Preventing Violence
From Global Perspectives to National Action

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Edited By
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Preventing Violence
From Global Perspectives to National Action

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The starting point for this initiative (from the British point of view) was the publication, by the World Health Organization, of its World Report on Violence and Health in 2002. The report involved a large, detailed, systematic analysis of violence as a Public Health issue. It examined violence against children, violence against women, one-on-one male violence, violence against elders, sexual violence, self-harm and communal violence. It really forced people to realise the extent of the problem.

I was asked by the Chief Medical Officer in this country, Liam Donaldson, to take the lead for the Department of Health on an issue for which there is no clear ownership. Violence is very much an orphan topic, and the compartmentalisation of involvement between different Government departments and between different agencies is a serious issue. From the point of view of many Departments of Health, violence is not seen as a health issue. However, as will become clear today and tomorrow, it is very much a health issue. This holds true whether you are talking about health services and the impact on them (costs to the health service are massive), or whether you are talking about violence and the wider concerns of external causes of death and injury. The fact that violence is one of the leading causes of death and injury in the US for males in their mid teens to age 40, is somehow not on the radar of Departments of Health. Instead, they remain preoccupied with the contemporary conditions of such things as heart disease and cancer. In actuality, when you look at the difference in life expectancy between different social groups (in this country, a difference of six or seven years), and you look at accidents as a contribution to that difference, you will find that childhood accidental deaths contribute seven months of that six or seven years. The Health Service can do precious little about that. It requires a multi-agency approach involving town planning, engineering, housing investment, schools, and recreational activity in the summer holiday. All these agencies, and more, can have an influence on child accidents. The Department of Health, therefore, has a target for reducing the difference in life expectancy between different social groups that can only be met by other people being engaged in that agenda.

When we look at violence, particularly young male violence, then the experience from elsewhere tells us that this can be tackled. We are going to hear about an example of this from South America later this morning. Preventing violence requires a much more sophisticated and systematic approach than we have tried so far, and it requires the full engagement of the community. The Public Health perspective, which will permeate today and tomorrow, is helpful in framing this problem differently. The Public Health perspective looks at the whole population, looks at risk groups, and looks at people who are the perpetrators or victims of violence. It looks at the problem on a population level.

An important factor is that we must move upstream; many people who are here from a health background will be familiar with the parable of Public Health. Healthcare workers are like lifesavers standing by a fast flowing river. Every so often there is a drowning person and the healthcare workers jump in, pull them out and resuscitate them. Just when they have finished their task, another person comes along so they jump in and resuscitate them. They are kept so busy jumping in and resuscitating, that they have no time to walk up the riverbank to see who is pushing everyone in.

When we relate this parable to the issue of violence, what we find is lots of different agencies that are downstream, and no joined-up approach upstream to tackle who is
pushing everyone in. That is what we need to seek; the upstream, joined-up approach, to tackle who is pushing everyone in. This impacts on many agencies, but also on the quality of life everywhere.

Before I turn to our first speaker, I would like to introduce this report *Violent Britain*, which has been produced at Liverpool John Moores University, by Mark Bellis’ team in the Centre for Public Health. This is a situational analysis of violence and health in Britain. It has been stimulated by the World Health Organization’s World Report and is an attempt to provide the intelligence and the reference for informed policy, intervention, and action in this country on both a national and sub-national level.

My role in leading on this for the Chief Medical Officer is to move violence prevention up the agenda in this country. Shortly, we will hear from Alex Butchart that over thirty countries have joined up policies on violence and health between Home Offices, Health Departments, and others; we do not have that in this country yet.

What we need to do is to join everything up at a national level. In order to achieve this we must place this issue prominently on the national agenda. So it is a great pleasure that I introduce Alex Butchart from the World Health Organization in Geneva, who is one of the prime movers of the violence programme with whom we have been working closely.
Thank you for that fine welcome, and thanks to the City of Liverpool for providing a most hospitable environment for this important meeting. I would also like to congratulate the UK and especially John Ashton and his colleagues in the Health Protection Agency and at Liverpool John Moores University on this conference and on the UK national violence prevention initiative. This is shaping up to be an exemplary national programme from which I am sure other countries will have much to learn from.

I would like to do four things:

- Briefly describe the magnitude and impact of violence from a global perspective.
- Review the current status of violence prevention efforts.
- Provide a snapshot of the World Health Organization’s (WHO) global campaign for violence prevention.
- Explore what this may imply for your work in the UK.

To understand violence in a way that assists us in prevention, it is important to agree on a definition and a typology of violence (slide 1). At the first level, there is a differentiation between self-directed violence, violence between individuals, and collective violence inflicted by larger groups such as states. Although not shown here, each category is further divided to reflect more specific types of violence. Self-directed violence is divided into suicidal behaviour and instances of self-abuse.

**Definitions**

**Typology**

- Violence
  - Self-directed
  - Interpersonal
  - Collective
Interpersonal violence is divided into family and partner violence, and community violence (which includes violence between acquaintances and attacks by strangers).

Collective violence is divided into social, political and economic violence. For each subtype of violence, the typology also includes the nature of violent acts, which can be physical, sexual, psychological, or involving deprivation or neglect.

Magnitude and impact of violence

Globally just how big a problem is violence? I see on the news today that we are reminded of malaria, the so-called “forgotten killer”. In the year 2000 there were over 1.6 million deaths directly due to violence. This was around half the number of deaths due to AIDS, roughly equal to the number of deaths due to tuberculosis, around the same as deaths due to road traffic accidents, and 1.5 times the number of deaths due to malaria (slide 2).

In the year 2000, the largest number of violent deaths was due not to war, but to suicide (over 800,000 cases). This was followed by homicides at around half a million deaths. Next, were war deaths, of which around 310,000 were directly due to war.

Deaths are a very important indicator of violence levels. However, of even greater significance in terms of disease burden and costs are the consequences of non-fatal violence. For each of the 200,000 young people aged 10-24 murdered each year around the world, there are 20-40 non-fatal injuries that require hospital treatment. Collective violence destroys infrastructure and disrupts vital services and contributes to infectious diseases and famine. Sexual violence affects up to 40% of women whose first sexual encounters are forced. Studies from a number of countries report that around 25% of women have been victims of completed or attempted rape by an intimate partner. The number of failed suicide attempts resulting in injury, hospitalization and psychiatric trauma is 10-20 times the number of successful suicides. About 4-6% of the elderly report having been abused in their homes by caregivers. Nearly one in three women worldwide report having been victims of childhood sexual abuse. There are countless numbers of children abused in other ways leading to a wide range of risky behaviours and diseases later in life.

Violence puts a huge burden on national economies costing billions of US dollars each year. I know that the report, Violent Britain, mentions these costs based on a number of studies in the UK. When you combine the direct and the indirect costs they amount to a huge amount of money which, if violence were prevented, need not be spent on repairing the damages due to violence, but could instead be constructively invested in social policies and programmes to improve the quality of life for all.

Violence is often seen as an inevitable part of the human condition; something we have to live with because we cannot change. There has tended to be a strong sense of fatalism in the way we view violence. As John Ashton mentioned earlier, the World Report on Violence and Health (released in 2002) began to challenge the notion that acts of violence are issues of family privacy, individual choice, or inevitable parts of life. Rather the report shows that violence is predictable and preventable. Many factors that increase the
risk of violence are shared across the different types of violence, and are modifiable. We have heard about the public health approach; the idea that violence is preventable is a basic tenet of this approach.

In moving from problem to response, the public health approach involves four steps:

- To describe and monitor the extent of the problem.
- To identify and understand factors that place people at risk for violence.
- To develop and evaluate interventions to reduce these risks.
- To widely implement measures that are found to work.

The public health approach is population-based and emphasizes primary prevention; going upstream to address the underlying causes and risk factors that lead people to behave violently in the first place. The public health approach draws on expertise from many sectors and is based in science. It asserts that everything, from identifying the problem and its causes, to planning and evaluating interventions, should be based on sound research and informed by the best evidence.

To look into the possible future of science-based violence prevention we must have a sense of where the field of violence prevention is now. In the following sections I will look at the current status of prevention efforts to highlight what works and what is promising. I will also identify areas where more attention is needed.

**Current status of prevention efforts**

We can begin by looking at public health interventions. These are traditionally categorized into three levels of prevention:

- Primary prevention: preventing violence before it occurs.
- Secondary prevention: focused on more immediate responses such as medico-legal services for rape victims,
- Tertiary: focused on long term care such as rehabilitation.

Looking at where the emphasis of prevention programmes has been placed in terms of these three levels of prevention, there are differences by type of violence. In youth violence, the majority of efforts are focused on primary prevention, for example, early intervention in childhood. With intimate partner violence, sexual violence, child maltreatment and elder abuse, the majority of efforts are focused on secondary and tertiary prevention; identifying victims and providing the necessary care and services to prevent re-victimization. Of course it is not an either/or issue. As the World Report notes, our primary prevention efforts must go hand in hand with improving responses for victims of violence and ensuring that offenders are appropriately sanctioned and wherever possible rehabilitated.

Prevention programmes can also be analysed by their level of influence. The ecological model proposed in the World Report (slide 3), illustrates the complex nature of violence.

Each level represents a sphere of influence and a point for intervention.

- We can modify individual behaviour directly.
- We can modify individual behaviour by influencing the close relationships of people such as in the family environment.

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We can influence behaviour by modifying the settings that people move through within the community.

We can make societal changes to improve educational and economic opportunities, or by changing cultural norms.

In short, we can aim to modify individual behaviour directly and to change the environments that create the climate for violence to occur.

Looking at prevention programmes by these levels of influence, far more efforts have to date been made at changing individual and relationship factors than at changing community or societal factors. In other words, more emphasis has been placed on changing individual attitudes, beliefs and behaviours than on altering the environments that create the conditions for violence in the first place.

Outcomes are also important to consider in prevention efforts. We can think about outcomes in terms of a continuum, with knowledge and behaviour change at one end and reductions in injuries and deaths at the other end. We can also think of these outcomes as a causal chain, with change in one leading to change in the next, although this is not always the case. In terms of outcomes, more efforts have been geared towards changing knowledge and attitudes than behaviour. Behaviour change is an important outcome and should be a goal of prevention efforts. As one might expect, smaller scale research efforts have generally not included injuries and deaths because these are rarer outcomes. They are difficult to measure in small intervention trials, and it is therefore very important to promote more society-wide and community-level intervention trials with these as outcomes.

Finally, it is important to note that the violence prevention evidence base is derived almost exclusively from developed country experiences. That is not to say that there is no prevention work being undertaken in developing countries, but rather that many of the programmes have never been systematically evaluated.

So do violence prevention programmes work? To answer this question we must first define what is meant by effective. The most stringent criteria for effectiveness include:

- Programme evaluation using a strong research design, whether experimental or quasi-experimental.
- Evidence of a significant preventive effect.
- Evidence of sustained effect and replication of the programme with demonstrated effectiveness elsewhere.

Based upon these effectiveness criteria, the next four sub-sections discuss specific interventions using the following terms:

- ‘Promising’ for programmes that are evaluated with a strong design and some evidence of a preventive effect, but which require more testing.
- ‘Effective’ for programmes evaluated with a strong research design and evidence of a preventive effect.
- 'Unclear' for programmes that have been poorly evaluated or remain largely untested.

**Individual-level interventions**

Individual-level interventions are designed to change individuals’ attitudes, beliefs, and behaviours directly. Programmes to prevent unintended pregnancies and encourage women to seek adequate pre- and post-natal care are believed to be key in ensuring better birth outcomes and reducing the risk for child maltreatment and the early developmental risk factors for youth violence. Both strategies, however, require more testing in terms of these outcomes. Pre-school enrichment programmes are designed to strengthen bonds with school and introduce children to the social and behavioural skills...
needed for success in school. Long-term studies of the prototypes of such programmes have found positive benefits including less involvement in violent behaviours.

Social development and life skills training programmes build social emotional, cognitive, and behavioural competencies. Such programmes appear effective in reducing youth violence and have yielded positive (though short term) effects for reducing dating violence. Educational incentives for high-risk youth to complete schooling are also among the most effective and cost-effective approaches to preventing youth violence. A study by the Rand Corporation showed that, in California USA, graduation incentives for high-risk youth were 5-7 times more cost-effective in achieving a 10% reduction in violence and crime than increased incarceration.

The evidence for counselling and therapeutic approaches is mixed. Counselling is not effective in reducing youth violence. However cognitive behaviour therapy shortly after a sexual assault can hasten improvement and may be effective in reducing suicide attempts. In both cases, while promising, the evidence is not conclusive.

Some programmes train police and health providers to better identify and respond to violence. Training police has largely proved ineffective in changing police behaviour. Training health care providers has led to changes in knowledge and awareness in the short term, but these changes have not always translated into changes in behaviour and practice.

Programmes for men who abuse their partners have helped some men modify their behaviour but there is a high dropout rate. These programmes work best when they continue for longer, change men’s attitudes enough for them to be able to discuss their behaviour, and work in tandem with the criminal justice system to act swiftly and effectively when programme conditions are breached.

**Relationship-level interventions**

Relationship interventions attempt to change behaviour by influencing close interpersonal relationships and proximal environments such as the family. The violence prevention evidence for programmes that address family relationships and functioning is strong; particularly for family management, problem solving, and parenting practices. The findings from scientific evaluations of such interventions are consistent, and suggest that they are highly effective in preventing child abuse, and are promising in the prevention of youth violence. The most successful programmes address both the internal dynamics of the family and the family’s capacity for dealing with external demands. The earlier these programmes are delivered in the child’s life and the longer the duration, the greater the benefits. Concerning child abuse, evaluations of intensive family preservation services have been limited and their findings inconclusive.

Mentoring, by providing a supportive relationship with a positive adult role model, is thought to be a protective factor for youth violence. Some well-designed studies do suggest this is the case. However, negative effects have been reported where the relationship breaks down between the mentor and the mentored, and where there is too little training of the mentors. Peer interventions emphasize modifying behaviour by changing peer group norms and activities: these approaches are not effective in reducing violent behaviour and some have even increased violent behaviour. One of the failed ingredients seems to be the mixing together of high-risk youth, which has the unintended consequence of increasing cohesiveness and facilitating delinquency.

**Community-level interventions**

Community-level interventions focus on modifying the characteristics of settings such as schools, workplaces, streets, pubs and clubs, since these are environments that may create the conditions for violence to occur.
Programmes to promote a non-violent environment in schools show promise. Further evidence of sustained effects and replication place these in the effective category. Screening for abuse whether for women, children or the elderly is generally considered good practice.

Unfortunately, little systematic evaluation has been carried out on whether screening does improve safety and health seeking behaviour, and if it does, under what conditions. Efforts to improve workplace, residential, and primary care environments through policies and protocols for managing abuse and promoting non-violent behaviour have also not been well evaluated.

More has been done along the lines of changing community attitudes and norms around violence through public information campaigns. These increase knowledge and awareness, shift social norms about domestic violence, and in some instances lead to increases in disclosure of child abuse and sexual offending. However, they have not been consistently associated with behaviour change.

Other community-level interventions focus on community organizing, coordination of services, proactive policing, reducing housing density and reducing alcohol availability. Most have been poorly evaluated and remain largely untested, although efforts to reduce alcohol availability show promise in preventing youth violence.

**Societal-level interventions**

Societal-level interventions focus on cultural, social, and economic factors related to violence. They emphasize changes in legislation, social policies and the larger social environment to reduce rates of violence. Measures for restricting access to means include restricting access to guns. With suicide, this also includes fencing in high bridges, limiting access to high exteriors of tall buildings, automatic shut off devices for motor cars, restricting access to pesticides and fertilisers, and measures to make prescription drugs safer. There is some evidence that restricting access to means is effective in reducing suicide. With interpersonal violence, a few studies of gun control laws do show a preventive effect. However, a recent US systematic review concluded that there was insufficient evidence to decide whether or not these were effective, citing methodological inconsistencies as the reason why we cannot draw conclusions yet.

The evidence for legislative measures is also mixed. Measures to criminalise family violence include broadening the definition of rape, criminalising the physical punishment of children, and mandatory reporting laws for child and elder abuse. These have helped to bring these issues out into the open. However, evidence for the deterrent value of arrest in cases of intimate partner violence shows that this may be no more effective than other police responses such as issuing warnings or citations, providing counselling or separating couples. Some studies have even shown increased rates of abuse following arrest, particularly for unemployed men or those living in impoverished areas. Protective orders can be useful, but enforcement is uneven. Further, there is evidence that they have little effect on men with serious criminal records. In rape, reforms related to the admissibility of evidence and removing the requirement for victims’ accounts to be corroborated have also been useful, but are ignored in many parts of the world.

As for other societal approaches, much could be done through educational reforms, policy changes to improve poverty and inequality, and increasing support for families. More could also be done to change social and cultural norms. Unfortunately, although critically important, many of these solutions remain largely untested ideas. We have heard from John Ashton, and it will be reiterated by other speakers, that violence prevention is a multi-sectoral challenge requiring multi-sectoral solutions. It is the task of public
health to unite all these sectors, and to put the puzzle together so that we can see the picture properly.

Public health can help to put the violence prevention puzzle together through data collection; through research into the underlying causes and risk factors for violence; through prevention by designing and monitoring primary prevention programmes; through impact and outcome evaluation; through policy development; through providing more effective trauma and healthcare services for victims; and through advocating for prevention.

**Global Campaign for Violence Prevention**

I will now briefly review WHO’s Global Campaign for Violence Prevention. At the heart of the campaign are nine recommendations, six of which are at the country level and three at the international level.

The country level recommendations outline the main activity areas for a multi-sectoral national action plan for violence prevention.

They are:
- Enhancement of capacity for data collection.
- Definition of research priorities.
- Promotion of primary prevention.
- Strengthening of responses for victims.
- Integration of violence prevention into social and educational policies.

At the international level the recommendations are:
- To increase collaboration and exchange of violence prevention information.
- To promote adherence to international treaties and laws that protect human rights.
- To seek practical and internationally agreed responses to the global trade in arms and drugs.
The major campaign objective is to promote country level implementation of these recommendations. So far, around 50 countries have involved Ministers of Health, Justice, and other sectors, in national launches of the *World Report* and policy discussions on strengthening violence prevention. Around 60 countries have formally designated Ministry of Health officials as violence prevention focal points. Some 20 countries, including the UK and France, are preparing national reports on violence and health. At least five countries have already gone quite some distance in preparing national plans of action for prevention. Around these national activities, WHO is working on developing international support for national activities through resolutions such as:

- World Health Assembly resolutions on violence prevention.
- A United Nations commission on human rights resolution.
- A resolution by the African Union.
- A policy statement by the World Medical association.

Working with the Council for Europe, WHO has also integrated its prevention recommendations into the Council's "Principles for an integrated policy response to violence in everyday life".

To help raise awareness, WHO has published three poster series: the 'red series', the 'explanation series' and the 'family album' series, all of which can be obtained free of charge from the organization.

Currently being edited, WHO has also worked with an independent producer on a television documentary about violence and its prevention, which will be launched in the second half of 2005. We have also prepared a number of technical documents (slide 4):

- Preventing Violence gives step-by-step advice on implementing the country level recommendations.
- A handbook for documenting violence prevention programmes.
- Guidelines for medico-legal care for victims of sexual violence.
- Guidelines for essential trauma care.

An important part of our global campaign is the Violence Prevention Alliance. This is a network of governments, non-governmental organizations and others, which aims to facilitate implementation of the *World Report* recommendations and strengthen cooperation around the shared public health vision for violence prevention. The UK, along with Jamaica and the USA (two of the other countries represented at this conference) are among the founding partners in the Alliance and we will be hearing later from Elizabeth Ward about Jamaican violence prevention progress and from Rodney Hammond of the Division for Violence Prevention in the US Centres for Disease Control and Prevention.
Possible lessons for UK violence prevention concern the importance of ensuring that policies that affect risk factors are supportive of prevention, the need for cross-sectoral coordination and leadership, and the globalization of violence.

Recent debate in the UK has drawn attention to policies about alcohol sales and family support programmes. These represent societal-level interventions that can increase or reduce violence, and as such their impact on reported violence should be closely monitored, and, if needs be, the policies modified so that they help to reduce violence.

Violence is increasingly a trans-national issue. For instance, recent immigrants may bring cultural values and norms that make them more or less vulnerable to violence than people born in the UK or who have lived there many years. This highlights a need for the UK to better understand its own cultural diversity as a means of improving efforts to prevent violence within the country.

Finally, examples such as the US Centers for Disease Control and Prevention’s Division for Violence Prevention show the value of establishing clear leadership and cross-sectoral coordination, something that Rodney Hammond, the Division’s Director, will I’m sure comment on in his address.

To end, I would like to appeal to all of you in your own way to join the global campaign for violence prevention. As Nelson Mandela writes in his foreword to the World Report on Violence and Health,

“We must address the root causes of violence. Only then will we transform the past burden into a cautionary lesson.”

I am really looking forward to enjoying the rest of the programme. Thank you.
I think you represent a very good example of achievement in violence prevention. I am, therefore, very happy to be here today.

I started my work in the field of violence prevention about 14 years ago when I was appointed as the Director of the Development, Security and Peace Programme, DESEPAZ, for the city of Cali, Colombia. DESEPAZ was designed to reduce and prevent the high burden of violence in Cali, under the leadership of Dr. Rodrigo Guerrero, mayor of Cali (1992-94). In 1994, candidates were running for the position of mayor elsewhere. One of them was Mr. Antanas Mockus, who was running for mayor of Bogotá. Mockus came to Cali to see what we were doing in the city to prevent violence. Although not a public health expert Mockus had the honesty to recognise the importance of the public health approach to prevent violence, and in particular what Guerrero, a Public Health doctor, had accomplished in establishing an integral violence preventive program (DESPEZ); supported by a reliable and timely information system on external causes of death (homicides, traffic crashes and suicides). The Cali’s DESEPAZ programme, launched in mid 1992, was abandoned after Guerrero left office. This is why I am talking about Bogotá rather than Cali. Cali’s violence prevention strategy was not a success, because it was abandoned.

Mockus (first term 1995-1997) is a mathematician and philosopher, who had been professor and President of the National University of Colombia in Bogotá. As a candidate, he wanted to know our experience in Cali. From this experience he took ideas to prepare and implement his own programme for violence and insecurity prevention in Bogota. Fortunately for the city of Bogota another very responsible mayor, Mr. Enrique Peñalosa economist and administrator, was elected for the term 1998-2000 (Peñalosa deserves recognitions and credit for his own achievements, as we will see later) and Mockus was elected for a second term in 2001-2003. The city of Bogotá, with a population of almost seven million people, has many problems. However, as I will show you later, it has since become a kind of landmark for violence prevention.

What I intend to present is how the public health approach for violence prevention can be implemented, enriched, and achieve positive outcomes on violence and crime reduction.

On the negative side before the programme, the homicide level in Bogotá was around 80 per 100,000 inhabitants, which is extremely high. The city had high levels of impunity, police corruption, effects of drugs trafficking (a very serious issue in Colombia), effects of armed conflict, lack of cohesion (Gini coefficient between .52 and .57) and the population had a high sense of insecurity because of robberies, assaults, and poor traffic control.

On the positive side, Bogotá has always been, and still it is, a centre for international culture, sporting, and political events. It is the capital of a democratic country with free elections and free press. The level of education at pre-graduate and graduate level is high, with national and internationally recognised universities; and it is an open forum for free debates on different issues. As the capital of Colombia and the centre of political power, Bogotá has a strong national influence and the country holds decentralisation of municipal and local authorities. It is worthy to recognise that Mayor Jaime Castro (1992-1994), did a tremendous job in assuring a healthy city budget with the monetary resources...
necessary to implement social and developmental programmes such as the one about to be explained. Finally, it is necessary to highlight that the inhabitants of Bogotá had been demanding action to improve the insecurity caused by violence. Besides being a professor, Mockus had the communicating skills to translate this impetus into proper and reliable dialogue with the city population.

As I already mentioned, Mockus is a philosopher and a mathematician who used the public health approach as a tool for violence prevention. However, he also had his own ideas. His approach is based on a theory that explains peoples social behaviour. In brief, there are three types of regulation of social and individual behaviour in daily life. First is the legal aspect, which is explicit and context specific. Second is the moral aspect, which is implicit and guides decisions based on what each person has learned (it is based on personal background). And thirdly is the cultural aspect which is incorporated into our attitudes as group behaviour. Gratification or punishment is a consequence of people behaviour. On the gratification side, we are all equal before law. If we behave properly we will receive more satisfaction, better communication and dialogue. In the cultural context we will have better verbal communications and better social relationships. However, on the sanction and punishment side, if we behave wrongly we will be punished by law according to the procedures previously defined by law. The moral aspect will involve self-blaming and our own tension will increase as a consequence. On the cultural side we will have social exclusion and shame. Using that particular approach, Mockus said that the high levels of violence and crime in Bogotá could be explained because of the divorce between the legal, moral and cultural aspects of behaviour regulation. However, according to his previous experience, the one aspect that influences wrongdoing most is the cultural norm. This is because it influences how we can behave as a group. The outcome of this theoretical approach was therefore to address a programme aimed to change, modify and improve cultural citizenship, as the way to reduce crime and violence.

Consequently, in 1995 the city launched a programme designed to improve citizens security and coexistence, called building Citizenship Culture. Peñalosa kept Mockus’ main ideas and also added his own democratic emphasis. His main emphasis was therefore, on recovering and rebuilding the city for the people living in or visiting it, with a strong sense of identity and ownership of the city by its inhabitants. Both men had the same idea and recognised that social security was their responsibility. They had to prioritise work on that responsibility at a city wide level.

The public health approach starts with a reliable information system aiming to know the characteristics and demographics of cases of intentional (violent) or unintentional deaths or injuries, as well as certain types of crime. Consequently, the observatory of violence and crime was established. This was implemented as an inter-sector task group, and involved people from the police, the health sector, forensics, and more, to work as a team and create good, reliable information about the situation in the city. There was also the creation of an epidemiological violence committee for the study of causes of death and injury. All the information coming from these bodies were put on the website and are still there. Since there was so much information and data, putting everything on the website was a very important step forward; it allowed people to see what was going on in the city. Internet access is a democratic way to share information. People can browse into the webpage to look for updated information on different programmes and data on violence and crime, among many other things. Graph 1 shows the webpage. Every month people can scroll down and see what is going on in that particular information system. Based on that information maps for different types of violent acts were created. This map (slide 2), for example, shows the worst areas for injury and the more significant
security sites. This is a very important tool for defining and monitoring the interventions.

The following chart refers to Bogota in 2000 (slide 3). It illustrates how the activities to reduce homicides were planned. Based on what happened in 2000 (top line) the city defined goals for 2001 (middle line), and at the end of 2001 compared data with what was really accomplished (bottom line). As the graph shows, there was a significant reduction of homicides, much better than expected.

This monitoring was conducted continually from month to month, which allowed the city to keep reviewing its expectations. In particular, the police and police authorities could decide who was responsible for what. This enabled the police authorities to be made properly accountable to the Mayor and the Security Council on a regular basis:

weekly, fortnightly, or monthly, depending on the problem. It fostered a permanent relationship with the police authorities. That is the basic idea of the public health surveillance and information system.

Research was conducted to determine exactly what the main risk factors were. The City supported research for programmes using external audits. It also provided funding for local university consultants to conduct research on the main risk factors for family violence, youth violence, child abuse and the others. External groups like the Chamber of Commerce were also monitoring these programmes and ensuring ample coverage in the media of exactly what was going on.

A further step in the violence prevention programme was to determine what projects needed to be implemented. Brief comments on those implemented in Bogotá are presented.

An important example is related to the reduction of alcohol and drug consumption. Changing the cultural norms was a very important part of this programme, so self control and personal control of alcohol consumption was stressed strongly. It is not enough to merely have the police behind the issue and prosecuting people. It was important to have the people themselves realise that self-drinking control is the best alternative. Drinking and driving increases the
risk of violence and traffic crashes. Also the decision to reduce the number of hours in which bars are open to the public helped decreased the number of homicides and traffic accident deaths. The media, in general, supported the campaign. This and other campaigns were under the Mayor’s control and leadership.

Another project was called “Life is Sacred.” For this particular project different activities and strategies were implemented, including voluntary disarmament to reduce homicides. This involved reducing the availability of guns, and also asking people to give up their own arms. Fireworks were prohibited from specific settings because, in this city, anyone could take a firework and explode it. This resulted in high levels of child injury. A key campaign called “No Child to be Burned by Fireworks” stated that the next time a child was burned, a complete ban on fireworks would follow. It happened and it worked. All public places were targeted for that particular project.

Police were very important and received better equipment for a quicker response. Listening communities were established with the police, and regular meetings were held between them. This improved relationships with the police and improved public perceptions of police performance from 30% to 60%. That still may be low, but it is an important improvement. Another initiative was the creation of good and well-equipped libraries in poor neighbourhoods. This helped children receive a better quality of education.

Bicycle routes were created along with many other kinds of public spaces recovered to be used by the city inhabitants as their democratic right to safely use public spaces; and therefore take advantage of the healthy cities approach. There were also conflict resolution projects, family police stations, increased and improved police performance, and the establishing of the House of Justice (Casa de Justicia), located in popular neighbourhoods attended by professionals such as lawyers, social workers, psychologists, where people look for help either to prevent a conflict or to resolve it. As a necessary legal process for conflict resolution “Judges for Peace” at the community level, were established.

“Communication for coexistence” used symbols for urban and social communication. Each one of these symbols has a positive meaning and relates to how people behave. The symbols were displayed prominently in the media so people could understand how to communicate with each other through the hands and make this kind of social communication (slide 4).

Now let’s examine some results based on reliable data provided by the Observatory of Violence. You can see here (slide 5) that by the year 1997 there was a peak in the overall number of crimes in the city (more than 25,000). This includes all types of crime. A continued reduction has been observed since that year to levels of 17,000 or less.
As far as homicide rates are concerned, there were approximately 80 per 100,000 in 1993 (slide 6). This rate declined year after year to 21 in 2004. This is still high, so a new goal now needs to be set. In synthesis, homicide had a 71% reduction in the period from 1993 to 2004. Deaths from motor vehicles peaked in 1995, with a rate of 25 per 100,000. In 2003 this had dropped to 8.7 per 100,000, a reduction of 65%.

Bogotá invested, during Peñalosa’s term (1998-2000), in a very impressive Public Space Recovery Programme. Before the programme the street vendors blocked the sidewalk. Now this is free and people can enjoy these urban spaces. Before the public space was recovered people would park their cars on the sidewalks. After the programme people could walk freely on the sidewalks because cars are no longer parked there (slide 7).

Bogotá has a massive public transportation system (called Transmilenio) with buses but no metro. As an example of the positive effect of Transmilenio and the urban development of the city, Slide 8 shows what happened in an intersection at one of its main highways. In the year 2000, there were 1400 crashes. In the year 2001, there were 240. Pedestrians hit by cars dropped from 800 to 4. The number of people injured was almost 1,000 in 2000. This number dropped to 190 in 2001. People killed by cars dropped from 67 to 4. There were 260 muggings in 2000, but only 95 in 2001. These are the effects of policies aimed at not only reducing violence, but also aimed at creating a better atmosphere in the city.

For this kind of approach to be successful, it is necessary to keep political sustainability. No matter what political party the mayor represents, as long as the programme keeps improving life in the city it must be sustained and led by whoever is in power regardless of new ideas and initiatives. Ten years of continued effort has significantly improved security and reduced violence in Bogotá. In comparison when a programme is abandoned, as it was in Cali, the homicides rate, initially declining, again increased (there is no DESEPAZ programme any more) (slide 9).
On the other hand, it is also important to recognise that to achieve what Bogota has achieved it is not cheap. It has cost money for the city. More than $150 million has been spent during these years to produce these outcomes. Success demands continued commitment from different Mayors. It has to go beyond single terms of Mayors and become a type of City Policy. Citizens need to keep demanding and getting involved in the issue of security and violence. Furthermore, media and society as a whole need to keep controlling the situation and evaluating what is happening.

The Organization also helps to increase our Government’s commitment to violence prevention strategies. In return, we are happy to promote and explain the case of Bogotá as a good example.

Thank You.
Abstract
Isaac B Weisfuse and Susan Wilt

Background: Homicides in New York City decreased precipitously over the course of the 1990s.

Objectives: To describe more recent trends in New York City homicides and to explore potential reasons behind these findings.

Methods:
Review of New York City death certificates with homicide listed as the cause of death. Review of public health and criminology literature on homicide trends.

Results:

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<tr>
<th></th>
<th>1990-1994</th>
<th>1195-1999</th>
<th>2000-2003*</th>
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<th>00-03(%)</th>
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<td>501</td>
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<td></td>
<td></td>
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<tr>
<td>15-24</td>
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<td>3,374</td>
<td>1,226</td>
<td>782</td>
<td>-309</td>
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</tr>
</tbody>
</table>

*Only four years of data available

Conclusions: The greatest decline in homicide occurred in the early 1990s, with the number of recent overall homicides in most demographic categories having reached a plateau, with the exception of 15-24 year olds which had a slight increase. Potential reasons for these findings will be discussed.
When you are talking about prevention as opposed to deterrence you are draining the swamp as opposed to fighting alligators. Cops across the world like to be thought of as alligator fighters. This was particularly true in the New York City Police Department (NYPD) who were not interested in pre-crime prevention. The notion of draining the swamp as opposed to fighting the alligators is important to this presentation.

This cartoon comes from the United States (slide 1). The US criminal justice industry is big in the USA. Between 1975 and 2005 the US increased the number of people incarcerated by a factor of more than three, going from 200 per 100,000 to 700 per 100,000 persons incarcerated on an average day. This is seven times the rate of incarceration in Europe! There are now two million people incarcerated in the US today. That is one in four of all people incarcerated across the globe. It is a staggering statistic. Of course, behind that statistic is a continuously growing industry promoting the importance of corrections in the US and also across the world. They also influence political parties. If you look at financial contributions to the political campaigns in California, you will see not only the prison construction industry, but also the prison unions, who are a much bigger contributor than the National Rifle Association. So the deterrence and incapacitation folk are a major challenge.

But it is not just a corrections industry. It is also a police and lawyer industry. The Clinton administration increased the number of cops in the US by 20% (100,000 additional cops). On a per capita basis, this is not so different from England and Wales. What this actually means is that if you look at what the average American tax payer has to contribute for cops, courts, and corrections, it is twice what a Canadian tax payer pays and would be twice what the British taxpayer puts out were it not for the strength of the pound. The US, British and Canadian rates were nearly equivalent thirty years ago.

When you incarcerate that number of people you do have some impact on crime, estimates suggest a reduction of about 25% due to this alone. I was interested that Alex Butchard in his very sophisticated presentation of factors contributing to crime did not mention the importance of incapacitation. If you put all your young African American and Hispanic males behind bars you reduce violent crime. So the issue is not whether cops, courts, and corrections work, they work. The issue is whether they are cost effective. Of the $167 billion spent in the USA, $56 billion is on corrections. $20 billion would go a long way to provide childcare, a college education or a living wage job for youth at risk, and secondary crime prevention through social development that is known to reduce crime and violence.

