youth organisations, communities and even the media. Collaboration at local levels can accomplish much to reduce violence and its consequences to local communities. However, interdepartmental collaboration is also

required at regional and national levels. The freedom to prioritise violence prevention locally, to work collaboratively across organisations and to influence policy (e.g. media regulations) are often national issues. Such cooperative working requires a multi-disciplinary approach to addressing violence prevention at national levels and ensuring that the strategic priorities and policies of all organisations incorporate violence reduction.

9. Violence prevention initiatives must be evidence based and such evidence routinely reassessed to ensure that established approaches are still effective as communities change.

8.4: Effectiveness

Where priorities and policies attempt to prevent violence it is important that they are evidence based. Much work on developing the evidence base for violence prevention has been pioneered in the US. Although this forms a useful basis for the UK, even within the US research suggests that violence prevention is most effective when tailored for different population groups. Here we have provided a broad overview of what has shown to be effective in some communities and shown promise in others (Chapter 7). However, the establishment of effective violence prevention programmes in the UK will require work to identify new prevention mechanisms and to adapt, for our communities, those shown to be effective elsewhere. Furthermore, violence prevention initiatives must be seen as a priority for all agencies. Instead of existing in separate policies, violence prevention should be integrated into those policies already dictating public sector development. This report shows

10. Work to establish the cost-effectiveness of violence prevention is poorly developed in the UK and abroad. This should be seen as a research priority to be developed both nationally and internationally in collaboration with partners in other countries.

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some of the most promising areas of policy across many government departments where effective evidence based violence prevention could be accomplished (Chapter 7).

As with all initiatives, violence prevention must compete for public resources alongside other priorities. This report began by outlining the enormous costs already paid by the British

population due to the consequences of violence (Table B). While much work is required to establish the cost effectiveness of a public health preventative approach to violence, it is likely that every pound invested in such prevention will save many more currently spent on dealing with its consequences.

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