Similarly for England and Wales, it makes no financial sense to have allowed the number of prisoners to grow by 50% in the last ten years. It would be much more cost effective to invest in pre-crime prevention.
Alex Butchard presented this slide (slide 2) based on the World Health Organization (WHO) report on implementation strategies. I have added an assessment of what is there already as well as where more is needed. There is a lot of data in England and Wales as a result of its long history of criminological research dating back to the end of the Second World War. This includes the establishment of the Home Office Research Unit and the important knowledge on causes of crime and determinants of recidivism that were pioneered in the 1950s and 1960s. It also includes longitudinal studies, victimisation surveys, and data sets on offenders that are unique by world standards and critical to effective violence prevention.

Now whether this data is well used is another issue. It is the national plan of action that is so important here but at this stage there is no office, secretariat or other vehicle to implement that plan of action other than the exemplary Youth Justice Board (YJB), which is useful in relation to youth crime.

In the UK, you have the British Crime Survey, a very large-scale 60,000 household interview survey. It is conducted every second year and the respondents are asked if they have been the victim of certain types of crime. They are asked if they reported this to the police, which more than 50% have not. It talks about attitudes to prevention and sentencing among other things. It is a very sophisticated survey. The US has a bigger one but the UK has a better one. These surveys provide a lot of information that could be very useful in trying to establish where you should be focusing to prevent violence and also to evaluate programs to prevent violence.

You have longitudinal surveys, which have been used by the WHO. These give information on the life experiences that occur before young persons become involved in frequent offending. These identify several critical life experiences, which include inconsistent and uncaring parenting and troublesome behaviour in school.

You have crime mapping for cities, which are often available to community safety partnerships, as well as local residents and foreign researchers, over the Internet. These show not only crime maps but also social deprivation maps. The fact that the local group do not really seem to use these yet in the best way is, in my view, irrelevant. Their potential for mobilising schools, housing, social services, police and others around the causes of crime across cities are critical for future efforts along the lines proposed by the WHO reports.

You have the worlds only proven successful national crime prevention agency that has
demonstrated it can deliberately reduce youth crime; that is the YJB. The most important thing about the YJB is that it was set up separate from the Home Office. Consequently, it did not get caught in the territorial wars between the police, corrections, and research, which have neutralised so many of the efforts to drain the swamp. It was also given a mandate to actually use evidence in prevention. Because it controlled a lot of funding it was able to implement, and within a relatively short period of time demonstrate success with its youth inclusion projects in 70 deprived areas across England and Wales. It is not just the 60% reductions in arrest rates that have been achieved by several US proven prevention projects but this was achieved across 70 sites. This makes it the most successful proven crime prevention program since Job Corps in the US in the 1970’s and better than job corps because the reductions were much more significant.

Nobody has mentioned it yet, but you also live in a country where every Municipal Authority or Local Government Authority has a crime prevention plan, developed by a community safety partnership. You can read these plans on the Internet for Birmingham, Liverpool, and Manchester, just to mention large cities near this conference. There are a lot of improvements that need to be made under the Crime and Disorder Act in 1998 to bring these partnerships in line with UN standards, but what is needed more than anything is something similar at the national level to deal with the prevention of adult crime and violence.

If you are looking at violence against women and children then the most violent place is behind closed doors, in the home and to a lesser extent in the schools. Most of your data does not look at that; there is a big gap in the UK on family violence. In researching violence, you have done some important work but you must put it to work in your community safety partnerships and in your national and local plans. In primary prevention you have things like Sure Start and the Neighbourhood Renewal Programme. I know you are going to be talking about bullying tomorrow, so I gather you are doing work on this.

Let me just re-emphasise some of what has already been said. There has been a range of agencies, not just the World Health Organization, that have said we can reduce crime. It is important to know that crime can be reduced. It is not just Bogotá, there are inspiring examples of things that have worked. Commission after Commission has agreed on that. The United Nations itself, the World Health Organization and a whole range of agencies in this country including the Audit Commission, the Home Office, the Treasury, and the British Inspectorate of Police.

You are going to hear from the Centers for Disease Control and others, but the prestigious commission that I like the most for both doctors and the ordinary public is the Surgeon General. The Surgeon General in the United States is the person who said there is a link between smoking and death. The situation we are in today with violence is similar. We know a lot about the causes of crime, we know a lot about what works, and the issue is mostly about getting that to be put into action. So the Surgeon General’s approval is helpful because, in smoking, that evidence led to change. The evidence that we have on violence will lead to change too.

Sir John Stevens, recently Commissioner of Scotland Yard, headed a major evaluation of policing, which basically said the majority of policing does not work and where it does work we do not have evidence. However, he said the way to success is to be more strategic and to work in partnerships.

This is a list of what has been shown by those blue ribbon groups that I mentioned earlier (slide 3). It is no longer debatable whether prevention works. It is very clear that every single blue ribbon commission has decided that it does. They have decided that there are some things that do not work, for
example, neighbourhood watch (which is very widely used in this country). Another example is community policing, a word that is used a lot. I was interested that when Alberto Concha Eastman talked about Bogotá he did not say that the police reduced crime. What he did say was that they were good at getting their image improved. Of course community policing is about getting your image improved and not about reducing crime, so that is basically what these studies say.

We know a lot about how you can intervene on some of the social causes: inconsistent parenting, school abandonment, situational determinants, and a range of things at the policing level.

These two bottom lines are important for justifying spending to the Treasury or City budgets. Tackling the causes is more cost effective than current policing and judicial remedies, particularly prison practices. This means that there should be a huge shift in resources from those areas, into what I am going to call the secondary pre-crime prevention area. The impressive thing about social prevention (for example, keeping children in school, anti-bullying programmes, mentoring, and so on) is that they not only reduce violence, but they also give other benefits. Children grow up to be better citizens; some go on to pay taxes.

You know much about what causes young persons to grow-up as persistent offenders from the British longitudinal studies. Crime, as we are all aware, is highly concentrated. The offenders are concentrated, the victims are concentrated, and the places where they come together (in so called hotspots) are concentrated.

So if we are going to make a difference to violence then we have to do much more strategic and that is a money issue. You cannot just wait until crime occurs and have a police officer respond to a 999 call in his fancy car with his fancy computer. We just cannot afford to go on doing it and it does not reduce crime anyhow. We have to start seeing where we can strategically intervene to use our resources better.
Here are some illustrations of what has worked in policing (slide 5), and I would like you to focus on the second one. It is an example from Boston. The interesting thing about this example is that it involves a joint police and university team. It involved the School of Public Administration and the then Police Chief, Bratton. He later went on to become the Chief of Police in New York, and is now the Commissioner in Los Angeles. Basically, they looked at what were the causes of the sudden rise in youth homicide in Boston, and then they found a way of addressing those causes. All of this was evaluated. I want to repeat that evaluation is important. It is clear that this programme reduced the number of youth homicides.

Slide 5

**Problem Solving Policing – examples**

- "Hot Spot" Analysis and Problem-solving (Edmonton, Canada)
  - use police crime data to identify local challenges and "hot spots"
  - engage high-risk neighbourhood in planning and implementing
- Edmonton Police: reduces crime 41%, violence 31% over 4 years
- Strategic Approaches to Community Safety (Boston + SACSI)
  - joint police and university teams to analyse causes of violence
- NB success of Operation Cease-Fire in Boston for youth homicides
- Replications across USA and now piloted in Brazil
- Partnership between police and business (e.g., Netherlands)
  - reduce commercial robberies by improving situational prevention
  - create a tracking system for robbery offenders
- create support community youth employment and educational initiatives
  - 26% drop in commercial robberies and doubled solved robberies
- Youth Justice Board created by Crime and Disorder Act (1998) to prevent youth offending and improve justice for youth.
- permanent public body, independent of police, courts and corrections
- power to persuade schools, housing, social services and police to collaborate
- committed to use evidence on effective practice
- business plan to achieve specific targets such as a 10% reduction in youth offending

I want to spend more time on the Youth Justice Board, as it is a very, exciting example. I have the privilege of advising governments all over the world and this is now at the top of my list. Bogotá has slipped to second. Basically, it is at the top because of the whole process. The Audit Commission looked at value for money and said in 1996 that expenditures on policing, courts and prisons are misspending on youth offending. If you wait until a child attacks a victim, then you wait to see if the victim reports it; then you wait until the police decide whether they are going to prosecute, then you have already wasted huge amounts of resources. Alex said it is important to hold children accountable and it probably is up to a point. If your interest is in reducing crime, however, the Audit Commission makes it very clear that you should be spending your money before the children get involved in those levels of violence, on pre-crime prevention.

**Slide 6**

**Pre-crime prevention, speedier justice, less offending paradigm shift from only juvenile justice**

- Example – Youth Justice Board, England and Wales
- Misspent Youth (1996)
- British Audit Commission review of programs to tackle youth offending
- Expenditures on policing, courts and prisons are misspending on youth offending.
- Youth Justice Board created by Crime and Disorder Act (1998) to prevent youth offending and improve justice for youth.
- permanent public body, independent of police, courts and corrections
- power to persuade schools, housing, social services and police to collaborate
- committed to use evidence on effective practice
- business plan to achieve specific targets such as a 10% reduction in youth offending

The Youth Justice Board was set up separate from the Home Office. It is not part of a Health or any other Ministry. Because of its independence, its mandate and its requirement for transparency, it is inspiring for others who want to reduce crime and violence. In their pre-crime prevention work, one of their areas of focus is on the Youth Inclusion Programme. This is also inspiring because it is a programme involving 70 different sites in England and Wales. Almost every example that the WHO, or that any of those other Blue Ribbon commissions mentioned, is one project, occasionally with one or two replications.

The Youth Inclusion Programme was set up in 70 of the most difficult neighbourhoods. In each site, they identified the 50 worst children, got them in, and tried to turn them around. They evaluated what happened, and while they did not achieve all of the results that they hoped, the outcome was staggeringly impressive. It is a cost issue too. They calculated the cost of what it took to manage, and the costs are roughly equivalent to just moving somebody through the Youth Justice System. So this is a very cost effective way of dealing with things. I gather that they are now moving this into other areas and involving younger children.

Alex has told you about some of the things that are proven. I do not want to spend too
much time on this; I just want to add the second one down, which concerns children dropping out of school. I am aware that you have interesting policies in schools for difficult to manage children. Basically, in terms of violence prevention, you have to somehow get those children who are most likely to drop out of school and keep them in school. You then get very large reductions in violence. This is an assessment that was done by the International Centre for the Prevention of Crime which has been used all over the world. You do not particularly need to look at the details. For example, if you look at the Incentives to Complete School Programme, you basically see a 62% reduction in involvement in crime. What is important here is not so much the specifics, but how large those percentage decreases are. Through prevention you can get huge reductions in all types of crime including violence. Of course this has to be used to get funding for those programmes. Dropping out of school is related to persistent offending, and working in partnership on this issue seems to be in the legislation here. It works but you have to make it actually happen.

Yes we need to use what is proven where it is relevant to the causes of violence in England and Wales but we also need to pursue programs that are tailor made to tackling those causes. Peer mediation may be one of the most important activities to change the youth view that they can achieve things through violence. It is also a way of getting back to the issue of violence in the home. To explain the potential of peer mediation, I draw a parallel with smoking. Thirty years ago a child was told that smoking was bad, so he came back and he took the cigarette out of his mother’s mouth. His mother said, “No, it’s my business, you are too young to know about it” and she went on smoking, but eventually she started to change her views. Well it is exactly the same on violence. If you can get children to go home and say to Daddy, “It is not a good idea to beat up Mommy” and Daddy will say, “It’s none of your business kid.” But over time he will begin to think. This is maybe unproven, but it is something in which there has to be a much bigger investment.

The cost of those proven programmes above is way less than the cost of incarceration. If you look at California data you can see what would be needed if you were going to reduce crime by 10%. If you invested in keeping children in school to achieve this crime

Tackling causes of persistent youth offending (5% responsible for 55%) reduces crime by 50% or more

<table>
<thead>
<tr>
<th>Program</th>
<th>Reduction (%)</th>
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<tbody>
<tr>
<td>Enriched pre-school and parental support (USA)</td>
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<tr>
<td>Responsibilisation and help (Halt, the Netherlands)</td>
<td>72%</td>
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<tr>
<td>Incentives to complete school (Quantum, USA)</td>
<td>62%</td>
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<tr>
<td>Enhancing parenting through nurse visitation (Elmira, USA)</td>
<td>50%</td>
</tr>
<tr>
<td>Focusing parents and teachers vs. causes of bullying (Norway)</td>
<td>50%</td>
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</table>
reduction, the increase in taxes per family is about $35 US. It is not a lot. If you wanted to do it through incarceration, which is what the Americans love doing, then it would cost over $200 US. The difference between the two is considerable. You basically have to pay about seven times as much to achieve crime reduction through incarceration as you do through the sorts of programmes that Alex has talked about. My title was “An ounce of prevention is worth a pound of deterrence.” This is not actually true. An ounce is only worth about half a pound, but who cares. Even if it were only three times, it is a very convincing argument.

This chart (slide 8) was used by the treasury people who were involved in setting up the Youth Justice Board. It was also used by the Crime Reduction Programme in the UK. The Crime Reduction Programme was where they put £250 million into what works. It was supposed to be partly on youth violence prevention and partly on burglary prevention; unfortunately all the money went to burglary reduction, which was not very successful. At least you can use charts like this to get money. Initially, the treasury did not believe that these figures were true, but when they checked, they agreed to them.

I want to give you a quick overview of what we know about policing. What we know is that large increases in policing like we have seen in the US or even England and Wales do not make a lot of difference to crime levels. Of course it also takes money away from what would work. We know that the way that modern standard policing, as it is organised in England and Wales or for that matter in Canada or the US or Australia, does not work. Devoting 40 or 50% or your resources to responding to 999 calls does not work. In fact, victims are increasingly not going to the police. Generally clearance rates are dropping. I have already mentioned that the popular US programmes like neighbourhood watch and Drug Abuse Resistance Education do not work.

There are some things that do work; the Compstat type process that makes the police more accountable probably has some impact. For things like targeting traffic violations, everyone in this room knows that deterrence works to keep us below the speed limit or stopping at stop signs. However, this is because as employed, middle class people, we have something to lose. The same is true for intra-familial violence, where research proves that middle class men can be deterred by arrest but unemployed men are not.

What is overlooked is repeat victimisation. Often it is the same woman being battered every Friday night, and the same child abused. Responding one at a time to 999 calls loses this important information. Focusing on repeat victimisation therefore becomes very important. Crime mapping with police organised to solve problems through law enforcement or partnership with community agencies become critical to success.
Helping victims protect themselves is probably the one thing I would like to see the police do in this country to reduce the relatively very high rates of violence against women and children. I would like to see some sort of all female police stations. The developing countries do this. I have just come back from Tamil Nadu where the chief minister is a woman; there were 200 all female police stations there. They have a murder rate more or less the same as England. This sort of action encourages more women to come forward. People overlook how few victims go to the police about their victimisation. Therefore if you can increase the number of women going to the police you may see some impact, particularly if this results in the man going to a battering programme that is known to work.

Holding young offenders accountable instead of pushing them through a justice system where an adversarial game is played and getting them to recognise the harm they have done is also important. I think that I have said enough about corrections.

You have heard a lot about the World Health Organization. I just want to make you aware of another inter-governmental agency. In 2002 the United Nations adopted a set of guidelines. These guidelines are much more driven by process than by particular solutions. They place a very heavy emphasis on establishing centres to spearhead. That means that every local government needs a very high level group to make things happen. You saw in Bogotá that their observatory was there to make things happen. That is what one needs at the local, and maybe the regional, and certainly at the national level. That is agreed by a very wide group of experts. You need to get schools, families and a whole range of others involved in the process. You need to use proven strategies to invest in training, and you need to engage the public. It is important to know that those exist.

This is, in fact, what every local government has to do in the UK because of the Crime and Disorder Act (1998). The question, therefore, is not if the model is a good one. The question is about how it is put into practice. You need to look at what the crime problems are and what the causes are, and you need to come up with a plan to deal with them. You need to implement this plan, and you need to evaluate it. Alex's chart for some reason did not have evaluation, but he did mention it verbally. You have to have a responsibility centre that makes it happen. The UK was actually quite slow in coming to the table although now you have the Crime and Disorder Act (1998), the effects of which is now quite widespread. It is important to know that basically, across Western Europe, those sorts of agencies exist. The issue is not just the existence of them but how you make them work.

I wanted to say something about both Bogotá and New York. Bogotá has been dealt with very well so I am not going to say any more than Alberto Concha Eastman has said except that it is an inspiring model that illustrates that political leadership and a city wide problem solving model works. It is also important to talk about New York, however, because you speak English and you read English and, unfortunately, you are incredibly influenced by the media machines from the US.

It is important to know that Giuliani had very little to do, George Kelling his main advisor estimates 5% with the reductions in homicide in New York. You can see it just by looking at the date that he was elected. Unless you think that it is possible for a mayor to take an eight million person city with 40,000 police officers and instantly, by dropping Compstat into it, cause a miracle. You should not believe the extent of those claims and Isaac has given you a reasoned analysis of it.

I want to say something briefly, about the victim issue because it has not been mentioned very much. Basically the system of justice that you have in this country (and the one that I have in my country) does not do a whole lot for victims. So it is very good to see
when people from the World Health Organization talk about placing an emphasis on victims; even if you do drain the swamp, or you stop pushing a person into the river, you do need to have some sort of response for victims. It is actually very much in the interest of the cops, courts, and corrections industry to start doing a lot more for victims. Relatively few victims report violent crime. Only about 45% of the average crime victims in this country go to the police. Once you look at sexual assault or wife battering that proportion drops even more. So please be cautious about the police statistics. We have been using police statistics as if they are very reliable. In the case of homicide they probably are, but most of them are very unreliable. It is very important when you come up with indicators that you use one that is independent. It is also important for the people in that industry to start doing more for victims.

In this country you have some agencies engaged in skill development and this is also very important and you have some experienced people engaged in training and coaching, the internationally renowned Crime Concern for instance is the one of which I am the greatest fan. It is important when you come up with a violence prevention strategy for this country, that there is a large investment in training and professional development. It is not easy to go from a basically reactive system of cops, courts, and corrections to one where you are focusing on prevention, bringing different agencies together, using data comprehensively and so, there has to be a very large investment in skill development and training to go along with that.

I would like to emphasise the importance of having different sources of data; not just health and police data but also survey data. It was very impressive to see the list of data available to New York City from Isaac’s paper, and it is going to be very important to get better data about violence against women. Alex talked about the international movement to get violence prevention implemented across the world. In two months time the cops, courts and corrections ministers (that is the home secretary here and his equivalent in other countries) will be meeting in Thailand. They do this every five years. They will be looking at a series of issues. An important issue is organised crime; this is not just guns and drugs, it is also trafficking in women and children. It is a much-neglected problem.

They will be looking at making standards work, and so they should be looking at Bogotá, the Youth Justice Board and the things that Alex has talked about, to see what they can do. I hope that you will get your government to include in their speech to that congress, some sort of statement about the importance of having an action plan for violence prevention. I hope that someone like you would be a member of that delegation so that you can spread the word about what you are trying to do and maybe bring back some additional examples to reinforce what you are doing. You need to follow through so that those going each year to the UN Commission on Crime Prevention and Criminal Justice do the same.

There needs to be major changes in policing in this country to get in a more strategic mode and working more effectively in the partnership structures. There needs to be much more on the social equality agenda, there needs to be much better support for victims including special programmes to encourage women to go to the police, and there needs to be some national plan of action with a responsibility centre that can ensure that it is implemented.

I would be happy to give you additional information on the sources that I have used by email. Also I am working on a book entitled Less Law, More Order on the truth about reducing the number of victims of crime that looks at pre-crime prevention, policing and the new role for cities that should be published in 2006.
I would like to conclude on the implementation of a violence prevention plan or strategy for the UK.

You have some interesting primary prevention programmes: Sure Start for instance, or the Neighbourhood Renewal Programmes. You have a Youth Justice Board and at the local government level community safety partnerships. You need more on bullying and family violence. You have got some great research on violence. You have some great data. But you have got to make sure that more is achieved and used in existing structures such as the community safety partnerships and in schools with training, education and coaching.

More than anything, you need a national violence prevention board to take the lead, invest an ounce in the effective prevention of violence for every pound or sterling that is squandered on inefficient cops, courts and corrections.

* * * * *
Thank you very much for inviting me today. I would first like to give you some background information on the Council of Europe so that you can better understand who we are and the exceptional international context in which we work, and then I will present some of the results of a very innovative three-year Council of Europe project, “Responses to violence in everyday life in a democratic society”, which I hope can provide you with some valuable input for your work in the field.

The Council of Europe has its headquarters in Strasbourg, France and is the oldest and largest European political organisation; like the World Health Organisation, it is an international organisation. It was founded in 1949 in the aftermath of the Second World War to promote human rights, rule of law and parliamentary democracy across a strife-torn continent. At the Council of Europe, “Europe” means a “greater Europe” as our organisation comprises 46 member states, which extends all the way to the Asian fringe. Twenty-one of these states are in central and eastern Europe.

We are very distinct from the European Union, which has 25 members, but we share the same democratic values and many joint projects, and none of the central and eastern states now part of the EU could have joined it without having passed through a democratisation process at the Council of Europe. After the fall of the Soviet empire in 1989, our most important work consisted of helping former communist states aspiring to become democratic ones with a free market economy, to change their political, legal, social and educational infrastructures to do so. Since 1989, we have become a human rights watchdog for post-communist democracies, and still help countries consolidate democratic reform. We are an inter-ministerial organisation, meaning that we work principally with ministries or their representatives.

Unlike the EU, the only criteria for joining the Council of Europe are democratic ones. States must show that they have a freely elected government by secret ballot, a parliamentary democracy, and that they protect the human rights of their citizens. We produce legally-binding treaties and conventions, such as our two cornerstone conventions, the Convention for the Protection of Human Rights and Fundamental Freedoms and the European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, and recommendations to member states which though not legally binding are treated as standard-setting guidelines. We are currently working on a new convention pertinent to violence prevention: the Convention for Action against Trafficking in Human Beings, which will shortly be open for signature, and another on the sexual abuse of children is currently under discussion.

Violence has been a major concern of Europeans over the last two decades; it has been on the political agenda of many European countries, and has been taken up by almost all political parties. If we ask ourselves if there is a statistical justification for this, replies are quite divergent, depending on what kind of reporting statistics are based on, and whether these have been appropriated (or misappropriated) for political reasons. If we take the example of violence at school, which has mobilised everyone across society, it may have increased in certain types of urban areas, but it is less sure that there has been a general increase.

What is sure however is that there has been an increase in media coverage of violence,
public fear of it, and feelings of insecurity heightened by the events of 11th September 2001. We also tolerate violence much less than in the past, and people in general have lost faith in the traditional, institutional means of handling violence, crime reduction and prevention.

This concern has been reflected in the work of the Council of Europe, which acts as a forum for member states to discuss issues and look for solutions to common problems. Almost all of our directorates and their departments have been working on different aspects of violence reduction – drug and alcohol related, violence in schools and at sports events, domestic violence, violence against children, violence against people with disabilities, and relatively new forms of violence such as terrorism and trafficking of human beings.

In 2002, “Responses to violence in every day life in a democratic society”, a three-year project, was set up. The project was innovative in the way it de-compartmentalised the work of Council of Europe departments and integrated them into its own programme, thus for the first time pooling knowledge, experience and financing. The project also brought together an array of outside partners, from ministerial decision makers, academics, non-governmental organisations (NGOs), the police, civil society organisations such as youth organisations, and other international organisations.

This project had two major objectives:

- To outline current trends in Europe and then formulate principles and general approaches that states could use to set up a comprehensive prevention policy which would be sustainable.
- To assist member states in applying this policy through practical tools. All Council of Europe departments worked together with outside experts to produce these, which are in the form of handbooks, guidelines, reports, policy declarations, and statutory texts such as recommendations, and European conventions which are legally binding. These mainly cover urban violence, violence in schools, youth violence, violence against women, trafficking in human beings, and violence at sports events.

Twelve policy principles were drawn up on the basis of conclusions drawn from sectoral work, and then adopted by ministers of justice and other ministers responsible for violence prevention, at a conference held in Oslo at the end of 2004. The policy principles should be used by the member states to set up a comprehensive global policy. Not all are particularly innovative or original; they express already-established trends, and there is an emerging consensus on the ideas contained in them. Even if an integrated approach focuses on co-ordination, partnerships, and relationships between different fields, specialised work continues, but with the added benefit of co-operation, and broader expertise. And the fact that policy principles have been put together like this for the first time, adopted by ministers and will be the subject of a Council of Europe statutory recommendation, gives them a lot more political credibility and clout.

The principles are not too directive; this is so they can be applied flexibly to suit the way institutions are set up in different countries. And as we all know, financial and human resources are very different throughout Europe, and within the same country as well. There are also cultural differences in perceptions and definitions of violence. And in some countries, certain types of violence, here I am thinking of school violence, is still an “unspoken” issue and is not part of the public debate, though it may be a concern of the government. In some regions, there is still not a common way of talking about violence or of defining it, and access to basic research texts is hampered because so few of them have been translated.
We focused on “violence of an intentional nature”, under which a wide category of acts could be subsumed, and based on the WHO’s three tier typology, on inter-personal violence. The project included the term “everyday life” in its title to accentuate that violence is no longer something that happens to others, but can pose a threat to people in places frequented on a regular basis.

What is an integrated approach to violence prevention? It is based on the idea that violence does not spring from a single source, but is a problem with many faces: economic, social, cultural and psychological, and any effective response to it must take these into account and bring together a wide spectrum of expertise and knowledge. Traditional prevention activities are often based upon thematic, conceptual or operational categories, which an integrated approach would link. For example, in any integrated prevention scheme, thematic categories such as types of violence against homosexuals, women, ethnic groups, would be linked to places of violence such as a sports events, school, in the streets and this lethal concoction can be worsened by a third category such as alcohol or drug consumption. There is also horizontal integration at local, regional and national level, which links all agencies and organisations dealing with violence, and there is vertical top-down, bottom-integration, or linkage between all levels of government.

A last example is that of international integration, from bi-lateral through to regional, European and global level, whose aim is to harmonise and co-ordinate responses to violence and exchange information and research results internationally. This type of co-operation does not yet exist, but will be one of the aims of a European observatory on violence, which for the moment is in its nascent stages, and which I will tell you more about later in my talk.

An integrated approach relies systematically on partnerships. Clearly, the criminal justice approach, with its traditional means of repression, has proven to be inadequate. Violence concerns too many people, victims, perpetrators and the neighbourhood, and the quality of life of all concerned is eroded when violence occurs, so violence prevention must be a joint responsibility. Agencies can no longer afford to work alone.

Many states already have a national co-ordinating body for partnerships but it is important that policy be fixed in consultation with actors from all levels, including civil society, to avoid being a strictly institutional policy.

Partnerships at local level are particularly crucial; for it is here that the conditions leading up to violence are best understood. But these partnerships must be meaningful ones, and not partnerships in name only. They must involve local authorities, whose participation must go beyond the services they normally provide. The police are vital to most local partnerships, depending on how local structures are set up across Europe, but also depending on local attitudes towards the police. They should not dominate over other fields of expertise. Finland is a country that has local partnerships set up which include the police but which are truly multicentred.

And once again, it is important that local partnerships are based upon more than agencies, they must also include members of civil society, whether NGOs, citizen’s organisations, youth organisations, parents and teachers, and this is something that needs more attention across Europe.

Partnerships should include those who are targeted by prevention schemes. These groups, communities or neighbourhoods, usually marginalised, should not be objectified, but should play a participatory role in both the content and the implementation of what is being set up. Not only can this type of inclusion give a sense of value and commitment to a community which may have been sidelined by the municipality, with a lack of adequate schools, security, and transportation infrastructures, it will provide
fresh viewpoints and first-hand knowledge that can be used to find and implement solutions. This type of participation gives forgotten people a say in programmes that directly affect their lives, and this is a formidable boost for democratic citizenship. One example, the Council of Europe has run a series of empowerment schemes for one of Europe’s most deprived peoples, the Roma, the aim of which was to provide training in project organisation and teamwork.

Partnerships may not be easy to form; there are barriers that have to be overcome. These may take the form of inter-agency rivalry, fear of losing autonomy, and/or bringing together agencies that most often work alone. Partnerships can also bring together people and groups that have a history of hostility, or have differences in social levels and language, or even strongly clashing viewpoints. Cooperation in partnership schemes may even cause some to fear reprisals for “revealing” aspects of crimes, and some local groups have feared reprisals for criticising the police. These divisions have to be overcome. In spite of the tensions, people are there because they are committed to a common purpose. Anne Wyvekens from the French National Scientific Research Centre speaks of partnerships in these terms:

‘Partnerships have an intrinsic function: to reassure various players who find strength in bringing together their difficulties and attempts to solve them’.

The project also stressed new methods such as a victim-oriented approach, and mediation or restorative justice, often called the community approach. Victims can develop anxiety and even severe depression and must be supported to minimise injury and other consequences. The police, health services or NGOs should provide counselling with the sensitivity of the crime, age, ethnicity, sex and sexual orientation taken into account. Progress has been made in this area, but just as the forgotten neighbourhoods I mentioned earlier, there are still too many victims who are the forgotten people in a crime. Their contact with the authorities can be reduced to reporting the crime and receiving a telephone call informing them of the trial date.

Developing mediation, or restorative justice, is both an offender and victim approach, which involves the community. It is a non-violent and restorative means of preventing and solving conflicts. Conventional justice systems have taken too little account of victims need, and excessive use of imprisonment has done little for offenders. This community and partnership response to crime should help the victim to recover, hold the offender accountable and encourage the offender’s re-integration into the community once reparation has been made. Restorative justice is not suitable for certain types of crime, such as domestic violence or sexual crimes, and both parties have to agree to go through a mediation process without any pressure. It may not be easy to set up but when conditions are met, it enables the victim to put a human face on the offender, and better understand the context in which the crime was committed. It helps the offender understand the repercussions of the crime, the harm that has been done to the victim and the need to make financial or some other type of compensation. Restorative justice does not mean “escaping punishment” provided for by law. It has many forms, and can even take place in prison, just after sentencing or before release. It is a relatively new phenomenon in Europe, and still does not enjoy wide acceptance from the public or criminal justice systems to which it is closely bound. For this to be achieved regular contacts between mediation services and the criminal justice system are to be encouraged.

Many here have spoken about the need for assessment. Prevention-scheme results and what is meant by “results” is not always clear. The project also accentuated the need for schemes to keep a clear record of what they were doing at all phases of operations, so that quality assessment could be carried out. Neither should a partnership scheme cloud
accountability and transparency of individual partners, whether agencies or civil society groups. According to one researcher from the Cambridge Institute of Criminology, with regard to school violence, there is a lack of information about what initiatives actually do, and if there is well-founded evidence, it suggests that the majority of programmes may not be having their intended effects. One of our Cambridge consultants made a strong statement along the lines of “in this multi-coloured garden of prevention schemes, we still are not sure of what does and does not work”. This is very important, because when there is evidence-based proof that prevention is effective, it can be multiplied and used as a model for good practice, and it can be shared on an international basis. And projects that are not working are taking money and expertise away from those that do.

Many of the speakers here today have mentioned the lack of statistics on crime; hopefully this will start to change in the future as the Congress of Local and Regional Authorities of the Council of Europe will hold a meeting with other partners this year to discuss the creation of a European Observatory on Violence. Although still in the planning stages, its proposed functions will be to:

- Include and improve on crime-data gathering.
- Make data available for comparisons.
- Gather examples of good practice and broaden exchanges between countries.
- Pool existing data banks.
- Improve working relations between different prevention partners, between institutions, and organisations.

By speaking about the integrated approach, partnerships, the inclusion of civil society, a victim and offender approach, mediation, and the need for quality assessment, I have very succinctly covered most, but not all, of the 12 policy points, and certainly not in detail.

I recommend reading the project’s final report, Confronting everyday violence in Europe – an integrated approach, which has been the basis for my talk, and which can be found on the Council of Europe website at http://www.coe.int (under transversal projects – violence).

I have left a list of our publications on the table and would be happy to send you any of the books requested. Among these are two that I have drawn on today, A partnership approach to crime prevention by Paul Ekblom for the UK Home Office and Anne Wyvekens, a French researcher, and Rebuilding community connections – mediation and restorative justice in Europe, co-authored by the European Forum for Victim-Offender Mediation and Restorative Justice in Leuven.

I thank you very much for your time and hope my talk has been useful to you. I am very interested in what you have to say, as it will also be feedback for me to take back to the Council of Europe, for we all know that there can be no coherent policy recommendations without listening carefully to those working in the field.
For another three weeks, those who work in my part of the Home Office will be governed by a target that requires us to achieve a number of outcomes, notably to reduce:


and to maintain that level.

From April of this year, we will move to a new target that will require us to reduce crime by 15% by 2007-08 (as measured by the British Crime Survey (BCS), which covers adults living in private households) and by more than 15% in the 40 top high crime areas.

In other words, robbery is the only violent crime that appears in our current Public Service Agreement (PSA), effectively our ‘contract’ with the centre of government and the public. And violent crime is not highlighted at all in our new target. On the basis that we are often told “What isn’t targeted isn’t tackled”, does this mean the Government does not regard violent crime as a priority?

Composition

If we look at the composition of the crimes which are covered by the Government’s overall target, we see that in 2003-04, violent crime in its various manifestations accounted for 23% of the British Crime Survey crimes and 22% of the police recorded crime which approximates to it the so-called “BCS comparator” (slide 1). 23% is a significant amount of crime but is less than the 48% of the British Crime Survey accounted for by theft (or as much as 56%, if we include burglary too). Or the 33% which comes under the heading of “criminal damage” in the BCS comparator and which ranges from the spraying of graffiti to the slashing of car tyres.

What is crime?

If we were only concerned about the impact on the crime figures, we might well encourage Crime and Disorder Reduction Partnerships (CDRP) to focus most of their efforts on criminal damage or theft rather than violent crime and indeed this is exactly what some of our critics fear will happen.

Yet if you were to look at the way in which resources are deployed in the area of the Home Office that deals with crime reduction, and for which I am responsible, you would find a different story. While most of my teams are reducing in size, as we seek to respond to Government’s efficiency agenda, our Violent Crime Unit is actually expanding.

Trends

Why is that? Is violent crime growing? Therein lies the conundrum. Certainly, you
would think so, if you were to look at the headlines screaming out from the popular press, when we publish the crime statistics each quarter. Police recorded crime statistics are the only series which is valid at the local level and they do indeed show violence against the person rising. But we believe there are technical reasons that explain much, if not all, of that increase and that is why the graph shows a discontinuity (slide 2).

First, the introduction of the National Crime Recording Standard (NCRS) in April 2002, which was designed to achieve consistency in the way in which police forces record crime across the country. That has had a particular impact on the figures for violence against the person because, for example, of past marked inconsistencies in the recording of common assault. We originally believed that the NCRS would have a considerable effect on the figures for recorded crime in the first year or so but that would then wear off. However, we know a number of forces are still not ‘NCRS compliant’, so it will take a while longer before we can establish a trend for recorded violent crime with confidence.

Second, targeted policing can in itself increase recorded crime. We believe this is particularly true of violent crime. The increasing use of CCTV, for instance, has meant an increase in the recording and detection of assaults that in the past would never have been picked up in the figures at all.

Third, the Government has been encouraging greater reporting of domestic violence, for so long a largely hidden crime. We must get it into the open, if we are to tackle it effectively.

So the Government last year passed the Domestic Violence, Crime and Victims Act, due to come into force this July. That made common assault an arrestable offence and has also made the breach of a non-molestation order a criminal offence, thereby offering victims immediate protection and so encouraging reporting. The police have introduced trained Sexual Offence Liaison Officers; routine enquiries are now made about domestic violence at antenatal clinics and new guidelines have been issued for teachers on spotting signs of domestic violence among their pupils. The Government has supported action by the voluntary sector too by, for example, funding the Women’s Aid and Refuge joint delivery of a single national helpline and the provision of refuge places. All these measures are designed rightly to encourage victims to come forward and report what has happened to them. But in the process, the violent crime figures are bound to go up.

Finally, the implementation of the Sexual Offences Act last May introduced some changes in definition. So we know that the 22% rise in sexual offences over the quarter to September 2004, compared with the previous 12 months, is almost entirely due to the reclassification of exposure as a sexual and therefore, by definition, violent offence, rather than the public order offence it was classed as before.

By contrast, the British Crime Survey has shown a downward trend in violent crime. The BCS is a continuous survey of around 40,000 people and is widely regarded as the most reliable and authoritative indicator of underlying trends in violence. The latest figures show that levels of violent crime (currently around 2.5 million offences) have fallen by 36%, since they reached a peak in 1995. They now appear broadly stable.
(There was an apparent fall of 9% between the year ending 2004 and 12 months previously. But even in a survey as large as the BCS, absolute numbers are fairly small and that fall was not statistically significant).

However, while we do not believe the rise in the recorded crime figures reflects a true upward trend that does not allow us to become complacent, far from it. The rise in police recorded crime resulting from the introduction of national reporting standards implies violent crime offences were under-recorded in the past. So does the consequence of our efforts to increase the reporting of domestic violence. What the recent increases have revealed, although it has come as no surprise to the Government or to the practitioners in the field, is that the problem was considerably bigger than the published statistics had been portraying. We know, for example, from research that victims suffer 35 assaults on average before reporting one domestic violence incident and that the severity of those attacks tend to increase over time.

So all I am saying is that the trend in violent crime is not necessarily inexorably upwards, as the media would have us believe. The absolute size of the problem is sufficient for the Government to take it very seriously indeed and the fact that the BCS suggests that levels of violent crime, having fallen markedly, may now be levelling off is a concern in itself.

Perceptions

Of course, we are concerned to establish what the factual position is, how much violent crime is being committed and whether the figures are going up or down. But the perception is very important to us too. I have already shown you that our current PSA requires us to reduce crime and the fear of crime. From April, we will have a new PSA that requires us to reassure the public by reducing the fear of crime and anti-social behaviour. It is abundantly clear that some types of violent crime have a disproportionate impact on perceptions. Murder, serious sexual offences, gun crime and other assaults with knives or offensive weapons are actually quite rare. But reports of them are likely to increase the fear of crime significantly.

At the beginning of 2003, Letisha Shakespeare and Charlene Ellis were killed in a drive-by shooting outside a hairdresser’s shop in Aston, Birmingham. Charlene’s twin sister Sophie, and 17-year-old Cheryl Shaw were also injured.

In October last year, Danielle Beccan, who was only 14, was shot and killed from a car around half past midnight, as she returned from Nottingham’s Goose Fair with a group of friends.

Knives can be used to equally fatal effect. In November 2003, 14-year-old Luke Walmsley was stabbed through the heart, while at school in Lincolnshire, and a year later John Monckton, a prominent financier, was stabbed to death at his Chelsea home.

All these names are only too familiar to the UK public, demonstrating just how powerful such incidents are in shaping the fear of crime. So, the requirements of justice apart, the Government cannot afford to ignore them.

Cost

The violent deaths of young people or those who leave young families strike us as especially tragic. The human cost is very high. But violent crime has a huge financial cost too.
We estimate it accounted for nearly two thirds of the cost of total crime in 1999-2000, around £38½ billion out of a total £60 billion. The average cost of an incident of violence against the person was estimated at £19,000. For domestic burglary, it was £2,300 and for criminal damage £510 (slide 4).

We are currently updating this research but the overall levels of magnitude will not change.

Definitions

But what do we mean by ‘violent crime’? Here again, we need to unpack the statistics. The police record 51 separate violent crime offences. They range from murder through to rape and various categories of wounding, to harassment and common assault that may amount to no more than a push and a shove. There are a few esoteric ones too, endangering life at sea, which accounted for only two recorded crimes in 2003-2004 and bigamy, of which there were 71 offences in the same year.

The slides I am about to show you indicate the incidence of three categories of violent crime across the country: the higher the number of crimes per 100,000, the deeper the shade.

Less serious violence covers offences such as harassment, common assault and the possession of weapons. The incidents may be quite minor; in half of all BCS “violent” incidents there were no injuries at all (slide 5)!

However, the category of less serious violence is where differences in recording practice will most distort comparisons between local areas, until the NCRS effect has worked through (slide 6). This may explain why the Welsh borders or the Isle of Wight appear to have a bigger problem than some parts of more urban South Wales! Targeted policing will also have a distorting effect: figures in one town centre may be much higher than another, simply because the local police have decided to launch an initiative to tackle nighttime, low-level public disorder there.
The statistics for more serious violence such as murder, manslaughter, attempted murder and acts of endangering life are more consistent across the country (slide 7). But even here, comparisons can be distorted, particularly where different approaches have been taken in the past to the recording of threat or conspiracy to murder. As a result, parts of rural Wales again seem to have a greater problem than we might expect. The most consistent comparisons probably relate to more serious wounding.

However, despite the anomalies, the message from the slides is pretty clear, the problem of violent crime is greatest in urban areas. You might reasonably conclude you did not need the slides to show you that, colourful as they are. But it is good to know that the evidence confirms our assumptions and that there is a very close correlation between the Crime and Disorder Reduction Partnerships (CDRPs) where violent crime is highest and the top 40 high crime partnerships in England and Wales.

The Government’s strategy

So what is the Government’s strategy for tackling the problem? If we were to focus wholly on our crime reduction target, 15% across the country and more in high crime areas, we would concentrate on volume violent crime. And according to the BCS, as we have seen, the greatest proportion of violent crime incidents are common assaults and less serious wounding. Of course, these offences matter. Many of them are linked to incidents of domestic violence where, as I have already indicated, a series of what may appear relatively minor attacks can build up into a much more worrying picture. Others may be manifestations of the alcohol-fuelled violence, which is deterring so many ordinary people from visiting our town centres later in the evening. But no one would claim they are our greatest problem.

So while we certainly need to tackle volume crime, we cannot, and should not, ignore the very serious offences like murder or other violent crime types which may well affect public perceptions or have a disproportionate impact on particular communities and individual victims.

We have therefore sought to develop a strategy, which focuses attention on those violent crimes that should be of the most importance to Government for a variety of reasons. That has led us to aim to:
Reduce volume violent crime.
Reduce violent crimes which contribute significantly to the fear of crime.
Identify and focus on more serious violent crimes which will not necessarily impact on our targets but nonetheless have importance in terms of public perception, impact on victims and communities and a disproportionate impact on social and economic costs.

What does this mean in practice?

Reducing volume violent crime

In terms of reducing volume crime, we have two strings to our bow.

The first is the Government’s Alcohol Harm Reduction Programme. We already have a wide range of measures in place to tackle alcohol-fuelled disorder and the new Licensing Act will give us more.

But the evidence from the Alcohol Misuse Enforcement Campaigns run last summer and before Christmas has shown that they are not enough. Rights and responsibilities are at the heart of the Government’s approach. Most people drink responsibly but we need to achieve a fundamental change in attitude, so that binge and under-age drinking are no longer regarded as socially acceptable. We are convinced we must no longer focus on simply containing or managing the disorder, so often associated with excessive drinking, but seek to eradicate it entirely.

For that reason, we have added four new alcohol offences which will enable the police to target under-age drinking, whether by the sale, delivery or consumption of alcohol in both on and off-licensed premises, and to deal with it on the spot by issuing fixed penalty notices.

Ministers have also laid an Order in Parliament to bring into force two further fixed penalty notices for:

- Buying or attempting to buy alcohol by a person under 18.
- Selling alcohol to a drunken person.

But we became convinced earlier this year we had to go further still, so we published our consultation paper, “Drinking Responsibly”. That contained a range of proposals, such as a new power to introduce Alcohol Disorder Zones, to tackle the problem of alcohol-related violence and disorder in the streets around licensed premises. They would encourage a partnership problem-solving approach by giving those premises at risk of falling within a Zone the opportunity to act to reduce alcohol-related disorder first. But if they failed to do so, they would then be required to contribute to the policing and other local costs of dealing with the problem they had helped to create. We believe this threat of the imposition of charges should act as a powerful incentive to the industry to get its house in order.

The consultation period closed at the end of last month and we are currently analysing the responses.

But important as alcohol-fuelled violence is, it is not the only form of volume violent crime. So we have also introduced the Tackling Violent Crime Programme to focus on those CDRPs, including Liverpool, where violence is a particular problem. I will not say more about that now, since my colleague, Irwin Turbitt, will be covering it in detail tomorrow.

Fear of crime

There are three key areas on which we are focusing in order to tackle the fear of crime: gangs, guns and knives, sexual offences, and domestic violence.

(i) Gangs, guns and knives

First, the interrelated subjects of gangs, guns and knives. The gangs I am talking about here are not, of course, the organised criminals engaged in serious criminal activity, smuggling
drugs from Colombia or people from China, but the street-level gangs of youngsters, often defined by their territory, the clothes they wear or the graffiti tag they share. They will often carry and use weapons – sometimes knives; sometimes imitation guns and terrorise the neighbourhoods in which they live.

There is a view that gun crime is out of control. In fact, true gun crime is fortunately rare in this country. In 2003-2004, it rose overall by less than one % and the number of homicides involving guns actually fell. But where gun crime does occur, often linked with the supply of drugs, it can have a devastating effect on the families of victims and local communities. So in January of last year, we introduced a 5 year minimum sentence for illegal firearm possession and made it an arrestable offence to carry an imitation or air weapon in a public place without reasonable excuse.

The Government is also strongly supporting dedicated police operations such as Trident in London, Ventara in the West Midlands and X-Calibre in Manchester. Meanwhile, Operation Bembridge last year represented one of the largest ever co-ordinated raids, targeting people across the country who had bought over the internet weapons which are either prohibited in the UK or are convertible to fire live ammunition. One hundred arrests were made and hundreds of illegal weapons were seized.

At the other end of the scale, we launched the Connected Fund last May to provide small grants to small community groups working with young offenders, providing support for victims and offering recreational activities for young people at risk. We were overwhelmed with applications. We allocated an initial £¼ million to 55 groups, with a minimum of bureaucracy, and a second bidding round, also for £¼ million, supported 59 groups.

The latest provisional figures thankfully show that serious injuries from gun crime have fallen, as have the use of handguns. As so sadly demonstrated by the stabbings of Luke Walmsley and John Monckton, to which I referred earlier, there is a need to deal with knife crime too. We are seeing a worrying trend being established of people, especially youngsters, carrying knives for so-called self-defence. So the Home Secretary announced in December that he was giving consideration to a number of measures

- Raising the minimum age of purchasing a knife from 16 to 18.
- Adding new categories of knives to the list of banned offensive weapons.
- Providing a power to require specific licensed premises to search customers for weapons on entry.
- Giving head teachers a new power to search pupils for knives.

(ii) Sexual Offences

Rape and sexual assault are serious crimes that have a particularly serious impact on the victim. Sexual offences account for only 5 % of recorded violent crime but it is estimated that only 15 % of rapes are reported to the police. Contrary to the myth that rapes are committed by strangers in dark alleys, as you will know, over half of them take place at the hands of a partner or former partner. Rape is more feared by women than any other crime. 30 % of those aged 16–29 have been shown in surveys to be very worried about it.

The 2003 Sexual Offences Act, which came into effect in May last year, provides a clearer and stronger legal framework for protection by, for example, legislating for more consistent sentencing and by removing gender discrimination.

The Government’s 2002 Rape Action Plan set out measures to improve the investigation and prosecution of rape cases to try to increase the number of offences brought to justice and we will audit its implementation later this year, in advance of a formal follow-up inspection.
And at a very practical level, thirteen Sexual Assault Referral Centres have been established, with Government support, most run in partnership by local police, the health service and the voluntary sector, optimising victim care and evidential integrity for all victims of rape, whether or not they report to the police. In all, the Government is providing £4 million of funding between 2004 and 2006 for services to the victims of sexual crime.

(iii) Domestic Violence

Domestic violence accounts for 16% of all violent crime and according to research undertaken in 2004, costs the country around £23 billion a year. One in four women and one in six men will be a victim in their lifetime, although women are likely to suffer greater injury and be classed as chronic victims. On average, a male partner or former partner kills two women a week.

In 2003, we set out the Government’s strategy for tackling domestic violence through prevention, protection and justice and, as I have mentioned, last year we passed the Domestic Violence, Crime and Victims Act, the biggest overhaul of domestic violence legislation for 30 years.

We funded a personal safety video, “Watch Over Me,” last September, launched a programme for treating offenders in October and issued best practice guidance for CDRPs the following month, while the Association of Chief Police Officers (ACPOs) issued guidance of their own to the police, who have launched specific domestic violence training. This month is designated Domestic Violence Month, with a range of activities, too many for me to mention. But to single out just two, which you may well see here in Liverpool

- Topshop has launched a month’s awareness raising campaign this week in their women’s clothing stores.
- Over 60 Burger King restaurants across the country are promoting the national domestic violence freephone helpline on their till receipts.

Hate crime

There are other violent crimes that do not impact in a major way on either of our PSA targets but are nonetheless important to public perception, due to their effect on victims and communities and for the disproportionate impact they can have in terms of their social and economic costs. Hate crime is a clear example. These are the religious and racially aggravated common assaults, harassment and less serious woundings, which the press report from time to time. But hate crimes extend to other areas too, such as crimes motivated by homophobia or even prejudice against people with disabilities.

I would be first to acknowledge this is the least developed aspect of our strategy. The Government needs to discover more about the nature of the problem and what works in reducing this type of crime; we must identify where there are gaps and work out how we measure success. But at least we are on the case.

Conclusion

Violent crime takes many, changing, forms. Who would have guessed, even five years ago, that alcohol-fuelled disorder would be the problem it is today? And like an iceberg, much lurks beneath the surface. We already have a wide range of powers to tackle it but the Government has shown itself ready to introduce more, if the case can be made. At a time when we are all conscious that resources are limited, the key to progress, as so often, lies in acknowledging that no single agency has all the answers and that we need to increasingly work in partnership. That, in my view, offers us the best prospect not only of reducing violent crime in reality but also of turning round public perceptions. And both matter.
It is a great honour for me to be here representing the Centers for Disease Control and Prevention. It was felt that it would be valuable for me to come and talk to you about the history and evolution of our structure for violence prevention at the Centers for Disease Control and Prevention. Many people are not aware of the details of that history and I am going to focus most of my comments on how it evolved. We now have a very strong Division of Violence Prevention within the Centers for Disease Control and Prevention with, some would argue, a substantial budget. From our point of view, however, this budget is not nearly enough in comparison to the size of the problem. One question that has been raised is “How did all of that happen?” I thought about it and I realised that I actually do not know. Therefore I was left with the opportunity to describe what happened and for people to draw their own conclusions. The other risk in this kind of presentation is that you have to react to what went before, and there have been a number of comments about the relationship between science and public policy in the United States. Professor Waller did a very good job of reminding us that we have done a fair amount of science in the United States, but that the uptake of it in terms of the policy is sometimes lacking. So I thought I would start with a story (slide 1).

The story goes this way: a man was travelling across the country in a hot air balloon, when he became disoriented. So he lowered the balloon closer to Earth to get his bearings and saw a man walking in an open field. He lowered the balloon to about 30 feet from the ground and called out, “Excuse me sir, but can you tell me where I am?” The man on the ground replied, “You are in a hot air balloon about 30 feet off the ground.” Well, the man in the balloon said, “You must be a scientist.” The man on the ground replied, “You are absolutely right, but how did you know?” The man in the balloon said, “Well, I knew you were a scientist because you have given me information that is technically correct but is of no use whatsoever.” Well, the man on the ground responded, “Ah. You must be a policy maker.” The man in the balloon said, “Darn, if you are not right! But how did you know?” The man on the ground replied “Because you don’t know where you are, you don’t know where you’re going, and now you are blaming me for it.” All of which is to say that sometimes bridging the communications between prevention science, public health or otherwise, and policy is an awfully difficult undertaking. This is our struggle in the United States. But we do try.

I want to start by describing a little bit about where we are as an agency in this kind of work, how we got there, and where we plan to go. Here is a chart showing the leading causes of death by the latest year that we have for the United States (slide 2). The reason that public health gets involved in an
issue is because of the burden of disease (or disability or in our case injury). From this chart you can see that the leading causes of death in the United States involve injuries. Within injuries, homicide and suicide remain the second or third leading cause of death for the ages of 15-34. Astonishingly, homicides are the third leading cause of death in the United States for ages 1-4, and fourth for ages 5-9. If you add all the figures together you have somewhere in the area of 10,000 people below the age of 34 who die every year in the US due to violence. It is five times more likely that someone in the 15-34 age range will die from violence in the United States than from AIDS or from any other well known diseases.

There was discussion earlier about the kind of impact that public health can have on policy makers. I can tell you that these kinds of rankings of causes of death have a significant influence on policy makers. We even have the ability to break these down in terms of a particular State. State legislators, for example, often want this information so that they can see how they compare with their neighbours. This becomes the impetus for prioritization of the issue. They may not always do the right thing but they will do something when they see that these are huge issues in their state or local area. The violence prevention priorities at the Centers for Disease Control and Prevention are legislated by appropriations language which earmarks our budget. They are, as you see on the chart, youth violence, intimate partner violence, sexual assault, suicide, and child maltreatment. This is our budget outlay, mainly in these areas. Our funder are the Congress of the United States. They tell us to focus on these areas even though scientifically, for health reasons, we know that all of these issues are interconnected. We try as much as possible to capitalise on that to do prevention research. Emerging for us of course are partnerships in global health that allow us to participate with the World Health Organization and Regional Health Authorities on violence prevention and research programmes. Elder abuse, which has a very small budget earmarked for us, is certainly an important area in light of the changing demographics in the US. It is also an area which we believe will be vastly better funded and more important in the future.

What is our bottom line? Our mission is to prevent injuries and deaths caused by violence. How? By encouraging the widespread adoption of preventative strategies that are known to be effective based on the best available science. In terms of the structure (slide 3), and this again has evolved for well over ten years, we have an Office of the Director where I work. However, most of the work of the Division occurs in three large staff communities of 20-25 staff a piece.

First there is an Aetiology and Surveillance branch whose main purpose is to see that we have good numbers on all of these forms of
violence, and that we are tracking and analysing the numbers. They also ensure that we are establishing what are risks and perhaps even protective factors for all of these areas. Their role is also to build surveillance tools and capabilities; not just for the Nation, but for State and local communities where possible. Second, we have a Prevention, Development and Evaluation branch. This is a community of prevention scientists who look at the data. We fund a fairly substantial extramural research budget in prevention research in all areas of violence, where we challenge the prevention research community to come up with well evaluated strategies. We also scan the literature to try to understand what it is telling us in terms of policies for prevention. But lastly, and this is our newest branch, Programme Implementation and Dissemination. We want to do all we can to encourage widespread adoption of effective strategies, and also to mount programmes within The CDC itself in order to promote alternatives to violence. One thing that I am very proud of, is that one of the emerging features of our Division is the development of a strong Health Communications and Health Marketing team, who are able to develop strategies for mass communication aimed at the prevention of violence. The public health model (slide 4) is certainly a way of categorising the full spectrum of roles public health is to play in violence prevention to the extent that resources and expertise are available. Investment in each of these areas is crucial.

Somebody mentioned earlier that having a Surgeon General speak to an issue symbolises its importance and its relevance in the health sector. But, in fact, CDC’s work in violence prevention began, as the result of a terrible incident in the Atlanta, Georgia. In that particular year there were a series of deaths of young, African American children between the ages of 10 and 14; some 60 in a single year. This terrorised the city and mobilised the focus of the nation. All of the federal
agencies in the United States that could have some contribution to make in the Atlanta area were asked to get involved; the CDC as well. It was epidemiologists from the CDC (whose work was based on infectious disease outbreak examinations and interventions), who joined the team of law enforcement, social services etc, to help the city deal with this epidemic of child homicides. The media was putting out that the Ku Klux Klan and other racist groups caused these deaths because all the victims were black children. There was widespread panic in the city. The CDC epidemiologists used field epidemiology surveillance techniques to analyse the pattern of victims; who was most likely at risk in terms of age, location, and times of day. The purpose of the field surveillance, as far as CDC was concerned, was not so much to aid in the investigation of the crime as to provide information to parents in the community so that they would have some guidelines that they could use to protect their own children from these deaths. That was very successful. The case was solved by the way. The outcome of the case was that the perpetrator was an individual who was posing as a member of the media as a reporter; not the profile of the killer in the popular mind. I will not say that the CDC solved the case, but it certainly was the first use of field epidemiology techniques to point out the distinction between stranger versus relationship oriented violence. The perpetrator was not necessarily related to the

The vision itself was established somewhat after that, and I will show that on the succeeding time line. But in that phase of building the case, the fact that the CDC was regularly reporting on the issue and using tools familiar to public health in the applications of violence prevention was very, very, helpful to the field. These represented achievements of our early work (slide 7).

Slide 7

Key Scientific Achievements

- Applying epidemiologic methods to understand violence
- Supporting and conducting evaluations of violence prevention policies, programs and interventions
- Contemplating the application of economic analysis to violence and its prevention

I think these three bullets speak for themselves in terms of some of our achievements. The last one I will comment on relates to economic analysis. The next decade saw an extraordinary increase in the resources going to CDC for public health oriented violence prevention (slide 8). The first congressional appropriations earmarked for youth violence prevention occurred in 1992. This came as the epidemic of youth violence and youth homicides in the United States was peaking. CDC funded a number of evaluation projects to establish what we knew about the prevention of youth violence. At the end of that era, we published Best Practices for Youth Violence Prevention. This is still one of our most widely circulated documents and provides a synthesis of some of the things known to be effective in this particular field. I think they were commented on earlier. At the same time, we also received an appropriation to begin working on intimate partner violence prevention. That funding came to CDC in recognition of the fact that violence was somehow related to public health work. It also happened because of the
advocacy of women’s groups; they felt that a public health outlook or viewpoint on this particular issue might add to the impetus for bringing public attention to it.

The last five years or so has really been characterised by our moving more towards compiling preventative strategies:

- Making the public more aware of effective approaches to violence prevention of all kinds.
- Moving towards greater partnerships with international partners around the world such as the World Health Organisation (WHO) and the work that we did with them on the World Report on Violence and Health
- Our work with regional health authorities
- A move towards more sophisticated health marketing approaches for violence prevention.

These were some of the significant niche contributions for public health in this field. Certainly, we felt that we added to the focus on primary prevention. That still is a very, very difficult thing for the public at large to envision. We thought that we did a good job in the last 10 years in linking science with prevention. We now have information resources. For example, we have our guide to community prevention services which synthesises what we know about different forms of injury and violence, and other health matters. We translate that information into community guidebooks that are widely consumed and reported on as this information is released. We provide some kind of integrative leadership between the different sectors that have a role to play in violence prevention; this is something that we have tried to foster. Increasing community participation and involvement are contributions that we constantly work on because, in the end, we believe that violence prevention ultimately occurs at the local level. We do not invent a programme in a box and distribute it. Instead, we challenge communities to take responsibility for the conditions contributing to violence, and to work in partnership with public health and the other sectors to address these things using the best available science.

As far as recent trends go, it is hard to synthesise all of this. In certain areas there is an increased use of data to guide public health priorities. Even in CDC itself, where we have many priorities, we have gone through a two-year internal process about the relative investment we make in certain disease categories versus others. The disease burden associated with violence, as well as with injuries that are unintentional, ranks very, very high on our list of new priorities for the future in the CDC. We are attempting to realign our budget so that there is more adequate attention to injury and violence issues. The idea of using premature mortality as an indicator of health burden is certainly
Health Organization have also shown that most of the deaths associated with violence occur in the younger age categories. This means that you can show how premature mortality creates a different ranking for health priorities than would otherwise be the case. We have been able to foster that. Thirdly, I think it has been very helpful to have behavioural and social scientists as integral parts of public health practice and science. In the division we have over 100 staff, but we combine the talents of criminologists, sociologists, psychologists, medical people and masters in public health. All of these people come together and work in the field of violence at the CDC, and that enriches the field and creates a new combined language for public health practice that taps into the strengths of these core disciplines.

In the future I think you are going to see an increased emphasis on health marketing and promotion as a universal approach to violence prevention. We have now added these to our series of disciplines. I just mentioned the role health economists in the CDC Division of Violence Prevention team. Adding their discipline in the form of research team is where we plan to put a lot of emphasis.

I am going to wind up by just mentioning a report that has received a great deal of attention. I spoke about this in Bordeaux, France last October. Using the tools and expertise of health economists we have looked, in the most detailed way we can, at the economic impact of violence. This is another way to raise and elevate the issue of violence as a priority for public policy response in an era where resources are very tight. I think Alex Butchard mentioned earlier that applying health economics to violence involves many components; direct costs, disability care and non-medical costs. It also involves using productivity lost data. This is a new element for this kind of research in which economists have expertise. They do it very well. They also provide further estimates. Our recent report is on the economics of violence against women. We were able to pin down (in terms of annual cost for this type of violence), a figure of five billion dollars a year for rape, physical assault, and stalking. The victims of these crimes are largely women, and the costs are very precisely defined. In our country, where the healthcare costs are vast and rising, the idea that you can contribute to improvements in healthcare spending by reducing violence has become very popular. 70% of the cost in the figure I gave you is in health care (slide 10).

The future of economic analysis and research into violence prevention will be, not only to ascertain the cost, but to establish the economic benefits of violence prevention strategies for women and other groups in hard dollar, currency terms. I think you will be seeing a lot more of this.

The globalisation of violence prevention efforts is a very important and a long needed trend. We value the partnerships we have with many countries. We have learned from them. One of the most exciting interventions that we are now researching for child abuse prevention is called the triple P (Positive Parenting Programme). This programme combines a universal strategy for elevating parenting skills along with a selected strategy for intervening with parents on issues of discipline. This is in addition to a tertiary care strategy for parents who have been identified as abusers. We think that embedding this kind of programme in our communities in the US.
will go a long way towards preventing child maltreatment. The programme itself originated in Australia and was replicated in Singapore and other places around the world. It provides a good example of the globalisation of violence prevention efforts, where we learn from one another.

I would just like to make three points about the CDC.

- For a long time we have recognised (and will continue in the future to recognise) violence as a substantial public health problem. When we associate the brand of our agency to this issue it messages the public that this is a health problem. The numbers that we produce certainly justify it as well.
- We think that public health adds value to the mix of other sectors involved in violence prevention efforts including criminal justice and education. We value partnerships across the sectors.
- Finally, I believe that health economics in this sphere will underscore the need for, and the benefits of, effective prevention strategies. And so as you are building your own capacities for violence prevention in the UK, I would encourage making sure that the discipline of economics is included in the multi-disciplinary team.
When we look specifically at Jamaica and examine a 30 year period we can see that there has been a tremendous increase in homicide rates, but no matter what country you are in, there is no place for complacency. Last year alone we had over 1,000 homicides in Jamaica (slide 1). That gives us a rate of 45 per 100,000-population making homicide the fifth leading cause of death. If you look at young males, homicide is the number one cause of death. But, as we know from the World Report on Violence and Health (which has been a great inspiration), for every person that is killed by violence many more are physically injured or psychologically damaged.

The World Report also highlights the importance of conducting surveys at the community level in order to describe the extent of the impact of violence. We have a sentinel surveillance system that has been operating in Jamaica for years. A few years ago we actually added both intentional and accidental injuries; when you look at the total, this amounts to 1.5% of all the patients that are seen in our 56 sentinel sites across the island.

We analysed our hospital discharge data (we have four health regions in Jamaica) (slide 3) and found that once you take out obstetrics, injuries are the number one cause of admissions into hospitals no matter what health region you are in. With regards to the direct cost of hospital care, we spend over $1 billion on injuries. Of that, we estimate probably 600-700 million Jamaican dollars of this is attributed to violence related injuries. For the country as a whole, the studies that have been done revealed that the cost of violence to the economy is approximately J$15 billion, and J$1 billion of that is due to hospital costs.

Having analysed the basic statistics, we wanted to further define the problem, look at the risk and the protective factors and test the
interventions. We need to make sure they are properly designed, implemented and evaluated, and then the hard part: applied.

**Slide 3**

In collaboration with many partners (Centers for Disease Control and Prevention, World Health Organization, University of the West Indies, and the Ministry of Health), we put together the Jamaica Injury Surveillance System. We used the International Classification called the International Classification of External Causes of Injury. We tracked the date of violence related injury, the place of occurrence (home school or work), the method of injury (whether it was a gunshot or a stab wound), and the circumstances of the injury (fight or robbery), victim perpetrator relationship, and geographic location of the injury. We started in one hospital. Once we had got it right in one place, we expanded it across the island. We now have it in the nine major hospitals. When we analysed the data (this is data for about 12,000 people), we noticed that there are more males and the majority of the injured are young. They are mainly under the age of 30.

Most of the violence related injuries (VRI’s) are occurring as a result of an incident that occurred with an acquaintance (slide 4). Stranger violence is not a common occurrence. For intimate partner violence, if you look at the data just for females, the intimate partner violence figure goes up to about 30%. Therefore within the female population, intimate partner violence is a very important cause of violence related injuries (VRI). The vast majority of cases are the result of a fight that went wrong. Not that many are related to burglaries and robberies, or drug or gang related. Sexual and child abuse accounts for about 6% of VRI cases.

**Slide 4**

Where does violence occur? When we first undertook this work we were mainly in the urban areas. We saw violence mainly happening on the streets. Now that we have extended surveillance to our rural hospitals we see a larger percentage of violence happening in the home. Of great concern is that about 4% of our violence related injuries are actually occurring in our schools.

What are the objects involved? Mostly it is a sharp object, but there are also a lot of blunt objects involved and bodily force (slide 5).
When you look at this by gender, you see that women are more often hurt by a blunt object or by bodily force, while men are more often hurt by sharp objects. Gunshot wounds (we do not count dead on arrivals) account for about 4% of our cases.

We have been able to look at the geographic occurrence of violence related injuries. We get a simple database where we can record different types of injuries, (whether it is more typical violence or accidental injuries), and we get two addresses. One address is the location of the injury, and the other address is the place where the person lives. Then we developed a semi-automated way of pulling up about 10,000 data points per minute. Once we have the streets centralised vector map, each of those red dots refers to the location of a violence related injury (Slide 6). You can then manipulate the data and carry out all the hotspot analysis. Resources are limited, so agencies want to concentrate on either crime control or violence prevention activities; those red hotspots are where you should get most impact for your resource allocation.

Then we can go back to our community areas. We looked at specific communities in Kingston (the army actually did some control work and they cordoned off this area) and when we looked at the nature of the injuries occurring during the curfews we could see that there were a lot fewer homicides, but there were still a lot of blunt and stab-wound injuries that occurred. That told us that we probably needed a different type of intervention (besides the army actually being there), to really deal with all the different types of violence.

This is what we are working on now. We are trying to build what we call asset based maps. Where do we have violence prevention programmes in those areas? We are going to be working with Alex Butchard at the World Health Organization and UNICEF on the Violence Prevention Documentation project. The projects will help us to make sure we know what assets exist in the areas where we have the problems. Where are the Violence Prevention programmes? Where are the churches? Where are the schools? What is the name of the school? What is the size of the population of the school? All these questions can be answered. To summarise: as well as having health outcomes, we will have asset based maps to enable us to see what resources might be available to deal with the problems identified.

We know that a large majority of these violence related injuries are due to reprisals. There is a criminologist we work with closely at the University. We have done some focus-group work with people in the hospitals, and this is good Jamaican Patois:

“you see like how me come take my stitches, she have fi take back fi her too”.

[Stab victim]

“me must get him back...”.

[Stab victim]

“As me go home, me a go fi my gun...somebody haffi get shot... truly”.

[Gunshot victim]

We have found that when crimes do not get reported to the police it is because people want to go and settle the problem by themselves. We can do logistic regression to see if we can prevent reprisals, decrease the severity of VRIs and reduce the hospital workload.
This shows our admission levels due to violence related injury (slide 7). If we could even get half of those injuries and reduce the sharp object injuries to blunt object injuries we would reduce our admissions significantly. When you convert this to a dollar figure and you show the government that this would save many millions of dollars every year (and we have actually got dollar costs for each of these scenarios), you get people starting to pay attention.

We are also looking at risk and protective factors. When we looked at inner city Kingston for a cohort of 11 year olds, we found that up to 18% were separated from their mothers and 51% had been separated from their fathers. Since the majority had been separated for over eight years, they had only spent three years together. This is sometimes because they have migrated or because the father has been killed, or because the parents’ relationship has broken down, or because the parents have just abandoned the children.

What factors are we associating with delinquent behaviours? Underachievement in school is a major factor. People already know about the dropout problem in schools and the need to follow this up. Exposure to and witnessing acts of violence is a very big risk factor, as are drugs, alcohol, suicidal thoughts, and interestingly, watching more than 20 hours of television per week. This was a major risk factor in later perpetration of violence. Some children did very well while still coming from this same deprived inner city. Those resilient children were the ones who attended church and participated in organised activity. They definitely showed less aggressive behaviours. It made a big difference if children came from a stable family unit where they experienced warmth and caring and had somebody that believed in them. Put simply, children who had somebody that loved them and gave them a hug did much better despite all the adverse situations.

From the World Report on Violence and other studies, we know that we can prevent violent injuries, so we have come up with a model. We examined if we were going to work at the primary prevention level when children are young, before they are even affected. This involves focusing on parenting skills and lifestyle, including what is watched on television and video games. It also involves focusing on what kind of life skills you build by the age of about six or seven. At a later stage the focus needs to be on issues like literacy, numeracy, mentorship, and supervised, structured after school activities. If this is unsuccessful, tertiary interventions can be implemented. This involves looking at hospital-based and community based interventions. So, depending where you find people at risk, you apply the most suitable intervention. All of us have to ask ourselves
this question, because none of us are immune: are we really raising our own children to resist violence? We have adapted parenting programmes adapted from an American publication called “Raising your kids to resist violence.” It has puzzles and games on parenting and lifestyle in the back (slide 8).

Because we could not print enough, we did most of these presentations on a CD. In addition, we have a video with some of the information and also wallpapers for computer screens that the children in schools across the island had designed for us in a competition. We have a resource directory about where people can get help. The issue is: how, in our resource-limited society, do we apply the interventions widely? There are a few projects in place. A very important one is having safe, clean, green spaces. We are seeing more of these popping up in difficult areas, not just in Upper Saint Andrew.

This is our violence free day campaign [video clip] (slide 9). What was very interesting was that we did not achieve our objectives but we achieved tremendous support. We had hundreds of participants. The Minister of Health was supportive, as were media personalities, musicians, graphic artists and taxi drivers.

We had a “cyclethon” that went across every parish. Bike riders, who were part of our Violence Free Day Committee, rode across the Island for seven days and stopped in every parish capital. This message was read by the Mayor in every capital in Kingston. It said:

“The spirit of hate and compulsive anger is let loose in this, our beloved land. There is hardly one Jamaican left who has not known somebody whose life has been wrenched up by the merciless force of a bullet, whether it is a relative, a friend, a co-worker or a distant acquaintance. Children bereft of parents, parents left to mourn the death of their young ones, youth crippled for life. This beautiful country of ours, robbed of the creative power of its youth. Indeed I call on every Jamaican in the spirit of one love to renounce the violent spirit of anger and hate. And with the help of the eternal Father, whose blessing and guardianship we evoke, turn our hands of violence into hands of love and creative endeavours.”

[The Honourable Howard Cooke, the Governor General of Jamaica].

This was his violence free day message. This is one of the posters from our children showing all the different interventions (slide 10). Let us have peace and let it reign above.
Magnitude of the problem

Worldwide, approximately a million people commit suicide annually. Ten to 20 times more attempt suicide. The mean global male suicide rate is 25 suicides per 100,000 men. For women, the corresponding overall figure is 7 per 100,000 (1).

Over the past few decades, a rising trend of suicide among young people has been observed. The results of a recent study from the European region show that suicide rates among males aged 15−19 rose markedly in 21 of the 30 countries between 1979 and 1996. Suicide rates also rose among females in the 30 countries studied, but less markedly; Norway and Ireland, with their major increases, were exceptional (2).

Analyses of the World Health Organization (WHO) Mortality Database show a rising global trend of suicide in young males aged 15−19 in 1965−1999. This rise was observed in both European and non-European countries (3). In most European countries, suicide is the most frequent cause of death for males aged 15−44. For them, suicide is thus more common than death from road accidents.

Reliability of suicide statistics

For many reasons, the reliability and validity of data on suicide and attempted suicide are questionable. As a cause of death, suicide may be embedded in the figures for road accidents and in some cases occupational accidents, violent deaths, drowning, alcohol and drug intoxication, mental disorders, sudden death, etc. The diagnoses of what are termed ‘uncertain causes of death’ may also mask suicide.

All these misclassifications stem from diagnostic traditions, religious and cultural factors, attitudes towards suicide and the level of education in the countries concerned. It is a well-known fact that diagnostics vary not only among countries, but also within different regions in a single country, as well as among age groups and between sexes.

It is commonly acknowledged that the global reality of suicide is much more serious than the statistics suggest. The cases include misclassification, underreporting and also the absence of reporting in many countries. Of the more than 190 countries in the world, only some 130 submit mortality statistics to the WHO Mortality Database.

Suicide taboo

Suicide and other forms of self-harm are surrounded by taboo and arouse shame and guilt. This has repercussions on suicide-preventive activities, and has made such measures a low priority among politicians and policy-makers. Suicide is perceived as a predestined act, impossible to prevent. Despite all the evidence that suicide and attempted suicide are preventable, many obstacles, not only financial, but administrative, stem from the powerful taboo that, unfortunately, still exists in developed and developing countries alike. Silence and ambivalence concerning the topic, and its neglect, are grave obstacles to any open and scientific approach to the problem. Nevertheless, there are several examples of successful suicide-preventive action (1).

Healthcare strategy

In suicide prevention, strategies can be directed at the general population or the healthcare services. The healthcare strategy includes early identification and good diagnostics and treatment, as well as access to
health services. There is evidence that effective treatment of major psychiatric disorders like depression, bipolar disorder and schizophrenia diminishes rates of suicide and attempted suicide (1). However, in children and adolescents there is a need not only for more research in this area, but also for great caution and close monitoring of young people for whom antidepressants are prescribed (4, 5, 6, 7).

Cognitive and dialectical behavioural therapy, as well as regular follow-up after a suicide attempt, one of the most powerful predictors of future suicide, can reduce repetition of suicide attempts (1).

Public-health perspective

Evidence indicates that environmental controls rendering means of committing suicide less accessible (regulation of gun possession, detoxification of vehicle emissions and domestic gas) as well as reducing the availability of pesticides, raticides and toxic substances including drugs and medication, can bring about a decrease in suicide (8).

Reducing alcohol consumption (as shown during the perestroika period in the former USSR under the Gorbachev rule in the second half of the 1980s) appears to be a highly effective measure of suicide prevention among men (9). The male suicide rate fell by 40% during perestroika, especially for men in the labour force aged 25–54. No corresponding decline for this age group has been observed in any other country in the 20th century. However, this sharp fall in suicide rates coincided with various other reforms in the former USSR, with the concomitant sense of hope for a better future, and greater freedom. All these factors were probably important.

Comparable natural experiments in other parts of the world have shown similar decreases in suicide (10, 11, 12). Examples include Prohibition in the USA in 1910–20; significantly raised alcohol prices in Denmark in 1911–24; and restrictions on the sale of alcohol in Sweden with the use of ration books in the 1950s.

Alcohol restrictions during perestroika also helped to reduce mortality from undetermined causes, accidental alcohol poisoning and acts of violence (9). Moreover, the decrease in mortality from cardiovascular and respiratory diseases in Russia during perestroika has been attributed to alcohol restrictions by other researchers as well (13).

School programmes

There is some evidence that suicide-preventive programmes in schools can reduce rates of suicide and attempted suicide (14, 15, 16). WHO Geneva’s Preventing Suicide — A Resource for Teachers and Other School Staff (17) can be downloaded from the WHO website. This publication advises teachers and other school staff, as well as parents, on how to prevent mental problems and suicidal behaviour among pupils.

National programmes of suicide prevention

National action programmes to prevent suicide exist in several countries. Reports on the European monitoring survey of suicide-prevention programmes and strategies carried out by the Swedish National Centre for Suicide Research and Prevention of Mental Ill-Health (NASP) on behalf of WHO regional office for Europe can be downloaded from WHO (www.who.int/en) and from the NASP (www.ki.se/suicide) website (18, 19).

Conclusions

The dearth of resources available for suicide prevention is in sharp contrast to written priorities and declarations (20, 21). The topic is neglected. Almost a million people who commit suicide, and the ten million families of suicide attempters, in the world each year are
left in the dark, with feelings of deep shame and distress.

Although more scientific studies are needed, current evidence shows that the complex causality of suicidal behaviours calls for multi-model intervention, adapted to specific populations, to prevent suicide. Most evidence comes from the developed nations, and there needs to be more focus on suicide prevention in developing countries. The world’s highest suicide rates are currently found in Eastern Europe, but Asia, especially China and India, accounts for the largest number of suicides. The situation of girls and women, and female suicide, should also be given more attention. Nowadays, suicide among young females in China, Cuba, Ecuador, El Salvador and Sri Lanka is more prevalent than among males (1).

REFERENCES:
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I am going to try to fit into about 15 or 20 minutes what I thought would be a useful overview of interpersonal violence. Yesterday a lot of people talked about how violence is being tackled in silos, and how these can be broken down to get a multi-agency approach. One of the other issues of course, is that we miss the commonality between different types of violence. True to course, the workshops of this conference are also arranged according to different types of violence so there is a danger that people may not see the full spectrum. To avoid this, today’s presentation gives a very broad-brush picture of some of the issues surrounding interpersonal violence in the UK. The report itself [Violent Britain] is not comprehensive. We wanted to include more, but we covered what we could about inter personal violence. This presentation is going to be even more cut down, and so obviously there are other issues that I will not have time to cover.

What I would like to do today is look at:

- Some of the links between different types of violence (some of which were covered yesterday).
- Some of the relevant issues relating to intelligence and data.
- The beginning point of trying to describe the problem properly (another key theme).
- Engaging services; it is all well and good looking at a multi-agency approach, but there are strings and levers which allow us to engage different agencies who may not necessarily see violence prevention as a priority.

The work we have done was achieved by a very broad coalition between the Centre for Public Health, the Regional Public Health Observatory, the Health Protection Agency, the Department of Health, and the Health Development Agency (Slide 1).

The International Violence Prevention Alliance has been supporting this as well. Yesterday, John Ashton gave a history of how this came about. I know there are some new people here today, so I will say very briefly why we formed this coalition. John Ashton has the delegated role of the Chief Medical Officer for Violence on the Public Health side. The Centre for Public Health, along with the Violence Prevention Alliance, have been supporting that role. Together with the Health Protection Agency, we are co-founding partners of the Violence Prevention Alliance which is an excellent initiative. All these agencies have come together to form the Centre for Violence Prevention and Intelligence based here at Liverpool John Moores University.

One thing that was mentioned yesterday is just how much violence we see in the media on a daily basis. Over the last couple of weeks, newspapers have printed headlines such as: “Rape soars as convictions plummet”, “Charlotte punches ex”, “Gang culture plagues one in five schools”, “Bond style protection for members of the community”. The latter relates to issues
around the protection from violence of workers in the public sector. If we go back a little further we see “Street violence jumps in binge drink Britain”, which I will refer to later.

The Public Health perspective was covered comfortably in a very systematic way yesterday. Today I would just like to mention some issues relating to primary and secondary prevention. More specifically, what can be achieved relating to earlier interventions at the root causes. I will discuss issues related to developing, collating and disseminating population data on violence later in the presentation.

Risk Factors: What are the risk factors for victims and perpetrators? Do we know enough about those? Certainly in some areas we do not have enough UK information.

Evidence of cost effectiveness: There is something about the cost of violence that is very important in terms of engaging people. We need to evaluate the effectiveness of what are being suggested as interventions and bring those together into cost effectiveness models. This will allow us to assess what is giving the best intervention per pound.

Implementation: How do we implement those? This is not so easy when you look at issues like the cost and the timing involved. Of course a multi-disciplinary approach lends itself to getting at groups that are vulnerable at early stages.

Violent Britain itself was put together for information, intelligence and policy. The violence covered in the report (limited to interpersonal violence) has been broken down into:

- Youth Violence.
- Intimate-Partner Violence (often called domestic).
- Child Maltreatment.
- Elder Abuse.
- Sexual Violence.

There are sections in the report that look at the extent, the impact, and the cost of each of these types of violence. We have also examined victim risk factors and perpetrator risk factors. A final section of the report pulls these types of violence together and highlights cross-overs. This allows us to look at what is effective in terms of prevention. Yesterday, Alex Butchart talked a lot about evidence in this regard so I will touch on it only very briefly today. More importantly, we have tied in policy areas which cover violence. In many instances you can find policy areas that are relevant, even though violence may not be explicitly mentioned.

**Youth Violence**

An estimate based on some Home Office figures places the cost of youth violence at approximately £12.6 billion per year. If you look at bullying, 46% of girls between 10 and 14 have been bullied at school (about three quarters of a million individuals using 2001 estimates). In terms of other types of youth violence, about half a million young men were victims of violence last year. We can use this information to look at the pressure this places on hospitals. This table (slide 2) refers to hospital episodes; people who have to be admitted for one reason or another to hospitals across England. If you look at the 15-24 year old age group, the second highest cause of admission is assaults. For the 25-34

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age 15-24</th>
<th>Age 25-34</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional injuries 19,977</td>
<td>Unintentional injuries 15,736</td>
</tr>
<tr>
<td>2</td>
<td>Assault 13,867</td>
<td>Malignant neoplasm 10,545</td>
</tr>
<tr>
<td>3</td>
<td>Malignant neoplasm 10,541</td>
<td>Assault 9,400</td>
</tr>
<tr>
<td>4</td>
<td>Intentional self harm 6,920</td>
<td>Intentional self harm 8,501</td>
</tr>
<tr>
<td>5</td>
<td>Diseases of appendix 5,308</td>
<td>Benign neoplasm 7,400</td>
</tr>
</tbody>
</table>

Smith, 2000; Upson et al, 2004; Hospital Episode Statistics 2002-3
year old age group the third highest cause is assaults. So in terms of what pressures we are seeing in hospital systems for these age groups, assault ranks highly. For females, assault ranks lower. It is worth mentioning, however, that intentional self harm is ranked fourth for both age categories. This topic was discussed at length yesterday, and I know from previous work that this is a gross under-estimate due to poor recording.

Risk factors for becoming a victim and/or perpetrator of youth violence include:
- Being male.
- Having a mother suffering from stress and depression.
- Parental conflict.
- Having been born to a teenage mother.
- Negative school experiences.
- Substance use (which will be an ongoing theme).

Intimate Partner Violence

Much work has been undertaken in this area, and the financial burden is more widely described for this type of violence. The highest estimates place the cost at approximately £23 billion. Homicides, as for other categories of violence, are proportionately low. In the UK, homicide levels are relatively low with most people surviving assaults and requiring hospital treatment for injuries from blunt instruments, and hands and feet. Victims of Intimate Partner Violence since age 16 amount to approximately two and a half million men and four million women. Surveys show that a third of the victims told no one about the worst incident. Information from the US shows that 90% of incidents against mothers are witnessed by children. Broad consequences of this include homelessness, risk to children of maltreatment, poor academic achievement, and future involvement in substance use.

The selected risk factors for direct victims include:
- Being female.
- Having a low-income.
- Pregnancy (about 40% of this type of violence begins during that time).
- Risk factors for perpetrators include:
- Being male.
- Having a low-income.
- Substance use.

Child Maltreatment

With regard to 18-24 year olds, about 16% have experienced some form of maltreatment from parents in childhood. Nearly 450,000 have experienced what could be described as serious physical abuse. The consequences of this in terms of behavioural development have been described in the literature. They include the development of aggressive behaviour, impaired educational progress, substance use, risky sexual behaviour, and impaired parenting skills. These of course are risk factors for other types of violence later on. Risk factors for child maltreatment include unplanned pregnancy, parental conflict, low-income and, for the perpetrators, substance use.

Elder Abuse

This is one of the types of violence we understand least. Broad estimates point to about half a million elderly people experiencing abuse at any one time (excluding those in institutional settings). Elder abuse also includes things such as the inappropriate prescription of drugs. One of the targets we share across many institutions is life expectancy. There is some work explaining the relationship between abuse and life expectancy (again, poorly described because little research has been undertaken in this area). Risk factors for the victim increase with age and include factors such as living in a
negative institutional environment. In the case of perpetrators, risk factors include substance misuse and financial difficulties.

**Sexual Violence**

Finally, sexual violence. Recorded rapes amount to approximately 13,000 cases a year, but the real estimate in terms of actual or attempted rapes in the last year is about 47,000. If we look at the number of sexual assaults, the estimated total is around 325,000 women and about 30,000 men. The most serious sexual assaults are committed by perpetrators well known to the victim: partners or ex-husbands. There is very little reporting of this; two in five victims tell nobody at all about the assault. Risk factors include: being young and female, living in a low-income household, being a victim of child abuse, having many sexual partners, and again, substance use.

Without over-emphasising this, I think one of the issues that is important concerns the cycle of violence (see slide 3). While not perfectly described, it certainly links everything together, which gives us something almost like an infectious model. It illustrates how people who are exposed to violence are more likely to become culprits themselves. Some of the links are shown here. For instance being a victim of child abuse and using substances results in a heightened risk of becoming either a victim or perpetrator of youth violence, of displaying anti-social behaviour, and of performing poorly academically.

Other negative environmental circumstances, when added to this, greatly increase the risk of becoming a victim or perpetrator of other types of violence. People are eventually placed in particular situations where they are at a greater risk of becoming the perpetrators of child abuse, thus completing the cycle.

Where do we get the information to start tackling these sorts of issues? Yesterday Margaret O’Mara looked at the Police Recorded Crime and British Crime Survey, and explained some of the differences between these in terms of trends. The ‘take home’ piece of information from this is that most violent crime is not reported and that we need to understand a lot more about this sort of information. One of the other problems is that police related information is closely related to how much effort is put into detection. It is, therefore, very important that

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**Slide 3**

Cycles of Violence

- Perpetrator of Child Abuse
- Victim of Child Abuse
- Impaired Bonding
- Neglect
- Substance Use
- Low earning potential
- Unemployment
- Poor Housing
- Living in High Crime Area
- Unintended pregnancy
- Poor Academic Performance
- Use
- Risk taking
- Victim and Perpetrator of Youth Violence
- Perpetrator of Intimate Partner & Sexual Violence

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**Slide 4**

Persons admitted with Condition per 100,000: (Directly standardised for age)
we get other agencies involved in providing information.

This is the North West of England and these are Standardised Hospitalised Emergency Incidence Rates for violence (see Slide 4). Effectively, they are emergency admissions to hospital for violence related acts. You can take these (shown in rates per 100,000 per year), and you can extract ecological information on what geographical areas are worst affected. It is already available to a relatively low level.

This is called a medium super output area and it is based roughly on the size of wards. The large green areas are not the size of a single area, they are all areas which are exactly the same size joined together. You can use these on a very frequent basis because the information is available monthly (although it needs to be cleaned up) to monitor what is happening throughout hospitals. You can also break it down in other ways to start looking at what is happening across populations. Again, this is independent from police data.

We can also create ecological models. This is not about ethnic issues and I stress that it is the areas, not the individuals, that are being described. This is a breakdown of this information (slide 6); the ethnic make up of areas not the individuals admitted. Basically, this means that when you get areas where less than two thirds of the population is white, you can then define them by the highest level of minority ethnic group within. As this illustrates, there is a big difference between areas that have high levels of black populations; we cannot tell why from this, but we know that there are some issues that need to be examined.

Before you even get involved in issues of disclosure, there is much information you can access. These (see Slide 7) use super profiling on the same data to examine violence as seen through hospital admissions, but what we are really describing is population profiling.
Thus, only a few weeks ago, Liverpool University did a piece of work defining groups in the country by different types. They have also used consumer information from people like Littlewoods, which is incredibly rich information if you can get it. Everyone who has a Tesco Clubcard sells information about everything they use pharmaceutically from Tescos, along with everything they buy and wash with; all sold for about a third of a penny a week. This is in contrast to the public sector where we worry about data protection issues. Here (slide 7) people are defined in terms of issues like being mature Oaks (which are older married people living in detached housing in rural areas) all the way down to the worst in terms of deprivation; urban challenged. This is the elderly and unemployed; mainly single people. I will not go through them all, but these are the main categories which can be broken down further into 44 sub-categories which can then be used to define sub-groups. You can then look at what is happening in terms of violence in these areas and start to understand which types of groups or communities are most affected. Again, if you look at urban challenged, you can see that they are the ones who are most likely to be admitted to hospital. This illustrates the way in which you can start to break down the information in some interesting ways.

Concerning Accident and Emergency (A&E) data; while we have had some great examples from other countries, our A&E data is not easily accessible. Here in the North West we have a Trauma Injury and Intelligence Group which covers some of the region. We can, therefore, extract some A&E data and I have given just some snippets about Accident and Emergency from these areas: half the attendees need treatment for injuries related to alcohol. 81% are males, 71% are between the ages of 16 and 35. Some postcode data is also available. For Liverpool, we do not have postcode data but we can look at events that have happened around pubs and clubs. We can then examine issues such as the involvement of glass and bottles as weapons, which can inform initiatives such as keeping glass off the street. We can also look at categories of perpetrators, for instance bar supervisors. Obviously not all the assaults coming into A&E are alcohol related. If you compare the temporal patterns of alcohol and non-alcohol related injuries you see peaks in the alcohol related ones around Friday, Saturday and Sunday.

I am going to spend just a few minutes talking about nightlife violence because I think this is an example of how you can pull a lot of groups together to work on a particular issue. Many areas influence this type of violence, including town and city design. Therefore town planners are important due to their role in terms of determining street lighting and access. Also, as has been mentioned already, licensing policy and strategy also play an important role. Routinely, local authorities and Crime and Disorder Reduction Partnerships should provide key fora for discussion between health, judicial, environmental, educational and other services on how violence can be prevented. Bar design also has a big effect on levels of violence so the industry also needs to be involved (I will go into this in more detail shortly).

There are other ways in which violence can be controlled in the night-time environment. The training of staff is important and this is now coming through in some policy areas. For example, in Liverpool on a Friday and a Saturday night there are 80 police out there, but there also are 1,500 door staff. Clearly, what those 1,500 door staff are trained to do is important; how they interact with everybody else will undoubtedly have an impact. Another influential factor is drink promotions.

Food outlets can also be hotspots for violence. We tend not to think about food outlets in this regard, but at 2 o’clock in the morning they are full of drunken people just like the pubs. As far as transport is concerned, the quicker you can get people
home the better. And finally policing; this incorporates many of these issues.

I have picked work from North Queensland, Australia, as an example of how these aspects can come together to form a strategy. Local communities can be unified to form fora (little task forces). This is how people worked together in Queensland: licensed premises were examined and those at risk were identified by the use of risk assessments. Models of best practice were highlighted in policies along with enforcement legislation. This helped reduce drunken arguments, verbal abuse, challenges, and threats of violence. Also, in doing this, they identified that the factors I just mentioned were most important; things like city design, transport, and bar design all emerged as very important factors (we have covered these issues in our report ‘Alcohol: a situational analysis of the North West’).

Staying with alcohol related violence as a unifying theme; 21% of violence occurs around pubs and clubs. The local authority has a key part to play in tackling this. Over 5,000 people each year are injured with glass/bottles and weapons. If we are to examine what is involved we need to engage environmental services. Males targeting drunken females for sexual assault in pubs are common occurrences. The Home Office recently published work on this, but the media and those involved in health promotion also need to be involved.

Of course, not all alcohol related violence occurs in and around pubs and clubs. For example, a third of all domestic violence is alcohol related. Alcohol is also a contributory factor in many rape cases regardless of where they occur. These types of violence involve health services other than those that are active in acute, night-time, situations. Alcohol has also been implicated in bullying. Bullies and their victims are more likely to be alcohol users, so there are issues about trading standards and education. One interesting area of study involves the effects of foetal exposure to alcohol on delinquent behaviour later in life. If this is to be combated, then teenage pregnancy and maternity services need to be engaged.

Themes like these can, therefore, bring people together for a multi-agency approach to tackling violence. In our report you will find an examination of what risk factors affect violence across a range of groups. For instance, evidence shows that lack of stimulation in terms of schooling and inconsistent discipline is related to many types of violence in terms of risk for perpetration and victimisation. There are also issues around the risks involved in bullying at school. For example, involvement with delinquent peers, which is a risk factor for a whole range of other types of violence. Obviously our report deals with more than this. We also examine strategies that can then be brought into place to affect all these different types of violence. For example, parenting programmes are necessary for dealing with lack of stimulation and inconsistency of discipline. Such strategies are important since they affect a whole range of violence types.

Finally, it is important to apply this sort of information to violence related key targets owned by other agencies. Further, although the Health Service does not necessarily have a lot of direct targets on violence, it does have indirect targets relating to things such as Accident and Emergency waiting times, ambulance response times, emergency admissions, and targets in terms of performance in hospitals.

If you look at broader public service agreements, you will find issues such as: taking children out of low income households, reducing crime, improving children’s communications, reducing drug use, and improving emotional development skills. All of these have an impact on levels of violence.

In summary, better inter-agency understanding of violence is a key issue. The resources mentioned here (and others), need developing to expand understanding of violence outside the criminal justice service.
There is still a great deal missing, however. In particular, engagement in issues such as elder abuse is lacking here in the UK. Further, there is a lot of international information that we do not link into. We also fail to share our information on an international basis.

In summary, joint intelligence is key; there is a lot we can do with the information we already have, such as:

- Utilising multi-agency sources so that we can get a better idea of what is happening (we have seen some great examples from other countries).
- Using a Public Health model for prevention. This involves an approach that is evidence based and cost effective.
- Examining how existing policies can be related to violence prevention rather than waiting for the prolonged period which it would take to bring in new policies. This means recognising violence where it affects existing policies across all the public sector.
Today I am going to talk about the Tackling Violent Crime Programme (TVCP). Firstly, I would like to provide some context. Yesterday, Margaret O’Mara did this much better than I could, so I will be brief. Following from this, I am going to talk about the TVCP itself. You will discover, as I go through this presentation, an endless list of abbreviations, which I am going to try and explain. I am very keen to get to a position where we can converse about these issues, so I am going to try and open the session up for a proper conversation at the end of my monologue. I am going to try and talk about the programme itself under these headings (slide 1), and then some next steps.

The programme is about providing support to areas with the greatest challenge with regard to volume violent crime. Violent crime is not evenly distributed by area across England and Wales nor by crime type. Domestic violence and alcohol-fuelled violence, often associated with what is called the Night Time Economy (NTE), accounts for the greatest volume of most areas’ violent crime problem.

The programme focuses on two key elements of support: Strategy review and practitioner support, and enforcement (slide 2). I will explain those in a more detail.

The programme is being rolled out in a number of tranches over a year and the slide below shows how this will work. Lessons learned and good practice identified will be shared both within tranches and across the programme as a whole as its roll out progresses.

The aim of the programme, as I have said, is primarily about reducing volumes of violent crime in England and Wales. Specifically, we are focusing on Domestic Violence and Night Time Economy Violence, but not exclusively. We hope that lessons learnt will have application to other types of violent crime also. It is also very important that we try and improve the police and wider Crime and Disorder Reduction Partnerships (CDRP) performance. CDRPs have been around since 1998, although health involvement only
became a statutory requirement last year, which is interesting given the strong connection between violent crime and the health service. However while there might now be a statutory requirement to be involved, that is somewhat different from an actual productive contribution. The amount of Health Service people around the CDRP tables, when we visit them, is quite disappointing (I am going to try and try and provoke you a little, if possible, because that is how we are likely to get a lively debate and conversation). I get a sense that there are many Health Service people here, so I hope that this might encourage you to raise issues and questions during the following session.

We focus, as you have heard, on those areas where there is a large proportion of violent crime. We also focus on best practice. It is very interesting that people keep asking us if there are any new lessons that have been learned from the programme. The answer to that is no! We do not intend to learn any new lessons from the programme about best practice. What we would hope to learn is lessons about how we might implement best practice. It seems to me that in every office I have visited, there are shelf loads of best practice; increasingly these are bound as very nice, shiny, documents. We look down their spines and find they are as pristine as the day they left the printers. It makes no sense that no one has ever looked at these documents, let alone thought about how they might implement the lessons they contain.

Rather than trying to discover new best practice, the programme is really about implementation or delivery. We have developed some guiding principles that we were lacking at the start. We developed these as we worked with people, and to some extent this was quite risky. It was risky for us as programme leaders, because people at the centre (Ministers and so on) were not comfortable without knowing exactly what it was we were going to do. However, we felt that it was right to go out there and find places where we might be able to help. In the course of that, we developed these guiding principles. They involve this idea of partnership working at the centre; there is a huge requirement to join up at the centre and I think you received some insight into this from some of yesterday’s speakers. The extent to which the Department of Health and the Home Office talk to each other at the centre is interesting. The extent to which people at the front line talk to each other is also very interesting. To observe this you only have to travel a couple of hours by train from London to a local CDRP. You find yourself introducing people who apparently belong to that same partnership, and you wonder the extent to which this is a partnership if you have to come from London to introduce them to each other. What is happening between the front and the centre is also very important. What we are trying to do is not to just come out from the centre and “dispense wisdom.” Instead, we need to find out what the issues actually are. We need to pinpoint where there are issues that require actions at the centre; to bring those back in and do something about it. We have been relatively successful with this, certainly around the alcohol agenda. The domestic violence agenda, on the other hand, is a whole different story (and I will mention that in a moment).

We want to strengthen the evidence base of activity. I was interested in yesterday’s balloon story by Rodney Hammond about the difference between policy makers and scientists. It is important to try and have some evidence base. However, it is also important to stop collecting, contesting, and analysing the evidence base and to start using it! This is because of the difference between the level of accuracy required by my good academic colleagues, and even by politicians (for external accountability reasons), and the level of accuracy required by practitioners to actually engage in some positive action. I do not care whether the information is 98.9% accurate or 98.7% accurate; over 90% is better than just sticking a finger in the air and
trying to do something! Although it is good to have evidence, in my view, it does not have to be precise.

I would like you to think about focusing on joining up activity, focusing locally, aspiring nationally, and examining barriers. We must be aware that there is a regional tier as well; we need to be satisfied that if there is a problem locally, then it is not a problem that can be addressed regionally. There is no point in us taking issues to Ministers at the centre if they could be dealt quite effectively at the regional level. We need to provide support that is timely, relevant, and makes a positive impact.

Some people will have heard of the Alcohol Misuse Enforcement Campaign (AMEC). That led in many respects to the TVCP. It was those campaigns that provided the impetus for this programme. A key focus for the AMEC campaigns was test purchase operations targeting those suspected of selling to underage drinkers. The drinks industry accepted that there was a problem, which they described as a few rogue operators that might occasionally sell some alcohol to children. This did not make sense to anyone who had ever been out and observed what was actually happening. However, it was important to build an evidence base around this. Investigations showed that, over eight weeks in the summer, 34% of the premises targeted were selling alcohol to underage children. At Christmas this was 32%. This highlighted the need for an increase of the improvement rate. However, we are aware that it is going to take a very long time indeed to address this issue.

I want to look now at the two elements; enforcement and activity on the one side, and strategy, review and support on the other side of the programme. These are coming out of the aims and guiding principles that are supported by success measures, performance management, and supportive governance. In looking at the enforcement activity, you cannot avoid the police. However, a lot of other people have enforcement capacity and they do not use very much of it. If they do use it, they do so in very strange ways. A good example of this is Trading Standards. Most Trading Standards Officers will tell you that they only do test purchase operations in off-licensed premises, and that on-licensed premises are the domain of the police. We have not yet been able to find anyone who can explain to us why that is. It is just one of those things; they have the power, they have the ability, they have the skills, but for some reason this phenomenon has emerged. What of course has been happening is that Trading Standards have been doing some test purchase operations in off-licence premises, but the police have not been doing any at all in on-licensed premises. This is strange since on-licensed premises are much easier to associate with crime and disorder. Partnership practices need to be widened to include people like Trading Standards. We need to join these up and create industry participation.

There are a number of ways in which you can encourage people to do things. You can, for example, try and persuade them reasonably and logically. However, the good thing about being in the public sector as a public servant is that you are given another option; state authority. Laws are passed by parliament giving public servants powers and you can use these powers to encourage people to do things they would not volunteer to do. We are quite comfortable in the police service about this, but my sense is that other enforcement partners are not so comfortable about it. Somebody described this to me one day as extortion. I responded by saying “Well no, it is extortion if it is outside the law. Inside the law it is a legitimate use of state authority.” It is a huge resource given to us as public servants, which can be used very wisely and very successfully. For example, when the home secretary writes to some of the biggest companies in the stock market (some of which you might buy your groceries from) and invites them to consider what they might do to improve their performance with regard to selling alcohol to children, they get on the
phone very quickly and are very concerned. They turn up to explain how they are going to improve their practices. One single letter and you can suddenly make progress on things that people have been struggling with for years. State authority is a very good resource.

For the Night Time Economy, there is a long list of actions identified and the slide shows Key Performance Measures for many of these. You will notice that the measures for domestic violence is a very short list (slide 4). That was because we started out believing that domestic violence has long been understood as an issue. We believed that the policy was developed, that the practice was developed, and that there was good practice happening on the ground. That may well be the case but I have yet to find much evidence of this. I find it extraordinary that, as a Police Officer, you can start from a position that both the perpetrator and the victim are probably standing in the same room in front of you, yet a very small percentage of perpetrators are successfully prosecuted. This is what is happening in some areas. I was thinking about the story that was told yesterday by John Ashton about people falling into the river and being lifted out again. One of the things that seemed to be missing in that analogy with regard to domestic violence (which I liked a lot), was that somewhere upstream there is somebody actually pushing, punching or kicking the victims into the river. That somebody is called a perpetrator. If you do not do something about that, then you pick the victim up, you fix them, and then you send them back upstream so that the perpetrator will force them back into the river again.

These key performance measures were negotiated with the people themselves. They are about enabling the people in the programme to understand the link between what they do and what they get. That is what the key performance measures are all about. These are not actually accountability measures as such. They should be considered more as ‘understanding’ measures; practical operational measures that help people understand. The outcome measures (slide 5) are the accountability measures. You can see that we are using serious woundings, common assaults and A&E admissions as the key outcome measures for the programme.

The Alcohol Harm Reduction Strategy is based on a report that was published about a year ago now. One of the pieces of evidence is that between midnight and 5am, 70% of A&E admissions are alcohol-related violence. Therefore, if there is a steep decline in those, we thought that this would be a good proxy measure to success. I know that there could be statisticians, perhaps in this room, that would say that is not very accurate. It is, however, accurate enough for what we are trying to accomplish.
On the other side then, (which is actually the longer term, more important side), is the strategy review and practitioners support. This is about starting to improve the work in the CDRPs. They are required by law to do crime disorder audits and then produce a three-year strategy every three years. The next strategy is due to go live on the first of April 2005, so it is a good time for us to be doing this.

We had the CDRPs send in their materials. The Practitioners Support Panel (PSP) examined them and provided feedback. This was designed to help the CDRPs improve. To explain how this works visually; we have two tiers (slide 6). The first tier is involved in the work I have just described. The second tier is more specialist; Mark Bellis belongs to this tier for example. This is about working across the areas to deal with some very specific issues. One of the very specific issues is to understand why nobody in health is prepared to give anyone in criminal justice any information whatsoever; bearing in mind we are meant to be on the same side. It is quite bizarre.

We then ran a series of regional workshops on the back of the PSP work, such as strategic support workshops supported by the core TVCP team. We also visited each CDRP in the programme ourselves. This necessitated travelling throughout England and Wales at strange hours of the day and night, talking to numerous people, and visiting numerous A&E departments. It also involved visiting many pubs and clubs to observe behaviour. Of course it also involved visiting and holding discussions with numerous CDRPs. We thought it would be useful to feed back some of the emerging findings from this, before each area had its focused feedback (as I described from the practitioners report panel). The Government Offices then facilitated an action planning session on the back of that.

So where are we going now? Important activities are being conducted in the area of Alcohol Misuse Enforcement. We are doing those in the TVCP areas during the run up to Easter. Seeing what sort of results you can get from working in a limited number of areas will hopefully provide some focus. We are particularly interested in seeing what sort of attention we get from the industry by doing this.

Another area of work involves master classes and workshops around the nighttime economy and domestic violence. The big theme that is emerging around domestic violence concerns the perpetrators. This theme involves getting everyone into that space. This includes getting victim groups and victim representative groups to recognise that it would be very helpful to victims if we could stop that perpetrator upstream from forcing them back into the stream again.

The second tranche of the TVCP will be starting some time next month. Consequently, we are currently going around talking to people who might be engaged in this, and showing them the value of working with us at the Centre of Government.

Thank you.
I would like to give you a very small flavour of
the approach that we have adopted in the
National Health Service (NHS) over the past
couple of years to avoid violence against staff,
and how we are integrating that into a
programme to ensure the NHS is properly
secure in all respects. I would like to start by
making four quick points:

This is a medium to long-term piece of work.
It is not designed to grab headlines. It is a
fundamental change in how the NHS
approaches the issue of violence against staff
and in particular how it ensures that it is
properly secure.

The next point I want to make is that the
NHS is still a relatively safe place in which to
work, in spite of headlines you might see, and
in spite of some of your personal experiences.
Statistics for 2002/03 show 116,000 incidents
of violence. This sounds a lot, but if you
compare that to the fact that the NHS has 1.3
million staff (including people who either
work directly for the NHS or provide
services) and multiply the number of staff by
the amount of people they see each day, it
puts the 116,000 into some context. But this
does not mean we can be complacent. One
incident of abuse or one incident of assault is
one too many, and that is why we are
undertaking the programme of work I am
going to speak briefly to you about.

The next point I want to make is that the
problems faced by the NHS are the problems
faced right across the public and indeed the
private sector. For example, the individuals
that disrupt NHS services are the same ones
that disrupt other services and divert valuable
resources from those who really need them.
And that is why, through the chartered
institute of public finance and accountancy,
the better governance forum are jointly
launching a common platform where the
public sector can get together. They will be
able to discuss problems, disseminate best
practice and promote common solutions.

The last point I want to make before moving
on to my presentation is that violence and
abuse are not confined to any particular
group of staff. They occur from board level
right through to frontline activity. It is
important that we gain the support and
commitment of staff, patients and the public,
to tackle this serious problem.

We are a special health authority. We were
created in April 2003 with a specific remit to
tackle security related issues in the NHS and
in particular violence. The point I would like
to make is that every pound lost to deal with
violence or a security related incident is a
pound that is lost to patient care. More
importantly, such incidents have a
demoralising impact on those who are simply
there to care for others. In 2003 we launched
a new strategy to deal with security
management and in particular the issue of
violence. Backed up through that strategy we
introduced two legal national frameworks.
We wanted people to be clear about what
was expected from them, and what was
expected from us in terms of national support
and guidance. We also wanted to give them
the authority to take action where that was
required.

Just picking up on the theme of the
conference “From Global Perspectives to
National Action”, I firmly believe that national
action can only work if there are strong local
structures in place to support it. Government
departments can have all the strategies in
place that they want, but if there is no one at
local level to do that work and deliver, then
they are not going to work.

That is what our strategy is designed to do. It
is designed to be comprehensive, it is
designed to be inclusive and it is designed to
be professional. Now to describe our business process; we want to take a holistic approach to security related issues and violence; an approach considering all possible opportunities to do with identified problems and to provide solutions. We believe that by following this process that we can develop and promote good solutions. These are the main areas we identified where the NHS needs to ensure that it is properly protected from attack.

I talked about national action, and I talked about the importance of having local structures. Through the security management framework we have started putting in place those local structures which we believe are essential if we are going to take good strong local action but within a nationally consistent framework. The first thing we did was require each health body to nominate a director at board level to take responsibility for this work. We also required them to nominate an executive non-director so that the non-executive part of the organisation could engage with this work and hold the executive side to account. In other words, to scrutinise and to challenge what it was doing. But the most important thing was the introduction of training for local security management specialists. We hope that through training and development, the local health bodies will have professional expert skills to deal with the range of problems they face on a day to day basis; in particular, to deal with the issue of tackling violence.

Moving on to violence, I mentioned that 116,000 incidents of assault were reported in 2002/03. We believe that is probably a very low estimate. We believe under-reporting in the NHS is around 39%. It is important, however, to put this in the context of day-to-day delivery of healthcare. Furthermore, the 116,000 did not really tell us much about the problem. This figure represents a combination of physical violence, non-physical violence and verbal threats. It did not really tell us what the problems were and where they are occurring. The figure is therefore very useful in terms of headlines but not very useful in terms of trying to develop solutions that are actually going to make a difference to the staff that deliver healthcare. Consequently, our first task was to separate and introduce common definitions for physical and non-physical assaults. We then brought in a national reporting system for physical assaults.

We use our own staff (experienced in the investigation of counter-fraud) to start supporting and working with the police. This will help ensure that more cases are taken forward in the hope of obtaining more prosecutions. By taking more legal action we aim to provide a higher deterrence rate. We also created a national legal protection unit, a source of consistent advice for all health bodies. Prior to this, health bodies had to rely on their own local legal advice. In some cases this meant going to outside firms of solicitors at very expensive prices. We wanted to encourage health bodies and their staff to take action against offenders where that was appropriate, and we wanted to make it cost effective to do so. We also needed to ensure that legal advice given did not differ from one part of the country to another.

Through the reporting system and all these other measures the most important thing that we introduced was to ensure that staff received feedback on action that was taken following reported incidents. We felt that although we had done a lot of work to encourage staff to report incidents, they were not getting feedback. Consequently, there was a danger that they would stop reporting incidents, and that we would lose valuable information regarding the nature and scale of the problem. This would impair our effectiveness in dealing with their problems.

Earlier, I mentioned the role of Local Security Management Specialists. These people will be placed in each health body to provide staff and management with professional skills and expertise to deal with issues such as violence. They will be trained to liaise effectively with the Criminal Justice System. They will get involved more and more with local
community partnerships such as Crime and Disorder Reduction Partnerships. This will ensure that the NHS does not try to solve the problem on its own, but rather in partnership with the community. We also believe that it is not simply enough to react to the problem once it has occurred. My view is that if an assault has occurred we have somewhat failed because somebody has been hurt, abused, threatened or suffered some sort of trauma or injury. That is why we believe it is important to try and prevent as many assaults or instances of abuse as possible from occurring in the first place. Hopefully, the measures that we have put in place in terms of prevention will go some way to achieving that utopian ideal.

We have introduced a series of syllabi to deal with training. Initially there were no standard or common learning outcomes for any of the training in the prevention and management of violence across the NHS. There was no reliable source of advice on what training staff should get, who should get it, and when they should get it. We are starting to put those building blocks in place. We want to move to a position where there are a series of syllabi that are delivered according to the risk and the need of staff, and are backed up with good evaluations tools. We are working jointly with the health and safety executive on one at the moment. This work is backed up with a competency framework for trainers who deliver this training. I will quote one example of some of the training that we uncovered when we looked at this issue. In one health body, a private trainer was teaching the method of jabbing somebody in the eye with a pen as a method of breaking away from a violent situation. Now clearly if you are in a dangerous situation you should probably use anything to defend yourself, but I do not think that is something we should be teaching healthcare staff. We believe that we should have quality training for our quality staff.

Another important point is that technology has an important role to play in protecting staff and protecting NHS assets, but it is not the solution. It has to operate with good management procedures and systems. It has to operate with staff to support it. I can quote examples of where massive amounts of money have been invested in technology (thankfully not in the public sector), but no thought has been given to the human resources that are needed to actually make sure the system works. So technology: yes it is a good thing but it has to work with the necessary human resources in place.

I mentioned the legal protection unit. I think it is one of the most exciting things we have developed. It is one of the things that is actually delivering real practical differences to staff at the moment. I would like to pick up one case we have taken forward. This was a case of civil injunction. I will not give his real name. However I will give his nickname since it was widely reported in the press. His name is Disco Pete. He is a 63-year-old man from Crewe and in the year prior to our gaining civil injunction he had called the ambulance service 118 times. This was a simple scenario. He used to go out on a Friday or Saturday night, get drunk, and then use the ambulance service as a taxi home. That would have been all well and good, but the problem was he did not go home. He decided he would go to the Accident and Emergency Department instead and he would start disco dancing (hence his name, Disco Pete). When he was asked to stop on numerous occasions he would get abusive and sometimes violent. Numerous ways had been tried to curb his behaviour from warning letters to threats of legal action. We were finally contacted because clearly, something needed to be done about the situation. We went to court and took a civil injunction out against him and since that time there has not been one single incident. So, sadly, we do need to resort to the legal process in some cases. This is not appropriate in all situations, but when necessary we will make sure that happens.

Now to turn to some future action. We are developing a memorandum in conjunction with the Association of Chief Police Officers. We need to work with the police to ensure
that the best protection is given to the NHS. This will hopefully ensure that we know what we can expect from the police, and they know what they can expect from us. It is a two way process. Next week we sign a concordance with the Health and Safety Executive to ensure that the work that we do and the work that they do is integrated; that it actually delivers better safety for both staff and patients in terms of violence.

Later on this year we will be launching a public campaign building on the zero tolerance campaign from a few years ago. It will deal with tackling violence against NHS staff and also with securing our property and assets in the NHS.

I will finish with a summary. This is about medium to long-term change. We want to make sure the NHS is as secure as possible. We want to recruit and retain the very best staff to work in it so we can deliver the very best healthcare to the people of this country.
FULL STOP TO VIOLENCE: STRATEGIES TO PREVENT CHILD ABUSE

Christopher Cloke
NSPCC, UK

Abstract:

This paper will address the prevalence of child maltreatment in the United Kingdom and consider the dichotomy between popular myths and the reality of child abuse. The National Commission of Inquiry into the Prevention of Child Abuse (1996) concluded that most cases of child abuse could be prevented provided the will to do so is there. A number of obstacles mean that the will is lacking. The UK needs a strategy to prevent child abuse. Child abuse deaths are the most extreme form of child abuse and highlight what is needed to prevent all forms of child abuse.

A “public health approach” is needed with interventions at all levels of prevention. The paper, drawing on the experience of the FULL STOP Campaign in seeking to change our culture which allows unacceptable levels of violence towards children, will use video footage from recent awareness campaigns.

* * * * *
Over the last day or so we have recognised that violence surveillance is the critical first step of the public health approach. We need to understand the size of the problem, look at the risk factors and put interventions in place. We then need to disseminate information and evaluate what actually works.

Today I am just going to talk about:

- Why we need information for action. This is pretty obvious. We need to understand the size, the causes, the circumstances, the local interventions, and of course evaluation as well.
- The European picture. More specifically, the size of the problem of youth violence.
- Surveillance, with an emphasis on the relative strengths and weaknesses of Health Service and Police data.
- The advantages of hospital versus community surveillance.
- A small study looking at Intimate Partner Violence in North London, and implications for policy and research.

Injuries as a whole were a leading cause of death in the 52 countries of the World Health Organisation (WHO) European region during the year 2002 (slide 1).

There were 800,000 deaths that is 8% of the total. This amounts to 21 million disability adjusted life years lost, or 14% of the total. Males bear about 75% of this burden. The leading causes were self-inflicted injuries, road traffic accidents, poisoning and homicides.

A basic typology divides interpersonal violence into family and community (slide 2). It includes issues such as child abuse, and partner abuse. The important thing here is to recognise physical manifestations of violence, and to remember that there are other manifestations such as sexual, psychological and also deprivation and neglect.

This table shows the leading causes of death in young people aged 15-29 years by European sub region (slide 3). There are three sub regions there: Europe A, Europe B and Europe C. The UK belongs to Europe A. Countries in Europe A have a very low mortality for children and adults. In Europe B we mean countries that have a low mortality for children and adults and in Europe C we mean countries that have a low mortality for children but a high mortality for adults. The injury causes are highlighted. The green denotes unintentional injuries, and the red denotes intentional injuries. You can see that
in Europe A self-inflicted injuries are the second leading cause of death and interpersonal violence is the sixth leading cause of death.

### Slide 3

<table>
<thead>
<tr>
<th>Rank</th>
<th>Leading Cause of Death, by European sub-Region, age 15-29 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Road traffic injuries</td>
</tr>
<tr>
<td>2</td>
<td>Self-inflicted injuries</td>
</tr>
<tr>
<td>3</td>
<td>Suicidal attempts</td>
</tr>
<tr>
<td>4</td>
<td>Violence</td>
</tr>
<tr>
<td>5</td>
<td>Road traffic injuries</td>
</tr>
<tr>
<td>6</td>
<td>Self-inflicted injuries</td>
</tr>
<tr>
<td>7</td>
<td>Violence</td>
</tr>
<tr>
<td>8</td>
<td>Suicide</td>
</tr>
<tr>
<td>9</td>
<td>suicide</td>
</tr>
</tbody>
</table>

There are large differences in rates of interpersonal violence across the 52 countries of the WHO European Region. This is shown in Slide 4, which shows the inequalities in interpersonal violence death rates in male’s age 15-29 years across the European Region in 2002.

### Slide 4

**The burden of violence and injury is unequally distributed across Europe**

Homicide death rates per 100,000 males 15-29 2002

Note: The designation employed and the presentation of this material do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area of its authorities, or concerning the delimitation of its frontiers or boundaries.

This shows data for the United Kingdom for deaths from interpersonal violence broken down by age and sex (slide 5). The highest rates are in male’s age 15 to 29 years and for females the highest rates are in the 30 to 44 years. Rates are higher in males than females for all age groups except for in girls under the age of 14 years, where this is higher in girls than boys.

### Slide 5

**AGE SPECIFIC MORTALITY RATES FROM INTERPERSONAL VIOLENCE IN UK (HFA-2002)**

As far as surveillance and the size of the problem are concerned, we have got reliable information on homicides, but it is difficult to obtain reliable information on sub-lethal violence (slide 6). Of course we have information from sources such as health agencies, the police, and surveys but we must remember that there is also violence that is neither reported nor disclosed. Furthermore, it is important to use more than one information source so that we can try and capture as much information as we can.

### Slide 6

**Surveillance and the size of the problem**

I am now going to move on to discuss the use of police data as opposed to hospital data. UK police data under records violence by about 70-75%. This is supported by both Accident and Emergency data the British Crime Survey. In particular, assaults against men in bars are
much less likely to be recorded by police in comparison to assaults against women and in other locations. Intimate partner violence rates in US Emergency Rooms are four times higher than reports to the police. The important message from this is that we need to use more than one source of data. Health Service data is more relevant to violence prevention efforts in view of the fact that Police data under records violence to a large extent, and because Accident and Emergency data captures serious violence more completely. The importance of Accident and Emergency data is that it is local. Furthermore, it can provide rich information about the causes, the circumstances, the weapons, the mechanisms, and association with alcohol. Not only can it be used for evaluation, it can also be linked to outcomes and seriousness. However, this huge resource is mainly untapped. Examples from South Wales show that information sharing can identify hotspots and can help inform action such as the UK shattering bar glass initiative. It is important to have this sharing of information for a multi-sectoral approach to the prevention of violence. Obviously Accident and Emergency data has some limitations since some types of violence do not necessarily manifest in overt, physical injuries. This applies, for example, to domestic violence and child abuse, which can also be psychological and sexual in nature.

How does hospital data compare to data derived from community surveys? There are some advantages to the latter. The British Crime Survey is a very good example of a community survey. One of its advantages is that data is collected on all injuries and violence regardless of where or if treatment is sought. You can, therefore, detect violence of different levels of severity, including that not resulting in physical injury or that requiring treatment. The study samples can be representative of general populations. A denominator can be used to determine rates of incidence and prevalence; all of which are very important for undertaking preventative work. Such surveys facilitate direct comparisons of violence and injury rates between different demographic groups and geographical regions. Information can also be obtained about perceptions of causes, the prevention of violence and also about the fear of crime. They can provide estimates of intentional injury burden and form a basis for the calculation of the cost of disability and mortality. They can also provide information pertaining to social and cultural determinants of violence.

It is important to find out a baseline for all injuries. One of the limitations of community surveys is that they do not give much detail on the kind of healthcare that has been used. Furthermore, such surveys are expensive to conduct and have the limitations inherent in self reported data. In contrast, hospital surveillance has the advantage of being readily accessible since patients who have been injured are on the premises seeking healthcare for injuries resulting from violence. Hospital surveillance provides useful information for studying outcomes such as case fatality rates and proportional mortality. Hospital data is relatively inexpensive to collect since existing hospital resources can be used. Another advantage is that ongoing surveillance can be undertaken to identify trends. Furthermore, the resulting data can be useful in highlighting the demand on the health services, and resulting resource constraints. Ultimately, this can be used to advocate for more resources for prevention and can be used to monitor improvements in the quality of health care.

One of the disadvantages of hospital surveillance is that only severe cases where violence results in injuries requiring treatment are captured, so estimates of incidence are not possible. Information on sexual and psychological violence are also difficult to obtain on a routine basis. When such information is sought, training needs in sensitive history taking and correct documentation need to be met.

I am just going to change from that very generic picture to a specific study that was undertaken in a North London Accident and
Emergency Department. The study was undertaken after a training intervention to train staff in the routine questioning of women attendees about intimate partner violence. However, in spite of the training sessions, the response from the staff was only about 3.6%. Therefore, in order to improve understanding of the problem, a specific survey was undertaken exclusively to ask about intimate partner violence. A representative selection of nursing shifts was selected over a five-week period. Exclusions from the survey included women under 18, women who were too ill, or too intoxicated to answer. Because of resource constraints, women who did not speak English were excluded. There was also some loss due to women who did not wait or refused to answer. Informed consent was obtained and a questionnaire was administered to obtain information about the scale and type of violence and attitudes to being questioned. Women were then referred to appropriate services as necessary.

This table shows the past year’s prevalence of physical violence by an intimate partner, and the association with age and employment (slide 7). Although there was no association with age, there was an association with employment. If women were in a paid job they were less likely to have suffered physical violence. The women were also asked if they felt it was acceptable to be asked routinely about their experience of Intimate Partner Violence. The majority thought that it was acceptable. In this particular study only 1% of women presented with actual trauma due to Intimate Partner Violence. The 12-month prevalence was 6%. For lifetime physical abuse the prevalence was about 35%, and for life threatening abuse this was about 11%. The majority of women found the questions comfortable and acceptable.

Although this study supports the notion for case detection, the jury is still out on the subject of national screening. The National Screening Committee suggests that it is difficult to ask questions without more evidence in terms of sensitivity, specificity and treatment effectiveness. Our study highlights the importance of training for health staff in this area and also illustrates the importance of making information available in a variety of languages given the diversity of our communities.

What were the lessons for practice? Before embarking upon such work it is important to think about the service constraints of a busy Accident and Emergency Department. It is also important to think about privacy and confidentiality, to plan and provide a realistic response, and to develop unit or departmental specific protocols as recommended by the British Association of Emergency Medicine. Other issues to consider include the promotion of the ownership of initiatives, since all staff and management should work towards a systems response which can facilitate change in practice. It is also important to acknowledge the limited capacity of staff in busy departments to engage in additional assessment and follow up of care. The development of victim orientated outcome measures must be given greater priority.

What is the importance of Health Service information? The Health Service is the only service with reliable information about the most serious forms of violence that result in injuries. Evidence has shown that if you can transfer aggregated data to police and local authorities then this can be used to implement public held interventions. The
information can then be used further, to monitor whether these interventions work or not.

There are huge advances in information technology that could be used to great advantage, but investment is needed to take advantage of this. Investment in staff training is also needed if recording is going to be reliable. All this needs to be conducted within a sound ethical framework, since we need to pay attention to respecting confidentiality. In many hospitals better data collection is needed on the causes, circumstances, mechanisms and intent of all injuries (the presentation yesterday from Elizabeth Ward showed how this was successfully carried out in Jamaica). Health professional training should also include sensitive areas relating to such issues as domestic violence. Work can then be undertaken to highlight the health consequences and to look at the service and the community response. This is a difficult issue. How do we engage health service chief executives and the Emergency Departments to get them on board? This is by advocating for the potential savings that could be made by preventing violence in the community for which the health service is presently picking up about 75% of the direct costs. The full potential of Health Service data needs to be used for surveillance as an essential building block in the public health response to violence prevention.

To conclude, interpersonal violence is a large societal and health problem in the UK. Health Service information is important for increasing the visibility of the problem and for prevention and evaluation. Until recently, violence prevention has not been high on the policy agenda. This conference and the launch of the report Violent Britain are therefore important initiatives. It is true to say that youth violence has received relatively little attention considering its impact on society and the burden it places on public services.

The World Report on Violence and Health emphasises the need for a multi-sectoral response and the fact that the health sector can provide leadership in this. We have good examples from domestic violence and child abuse, where health professionals are beginning to engage in responses using such an approach. At a regional level, the WHO European Regional Committee is developing a strategy for violence and injury prevention. We welcome such initiatives as the excellent report Violent Britain that was presented earlier today and look forward to receiving more information on the development of a strategy for violence prevention in the UK.

Bibliography


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Dedicated centres need to be created as conduits for victims of drug facilitated rape in order to gain an accurate picture of the situation. If you left this work to be undertaken by forces that lack the necessary facilities, there would be cases slipping through the net. These forces are all now switched on to ‘Matisse’, which involves the use of Drug Facilitated Sexual Assault (DFSA) rape centres for all alleged or suspected cases. We had over 100 in just over four and a half months. This is not many given the publicity this subject has received.

The difference between this piece of research and any other research that has been conducted to date is this; we will process all the samples, provided we get them in time, and that is the key to this. This will hold true for every victim who either alleges this type of offence (it does not matter if we believe them or not, allegation is enough), or where the police or rape crisis advisor thinks they have been a victim of DFSA. Therefore every DFSA case is a Matisse case. We then ask the victim if he or she will participate in the research. Very few to date have said no. We then give them a really simple questionnaire:

- Are you taking prescribed medication?
- If so, for how long and in what quantity?
- Do you take controlled (recreational) drugs?
- If so, for how long, what type, and in what quantity?

They are asked to sign a disclaimer and the police will also sign it to say there will be no prosecution for this particular drug taking.

Then we ask about drink tolerance levels and drinking behaviour:

- Are you a binge drinker?
- Are you a ‘one glass of wine’ person?

In this way, we obtain information about drink habits and tolerance levels. This is all to assist the scientist in the analysis. Rather than taking a cold sample of blood or urine (because we take both from the victims with their consent), we have got a better chance to help if he or she tells us they are taking heroine for example. We have found this in some cases. If they tell us they are on Prozac, this also helps. We have also found some cases of this. So if we find a residue of drugs we go back to the victim for verification since their initial statement may have been inaccurate. We ask if they were aware that the drug was in their system. If they say they were unaware of the drug we rely on their honesty and act on the fair assumption that the drug was in the victims system due to a sinister motive by somebody else. That is about as scientific as we can be. However, this strategy does require that we get those samples within the 72 hour cut off period, since many drugs, including Rohypnol, dissipate within hours. The average for Rohypnol is about 48 hours. Many tranquillisers can be detectable for 72 hours.

Imagine a scenario where the victim spent Saturday night in a club. She has a couple of drinks and something happens. The next morning she wakes up with evidence of sex but does not know what happened. That victim will normally start to worry about this. She might tell a friend who might tell another friend who might tell her mother. Time is elapsing during all of this. The victim may come to us after four, five, or even six days. The incident will be recorded but we cannot do anything for them in terms of science. We can do something investigation wise, but without the forensic evidence. Therefore one of the main difficulties is having time to get the samples away to the lab. The difference with this current research is that we will...
submit the samples even if the victim does not wish to prosecute. We do still need their consent. Sometimes the perpetrator is well known to the victim, and she does not want to get him into trouble. In these cases we will ask for consent to send the sample for analysis even without the chance of a prosecution. The purpose is solely research. In summary, we will submit every case for analysis, irrespective of the victims wish to prosecute, providing that the victim has given consent.

Samples from as far afield as London and Northumbria are sent to a lab in Chorley for analysis, where they are screened for a whole family of drugs. There are a total of 78 different tests that are carried out. Admittedly, you cannot screen for everything; not long ago a man used video head cleaner to stupefy his wife so that his son could have sex with her! The point is that domestic products can be used in large volumes to perpetrate this type of offence, and we cannot screen for them all. We therefore limit analysis to the pharmaceuticals that we know have the ability to overpower, stupefy, and debilitate. We are comfortable, and the forensic science services are comfortable, with this type of limit to the analysis.

We have got the results coming in thick and fast now. I am not going to stand here and say that the police are not going to see evidence of involuntary use of drugs; we are. We do not yet know the extent, but at the moment there are no surprises. On the recent channel 4 programme “Dispatches” girls who were interviewed made claims such as “Thirteen Bacardi Breezers and then all of a sudden I don’t know what happened”. Fancy!

So I am not going to say that DFSA is not happening. What I say with a fair amount of confidence is that it is not happening at the level that certain people would have us believe. The evidence also suggests that the majority of these offences do not happen in the pub or club. It perhaps happens in the aftermath when the victim is in a domestic environment. Furthermore, the oldest trick in the book is for a man to give a woman a double vodka instead of a single; getting someone drunk without their consent or knowledge is as bad as using a drug like Rohypnol. Hence the question to the victim “How much drink did you have?”. In the 1970s and 1980s this behaviour was seen as acceptable. So the main drug involved in DFSA is alcohol. Rohypnol is not manufactured in great quantities and is not widely available. We are finding that some people take it recreationally; they do this voluntarily.

With alcohol, we can say something about drinking habits. I have been criticised because the advice I give to girls and boys who go out at the weekends is, “if you want to prevent yourself becoming a victim of this type of offence then remain compus mentis because there are predators out there.” You will all probably know somebody who is, in your mind, a “sex pest.” You will all have probably encountered someone who indulges in lecherous behaviour at work, for example. These people are out and about in the clubs at the weekend and they are preying on people. They are out in every city in every town every weekend. Sometimes they hunt in packs. They are looking for people that are vulnerable. People are vulnerable if they are dishevelled and uncoordinated through drink. Advising people to remain compus mentis may be naïve when you see places like Liverpool on a Saturday night. Girls are often more drunk than boys. Julie Brown is going to do a lot of work with Alcohol Concern and the Home Office in order to establish a link between excessive alcohol consumption and drug facilitation of sexual assault, using alcohol as the drug.

Is anybody old enough to remember Reading, Thames Valley Police? It was horrendous. They featured in the first documentary about how the police dealt with rape victims, and depicted a poor woman in a tiny room being questioned by four male detectives. The woman was obviously of low academic skill and poor socio-economic background and liked to drink; there is nothing wrong with
any of this. The police ripped her to pieces, which is how it used to be in the police. Although things have improved we are still getting judgements based on the perceived value of people as potential witnesses rather than the quality of evidence. Female detectives are sometimes worse. “Look at her! What does she expect?” All I will say is that the Police Murder Manuel instructs that cases should be treated as murder until it is established otherwise. That way you have got the best chance of getting all the evidence forensically, physically and statement-wise. If you treat it as nothing to start with, then you lose your opportunity to be effective. The same goes for rape.

We have got to challenge stereotypes. While in Rhyl I talked to a female officer with 12 months service about rape. She said that it depends on whether it is a Rhyl rape or a real rape. Some police have expressed that they fail to see the point in prosecuting domestic violence cases since women so often retract their statements. But we are going to challenge the stereotypes of society. There are only 3 or 4 males in this audience, whereas males make up over 25% of the total conference audience. This saddens me because I consider it to be negligent. Many men still see this form of violence as rather “fluffy” and nothing to do with the real issues in society or with real policing. We do not, as males, treat the issue seriously enough.

Today the Police are being encouraged to report more and more crime. At the same time they are being asked to reduce crime. This really is a contradiction sometimes. Recently we have made huge strides on the issue of rape. We have now got seven real sets of Sexual Assault Referral Centres in the country. The emphasis is not on catching more rapists, but on making victims feel their cases have been dealt with properly and on giving victims the confidence to face society again. That might all sound rather fluffy from a hard-nosed cop but I actually believe it. If the offender is caught then that is good. If the victim stands up and gives evidence that is also good. However, we should not be upset if the victim walks out, but feels that they have been looked after and can continue with their lives.

This is a better outcome than being able to tick a box to say the perpetrator has been detected. Today victims will send us flowers and they come in to see us. This is great, but the fact remains that the government measures success in statistics; there is no quality assessment. Quantity and counting competes against quality.

The results of Operation Matisse will be published in August. There will also be a television programme on the issue. Meanwhile, if you want any advice on this topic, or if you would like an “off the record” conversation about where we are going with DFSA, then please contact us.
I had the great privilege this week of being in Cardiff with Inspector General Nayyer Haider from the Karachi Police, because, through the generosity of Muslim men in Cardiff, he has been sponsored to come over to the UK to speak for Amnesty International on International Women’s Day in Cardiff. While I had him here in the UK I thought I would not waste him; I am going to share the platform with him. He is an expert in Honour Crime and Honour Killings, which are evils that are coming to the fore in the UK and throughout Europe. I thought it would be of great use for us to also learn from him, and so I am going to split the session.

I am taking it for granted that everybody sitting here knows a great deal about Domestic Violence, so I am not going to give you a basic background. I am intending to tell you the things that are going on concerning the linking up of police, the courts and other services. I will use this as a point of discussion of where we are and how far we need to come in the future. I will be showing you some of the media materials that we are now using throughout the UK to combat this matter. As we are in Liverpool I am going to start off with an opening to set the scene for us that was developed for Wirral Domestic Violence Services. [Video shown].

Mark Wynn from the United States Justice Department describes Domestic Violence as domestic terrorism. It destroys the internal structure of society and its citizens as insidiously as other forms of terrorism. Its defeat requires similar determination. We must be trained, committed and vigilant. Structured information sharing on these enemies between professionals is essential. Like any army we are only as strong as our weakest link. This battle will be long and hard, but the rewards in each one of us in saving the lives of so many victims and their children make it inescapable. I am going to turn now to the developments in the police because I am a member of the Association of Chief Police Officers (ACPO) Steering Group on Domestic Violence. It is fascinating that many of the police officers in this country who have been at the forefront of the changes in tackling Domestic Violence were, in their previous lives, anti-terrorism officers. In particular many of you will know that larger than life character Jim Gamble, who is the ACPO Domestic Violence lead and Deputy Director of the National Crime Squad (NCS). His entire life before NCS was as an anti-terrorism officer in Northern Ireland. John Greaves and John Godsave, who were the leads in the Metropolitan Police, conducted work that was very much breaking the mould. They would tell you how similar the two types of perpetrators are and the usefulness of their background in anti-terrorism. It was their team that were sent to New York after 9/11 to attend to UK victims and their families.

What has been going on in the UK with the police? Firstly, Her Majesty’s Inspector of Constabulary (HMIC) conducted a one yearlong thematic inspection into the current approach to defeating Domestic Violence in the 43 police forces. It revealed that some forces still do not have any training whatsoever, which I really could not believe. There were great centres of excellence; one of these is Merseyside I am very proud to say. This is because of the amazing leadership we had from our last Chief Constable Norman Bettison. He truly led from the front. HMIC have made a very full report and they are following that up with a further review a year later. Through the Police Standards Unit they are insuring that the recommendations that they have made will actually be carried
through. We have developed through ACPO something which really is ground breaking; there is now an ACPO policy on police officers who are perpetrators of Domestic Violence. If a police officer steals a Kit Kat from a shop, he will almost invariably lose his job, his pension and everything else. If he repeatedly beats up his wife, in the past it was unlikely that he would lose his job and there are many occasions where there have been shameful cover ups of that behaviour. As Jim says, a perpetrator in the police force is far worse than a normal person. Because if Mrs Brown in number one Acacia Avenue is a police officer’s wife and she is beaten up and nothing happens, how are the rest of the women in the road ever going to feel that they can have faith in the police? It was a very hard piece of work for Jim to do and there was opposition from some quarters in the police as you can probably imagine. In spite of this, all 43 chief constables signed off the policy in January of this year.

I do recommend that you go and get a copy of it from the website. If your local force is not complying, you must hold them accountable. What will be very interesting (and I say the police are at the forefront in the UK in developments in domestic violence) is to see how many other professionals take such an approach to perpetrators. What will happen to Judges in the future if there is a civil or criminal Domestic Violence Order made against them? Medical Consultants, Professors of Public Health, people like this; are they going to lose their jobs as well?

I remember a few years ago I had an appalling case in my court where the Children and Family Court Advisory and Support Services (CAFCASS) Officers were actually frightened to be with a particular man because he had seriously threatened them, and they would only see him in certain circumstances. He had a conviction for violence. He was a mental health nurse in one of our teaching hospitals. I was torn at the time as to whether I ought to report him. If he was doing this at home what was he doing to vulnerable patients? What was going to happen there? I was a coward and I admit I did not report him. I asked a senior judge and he said, “none of your business”, leave it alone. It would be very interesting to explore where you think it should happen? I would like to know of experiences in other countries; what they are doing about perpetrators and their employment.

The police, through Commander Andy Baker at the Metropolitan Police, have been conducting Domestic Violence Murder Reviews for some years now. They have been analysing and utilising the results. This has formed part of our new Domestic Violence Bill which passed Parliament and will be coming into force in July of this year.

Further, I have lectured in the last few weeks to the Independent Police Complaints Commission. We spent a whole day informing the 18 Commissioners about Domestic Violence and how seriously they should be taking it in terms of Police Standards and Police Behaviour. As you have heard this morning, the Police Standards Unit is very much on the ball about this and I am very grateful to them. They have recently given me £10,000 to set up our new Asian Women’s Platform throughout the UK. This developed from the six national Asian Women’s Conferences that we held, and were generously supported by my department, the Department for Constitutional Affairs (DCA), 6 Police Forces and GlaxoSmithKline. In terms of the issues of Forced Marriage and Honour Killings, again the police are making great strides. There is an Honour Killings Working Party under the auspices of the Crown Prosecution Service and Nazir Ahmed. It is a multi-agency body to investigate the causes of Honour Killings and how we can look to trying to understand and reduce them. Part of that work involves looking at how much we have to look to the experience of other countries and how much we can learn from them. In fact, at seven o’clock tonight I am going out to Pakistan for 10 days to learn from the people there who have had to deal with this problem for a long time. ACPO officers and
Metropolitan Police officers at a senior level accompany me.

ACPO have recently launched excellent national guidelines for Police investigation of crimes of domestic violence. You can now hold your local police force accountable if they are not keeping up to the standards of the National Police Guidelines which will be constantly updated. We look to have further guidance on Forced Marriage and on Honour Killings in the next year developed through Dr. Kate Paradine and the team at CENTREX.

In terms of the courts, we obviously have the new legislation- the new Domestic Violence and Victims Act which will be coming into force over the next year. Common Assault becomes an arrestable offence, there is provision for domestic violence murder reviews, a restraining order can be granted by the criminal courts on an acquittal, victims can seek anonymity, and a further provision is that a breach of a civil injunction will become a criminal offence. This is an example of where we have learned internationally; in this case from Northern Ireland and Eire.

I chair a committee called “Raising the Standards” which is an inter government committee of England, Ireland, Scotland and Wales, Northern Ireland and the Channel Islands. We share best practice and initiatives at government, police and court levels between the jurisdictions. This has proved an extremely useful tool in increasing protection to victims, and has actually saved our respective governments a great deal of money. A typical example would be as follows: Wales wants to have a national domestic violence programme for schools so, instead of them reinventing the wheel, we all send in what we have already developed and they use it as their base.

I want to emphasise the importance of a positive approach in the media to changing public attitudes. In the area of Domestic Violence, Scotland is the leader in the UK. They also have better funding. Every refuge has a child worker funded for the next five years. They have an annual media campaign, based on campaigns from Canada and Minnesota. Through Raising the Standards (and this is a wonderful piece of cross border work) Northern Ireland and the Republic jointly took the media campaign developed by Scotland. They have had it dubbed into Irish accents, and it has been going out throughout Ireland in the last few weeks as a joint enterprise. England and Wales are now looking to take that up later this year.

Hopefully, the courts are now starting to get cases right and from 30th January 2005 every application made under the Children’s Act (2004) is screened for domestic violence. Information is sought from refuges, health, social services, and the police. There is going to be an inevitable increase in court time needed to hear findings of fact. Such hearings can often take up to two days, because they may involve going through the whole history of the couple’s life together.

I am so ashamed that for twenty years as a barrister I went along with the conspiracy that we did not allow women to raise issues of domestic violence in children cases, no matter how serious. Victims were told that they were being difficult and how it was wrong to dwell on the past; it was damaging for the children for them to do this. Where this myth ever came from I do not know. Thankfully those days are now over. Jenny Cohen from Manchester CAFCASS says 60% of Manchester CAFCASS’s caseload involves domestic violence. I heard a list this week and every other case involved domestic violence. We are going to need greater resources for being able to refer families to services such as the National Society for the Prevention of Cruelty to Children (NSPCC), Barnardo’s, and perpetrator programmes.

There is a Select Committee of both Houses of Parliament presently sitting and taking evidence on enforcement of contact provisions. These are suggestions involving having women tagged or doing community service if they unreasonably do not go along with contact. Alongside that, for the first time, the courts will have the power to order
people to go on programmes. It could be that either or both parents need to go on an alcohol or drug programme, or a domestic violence perpetrator programme. Unfortunately these programmes do not exist in most parts of the country, so there is going to be a huge problem of setting up expectations for families which we can then not fulfil. Where are these perpetrators and other programmes going to come from?

I have just been speaking to Alex Leith from NSPCC about this. There is a resource problem and there is a judge time problem. There is also a training problem for judges, for barristers, for solicitors, for CAFCASS officers, and for social workers. All of those need addressing if we are going to meet the requirements and expectations that families reasonably have.

Outside the provisions of the Bill the government is proposing the introduction of independent advocates for domestic violence cases similar to the New York model. I recommend that, if you get a chance, go and see the Manhattan or the Brooklyn Domestic Violence Integrated Courts. If you do not get that chance, then go to Croydon. The DCA is setting up our first integrated domestic violence court there. An integrated court is where one judge deals with all aspects of the case. It hears the family side, the injunction side, and the criminal side. A specialist court is a criminal court where the judges, and all the people around the court, are specialist. We are now developing this all over the UK.

The DCA have given guidelines for local areas in setting them up, but the integrated court is one step further. It is a one-stop shop for all aspects of the case and that has to be the future. The advocates will be the link worker. They will guide the woman through the process. They will deal with her housing, education, and health needs. They will assist as the liaison with her lawyer, and they will report back on how a man is progressing on a perpetrator programme. At present, in order to get successful prosecutions, police officers are having to be social workers by supporting the woman through the process. That is not a good use of their time. They are not trained to do it. They should be the investigative officers, and this aspect of the work should be handed over to advocates. It is going to happen. The Government are committed to it. All we are looking into through the advisory boards at this time is the structure; delivery will probably be devolved out to local Crime Reduction Boards.

There is a great deal happening in the courts. We are training every magistrate in the country. The training package was developed on Merseyside through LA Productions with Colin McKeown who set up Brookside with Phil Redmond. This wonderful training package is going out to our judges, but we still have a long way to go.

I am a member of the Family Justice Council which has the job of reforming the entire Family Justice System. The Government are committed to that, and we are setting up 42 local Family Justice Councils in every area to feedback into us nationally. You will see that being set up in the course of the next six months. I do suggest that, if you are living in the UK, you should put yourself into that process. I am going to be heading up the Family Justice Council, Domestic Violence Group with Terry Grange, the Chief Constable of Dyfed and Powys.

There is an amazing group called “Kids Aloud” in Sefton here on Merseyside. It is a therapy group set up by Sefton Council where I live, for Children who have been victims of Domestic Violence. Once a month they hot-seat one of we professionals. They have had police, teachers, and social workers in the hot-seat. The children tell them how they are getting it wrong. Because of what they have inputted about the police not listening to children and keeping them informed, Merseyside Police’s entire policy has been changed. I accompanied a new High Court Judge when she visited them. She was wonderful with them, and when she had finished a little girl came up to me with a piece of paper folded again, and again, and again;
down to a one inch square. She said to me, “Please take this away with you and help other children like me and my sisters”. This is what was written on it, totally unprovoked from her. I think it really says it all. This is our client group. These are the people that we purport to listen to, but we do not listen to.

Perhaps when you see people up cranes (and we have the police here today to protect me from them), you should remember this; nobody is actually putting on the news the views of the children and what they are actually suffering. We have got to get it right. We have got to have prevention programmes in the schools. We have got to make sure our young people grow up to respect each other. We have got to have the criminal justice system making sure that people are brought to justice. We have got to make sure that victims are supported through that process. Then we have got to have the therapeutic systems to assist people and to keep families intact as much as we can. We have got to heal them from the damage.

You heard yesterday from Margaret O’Mara about a personal initiative from the Prime Minister, “Watch Over Me”. This is a set of videos that is going to every school in the country. This is the second series.

The third series has just been commissioned. It is a soap opera like Hollyoaks, which is great for the kids. It is a wonderfully done piece of acting and very exciting. It is a joint project with young people in prison, the police, social services, and Muslim leaders. It deals with bullying, gun crime, drugs, domestic violence, and in this new one, forced marriage, (my particular interest). On this video, one of the leading Muslim scholars in the world Shaykh Hamza Yusef Hanson is speaking out against forced marriage. I think it is amazing that every school child in the country will actually hear that message. Anybody can get copies of them and use them. That shows the sort of interplay that we can have. To me it is children first, second, third, and fourth.

I am going to hand over now to Nayyer to tell us about what is happening about honour killings and the picture generally in Pakistan.

Inspector General Nayyer Haider

I am sure you are all aware of honour killing traditions. In England the problem is not as serious as it is in the India/Pakistan subcontinent. Honour killing is such an issue that has really plagued the subcontinent for a really long time. Historically, this problem persisted even when the British were there and tried to control it. As far back as 1840 Sir Charles Napier, who was then the ruler of one part of the continent, came up with a proclamation against honour killings. He tried to set up a very strong nexus of British administrators and Lords. This subsided for a while, but we still continue to have this problem. People continue with this practice of honour killing, because the concept of honour is very dear to the people of that area, particularly in rural settings. When the British tried to control it through the proclamation, the people still continued with this practice and tried to disguise this as suicide. The rate of
suicides increased all of a sudden. Later on, they came to realise these was not actually suicides but was still the honour killings. The problem has persisted since then.

Even in this day and age, we still have this problem of honour killings. Just to give you a figure to illustrate the extent of the problem we are faced with in Pakistan; on average over 1,000 women are killed in the name of honour every year. Therefore the task for the police to deal with is absolutely gigantic. There are a number of factors that can be attributed to this:

- The literacy rate amongst these people is pretty low. Consequently, we have more cases in the backward areas such as the rural areas and the hinterlands.

- There still exists a very strong gender bias within the criminal justice system itself. It exists in the police, the judiciary, the legal profession and the other stakeholders. This means that the perpetrators of these crimes do not get the type of punishment they should get under the law. They receive lighter punishments and sometimes are even acquitted.

- The recourse to the customary laws, or tribal laws. In the presence of this system, the people like to have recourse to the local elders and they will then sit and try to decide this case. This is preferred to the formal laws where the case will be tried by the normal court. Although customary/tribal laws do not have sanction under the law, there is still a lot of dependence on this system. Once a compromise has been reached through the local elders, a compromise is filed in the court and is accepted. It normally ends by giving money in view of the murder.

So what we are trying to do is to contain this. The government has taken a very, very strong position on it. Recently there has been a new Honour Killing Bill in which the punishments have been enhanced for the perpetrators of this crime. The second thing that has come about through new legislation is that there cannot be any private compromise as long as the case is being tried in the court.

Above all, there is a lot of effort being made by the government to socially impart women. This involves introducing new concepts, and financing projects. The aim is to ensure that the women are empowered, and also socially and economically independent to work within the rural areas. This involves engaging small entrepreneurs and others. There is a lot of effort through the Non Government Organisations, through the civil societies, and through the media, to bring about awareness amongst women in particular and people in general. They are trying to ensure that women are aware of their rights. We are seeing more and more effort by way of seminars and media campaigns. Both electronic and print media have been involved in this regard. On the criminal justice side a lot of effort is being made now to sensitise stakeholders, particularly the police. We have taken it upon ourselves to introduce a lot of new techniques for dealing with such a crime. There is more emphasis now on forensic science rather than ocular evidence; we previously had access only to the latter. So we are trying to put this together. Even with no ocular evidence available we should still be able to prosecute cases through creditable forensic evidence. There will be more and more emphasis being placed on chemical examinations and DNA.

Secondly, we are trying to introduce new concepts such as human rights. We are trying to introduce sensitise police officers about the issues surrounding honour killings and violence against women. We are trying to introduce all these things in the police training as a curriculum. Much effort is being made to conduct workshops for police officers and other stakeholders like judges, lawyers, politicians, and media people. Recently, in collaboration with Northamptonshire Police, we held two workshops in Karachi through the British Council. We are also having more exchanges of officers so we can train them to
work against violence towards women. We are trying the whole range of things that are being done to control this. It is a very difficult task in the sense that there is a lot of resistance from the people themselves who still want to cling to this concept. They genuinely feel that if any woman has crossed the perceived honour barriers, then she should be dealt with the way things have been done for centuries. There is a very strong tradition that they want to hold on to. When you have such traditions it is difficult to change attitudes. Nevertheless, the government resolve is there to change and control this, if not eliminate it. The effort now, is to implement the new legislation, raise awareness, and unite all the stakeholders to try and control it as much as we possibly can. It is a tough task for us police officers to deal with; we are trying to do whatever is possible in this regard. Our government is giving us a lot of support in this respect.

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**Introduction**

I work for Action on Elder Abuse and I am here to talk to you today about something called, “Elder Abuse: The Prevention Agenda”. For those people who do not know, Action on Elder Abuse is the only charity in the UK dealing specifically and exclusively with the abuse of older people.

Although we are talking about older people, a lot of the things to which we are referring are just as relevant for other vulnerable groups, such as those with learning disabilities, mental health problems, and so on. Just bear in mind that it is only we as a society that lump older people together as one homogenous group.

My presentation today will be split into three parts:

- **What is elder abuse?**

  What do we mean by elder abuse? Why is our understanding of elder abuse crucial to this subject?

- **The scale and nature of elder abuse**

  I will warn you that I will be providing you with some case studies that are designed to be quite shocking and provocative.

- **Responses to elder abuse**

  This includes the government responses, the legislative responses, the responses of agencies and organisations, and our responses as a society.

Action on Elder Abuse is a ‘four nations’ organisation. Although based in London we do conduct work in all four nations. Our approach to each nation is based on what is appropriate to that nation. We were established in 1993 by practitioners in Health and Social Care; people who were concerned that the on-going abuse of the elderly was not being recognised.

**What is Elder Abuse?**

We define elder abuse as “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 another older person”.

There are three key points that I would like to emphasise about that definition. Firstly, we clearly define elder abuse as happening within relationships where there is an expectation of trust. That means that we do not consider issues such as muggings or the low level of the state pensions as being abuse, important as those issues are. Secondly, we very clearly cover the idea of neglect as being abuse. This is important to bear in mind. In the case of an elderly person with grade four or five pressure sores who has been in a residential care home or hospital, we would very clearly argue that that is neglect (and therefore abuse). Thirdly, we try to measure abuse in the feelings and experiences of older people themselves.

Action on Elder Abuse considers there to be five types of abuse:

- Physical abuse (this is straightforward when carried out in the form of slapping and hitting. Somewhat controversial, the over prescription of medicines. Anyone who has worked in residential care home or nursing will know about this issue).
- Psychological abuse.
- Financial abuse.
- Sexual abuse.
- Neglect.

One notable omission from that list is discriminatory abuse. That is not because we do not feel it is important but because we need to do more work in order to establish how it actually manifests itself in terms of elder abuse.
The Scale and Nature of Elder Abuse

We run the only UK Help Line on Elder Abuse. This is the practical source of support for anyone and everyone concerned about the abuse of older people, whether it be the older person themselves, family, friends, workers or someone who feels that they are about to abuse an older person. At the moment it represents the only source of statistical information on elder abuse in this country. Most policy that has come out of the Department of Health in the last five years has been based on the statistics provided by our help line.

We have information on abusers, location of abuse, and victims. I will now discuss this in further detail. Our helpline has been running since 1993. In the ten years subsequent to this we have taken 10,875 calls of which 6,867 were calls reporting 10,528 incidents of abuse. So it is a fairly comprehensive guide to the feelings of older people and the experiences of abuse.

Who calls us?

The highest percentage is calls from the relatives of the older people who they fear may have been abused or are about to be abused. The second figure of 27% are cases where the victims themselves called. That is merely the tip of the iceberg. You need to consider that an older person in a residential care home might find it very, very difficult to gain access to a private telephone in order to contact the Elder Abuse Help Line. For example, someone with a severe impairment such as Dementia or Alzheimer’s would find it very difficult, if not impossible, to make such a call.

19% of calls to the helpline are from paid workers who are concerned that they have either been asked to do something, or they have witnessed something, that they regard as elder abuse. We know that whistle blowing does not work in this country. Figures suggest that somewhere in the region of 70% of people who blow the whistle on abuse are no longer working in that same environment a year later. We know that whistle blowing is a painful experience in this country.

Types of Abuse

One noticeable issue is the extent to which elderly persons suffer from multiple forms of abuse. If we were able to record all elderly people suffering multiple forms of abuse, I estimate that this would be the highest category; it is very rare that someone experiences only one form of abuse. Psychological abuse is the most frequently recorded category. Part of my work is looking at the implementation of No Secrets across the country. This includes examining the data recorded by local authorities and adult protection where psychological abuse amounts to less than 10% of recorded cases.

So there is a clear difference between what is being reported to us and what Local Authorities are collecting. What is extremely worrying to us is the 3% of sexual abuse. Just over a year ago that figure was just less than 1%. We are at odds to explain just why there has been such a growth in sexual abuse. It may just be that more people are willing to report it, but this is still something that is very disturbing.

Age of Victims

Over 78% of abuse reported to us occurs against individuals over the age of 70; the most common age of those abused is 80-89. People say that (in terms of adult abuse and adult protection) we are where we were with child protection 20 years ago. If a person being abused at the moment is over 70 or 80 years of age we do not have that long to catch up. Another important factor relating to age is that if you look at Social Care in this country, you do not officially become an older person until you reach 65. However, if you look at the major age related charities such as Age Concern or Help the Aged, they clearly define this category as beginning at age 50.
These factors all make it difficult to estimate the prevalence of Elder Abuse. On the television you will see some very powerful statements about Domestic Violence, such as “one in four women in this country will experience Domestic Violence at one point in their lives”. At the moment there is no comparable figure for abuse of vulnerable adults or older people. Within a year there will be a similar national crime survey on the subject that will provide a more accurate picture.

Gender of the Victims
Over 67% of the victims of abuse that call our helpline are female. That figure ties in very well with the information collected by Local Authorities.

Who are the abusers?
Relatives other than the main caregivers make up 46%. I want to make that distinction very loud and very clear. It is the next person removed from the main caregiver. It is the husband, wife, daughter, son, niece, or nephew of the main caregiver. We have no evidence to support any assertion that the stress of informal care giving leads to abusive care practices. No one doubts the pressures that informal carers face; it is the largest unpaid role that people undertake in this country. In spite of this less than 1% of people who call our helpline complain of abuse by the main, informal caregiver.

I want to clarify the difference between informal carers and paid home carers who are also sometimes referred to as carers. Abuse by paid care workers makes up 34%. We would expect this to be higher. People are often surprised that the level of abuse by the main caregivers is so low. This could be partly due to the growth in support networks now available for informal, main caregivers. These networks can help to diffuse some of the tensions.

Gender of the Abuser
In 41% of cases the perpetrator is male, in 25% female. In 33% of cases there is both a male and female perpetrator. This seems to support our other findings that indicate it is the next person removed from the carer who is most likely to perpetrate abuse.

Location of Abuse
An examination of the distribution of abuse shows that 4% occurs in sheltered housing, 5% in hospital and 64% in the home. These figures must be taken with a “pinch of salt” since most older people in this country still live in their own home. What is worrying is that 23% of the calls are about abuse that is occurring in care homes, yet only 5% of older people in this country live in such institutions. To us, that figure is disproportionate. It indicates that there is a major problem in terms of abuse in care homes; we believe there is a major, major problem.

Case Studies
I am now going to present a few case studies to show the reality of elder abuse. Figures and statistics can be a bit dry, so it is important to remember that when we talk of figures we are talking of real human beings and we are talking of real suffering. These are all real cases that were either reported directly or picked up in national or local media; none of these have been made up.

Case study 1
Alec Taylor was a gentleman who had a severe learning disability. Due to the care management process in this country he was considered an “Older Person” on reaching the age of 65. At this point he was placed in an older persons’ nursing home, where he was described as someone who had challenging behaviour. He was administered large amounts of Respiradon and other anti-psychotic medication, which largely confined
him to his bed, hence the development of pressure sores.

Action on Elder Abuse is often accused by various people of sensationalising abuse and “running down” on the care home sector. Our response is that while these things are tolerated and allowed to continue, we will continue to report them.

Case study 2

Obviously national media sometimes generates a greater amount of calls. For example, Comic Relief always generates a massive amount of calls, as does the Daily Mirror coupon campaign. Everybody here has heard of Victoria Climbié, the young girl in Tottenham who was failed by the authorities when she was abused horribly by relatives to the point of death. There was a lot of documentation about the failures of the statutory services to protect her. Who here has heard of Margaret Panting? The difference between Victoria and Margaret was 80 years. Margaret Panting was an elderly lady that moved in with her family. At the time of her death, she had over 89 separate injuries to her body. The coroner determined that they had been wounds caused by a razor blade and the stubbing out of cigarettes. Nobody has ever been charged with the murder of that lady because both members of the family blamed each other. Fortunately, new legislation is coming into effect, which will not allow that situation to happen.

There are many differences between child protection and adult protection. In a child protection case there is something called a “Part 8” review, which is a statutory process. Adult protection has only section 7 status that is not statutory. Therefore there is Part Take review situation.

Factors that Lead to Abuse

There are complicated relationships between Elder Abuse and Domestic Violence. Not much work has been done in this area, but it is a growing phenomenon that requires much investment in research.

Age:

High levels of dependency and age can be factors. Due to improvements in the detection of conditions like dementia, dementia services can now look at the early onset of dementia in terms of people in their 50s. As this happens, I believe there will be a decrease in the association between abuse and age.

Stress:

With stress, people sometimes find themselves in abusive situations. People find themselves committing abuse without necessarily the will or the intent. I came across such a situation in Liverpool, involving a woman who was the main carer for her husband. The husband was very ill and the local authorities wanted him to go into full time care. The wife fought, and fought, and fought, to have him at home. When she had to go out she strapped him to the bed to cope with her fear for his safety. This provoked a huge argument in Liverpool. Was this abuse? There was no intent to commit abuse, but this was clearly an abusive situation.

Social isolation:

We need to be looking at Elder Abuse in terms of those who are socially isolated; that umbrella term relating to Black and Minority Ethnic (BME) Communities, and Gay/Lesbian/bisexual groups. These tend to be groups with whom it is not fashionable to work, who get less community support, and who have less access to mainstream services. We need to look at incidents of elder abuse in those groups.

Case study 3

This is a tragic case involving a gentleman who was caring for his wife who had dementia. On nine separate occasions, health care staff attempted to make an adult protection referral because there were increasing levels of violence and unexplained bruises. On nine separate occasions the adult protection referral was stopped because the Local
Authorities said that the gentleman did not wish for it to proceed. I take great issue with that argument. I think that people have the right to make choices and take risks, but those choices and those risks must be based on information, not shame. I think that this gentleman’s choice was probably based on shame. That a) he could not care for a loved one, b) he was a male victim of domestic violence, c) a fear of what would happen to his wife and himself. On the tenth occasion he was stabbed in the neck with a pair of scissors and died. The serious case review conducted by the Local Authority found that its own adult protection arrangements were not at fault because the gentleman has the right to take risks. An interesting argument. The difference between child protection and adult protection is quite clearly the wishes of the child are irrelevant.

We could ask 50 people about the relationship between domestic violence and elder abuse, and we would probably get 50 different answers. The government would argue that you have an adult protection system and you have domestic violence and the two are separate systems; if there is domestic violence it is dealt with through the domestic violence system. Many Police units (and I take Liverpool as being a very good example), have to produce figures for domestic violence, in terms of the numbers of incidents it deals with. They have to produce figures for child protection. They do not, however, have to produce figures for vulnerable adults. The starting point should always be “Adult Protection”. Domestic violence is the way you characterise the abuse and, in a sense, how you characterise the response. You should record figures on both. If we are ever going to get the adequate sources, we need to start monitoring vulnerable adults and elder abuse. It is very easy to get resources for Domestic Violence because there are figures collected on it. You can quite easily go to people and say, “These are the numbers on Domestic Violence cases”. Child Protection is the same. In the case of vulnerable adults and older people, it is virtually impossible. Until people like the police actually collect separate data on this, it remains very difficult to make the case for extra resources.

Further risk factors for abuse include:
- Age.
- Discrimination.
- Minority Status.
- Disability Discrimination.
- Communication Difficulties.

I hope you can see that elder abuse is a complicated subject, but a subject we do need to tackle immediately.

Responses to elder abuse

Most people have heard of the National Services Framework (NSF). It contains no standards on elder abuse. Obviously it contains things on slips, trips and falls, etc. At the moment it does not inspect hospitals in terms of adult protection arrangements. In its new inspection arrangements it will start to inspect on adult protection. In most hospitals, if you ask staff about the multi-agency approach to adult protection described in No Secrets, it is a fair bet that most people will not have heard of it. If you ask hospital staff about the NSF and Person Centred Care, you will find there is a greater uptake. No Secrets is very clearly seen as Local Authority Social Services owned, and NSF is very clearly seen as the Health Response. So we will talk about that a little later and where the failings are.

Initially, I want to look at some of the legislation available to prosecute abusers and to protect vulnerable adults. Legislation is framed in terms of vulnerable adults; it is very rarely framed in terms of older people.

There is no straightforward piece of legislation that will allow someone to be prosecuted for the neglect of an older person. It is possible to do this through Section 127 of the Mental Health Act 1983, but that is based on a very complicated and rigid definition of a patient. The Children’s Act...
makes it possible to prosecute someone for the neglect of a child. I think that difference speaks volumes for our different societal attitudes towards older people and children. The Domestic Violence, Crime and Victims Act (2004) allows someone to be prosecuted for a death where it is not possible to attribute that death to one person. In the case of Margaret Panting, that Bill would allow both adults to be prosecuted for her death.

Most people that work in adult protection talk about a “Tool Kit” approach. This is because there is much relevant legislation, but there is no one over arching piece of legislation. People are required to dip in and out of various bits and make them fit. Very clearly there are plans from the Department of Health to try and create a Vulnerable Adults Bill.

Care Standards Act (2000)

The Care Standard Act (2000) has given us the Commission for Social Care Inspections, formerly known as the National Care Standards Commission. This body combines elements of the old Social Services Inspectorate (SSI), Audit Commission and the National Care Standards Commission. It is responsible for regulating and inspecting Care Homes and Domiciliary Care Agencies. Inspections are based around national minimum standards for Care Homes and Domiciliary Care Agencies.

There is no doubt that the existence of National Minimal Standards and regular inspections to and about the National Standards, help to drive out abuse and abusive practices. However there are problems with the required inspections; only two inspections a year for every single care home, one announced, one unannounced. How does an older person with dementia in a care home report abuse? Can they go to the manager and say, “I would like the telephone number for the relevant local office to make a complaint about abusive practice”? Very, very difficult. How much of the true picture do the inspectors ever get?

Care Standards Act (2000): POVA List

Very importantly, Care Standards (2000) have given something called the Protection of Vulnerable Adults list, also known as the POVA list. This bars those who have harmed or placed vulnerable adults at risk from working in Care Homes etc. One of the problems around that act has been getting people to recognise financial abuse as harm. Financial abuse of someone with dementia can occur at a low level when someone is taking a few pounds of someone’s pension, or a few pounds from someone’s allowance. Many would argue that this does not represent harm, and does not make someone unsuitable for caring for older people. If you measure harm in terms of the experiences and feelings of the older persons themselves, the suffering they feel, their distress at the breaking of a trusted relationship, it allows you to build a case that there is actually harm there.

National Minimum Standards relate to the entire package of someone’s care. For example, quality of life is a minimum standard, access to activities is a minimum standard, and training of staff is a minimum standard. What is interesting, is that there are no minimum standards around staff to resident ratios. If you look at other countries, especially America, you will find very strict standards around this.

The POVA list relates to harm, so an Inspector will not necessarily be inspecting on the vulnerability of adults. That list is held by the Department of Education and Skills. When someone goes on that list, the harm has already been done, so it occurs “after the horse has bolted”. An employer has a legal duty to report someone to that list if there is a suspicion that they have either harmed or placed someone at risk of harm. With the Bichard inquiry coming out of the Soham Murders it is accepted that the protection needs of vulnerable adults may be similar to those of children. Sir Michael Bichard wants
to determine those people whose behaviour makes them unsuitable for certain responsibilities, which has happened before. A good example is those people who are on what is known as the Protection of Children Act (1999) PoCA list of individuals who have abused children. Does someone’s appearance on the PoCA list automatically make them unsuitable to work with vulnerable adults? We do know that people who are banned from working in children’s care homes, do turn up in adult care homes. I think protection of vulnerable adults is flawed but it is better than what we had before, which was nothing. There are still major omissions from the POVA list, since it does not cover NHS staff. It does not include staff employed with direct payments. Local Authorities are given the choice in terms of who they employ as personal care assistants. This is not covered by POVA. You can do a Criminal Records Bureau (CRB) check, but you cannot do a POVA check against someone on direct payments. The Independent Living Fund (ILF), is not covered by the POVA list. The POVA list was rushed in its implementation so there have been a number of major glitches. We are hopeful that the Bichard inquiry will lead to a better system.

No Secrets Guidance

The No Secrets guidance has a very clear definition of a vulnerable adult, which has its own problems. In terms of developments for the Commission for Social Care Inspection, there is a re-think on the focus and the method of inspection. There is a move towards a system of proportionality, therefore more will be spent on resources. More inspections will be carried out in homes that consistently fail to meet National Minimum Standards. Although this is welcome, I do have some concerns. Quite often Homes pass their inspections with flying colours and a week later there is major, major abuse reported.

This work used to be located within Social Services Departments, using lay Inspectors, who were experts from the community in a relevant field. There would be older people and people with learning disabilities who would assist in the inspection process. One of the ways to make an inspection work is to include the voluntary sector and advocacy projects to feed into that process. This is one thing the commission are looking at. Care Standards (2000) is good in what it does, but it is limited in the protection that it offers.


This is the bible in terms of responding to allegations of abuse for anyone who works in Local Authorities at the moment. No Secrets Adult Protection has section 7 status which means Local Authorities are obliged to follow it. It is just guidance and is not statutory; there is no central government finance attached. No Secrets sets out the development of multi-agent procedures for the protection of vulnerable adults from abuse. This places a duty for all Social Services departments to develop multi-agency procedures including mental health services, learning difficulty services, and physical mental impairment services.

This policy has a very clear definition of a vulnerable adult: a vulnerable adult is a person who is entitled to or may be entitled to a community care service, by reason of ill health, illness, age or other disability, and is or may be unable to protect themselves from significant harm or exploitation. The major problem with that definition is that it very clearly links every vulnerable adult to receipt of community care service. A lot of people do not seek community care yet are still vulnerable. Many older people who live at home, who have never received community care, are vulnerable to abuse. Most Local authorities have a threshold to determine if an individual requires learning disability services or mental health services. If a person fall slightly out side that threshold, where do they fit? For example, victims of forced marriage are very unlikely to be in receipt of
a community care service, yet the response to victims of forced marriage falls in the No Secrets remit. A similar situation exists for people with a drug or alcohol problem. Such people are not fashionable to work with but, by the nature of their addiction, I would argue that they are vulnerable adults. People with borderline personality disorder do not fit neatly into the No Secrets definition of a vulnerable adult either. If you look at last year’s statistics for No Secrets returns, 18,000 referrals were made. Only 10,000 of those referrals can be directly attributed to a service user group under the existing classifications. This leaves over 8,000 people who do not fit neatly into social service user group categories. The people who do not easily fit that definition are people with drug or alcohol problems, asylum seekers, people with borderline personality disorders, people with low level mental health problems and low level learning disability who do not qualify for services.

Officially, referrals can be made by anyone but in reality they cannot. Referrals are made largely by professional staff. I think most people working in the community would know where to go in terms of child protection if they had concerns. I do not think this the same for an adult protection referral. Referrals can be anonymous. They can also be made without the consent of the vulnerable adult if it is in the “Public Interest”.

The concept of No Secrets is intervention plus prevention. The idea is that you can intervene, provide a service, and remove someone from abuse, but you must also seek to prevent further abuse. A major problem for adult protection is there is no benchmark. For child protection there is the Child Protection Register. For protection of vulnerable adults, one individual can have ten adult protection referrals made about them in a year.

There is nothing that says action must be taken to protect them and stop them being vulnerable. Part of the work I do is in terms of introducing performance indicators for the local authorities around this; at present no one questions local authorities on their performance in this regard.

There is a data-collection requirement in No Secrets, which no one adheres to at the moment. There are no penalties for local authorities that have no adult protection arrangements. Since there is no central government finance, most authorities have an adult protection coordinator. In many authorities you will find that the complaints manager is also the adult protection manager and the training development manager. Furthermore, you will find that such positions are usually part time.

Adult protection in this country is based on relationships and personalities. It is based on people having a personal commitment. It is not engraved in the stone in the same way that child protection is. We would argue that legislation has not impacted greatly on family abuse. In terms of domestic violence on older people, it does not even get through the front door. We all need to think in terms of how we can change this situation.

POVA legislation does not work to criminal standards in terms of whether someone is guilty, it work on the balance of probability. There are employment issues around POVA in terms of whether you can suspend somebody.

There is something called the Provisional POVA List, where there is the duty to suspend somebody on the grounds that you suspect there is some substance to the allegations. In such instances you have a legal responsibility to put them on what is known as the Provisional POVA List. It is a criminal offence to seek work in another care profession once you have been placed on the Provisional POVA List. Problems arise in some cases if an employer does not have a robust employment policy.

In other instances employers are waiting for a test case to go through a tribunal before they
In some cases employers are acting contrary to the legislation and the spirit of the legislation. Many of these problems have arisen because the legislation was rushed through; providers were given approximately a week’s notice of the legislation to get these policies in effect. In some areas you will see fantastic responses, in other areas you will not. This is because the legislation has section 7 status and no government finance. Why does this happen? The answer is because we let it happen. Governments introduce policy and introduce legislation, but they take their lead from us; our lead has been one of complacency. The thought I will leave you with is this: if we can make domestic violence seen as a hate crime, then we can do it for the abuse of vulnerable adults.
Introduction
The development of effective anti-bullying strategies in Scotland in the last eighteen years has been due largely to work within schools by partnerships of pupils, parents, teachers, and other professionals supported by the Scottish Office, the Scottish Executive, local authorities and other agencies such as ChildLine. This process would have taken much longer if we had not been able to draw on the wealth of research, literature and materials developed in Scandinavia and elsewhere.

What does research tell us about bullying?
Most of the research into school bullying has been inspired by the Scandinavian example. Norwegian academics such as Dan Olweus and Erling Roland report findings, which have been confirmed by numerous other studies:

- Bullying happens in all schools.
- Approximately half of all pupils report having been bullied at some time.
- The reported incidence of bullying decreases with age.
- Boys are more likely to be involved in physical bullying than girls.
- Bullying takes many different forms.

The most comprehensive worldwide survey of research into school bullying is contained in:

Scottish Research
The first attempt to quantify the problem in Scotland was through a pilot project carried out among 12-16 year olds in three secondary schools (Mellor, 1988). 6% of girls and 11% of boys said that they had recently been bullied “sometimes or more often”. Another finding from this small survey was that 40% of the sample said that they would do nothing to help if they saw someone being bullied.

The 1989 Study
The Scottish Office was sufficiently interested in these results to sponsor, in 1988, a study, which attracted much media attention when its report was published (Mellor, 1990). This was the first government-sponsored research into bullying in the United Kingdom. The project was carried out in ten secondary schools in 1989 with a sample of 942 12-16 year olds. In order to allow comparisons, a Norwegian methodology and definition were adopted. We expected to find a higher level of bullying than had been discovered by Professor Dan Olweus in his 1983 survey of Norwegian schools. In fact the pattern and incidence of bullying revealed was very similar to that in Professor Olweus’ very much bigger survey. For example, 6% of Scottish pupils said that they had been bullied recently “sometimes or more often”, the same figure as for the 12-16 age group in Norway. The
number of children who said that they had bullied others was slightly lower in Scotland, 4% as opposed to 7%. Comparisons were also made with an early study in Sheffield, England by Colin Yates and Peter Smith. Although most subsequent English studies have produced lower figures they tend to be consistently higher than in this Scottish study.

During their school career as a whole, boys and girls were equally likely to be the victims of bullying. But when pupils were asked how often they had been bullied recently there was seen to be an increasing gap between the number of boy and girl victims in the older age groups, as well as an overall decrease in the number of older victims.

Children from ethnic minorities said that racism was a major cause of bullying. There were also suggestions that children who usually successfully avoided bullies could become victims at certain times, for example, when changing schools or during a marriage break-up.

Half the boys and just over a third of the girls admitted having bullied others at some time. The difference between the sexes was most marked amongst 15 year olds. An alarming 12% of 15-16 year old boys said that they had recently bullied others and 5% said that they had bullied someone every day. How much of this was due to an element of bravado is not clear.

Children were asked “Where does bullying usually take place?” The most common location for bullying reported by the sample as a whole was the playground (48%). However, since half of these pupils have never been bullied, the views of recent victims were examined. 44% of them said that bullying usually takes place in the playground while 28% cited the classroom.

Perhaps the most important finding of this survey was that there were significant variations in the reported incidence of bullying between the ten schools. For example, the number of children who said that they had recently been bullied “sometimes or more often” ranged from 2.4% to 15.4%. These differences could not be explained by the size of the schools, their academic achievements, their geographical locations or by the social class of the parents of their pupils. However, even though none of the schools had at that time developed a specific anti-bullying policy it seemed that some were succeeding in containing the level of bullying.

After examining what these schools were doing and looking at the research that had been carried out in other countries it was suggested in the report that there were three prerequisites for a successful anti-bullying policy:
• **Recognition:** schools must be honest about admitting that bullying exists.

• **Openness:** opportunities must be provided for people to talk about bullying without fear of rebuff or retribution.

• **Ownership:** if parents, teachers and pupils are involved in formulating an anti-bullying policy they will have a vested interest in making sure that it succeeds.

**Recent Research**

In 2004 the Anti-Bullying Network collaborated with Edinburgh University’s Child and Adolescent Health research unit on a secondary analysis of data collected in the 2001/02 Health Behaviour in School-Aged Children (HBSC): World Health Organisation (WHO) Collaborative Cross-National Study. (See Todd et al 2004). 4,404 young people between the ages of 11 and 15 were interviewed. Some findings of the analysis were that around 1 in 12 pupils said they had been bullied, and around 1 in 20 said they had bullied others, at a frequency of at least four times in the previous two months; and reports of being bullied declined between 1994 and 2002:

The young people were also asked about fighting. Around 1 in 7 pupils said they had been in a fight three times or more in the previous year. A particularly interesting finding was that Scotland had a relatively low rate of bullying but a relatively high rate of fighting when compared cross-nationally:

We can only speculate about the reason for these different rankings. It might be that this was caused by variations in the wording of the questions about bullying and fighting, or it might be that anti-bullying work in Scotland has started to reduce the level of the problem. It is certainly true that the problem of fighting...
has not attracted the same degree of attention as bullying.

Another unexpected finding that deserves further study is that there is only a small overlap between the group of young people who said that they had bullied others and the group that said they had been involved in fighting:

The fact that we cannot yet explain the reasons behind these findings helps to emphasise the need for a long-term approach to the problem. Tackling bullying effectively requires an attitudinal shift at many levels and an acknowledgment that there is no magic bullet solution.

Why is it important for schools to tackle bullying?

Until the late 1980s bullying in Scottish schools was acknowledged but there were few effective strategies for tackling it. This left thousands of victims of bullying unprotected and unsupported. Often, the only advice they were offered was to "ignore it" or to "hit them back". All children have the right to be educated in an atmosphere that is free from fear. The anxiety experienced by bullied children can make it impossible for them to learn effectively and this can cause serious long-term damage to a person's self-esteem and achievement.

Prevention is better than cure. The most important thing that schools can do to minimise bullying is to establish an ethos in which bullying is unacceptable and in which all feel free to speak up if bullying takes place. Secrecy and silence nurture bullying. So creating an atmosphere in which young people know that their concerns are going to be taken seriously and where they are actively involved in working out a policy on bullying is important. The anti-bullying strategies being developed in schools are teaching children important lessons about things such as empathy, assertiveness, rights and responsibilities. They are also encouraging openness, honesty, self-esteem and a respect for others.

Underpinning all the work lies the importance of school ethos. A positive ethos promotes positive discipline, encourages regular
attendance, has high expectations of pupils, and makes young people feel safe and secure, and ready to learn. So developing a positive ethos is part of the concerted effort schools across Scotland are making to raise standards. It is not an optional extra.

How are Schools tackling Bullying?

The Anti-Bullying Network has collected evidence from schools in Scotland to show that a variety of strategies are working and that these have a number of common features. It is clear that effective anti-bullying strategies:

- Look towards finding solutions to problems rather than "getting to the bottom of things".
- Involve young people and/or parents as well as professionals.
- Focus on relationships, including those between adults as well as those between young people.
- Encourage open discussion and the development of a positive ethos.

It is important for all members of school communities to be involved in discussions about the different ways in which bullying must be tackled:

- **Pro-active strategies** are those, such as short-term campaigns, which initiate change.
- **Preventative strategies** are those, such as circle time, which encourage pro-social behaviour and/or discourage anti-social behaviour.
- **Re-active strategies** are those, including restorative practices, which can be used in response to bullying behaviour.
- **Supportive strategies** are those, such as counselling, which can provide long-term help to people who have been significantly affected by bullying or which can help to modify the behaviour of people who bully others.

The following lists include some of the strategies that Scottish schools have used. Some have proved more useful than others:

**Pro-Active Anti-bullying Strategies**

- Questionnaire survey.
- Use the research.
- Invite discussion/comments.
- Apply ethos indicators.
- Poster campaigns.
- Events.
- Meeting for parents.
- Staff training.
- Preaching.

**Preventative Anti-Bullying Strategies**

- Develop a clear policy.
- Promote understanding.
- Use the formal curriculum - novels, PSE.
- Use the informal curriculum - drama, role-play, and enterprise.
- Civilised surroundings promote civilised behaviour.
- Circle time.
- Peer Support.
- Focus on issues (racism, homophobia, etc.).
- Assertiveness training.
- Review practice regularly.

**Re-Active Anti-Bullying Strategies**

- Safety first.
- Recording and monitoring.
- Bully courts.
- Bully box.
- Restorative Practices.
- Shared concern method.
- Support Group - "No blame" approach.
- Mediation???
- Punishment?

NB Always assess the nature of an incident before reacting.
Supportive Anti-Bullying Strategies

- Counselling.
- Peer counselling.
- “Safe” Rooms.
- Behaviour modification.
- Circle of friends.
- Help lines.
- Involve specialist agencies.
- Remain aware.

An Anti-Bullying Checklist

The school inspectorate in Scotland has had a crucial role in putting the creation of a non-bullying ethos on the educational agenda. Bill Maxwell, HM Chief Inspector of Schools in Scotland has kindly provided us with the following checklist:

What should we expect to find in a school’s anti-bullying policy?

HMI look for a pro-active push to minimise bullying in the school and, of course, the school ethos must be positive in the first place, for the school to be able to work on bullying issues.

A Checklist

The Anti-Bullying Policy may be found embedded in another policy, perhaps on relationships, but wherever anti-bullying sits in a school’s policy framework HMI will look at the following points during an inspection:

- Whole school ethos, which is a critical factor.
- Practice, rather than policy.
- Pupil complaints procedures, especially in regards to teacher bullying.
- Parent, staff and pupil awareness of the anti-bullying policy and whether pupils and staff were involved in its formulation.
- A consistently high level of vigilance, with staff looking for signs of bullying, and tackling incidents of bullying without over-reacting.
- How recent incidents of bullying have been handled - HMI check that a school didn’t go into “crime and punishment” mode, despite possible pressure from the parents.
- How PSD programs take pupils through the issues, e.g. how concepts of power and conflict are handled as part of a wider agenda to develop kids effective social relationships.

HMI will check that:

- Teachers look at the perception of the victim, and check what the victim’s needs are.
- Teachers have tried to work out the intention of the bully, were their actions intended or simply thoughtless?
- The school don’t rate the seriousness of the bullying by the nature of the incident.
- Teachers consider the support needed by both the victim and the bully, and make an appropriate response to those needs.
- The school records bullying incidents and that appropriate actions are taken.

To download a free copy of Reasonable Expectations? the discussion paper in which this checklist was published, visit the Anti-Bullying Network’s website: www.antibullying.net

What is the Anti-Bullying Network?

The Scottish Executive established the Anti-Bullying Network in 1999 so that teachers,
parents and young people could share ideas about how bullying should be tackled. Its services are freely available to all. There is no membership fee and no age limit (minimum or maximum!)

**What Services Does the Network Offer?**

- [www.antibullying.net](http://www.antibullying.net) - Our website contains a wealth of free information.
- A telephone Info Line is available on **0131 651 6100**.
- Information packs and other publications for teachers, parents and young people are available to callers to the InfoLine.
- Conferences in various parts of Scotland provide an overview of anti-bullying strategies, highlight good practice in schools and enable teachers, young people and parents to share their experiences.
- Newsletters are distributed to Scottish schools and to individuals.
- Support is offered to schools and local authorities that are organising their own training activities.
- A database of initiatives and materials is being developed in partnership with our sister organisation, the Scottish Schools Ethos Network ([www.ethosnet.co.uk](http://www.ethosnet.co.uk)).

**SELECTED REFERENCES AND RESOURCES**


SCOTTISH COUNCIL FOR RESEARCH IN EDUCATION (1993) Supporting Schools Against Bullying. Edinburgh: SCRE


**Andrew Mellor MA Hons. FEIS**

Andrew Mellor is Manager of the Anti-Bullying Network (ABN) and the Scottish School Ethos Network (SSEN). He is a teacher with 25 years experience who has also worked as a researcher and developer. He conducted the first substantial research into bullying in Scotland in 1988-90 and was seconded from his teaching post as the Scottish Anti-Bullying Development Officer from 1993 to 1995. He has written widely on the subject and has given talks and lectures to a wide variety of audiences throughout Scotland, various parts of Europe, and Australia.
COMMUNITY COHESION AND VIOLENCE PREVENTION

Dominic Harrison

Health Development Agency, UK

Until recently, the North West like many other English regions did not have a formal strategy for equality and diversity. Consequently, in 2004, a group was established to begin the development of a strategy, which is now in consultation form established under the North West Regional Assembly with support from a range of sectors, including the health sector. One of the first issues examined was the classification of different groups. Eventually, the regional strategy agreed to review six specific groups relating to: ethnicity, gender, disability, gay/bisexual/lesbian/transgender communities, age (younger people), age (older people), and faith and beliefs. The group reviewed existing policies and strategies, regional data relating to inequalities, and promising and effective interventions to promote equity.

In addition, the group commissioned an economic assessment of the costs to the economy of the lack of social and economic inclusion for those groups. One of the, key questions we asked was, “If the employment participation levels in those ‘excluded’ groups were the same as those of the rest of the region, what effect might this have on the economy?” The northwest economy (GDP per head) is about 15% lower than the average for England and Wales. The report found that if the employment levels for the excluded groups were the same as the average then the northwest region would be 10% wealthier than the national average rather than 15% poorer (this is average income per household).

There are as many definitions of Community Cohesion as there are sectors and academics engaged in it. John Denham, when talking about the riots in Oldham and Bradford in 2001, said “community cohesion is what we achieve when diverse communities within local areas share a common vision for the area, reflecting both shared values and the respect for diversity. Local authorities have a key role in fostering community cohesion by ensuring that all communities have a true sense of belonging in their local area, by ensuring that there is a true celebration of diversity, by tackling inequalities between different groups to build real equality of opportunity, by overcoming the fragmentation of communities, and by building strong positive relationships.”

In this country, in terms of Public Policy, community cohesion is ‘owned’ by the Home Office. It is seen primarily as a solution to public order issues. This characterisation may be an over-simplification and slightly unfair because in the strategies that they have produced more recently they have included a range of other policy and priorities relating to community cohesion. These include: race equality, diversity and the development of social capital citizenship, identity and belongings, civil and civic society, delivering community engagement, eradicating extremism, reducing inequalities in health, social inclusion, and economic regeneration. These are seen as the building blocks. However, because it is a Home Office owned activity, reducing inequalities in Health is not viewed as central in national community cohesion guidance, although this is referred to. The most recent Home Office guidance is called, ‘Improving opportunities, strengthening society’. That was produced within the last 6 months as a response to an initial consultation paper, ‘Strengthening Diversity’. Therefore, even within the Home Office, the concept is shifting.

Professor Richard Wilkinson researches health and inequalities; he has conducted a great deal of research on inequality in health and the determinants of those inequalities. He points out that strong correlations exist
between poor health within communities, low levels of social cohesion, civic participation and social trust, and also with high rates of violence, homicide, alcohol consumption and deaths. The Cantle Report, which looked at the causes of the northern riots in 2001, identified a number of deterrents: the degree to which communities where empowered, how much participation, trust, collective norms and values, supporting networks, reciprocity, and safety and belonging. All those things are cited as deterrents to community cohesion.

Italy was regionalised back in the 1970s. Northern Italy started pumping money into the poorer Southern Italy and continues to do so. After about 15 years of pumping money into Southern Italy with no significant improvement in the economy or any of the other social indicators, an academic called Putnam was asked to investigate why economic development was failing following regionalisation. Putnam was the originator of the term ‘Social Capital’ and he defined it as “those features of social organisation, such as networks, norms and trust that facilitate coordination and corporation for mutual benefit”. He also elaborated on the idea of civic societies and which value solidarity, civic participation and integrity, where social and political networks are organised horizontally and not hierarchical. For example, you might meet your MP in a local Café rather than having to bypass security and apply six months in advance for a meeting with him in London.

Non-human primate research has also contributed to this body of knowledge. In the mid 1990s researchers explored issues concerning hierarchies, and social groups pulling together a range of different research. One of the research projects looked at the role of alpha males in chimpanzee groups. The alpha male was the healthiest and biggest, and was going to live the longest. They took the alpha male out and put him into another group where his status was uncertain. The consequence of that lack of social status, lack of self-knowledge of his social status invariably caused one of two responses: fight or fight. Some of these alpha males were taken out and put into a place where their social role was uncertain; they became depressed, sat in a corner, and did not engage. The ones that fought either became the new alpha male or did not win. Researchers looked at the physiological indicators and they were able to see the building up of atheroma in the blood transport systems, which is one of the precursors to heart disease. This is regarded as a non-human primate model of how social conditions are mediated by psychological responses to create definable, measurable, bio-medical outcomes. Understandings from this became labelled as the bio-psycho-social model of health; social conditions determine psychological responses, which determine physical health outcomes. This process is also referred to as “socio-biological translation”.

There are also similar sorts of evidence of this in human populations. One ‘natural experiment’ was in Central and Eastern European countries following the collapse of the Soviet Union; male life expectancy, which was already low, dropped dramatically. This was particularly evident in the 35-55 age groups. There were a whole host of reasons; violence was certainly one cause, but there were also factors such as heart disease. Heart disease and deaths from heart disease rose dramatically within two years; if you have a long ecological model of heart disease then you should not get a variation of such immense proportions in such a short of time. One of the things that has been commented on is that this was simply socio-biological translation; the people in that age group were neither old enough to have become powerful within the Soviet systems or young enough to adapt by learning new languages and joining the new ‘cowboy’ economy that was emerging in many of those counties. They had lost their social role and had nowhere else to go. Consequently their responses were to fight or fight. Many social policy issues arise...
from this analysis and it has a great deal to tell us from a community cohesion perspective.

As far as inequalities in life expectancy are concerned, the northwest is the worst in England. London always says it has more health inequalities, but the northwest here in England has the most number of people with the shortest life expectancy for males. London has the greatest inequalities, but it has fewer people suffering shorter life expectancy. London only appears to have the greater differences because it has got more wealthy people. The northeast looks similar to the northwest. However, it only has a population of 2.9 million compared to 7 million in the northwest region. When we look at the contribution to life-years lost, we find the usual suspects for those engaging health issues (cancer, heart disease), but injury and poisoning are a massively growing area. Many of the injuries are alcohol related or violence related. There are also a great many drug related deaths.

If we look at deprivation by local authority in England and Wales, and compare it to crime rates and life expectancy the following story emerges. The poorer you get the worst life expectancy you have, and the poorer you get the worse crime you have (with some exceptions). One of the interesting questions about this is, “what is it about the areas that have high deprivation yet have low crime rates and high life expectancy?”

One of the problems with the way we research these problems is that we always look at the negative; we never look at the positive. We know what the causes of early death and disease are but we are not very good at telling you what the causes of health are. We do not know why some people live longer. Take the example of smoking. We know the biomedical reasons why roughly 60% of people who smoke 20 cigarettes a day will be dead or have a smoking related disease by the time they are 65. We know why this is; we have researched it with biomedical science. The questions we have not asked is why 40% are not dead and have no disease. We have not got the answer to that. One commentator said, “we are missing half the story here because what we haven’t got is a solutagenic analysis.’ We have not studied the origins of health. In this regard, there may be a lot of questions to do with violence that we have not asked. Why do certain communities that we would expect to have high levels of violence, actually have very low levels? What are the mediating factors in those communities? Could we promote those mediating factors rather than just trying to prevent known causes of increased violence? What connections are there between these things?

Research has shown a wide range of mediating factors for social cohesion. This is a little dated now and the index used is not a universal one. For the northwest, Central Liverpool, East Manchester, and East Lancashire show low levels of social cohesion. If we look at the distribution of knowledge workers (sunrise industries analysis) we can see those areas that have the least number of people who will earn a living by having knowledge and qualifications, we can see that this mirrors the social cohesion index. If we look at the 2000 data on mortality from heart disease in males we see a similar distribution. This does not mean there is a causal correlation. It is not necessarily causative, but the associations are noticeable.

Professor Layard of the London School of Economics was commissioned in 2001 to look at happiness. One of the things he realised was that the average income has been rising, but all the evidence tells us is that people are not proportionately happier. This is counter-intuitive. One of the things Professor Layard associated with this debate was the idea of trust. He looked at the social capital data and arguments.

Some countries have increasing social trust within society between groups and some countries have decreasing social trust. What is very noticeable is that the UK, USA, Ireland, Northern Ireland and Australia are in a decreasing trust group and have declining
social capital. In Japan, Iceland and Spain these are increasing. Research has been undertaken concerning incomes and happiness in the USA. Between 1946 and 1996 the GDP per head has been going up dramatically, but the percentage of the population who say they are happy has not kept pace. There is a consensus between researchers that during the late 1950s the two factors became disconnected. Levels of wealth may rise and fall, but it makes little difference to happiness.

Professor Layard conducted research on this issue that was published in a 2001 paper in the UK and he published some work called 'Joyless Growth.' He showed how incomes have increased since 1970, but the happiness levels have remained the same. What is that telling us? He used the term ‘life satisfaction.’ This was a subject discussed at the recent Office of the Deputy Prime Minister (ODPM) conference in Manchester on sustainable communities. John Prescott was talking about life satisfaction and liveability, and the connections between the two. If we look at associations between low income, life satisfaction and high stress, we see that the higher income you have the less stress you have. There is a gender influence, since women have twice as much stress as men. The difference decreases significantly when you get to the lower income quintile. We could say that gender issues start playing an increasing role with increased wealth.

Wilkinson looked at income equality by state in the United States and put the states in rank order. He undertook the same analysis with life expectancy and then he looked at indicators of community cohesion. Some of the indicators he listed were particularly violence related; family breakdown, domestic violence, alcohol and drug use, crime and homicide. He actually found that homicide was a reliable indicator of inequality and lack of social cohesion. He discovered a very strong correlation between all three. In other words the higher the income equality at state level, you would expect the longest life expectancy and the lowest negative indicators of community cohesion.

Community cohesion and violence prevention need to occur at all levels of governance where decision-making and resource allocation occur. Certain policy and decision-making issues are controlled at the regional level (7 million in the NW). Some are controlled at the sub-regional level; local authorities and primary care trusts determine policy and decision-making issues at population levels of around 500,000 to a million. There are also small area initiatives at the community and neighbourhood level, which deal with populations as small as 2,000. You need a set of concentric interventions to make a difference to something like community cohesion that addresses and pick up the kind of evidence that I have just talked about. You need bodies from all these levels to intervene because of the range of agencies that control decisions around policy, for instance, relating to what happens in social space. ‘Common Ground North West’ is a regional non-governmental organisations (NGO) invented to crosscut a range of sectors and levels.

Common Ground North West has had a regional, annual conference for the last three years. We have been working together with the Home Office team to devise plans for community cohesion in the north west because we do not yet have a formal community cohesion strategy. We are planning interventions in other ways, together with NGO’s, Government Office, Local Authorities, and National Health Service (NHS) practitioners. Jenny Ager of Common Ground North West is presently completing an NHS Briefing on community cohesion funded by the Health Development Agency. What can the NHS do to contribute to community cohesion? If you were to look inside a hospital and take a snapshot you would probably find less that 2% of staff actually conducting medical interventions. The other 98% would be walking down corridors, tapping computers, making reports, and
talking to people. One of the biggest outcomes of hospitals is actually community cohesion or the increase of social capital. It is one of the main places where people in the community meet and have conversations with other people with a purpose in mind. Unfortunately this often gets missed; we fail to mobilise it, and we fail to strengthen its capacity. The NHS has an enormous capacity to promote community cohesions in a variety of ways.

McKnight is an important researcher in the arena of anti-poverty programmes in Canada and the US. He looks, not at the capacity building or asset building, but at asset release. He has explored the notion that there are hidden assets, particularly around public sector spending, where we could obtain added value. For example, community cohesion can be regarded as an added outcome of existing assets if we can only release the capacity that is already there. McKnight maintains that communities have never been built on their deficiencies. Building community has always depended on mobilising the capacities and assets of people and place.

Putnam, as described earlier, examined the economic agenda in Italy. In the North, norms of reciprocity and networks of civic engagement had been embodied in society guilds, mutual societies, operatives, unions, soccer clubs and literary societies. Horizontal bonds have underpinned levels of economic and institutional performance.

This was generally much more evident in the North of Italy than in the South, where political and social relations had been vertically structured. Although we are accustomed to thinking of the state and the market as alternative mechanisms for solving social problems, this history suggests that both states and markets operate more effectively in civic settings. This has fundamental implications for regional economic strategies.

The development of social capital in and between communities is a primary building block of economical capacity. Going back to the research that we have undertaken on the financial cost of social exclusion, there is a big agenda for community cohesion and economic development that requires a great deal of work and investment.

The Carnegie Commission in 1997 features in the World Health Organisation (WHO) report on Violence, and spells out the evidence base for preventing deadly conflict. Different levels were explored, mainly at the community level. Inter-racial and inter-country violence were also examined. Four important factors emerged:

- Conflicts resulting in fatalities occur because of a lack of democratic process and equal access to power.
- Social inequality marked by grossly unequal distribution of access to resources leads to deadly conflict.
- Control of valuable natural resources by a single group (for example access to diamonds in Africa) results in lack of community cohesion that can result in war. Rapid demographic change and the inability of the state to provide essential services can cause disintegration and loss of community cohesion.

If you examine health inequalities, the percentage of knowledge workers and the index of community cohesion, you are still going to be able to find all four of these factors in some of our communities. The WHO report says that we need to make a difference. We can look at the data, we can provide services; the State’s usual way of solving problems is to look at the data and employ somebody to provide a service and address what the data is indicating. However, WHO emphasises the need for more primary prevention. If we can identify the causes then why do we fail to prevent the need for services in the first place? WHO uses the
ecological model to conceptualise this. You can have loss of community cohesion or increasing risk of violence from social conditions at several levels.

They can arise at the personal level, the relationship level, the community level and the societal level. One of the important understandings of the ecological model is that interventions at the societal level will impact distantly but significantly on what the individual does. The idea of the ecological model is that all levels are interdependent.

What we need to do for the prime prevention of violence is to look at what is known in this region. There is existing knowledge relating to community cohesion as the primary prevention of violence. We can reduce the likelihood of violence to individuals through some of the interventions indicated by the kind of evidence I have already described.

We cannot proscribe everything that might be done to produce community cohesion. There is, however, guidance on community cohesion for local authorities and they should all have some reference to community cohesion in their local strategic partnership Community Plans. The NHS has been a poor contributor to this, but we are hoping to improve this in the North West.

Forthcoming guidance from the Health Development Agency will inform NHS Trusts about exactly what they can do to make a difference. This is only part of a wide range of action required by the NHS to reduce the population risk of violence in all its forms.
This paper is based upon research carried out for a PhD in legal responses to football hooliganism at Lancaster University (1995-1999) and then a research project into the policing and regulation of football crowds undertaken whilst working at the University of Liverpool (1999-2005) and partly funded by the UK Home Office.

What is ‘Football Hooliganism’?

The starting point for this research was an assessment of the idea of football hooliganism itself and this has resulted in a certain amount of cynicism towards the use of this term “football hooliganism.” I would suggest that it is not the most helpful of terms when we are actually looking at how we deal with different aspects of violence connected with football. For example, there are obviously differences between the serious, organised violence orchestrated by the hooligan “firms” and low level, spontaneous disorder such as missile throwing from the stands. The latter has increasingly been dying out in English stadia.

I want to start by just looking at this term “football hooliganism” and examining what we mean by it. It was a term that was first coined by the media in the 1960s. Up until this time people did not talk about football hooliganism. It is fascinating that in legal cases concerning football crowd offences from the 1970s to the present day, judges cannot resist making a statement about the “shame and menace of football hooliganism”, often before imposing a higher sentence than perhaps they otherwise would have done.

This is in stark contrast with cases before the advent of the term ‘football hooliganism’. The case of Munday v Metropolitan District Receiver in 1948 came about as a result of Chelsea playing Dynamo Moscow just after the Second World War. The ground was full to capacity, and a group of young, male, Chelsea fans decided that since they could not get into the ground, they were going to break into a house next to it. They broke in and physically assaulted the gardener, broke into the shed and started stealing ladders. A female occupier of the house came out to try and stop them and was pinned against the wall whilst the fans dragged the ladders away, broke down the fence, climbed up onto the roof of the stadium and watched the match. This was quite a technical, legal case in terms of whether the people who owned the house could actually get compensation under the riot act but it was interesting to see what the judge said about these fans. If it had happened today, or in the 60s, 70s or 80s, it would have been about the scourge of football hooliganism. However, the only thing that the judge actually commented about these fans was that they were excited, and that they were enterprising.

I think this illustrates that the term “football hooliganism” is relatively new. It also has connotations that go with it. People do not talk about “vociferous” fans, nor do they talk about firms as meetings to engage in “rough and tumble” between consenting adults; instead “hooliganism” is talked about in very, very strong terms. Although the phrase was only coined by the media in the 1960s, violence and disorder involving football crowds had taken place long before this. Some excellent academic research has been done on this subject. Researchers in Leicester looked at the type of violence and disorder that took place as long ago as the 19th century, for example pitch invasions and attacks on referees. So the actual phenomenon of violence and disorder related to football crowds is not new by any means.

Levels of disorder may rise and fall, and certainly arrest statistics illustrate that this is
the case. However, there has been a lot of interesting work done suggesting that the way in which the media portrays football violence has a great influence on whether it is perceived as a serious problem or not. It is interesting that when there is disorder involving England fans abroad the media coverage is all consuming. In contrast, serious violence and disorder that takes place week-in-week-out involving the firms attached to the bigger domestic teams is barely reported at all. The reason is quite simply that the press do not have an angle on it. They do not have pictures and they do not have film, so it is very difficult to make a big, front-page splash in The Sun or The Mirror.

Another point regarding the label ‘football hooliganism’ is that it has never been defined by law. It is not an offence to be a ‘football hooligan’. The nearest we have to a legal definition actually comes from the definition of ‘football-related offences’, which derives originally from the 1986 Public Order Act. There was pressure in the mid 1980s for an offence of football hooliganism but it was considered to be unworkable. The definition for football-related offences, which we do see in the legislation, identifies certain types of offence committed at a match, on a journey to or from a match, or 24 hours before or after a game. The legal definition is quite narrow, but this is the closest the law has come to defining the term.

My problem with the term “football hooliganism” is that it is an extremely ambiguous label covering a multitude of different phenomena. It ranges from the serious, weekly, violent disorder carried out by criminal gangs, to somebody throwing a coin onto the pitch or someone selling a spare ticket on the street. All of these things have been bundled under this term football hooliganism. This means that when we are debating how to stop ‘football hooliganism’, we need to be more specific and decide exactly which phenomenon we are focussing on.

The Characteristics of Contemporary Football Violence

There has been an apparent reduction in domestic hooliganism from the 1980s onwards. Anyone who attends live matches week-in-week-out will probably agree that football stadiums are very safe places to be. I personally feel a lot safer going to Old Trafford rather than going to the centre of Liverpool or Manchester on a Saturday night. That is because of the reduction in violence in and around the stadium.

There are several characteristics of contemporary football violence. Widespread disorder in and around grounds is now very rare. When it does take place it gets reported. The isolated incidents of missile throwing at the recent Everton vs. Manchester United match were heavily reported. This was not a situation where the fans were trying to climb over fences to attack each other, even though this was such a high-risk game.

One reason for this change is that football grounds have been redeveloped. All seater stadia have played an important role, particularly because for many clubs you need a season ticket to attend the important matches. Fans are not willing to risk losing their season ticket by fighting. Another important thing is Closed Circuit Television (CCTV). Every ground is now covered by CCTV. Offenders know that if they cause disorder they are likely to be identified, banned, and have their season ticket confiscated. Consequently, football grounds are definitely getting safer.

Furthermore, there has been a substantial fall in football-related arrests. When the National Criminal Intelligence Service was set up in the late 1980s, arrests were over 6,000. They are now down to under 4,000. At the same time, the number of spectators attending football matches has increased substantially; so not only are arrests going down, but the amount of people attending matches and not being arrested is going up; at the moment we are
looking at only 0.01% of spectators being arrested. Another important factor in this decline in violence at games is the fact that many 'hooligans' have been banned from attending matches. Those who have been convicted of football related offences are now unable to attend.

Although this paints a very healthy picture about violence inside stadiums, problems do persist surrounding football matches. Serious violence between organised criminal firms persist in relation to matches, and it is this phenomenon that needs to be addressed. These are groups are highly exclusive and tightly-knit; it is very difficult to infiltrate them. Many of the senior members of the firms know their rivals in other gangs, so they can actually organise disorder in advance of matches.

The size of the groups ranges from 30 at the lower end to anything up to 400. This can mean a very large gang which can turn up at a game with the specific intention of fighting another football firm. Obviously if two firms with similar intention meet there is the potential for very serious disorder, injury and criminal damage.

Whilst disorder in and immediately around stadiums has decreased, the serious violent offences have not decreased at all. If anything, there has actually been an increase in offences such as violent disorder. The offences in which we are seeing a reduction tend to be the lesser offences; throwing missiles, running onto the pitch, or breach of the peace. The serious offences are still as much of a problem, if not more of a problem, than ever.

Another characteristic of contemporary football violence is public disorder from non attendees. This would not fall into the definition of football hooliganism in the legislation for football-related offences. It involves people who sit in the local pub in their own town watching the game; when England get knocked out (inevitably in a penalty shoot out), problem behaviour will often spill out onto the streets of provincial towns resulting in quite serious disorder. This can also happen when England wins, for example the disorder resulting in police baton charges after England beat Argentina in the 2002 World Cup on Deansgate, Manchester. If we think of the term “football hooliganism”, would this disorder fall within that definition or not? Obviously, we are looking at an entirely different problem than the serious organised disorder or, on the other hand, missile throwing inside a football stadium.

**Legal Responses to Football-Crowd Disorder**

There have been a number of legislative responses to football related violence. The first statute, the Safety in Sports Grounds Act 1975, was not primarily concerned with football hooliganism, but with the safety of spectators. However, it gave powers to the police to insist upon police control rooms, segregation, perimeter fencing, sterile zones, and now closed circuit television. Basically, if the football club does not agree to this then it will not be permitted a safety certificate and will not be able to allow football spectators into its the stadium.

The 1985 Sporting Events (Control of Alcohol and Fireworks) Act prohibited drinking alcohol within sight of the pitch and entering a football ground whilst drunk. Fans were also not allowed to take alcohol on a football special (a train or a bus specially commissioned to take fans to the game). Later legislation also banned fireworks from grounds.

Exclusion Orders for domestic games were introduced by the 1986 Public Order Act and Restriction Orders preventing convicted hooligans from travelling away from England were introduced in 1989 by the Football Spectators Act. This was also the statute that intended to introduce the national identity card scheme for football fans. The ID Card scheme was meant to break the link between football and violence. It is still on the statute book, but it has not been implemented
because of the Taylor report which said it was unworkable. It was described as a sledgehammer to crack a nut that may lead to as much disorder as it actually prevented.

The Taylor report also led to the Football Offences Act 1991. This legislation criminalises the following: invading the pitch, throwing any item in a football stadium, racist and indecent chanting. With regards to the prohibition on indecent chanting in particular, the Act is clearly not stringently enforced.

Ticket touting was criminalised by the 1994 Criminal Justice and Public Order Act because it was felt that segregation in stadiums was breaking down as a result of ticket touting. The 1999 Football Offences and Disorder Act closed a few loopholes in the previous legislation.

The 1999 Act was a watered-down version of a private members bill which was eventually introduced by the government in the 2000 Football Disorder Act. This is a contentious piece of legislation. It allows magistrates to impose banning orders preventing fans attending domestic matches and also prevents them from leaving the country when the national team or their club team are playing abroad. These banning orders can now be imposed on people who have not been convicted of any football related offence. Previously under the 1986 and 1989 Acts, those subject to bans had to have been convicted of a football related offence. However, now if the police can prove on a balance of probability that a fan has committed acts in the past and a banning order will prevent disorder in the future, a stringent banning order can be imposed. These are being used increasingly; during the run up to the European Championships in 2004, the number of banning orders ‘on complaint’ rose considerably to over 2,100.

There has also been a significant change in police tactics to deal with football crowd disorder, characterised by a move from the mass policing of the 1970s and 1980s to the more targeted policing we see today. Under targeted policing, hooligan groups of so-called ‘prominents’ will find themselves put under general surveillance, followed, filmed and filed. The police will then compile a profile on suspected hooligans, including details of situations where group disorder has taken place. The police will then go to the Magistrates court with a profile and request a banning order to be imposed upon a particular individual. The Magistrates Court will then assess whether they believe the individual has committed those offences, and secondly whether they think a banning order is likely to reduce disorder at future games. If the magistrates believe both of those two tests, then they will be forced to impose a banning order. If the banning order is then breached there is the likelihood of a custodial sentence as a result.

This obviously brings us back to the Football Disorder Act 2000. One of the interesting issues is that as its use has increased we have seen a reduction in serious disorder involving English fans abroad. Obviously it is very tempting to say that these banning orders are actually working, that there is a causal link between the number of banning orders and the extent of disorder. However at this moment we cannot make that judgement.

This is because there have been several other factors in play that have been as, if not more, influential in reducing violence involving English fans abroad. One example is the Home Office initiatives for Euro 2004, working with the Portuguese police to find better ways to police English fans and reduce conflict. Certainly the sort of disorderly and potentially violent incidents that took place at Euro 2000 and in France in 1998 were avoided at Euro 2004, but my own experience and research would suggest this was as a result of the way in which the tournament was policed on the ground.

The third leg of the legal response to football crowd disorder comes from the judiciary. This is characterised by an increased use of banning orders from 1997 onwards. In terms
of sentencing policy, towards the end of the 1970s and the mid 1980s the judiciary started using deterrent sentencing, particularly in the Crown Courts and the Courts of Appeal. This means that high custodial sentences were handed down for incidents which, had they not been committed in connection with football, would have led to a much lower sentence. In the case of *R v Squibbs* in the mid-1980s the defendant attacked a linesman, breaking his jaw and received a seven month custodial sentence as a result. The judge stated that it was clearly a case of football hooliganism. The defendant appealed and the Court of Appeal judge noted that it was “a single blow of the fist with no question of football hooliganism”. The sentence of seven months was reduced to nine weeks.

However, my own research has indicated that the Magistrates Courts do not tend to follow this line. This can be illustrated by a case in the Preston Magistrates Court back in 1997. During the “worst night of violence the town had seen in 30 years” (according to the Magistrate) a Preston fan ran onto the pitch, ran the length of the pitch pursued by stewards, and then threw himself into the Blackpool end causing a near riot. He received a £250 fine and a banning order of one year maximum. So deterrence sentencing is not taking place at all levels.

**Have these responses reduced violence and disorder? Blanket vs. targeted responses**

We have seen that there have been legal responses at three levels but we have not yet looked at what responses work and what responses do not work. Types of responses can be split into two. There are blanket responses against football crowds as a whole. These have resulted in some notable failures in terms of safety. Perimeter fencing is an obvious example of a blanket response. It not only pens in hooligans, it also pens in the normal fans. If the stadium’s safety mechanisms break down, the potential for death and injury is very high and this was demonstrated by the Hillsborough disaster, which resulted in 96 deaths and 730 injuries (and this was not the first time a serious incident had occurred in that same section of the stadium at Hillsborough in Sheffield).

Another blanket response was the Sporting Events Act of 1985, which banned alcohol inside stadiums. Originally when this act was introduced, fans could not get an alcoholic drink inside a football stadium, which meant that fans who wanted to have a drink would go to pubs before the game. Further, the second leg of this act, preventing drunken fans from entering the grounds, has not been strictly enforced. This means that it is quite a common sight to see large groups of fans going into pubs, and drinking until five minutes before kick off. Therefore, instead of actually drinking in a safe environment in a stadium where there is CCTV, where the situation can be heavily controlled by police and stewards, where there is segregation, and no access to weaponry, fans are drinking in unsegregated pubs with access to bottles and glasses. This is followed by a mad dash to try and get through the turnstiles in time for the kick off. Clearly the 1985 Act has caused more problems than it has solved.

There is an inherent danger in treating all football fans as potential hooligans and lessons from the treatment of English fans abroad have demonstrated this. Perceived injustices in police response, particularly where fans have been drinking heavily, do have the potential to lead to often to a violent reaction. In Euro 2000 the police response to a small number of fans throwing chairs was to surround a group of about one and a half thousand fans with riot police and then water-cannon them. The disorder escalated in response. Normal fans are significantly more likely to retaliate against the police in these circumstances than if they are merely targeting and arresting offending fans.

However, this is not to say that important steps have not been made in the control of football crowds. There have been huge successes in targeted responses; responses targeted against the individuals who are committing criminal offences rather than a
crowd as a whole. CCTV has played a major role in this; being able to identify and pick somebody out from a crowd just by use of a joystick in a police control room. This has had a huge impact because fans inside stadia now know that they will be caught if they commit offences. Banning orders for those who have been convicted have also played a major role domestically. Targeted police operations against the firms have shown some success; if the firms want to have a serious conflict with another firm they know they are not going to get it inside a stadium. Instead they will need to organise violence away from the stadium in terms of both time and space. Obviously this is not an ideal situation, but what it means is that in 99% of the cases the average football fan is not involved, or is not at risk of becoming involved.

Another advantage of targeted policing is that it increases the segregation of fans from hooligans which in turn provides a real opportunity for self-policing (or ‘fan policing’). What I am referring to by this is not football fans performing citizens’ arrests of football hooligans, or frog-marching them to the cells. Self-policing can only occur when the police, the authorities, and stewards act to protect the ‘normal’ activities of fans. Drinking and wearing colours, chanting and being boisterous, are legitimate expectations for most football fans travelling abroad. If these activities are reinforced by the way in which they are policed then the fans have something to protect from those who wish to cause disorder. That will lead them to segregate the small minority that are becoming aggressive. Serious violence involving English fans has always occurred when these two groups of fans, the boisterous and the violent, have been treated the same. What occurs is a ‘recruitment’ of ordinary football fans by the serious hooligans upon a reaction by the police which is seen by the ordinary fan as unjust and provocative (e.g. a baton charge into a group of fans, the indiscriminate use of tear gas or water-cannon).

Conversely, self policing happens if you can encourage the football fans so they know that only if they cross the boundaries by starting to become aggressive or violent will the police take action. If you can achieve that, then you suddenly start finding that the fans are turning round and saying to people who are going too far “that is out of order.” This sort of self-policing already takes places, particularly when large numbers of fans from Liverpool, Manchester United, and Celtic fans travel abroad. We are seeing self-policing. There were 60,000 Manchester United fans at the European cup final in 1999 and only one arrest - clearly, self-policing was going on all the time. People were having the confidence to say “that is out of order” because it was in their interest to protect their right to sing, drink, and have a good time.

Conclusion

It is important to gain a better understanding of disorder in and around football events. What do we mean when we talk about football hooliganism? What do we consider to be the serious problems, is it the spontaneous disorder, or is it the serious violent disorder that does not involve normal fans? We need proportionate legal and policing responses to the problem of violence involving football crowds; past incidents have demonstrated that groups of fans respond more positively to action taken against individual offenders rather than entire crowds. It is this targeted, rather than blanket policing, that is the most effective.

Finally, the facilitation of self-policing is also very important. Research has shown that if self-policing is allowed to take place, violent groups will just leave the main body of support because they are not interested in just singing and drinking and putting their flags up on statues. If we can get football crowds to isolate those criminals who want to become involved in football violence, then the job is already done.
I am going to be talking to you about working safely in other people’s homes. I have no statistics or data; I have no graphs or tables for you. All I am going to talk about are very simple, common sense, issues about how you can help to keep yourself safer if you are out working in other people’s homes. I am not an expert and a lot of what I talk about will seem obvious to you. I am hoping that this is the case, because if it is, then it already means that you have a toolbox of personal safety.

The Suzy Lamplugh trust was set up 20 years ago; next year is our 20th anniversary. It was 20 years ago that a young estate agent called Suzy Lamplugh disappeared whilst going about her work. Suzy disappeared, she was never found, and no one was ever convicted of her suspected murder. She was officially declared dead 8 years ago. Suzy’s parents, Paul and Diana decided that her disappearance had been unnecessary. They cited two main areas where, if something had been done, she would probably have still been here. The responsibility for this lay with her employer because there were no policies, procedures or guidelines in place in that Estate Agency about how to make sure that people who were working outside the office were kept safe. The other side is Suzy herself, who was not living her life based on personal safety. She told her parents three days before she disappeared that had there been a man who had been making a nuisance of himself. What we now think is that Suzy had a stalker. But of course 20 years ago we did not really know about stalking. It was not very much part of the agenda. We do know that she was bothered by somebody who kept turning up; he was always waiting there when she came out of a house. He kept sending her flowers, and standing outside her work place. What she said to her parents was “I’m going to have to have a word with him.” We do not know if that man was responsible for her disappearance, but it seems highly likely. So Diana and Paul set up the trust with a view to encouraging workplaces to have policies and procedures in place. The trust has moved on, developed, and expanded and over the last 20 years, and has grown to be the national charity for personal safety. There are many people who work in the field of safety, including many commercial training companies. We are the biggest charity that works in personal safety. We do not just work with women, we work also with men. We no longer just work in the work place. We have training and conferences in the work place and consultancy services that will work, for example, with hospitals that are experiencing violent incidents. We will go in, talk to the staff, and we come up with suggestions as to why we think that a particular area is having problems. It is always something that is glaringly obvious, but it is only an outsider coming in that can see it. We also do a lot of work in the community, so we work with young people, schools, and youth clubs. We work with elderly groups. Much as our work these days is about fear of crime and perception of that crime, but it is also about giving people those skills to lead a safer life, particularly the elderly. They have a very, very disproportionate fear of crime. A lot of our work with the elderly involves persuading them it is all right to go out; there are some very simple things to do to keep yourself safe.

Today we are going to begin by looking at things you need to think about before a visit to a home. We will take a look at policies and procedures and the role they play. Then we are going to think about things you can do to keep yourself safe during a visit. Then we are going to think about what to do if the worst happens and there is an incident. What does
an organisation and individual need to think about in terms of dealing with that? Finally, we will look at some of your own organisations. What I am not going to do, because there simply is not the time, is to look at the legal requirements and implications around this.

How many people here actually do go to other people’s homes as part of their job? How many people here do not go themselves but manage people doing that? How many people here have had an incident or a near miss as a result of going about your job? Did you have any policies or procedures about what to do? Policies and procedures are fine but they are not worth the paper they are written on unless they are supported by on going training and support.

As a health professional going in to other people’s homes, there are some concerns around provision of a service that is not wanted or welcomed or that the person does not think they need. These factors can create a very difficult dynamic. We need to think about “who else is there in the house?” You can often be in the situation of visiting a client, but you do not know if there is going to be anyone else in the house. I was talking to a midwife yesterday about such a situation. She had gone into a property; it was the first visit after a baby was born. The door was opened by a man she did not know. She took one step in and he produced a knife. We asked her how she responded, and she told us that she carried on walking in and said “that’s not a very friendly welcome is it?”

I can understand why she did that. She said she was worried about the mother and baby. We hear this all the time from caring professions; the first thought is not about yourself, it is actually about the person you are going to work with. What we would always say is that if you are not safe then you are not well equipped to look after that other person. You must put your personal safety first for your benefit and for the clients benefit.

Another massive issue is the whole area of training. Often an organisation will put in fantastic procedures and policies and they spend a fortune on safety tools for their staff. Unfortunately, they do not teach them how to use them properly. Very often they give a tool and staff who think, “Well, I’m safe now, they’ve got this tool.” This is very dangerous. The tool is not going to stop them from being attacked. When someone is going to get very violent, my mobile phone is not going to stop someone from smacking me in the mouth. If anything, it is going to stop my ability to communicate, to diffuse, and to manage that situation verbally. I am not saying there is no place for tools; there are. They must, however, be accompanied by training and other soft skills.

I am sure that most of you, at some point in your lives, have worked where there was a culture where the threat of violence was always part of the job. I used to be a youth worker. I know that when I was a 23 year old youth that my attitude was very different from what it is now. I worked with young people with problems. When in this environment you sense that you have to feel cool and special to them; I worked with kids that got knives out all the time. I was not thinking about my personal safety. I think that this is quite generic to many caring organisations; few of the workers are concerned about their safety. It is an unspoken expectation, there is a certain level of threat that you expect and that you tolerate.

This is something that we need to challenge on an organisation level. All staff should have the right to be able to get themselves out of any situation that threatens danger. On the other side of that is the staff and what they
are willing to do to change; if you do not have both sides then it will not work.

**Before a visit**

In order to take into account personal safety issues, there are several different questions that we need to ask ourselves before we even embark on a visit.

**Who?**

Firstly, who is it that we are going to visit? It is important to know as much as possible about the individual in order to gauge the risk and the likelihood of something going wrong. This is a really crucial point in terms of working and sharing of information. Often, we take a referral from another agency. The information you get can be pretty sparse, which means that you can not make a very good decision. Consequently, it is absolutely crucial for your own safety that you do get more information. Sometimes you get a referral and it does not tell you about a client’s mental health history. Do not go to that home until you have made a call back to the referring agency and say “Can you just give me a bit more here?” I have a personal friend who was held hostage for four hours by a client. This was because when he was referred there was a very crucial bit of information missing; he had a problem with redheads. He became violent towards redhead woman because he had issues with his mother. My friend is a redhead. She was given the case, she went into a room with him and he barricaded her in there for four hours. Now if her employer had known that information it would have simply been a different worker that was allocated to him and that would not have been a problem. That lack of information meant that she did not know enough about the individual to make an informed decision about what was going to be safe for her.

We need to think about all sorts of different issues; what is their age? What is their physical ability? Are there any potential conflict situations likely? Is there a substance use issue, and if so, what? How many people will be there? You are going to see a client, but do you know if the client’s niece, nephew, etc. are all going to be there? If they are, what do you know about them? What is their situation and history? What are their ages? What are their genders? Cultural and language issues are very important and can often be a point of conflict. This does not have to be intentional; if you do not know a lot about a different culture or know someone’s religion, it can be very easy to offend, misunderstand, or misinterpret something. This can then cause the beginning of an escalation. For example, if you know that the cultural background of that person means that they will not look at you when they talk to you, then you can avoid misunderstandings. This is something that I personally made a mistake on once. I assumed that a man was being rude and sexist by ignoring me. This was getting me very, very wound up. This was actually a cultural issue and he was actually being polite in his manner of talking to me. Unfortunately, my ignorance about his culture meant that I misread his messages. You may be asking yourself, “Well I’ve got 6 visits today and you want me to think about all of these issues, about every single one of them before I go.” I know many of you are thinking that people who are going out everyday with a heavy caseload do not have time to do all of this. All I am saying to you is that, in terms of your personal safety, these are the steps that we would advise you to take. Get into a routine of doing this.

**Why?**

Why are you going to see that person in that home? What is the nature of the referral? Is everybody in the household going to be happy for you to be there? For example, are you going to see a woman and there is a man in the house who does not want anybody interfering with her? He may not want her talking to other people. Are you going to see a child? Are you a mentor? Are Mum and Dad not particularly impressed with outside interference? Do they feel they know how to
bring up their own child? What is the emotional temperature going to be like in the room when you get there? Is it likely to get hotter while you are there or not? If so, what might you need to think about? Does the person actually want your involvement? It could be that the person you are going to see thinks “I’ve got a drug and alcohol problem and I’ve been referred to you by the local drug and alcohol action team so you are coming to help me with my drug and alcohol problem. I don’t think I’ve got a drug and alcohol problem and I don’t need any help from you thank you very much. I don’t even see it as a problem. What are you doing here?”

This was often the case when I was working with people with drug and alcohol issues. They did not want a visit and would often go out. They would do everything they could to avoid me. So again, how might that mean that the dialogue goes? How much might the temperature rise in the room as you are trying to work with that person who does not want you there?

When?

This is often an issue that is ignored. When are you going on the visit? What time of day is it going to be? Is it going to be daylight or is it going to be dark? Is it summer or winter? What are the physical conditions going to be like? Some organisations have policies and procedures about when you do your visit. For example, I used to work with drug and alcohol users and we had a policy that we only made home visits early in the morning. We did that because the clients were less likely to have had time to get drunk early in the day. If you went after lunch, then they were likely to be drunk and they were more likely to have begun to use their substances by that time. If this happened you could not actually do any work with them. We therefore tried to gauge what point in the day we were able to have a meaningful interaction with that person; when they are least likely to become violent and aggressive. So again, policies and procedures and thinking about your client group are very important. You all know your client group. You might for example think that it is the evening that is the best time to go to your client group, whoever they are.

Am I expected?

Do not ever go on a visit that is not a prearranged visit. One reason is that the client may well get “wound up” if you arrive unannounced. Another issue is that people might select not to be there at the appointed time. The location of the visit might be somewhere where there are a lot of drug users for example. If they know there are workers coming, they all get out the way, whereas, if you turn up unexpectedly they are all going to still be there. They are not going to want to be there while you are there and vice versa, so it could lead to some difficulties. These are all things for you to think about before you go on your visit.

Where?

This often gets overlooked. Do you know where the home you are visiting is located? Do you know how you are going to get there? Do you know how long the journey is going to take? Do you know the type of area that you are going to be going through? Is it a really quiet rural area where there are not many properties around? Is there a big block of flats in the middle of an estate that is known for having gang violence? Does your mobile phone work there? We did a conference once and there was a fantastic piece of advice given to us by an organisation. They worked in a rural area that often had black spots for mobile phones. They have actually gone round their whole region, and found the spots that did not have mobile phone signals. In their office they have a massive map of the area upon which they placed markers indicating where mobile phones do not work. They have done this in order to alert colleagues who go to work in one of these areas, so they know if they will
not be able to ring if they get into trouble. They then know that they need to explore other measures to deal with this.

There are more issues around mobile phones. There are many places where they do not work; sometimes at the tops of flats, lower flats, or basement flats for example. We have become quite dependent on our mobile phones. We feel safe when we have them, but we really need to think carefully about this. There is a lot of technology involving mobile phone guardian schemes, where you can log in and log out to let them know you are safe. If you do not log back in at a certain time to let them know you are safe, then they send out a search party to the place indicated by the mobile phone signal. This is very inaccurate. If I was attacked in Euston Station, the signal would indicate that I was somewhere in Euston Station, which is of limited help if help is needed quickly. Again, I am not saying do not use these things. I am suggesting that you be aware of limitations and ensure you have other additional strategies.

Is there a lift or stairs? Are you able to use the lift? If there is no lift, what might the personal implications of that be? Are you going to be parking somewhere where you know your car is going to be safe? You may go somewhere in the daytime but you know you will not be coming back to the car until night time. If this is the case, then you need to have a look around and see what that area might look like at night. Things can look very different after dark. You may be happy to leave your car somewhere in daylight, but would you want to return to that place after dark? Knowledge like this allows you to develop strategies and it equips you if you know all of this information before you even set off on your journey.

The mere fact of having thought about all of these things will mean that you are going to be far more aware of any potential danger or situations that may arise. Awareness is half the battle when it comes to personal safety.

Policies and Procedures

Policies and procedures are things that we must do, and they are not to be confused with safer working guidelines, which are things that an organisation will recommend as best practice. Policies and procedures are things you are obliged to do. I read some policies and procedures recently that talked about walking. They advised staff to walk at a brisk pace. I wondered how it was possible to measure that. Would it involve following all of your staff just to see how fast they are walking? This clearly did not belong in a policy or procedure, it belonged in the safer working guidelines.

Do you know your organisation’s policies and procedures around your personal safety? Do you know what they are and do they work? Have you ever tested them? Often we find the most incredibly fantastic policies and procedures that actually do not work. The classic one is the “panic button”. Many of you will have panic buttons in your buildings. Whenever we go into a place of work and they tell us proudly about their panic button, the first thing we do is we hit it to see what happens. 99% of the time everybody runs around like headless chickens or think it is the fire alarm. This is dangerous. If you have a red button and think that if you hit it you are safe, but in reality nothing will happen, then it is actually more dangerous than not having a red button in the first place. You need to ensure that something is actually going to happen.

Buddy systems are also in place in many organisations. This is where you have a buddy and you check in on them and watch out for each other. When I get home tonight I will be texting my colleague to say I am home safe. It is not until she has got that text that she feels she can switch off her mobile. If she does not get the call within an hour of the expected time she will inform my partner. Some systems involve calling employees 10 minutes after they have been in a home to check that they are safe.
Another procedure involves code words. Code words are useful when working in other people’s homes. Often you can use a code word to alert the office without alerting the person you are with. For example, you can say “Could you just have a look for the green folder in the filing cabinet for me?” Now you have no green folder or filing cabinet, you are using the phrase to tell people in the office that you are worried about something. For this to be of use, the people in the office must know exactly where you are and who you are with.

Other policies and procedures are around equipment, for example, mobile phones, tracking devices, alarmed badges, and personal alarms. Debriefings can also be really important. When you are on a visit, you may experience an incident that leaves you feeling worried. By the next day you may forget about it, or it may seem less important. You must go back and tell your colleagues about it. If you do, you may find that they will tell you they experienced the same thing, and also came away feeling worried. Early warning signals are really, really important; if you spot a pattern soon enough you can actually act before it becomes an incident. The sharing of information, hunches and gut feelings are very important. Team meetings obviously play a very important part in this. Incident Forms should be used properly; every time an incident happens log it. This includes near misses, not just actual incidents.

Access to support is absolutely crucial, as is training. When we are looking at policies and procedures there are a few things that are a key to success. First of all; Assessment. Most problems occur before you put policies and procedures in place. Most organisations push out the most fantastic policy, but no one has really talked to the people on the front line to find out what the real problem is. They think they know. I can say this about senior managers because I am one. It is very easy to think you know what is happening in your organisation but the higher up you are, the least idea you have about what is actually going on and the reality for the people on the front line. You have got to talk to the people who are going out to the homes every day to find out the real issues. You have got to do that before you can think about what your policy or procedures should be. It is really necessary for people to understand policies and procedures that are issued to them and how they relate to their day to day work. Again, there is no point in me giving you a lovely set of policies if you do not really know how this is meant to relate to the practicalities of your job. It really has to be understood by the people that have to put it into practice.

This is why communication is really important. It is essential for managers to know what the real issues are, and it is essential for the workers to know why they need to have the policies and procedures in the first place. Without that, you will not get ownership at the main level of the organisation. If you do not have ownership, the policies and procedures will not be implemented; at the end of the day they are just bits of paper with words written on them. The people that make a policy or procedure real are the people that go out and work with people in their homes every day. It is only if they choose to follow a policy or procedure that it actually becomes something real. People do have a choice; you have a choice whether you bother to follow the policies and procedures of your organisation or not. People are only going to do that if they can understand how these relate to their everyday life. It is absolutely essential that there is ownership.

Action is also essential. It is no good just having the piece of paper; it has to be supported with training. So if I am going to give you all mobile phones, I should not assume that everyone knows how to use a mobile phone. If I am going to give you a personal alarm, I need to explain to you what they are used for, how to use them, how not to use them, and what is the best situation to use them in. If I am going to say what you need to do is diffuse a situation that is
becoming worrying, then I need to make sure you have had training in how to diffuse a situation, how to recognise signs of violence and aggression, and how to recognise if the heat is going up in a room. All of these things need training and backup.

**During a visit**

So you have done all that planning beforehand and you are on your visit. We need to trust what is called the dynamic assessment. Obviously you all know about risk assessments: laborious things that you do to assess the risk of any given scenario. A dynamic assessment is intended as something you can do on the spot in a few minutes. This should be undertaken in addition to the bigger risk assessment. Even with the best policies and procedures in the world, even with everybody following them, there is still potential for violence and aggression at any point in a home visit. When you get out of the car, think about any concerns regarding your personal safety at this point. So: I am getting out the car and I am looking at the area; any personal safety concerns here? No, keep walking to the front door. I am now at the property. I can hear noises from the property, I get a sense of smell, and I get a sense of what the property looks like from the outside. Any concerns yet for personal safety? No, keep going. It is the constant checking that is important. It is something you do in your head that will eventually become instinctive. It sounds quite laborious when you think about doing this, but it actually becomes very much part of you and you can think about it.

**Reasons for visits**

We need to think about why we are there, we need to think about the people involved, we need to think about the attitude, we need to be aware of what is going on, and we need to think about strategies. Strategies are really, really important. Do any of you have strategies that you keep up your sleeve? Here are some examples:

- "Oh, I’ve left something in the car. Do you mind if I just pop out to get that?"
- "I need to make a call but I can’t get a signal in here. I’m just going to pop outside."
- If there is a dangerous looking dog in the house, “sorry I’ve got an allergy to pet hairs, can you pop the dog in another room for me?"

It does not matter if these sound silly. You should have a memory bank of exit strategies stored in your head that you can retrieve when necessary. You can try all of them first before you need to move onto using them under more serious circumstances.

Think about possible warning signs. If your in someone’s home with them, what things might happen to make you feel a bit anxious or concerned? Here are some examples:

- A sudden change in behaviour; if you have a person who has been very quiet and submissive and then, all of a sudden, they get very, very loud and more gregarious.
- Tapping the fingers or pacing; especially if it get louder and speedier as it goes along. Clenched fists/crossed arms; one of the things that tells you that blood is leaving that part of the body to go to other parts. This means they are thinking about doing things with these.
- Raised voice and eye contact; if someone has been talking to you in a relatively normal voice or in fact a very angry voice and then it suddenly drops to really rather quiet and low, then you’ll feel it in your stomach, you’ll think something has shifted in here. Similarly eye contact; if they were not really looking at you and now they are really, really focusing on you. Conversely, if they were focusing on you and now they are not.
- Signs of agitation; if someone is crying or upset.
All these changes in behaviour are warning signals. There is no set pattern for, “this is somebody who is about to get violent,” because everybody is different. For example, some people use very threatening language as part of their normal communication. It is not simply about behaviour; changes in behaviour are more telling.

Dress codes are also an interesting issue that often arise in these discussions. You often hear comments about what women are wearing. Comments like, “well if she’s going to go about wearing that…” What do we think about that, in terms of whether women should wear modest clothing with certain clients? Should that matter? Do you think about that before you go out to work? How many people consciously think about this before they visit a certain client? I am not telling you what you should wear because, at the end of the day, what you wear is very much your own business. All I would say is that you should be aware of whatever you are wearing and what the implications of that might be. There is no rule that says if you look like Mother Teresa you are always going to be safe. Similarly there is no rule that says if you wear a short skirt then you are going to be attacked. It does not work like that. You can go to work nude as far as I am concerned; you have the right to do that if you want to. Just give a moment’s thought as to how that might impact on who you are going to see that day.

I had a colleague who worked in a hostel for people who had significant alcohol problems who were also street homeless. It was a “Wet” hostel, which means that people were still allowed to drink alcohol while staying there. She would always go to work in tops with very high neck lines because the clients were constantly being very, very, overtly sexual. They behaved this way in spite of her modest attire. She was constantly wearing the baggiest trousers and they still did that. I asked her about this, expressing my belief that her modest clothing did not seem to make much of a difference. She responded by saying “But can you imagine if I wore something sexy, given that they do this now?” In other words, she had thought about the issue and made a choice she was comfortable with. It might be worth thinking about this.

There are also associated issues involving escaping if you need to get out of a situation quickly. How well equipped are you for running? Can you not run because of the height of the heels of the boots you are wearing? Does the skirt you are wearing give you enough legroom for doing a really good run? Would you probably fall over and break your neck before you got away?

These are things we might see and things we might simply hear that can alert us to potential danger. We can receive these signals before we even get into the house. It could be that you are conducting your dynamic risk assessment on the doorstep; when the person opens the door there are a couple of Rottweilers barking in the background. You may want to bring up your armour at this point by saying “I’m allergic to dogs. Can they go out in the garden?” How does the person look when they open the door? What is their tone of voice? Are they already being aggressive and threatening? Is there a significant smell of alcohol that you might or might not be expecting? Are there signs that there might be a mental health issue? Are there sounds of other people in the house? Does it sound like there is a party going on in the bedroom upstairs? All of these things can provide you with warnings if you simply stand for a minute on a doorstep and listen. Silence may also be significant. What does silence tell you? What if you are knocking and knocking and no one answers, but you know they are in there? What if you are sitting in a room with them and they are not communicating with you on any level, and there is absolute silence? These things also tell you something. One of the things that we will always say at the trust is, remember your sixth sense is in operation; trust your instinct, because that instinct is actually your survival mechanism. It is not just being silly. If your hairs go up on
the back of your neck and you get a feeling in your stomach, do not ignore that. We are not saying every time you get these feelings you are in a dangerous or perilous situation. We are just saying pay attention to these feelings and give a bit of thought as to what they are telling you. Make a decision as to whether you need to respond to these feelings.

**After an Incident**

It is really crucial that an organisation has policies and procedures in place for dealing with an incident if one should occur. This is often an area where people and organisations fail. Even if they have their risk assessments in place and everybody has their mobile phones, many organisations have not thought about what happens if an employee does become a victim of an attack whilst they are at work. Some of the effects on the individual can be a physical injury. Most certainly there will be emotional distress. There will possibly be a desire to leave the organisation or the job. There will very possibly be time off work as a result. Loss of confidence, stress, and adverse affects of relationships outside of work are also likely consequences. This is a very big issue; being a victim of violence or aggression at work or anywhere else does have a very profound effect. Employers should be very concerned about this if it happens to their staff; not only for the well-being of the individual, but also for the well-being of the organisation or service. Any organisation really needs to be looking after their staff in these situations; unfortunately many do not. So let us think about that.

What are the affects on an organisation? There is a possibility of litigation or prosecution. The worker could have grounds for saying “I got attacked and you didn’t have any policies or procedures in place. You didn’t have any guidelines. You didn’t give me any training about how to look after myself in a situation.” If this is the case, then that organisation may be liable, because an organisation has a responsibility look after its staff. The organisation might lose a valuable employee. There might be adverse publicity or poor public perception of the organisation. Moral around the whole staff team might be affected. It might become difficult to recruit staff. There are customers, beneficiaries, or service users who may get a poor service as a result. It is going to cost the organisation financially in terms of sick pay and other areas. You can see that this is actually a big issue.

What are the needs after an incident? We can think about it on three levels. The individual’s teams and organisation will have needs after something like this has happened. For the individual, the victim will need debriefing. This will need to happen swiftly; they will need someone who they can talk to about what happened. This needs to be available quickly, and it needs to be available from somebody who has the skills to actually listen effectively. They need to be able to offload as soon as they can. They need the support and reassurance; reassurance that it was not their fault that they did not do anything wrong. They need support to help them get through this. Counselling is the next step. Some organisations offer this, many do not. Proper counselling can take several weeks, several months, or longer. This depends on the individual and the issue.

The victim may need time away from that particular role or they may need to be placed in a new role within the organisation. The person needs to recognise that they are still valued within that organisation. They may not want to go back to that particular organisation, particularly if the job involves working with a specific group of clients in their own home. At least for the short term, they should be able to do that. The issue could be about lack of training. Maybe the organisation did have clear policies and procedures in place, but that the victim just had not picked up the skills of diffusion. Maybe more effective training is needed, or possibly re-training or a move into a new area. Justice is, of course, an important issue. If somebody has been a victim of an attack then that is a whole separate agenda outside of the
organisation. It is an issue for the Police. If they want to press charges, then the organisation should support them.

We need to remember that most individuals are actually part of a team; something happening to one member of the team will have a significant effect on the other people. The number of people affected may vary. It might just be one other person; it might be four, five, six, seven, or more. The team need feedback; what happened to their colleague may have a wider significance if that colleague were also a friend.

What are the details of what went wrong in that situation? How can we address the issue in order that it doesn’t happen again to that person or to anybody else in the team? What will be done and what can be done? This needs more sharing of information. It also needs team-building. These issues are particularly important if the organisation did have some systems in place to look after employees, but someone still got hurt in some way. In such a situation work is going to be needed around their strength as a team.

What are the ultimate implications for the organisation? They need to know about the incident. They need to know what happened, where it happened, and why it happened. They are going to need to make sure that appropriate services can still be provided to the clients, possibly even including the perpetrator of the attack.

Practice strategies can be both immediate and longer term. In terms of proactive strategies, there are a range of policies and procedures that relate to violence and aggression. Reporting procedures are really important. People need to feel able to report, and they need to understand how to report.

The process needs to be simple and quick because the last thing people want when they have experienced an incident is to have a 10 page form to fill out. It needs to be something that can be done quickly and easily. One organisation I know has email and telephone reporting. People do not need to fill in any bits of paper; just email an incident report to their line manager if they want to. It is important to find other creative ways of encouraging people to report incidents and near misses. Confidential support should be available if needed, as should continuous debriefings. A big incident followed by a debriefing session, after which everyone goes home and fails to talk about it again is of limited use. Sometimes debriefing is going to need to continue for several weeks following an incident, because the repercussions for the individual and the team will go on for that long.

Organisations need to provide: debriefs, peer support, management support, time off work, contingency plans, media management and legal help. In the longer term: counselling, review of longer term policies and procedures, and communicating staff on what changes have been made. If a member of staff has become a victim of an attack everybody is going to be feeling uncomfortable. Everybody is going to be looking for reassurance about how this is going to affect them on an individual level. It is going to be essential that people see that the organisation is responding appropriately.

Reporting back to other organisations is vital, which brings us full circle. If we know there is a problem with an individual then we have a duty to report that. We know there is a difficulty around data protection, but we need to make sure that we do not have somebody else finding themselves in the same situation with the same person. Here are some examples of management action that we know are effective:

- **Sharing information;** this may help ensure that incidents are not repeated.
- **Appointments;** certain people may be too volatile for home visits, and will therefore require meetings in an office or public place such as a café.
- **Visiting in pairs or the temporary/ permanent withdrawal of service;** you
should not be afraid to take this action if someone’s safety has been placed in jeopardy.

- Letters; sending out letters outlining the behaviour that is expected from the client, informing them of a fair chance to change their behaviour.

- Police; obviously reporting to the police if necessary.

- Manager visits; a manager actually going out on visits helps them to understand the reality of situations faced by front line workers.

- Action against tenants; this can be undertaken if an individual’s behaviour is in breach of their tenancy contracts.

- The “choice triangle.”; this sums up the way the Suzy Lamplugh Trust approaches issues of violence and aggression. We do not deal with physical self defence training. If you are about to get mugged, raped, smacked, stabbed in the face, then physically you will do anything you can to try and stop that happening. What we want you to do is take action at this end of the scale; if you act early then your choices are so much more wide and varied. You can actually prevent, avoid, deter and diffuse situations at this end. If you get to the far end of the scale, then your options are so limited that all you may have left is a physical response.

Finally, all of our advice is about trying to do as much as you can at this end of any situation. This is why the whole planning and preparing of policies and procedures is so important; having thought through every situation and considered what you might do in dangerous circumstances, is going to equip you in the best way possible. This is going to be the best way of keeping yourself safe.

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We had more high visibility jackets in Manchester on a Friday and Saturday night than you can imagine; this just meant that people did not have as far to go to report the crime! Somebody jokingly said that the only way we were going to reduce crime statistics at that point was to stop answering the phones. We were feeling a bit browbeaten and so we started getting together with other people and really trying to understand our problem. I do not think we had ever done this before. We had been just trying to react to it. I do not think that we had really tried to sit down and understand what our specific problems really were before. As part of this process, we found out a lot more about our environment and how it came to be. We also found that there were a lot more people out there who were working towards similar goals as ourselves. Quite surprisingly we actually found there was a large part of the industry itself that had similar aims to us; who also wanted to reduce violence and reduce crime on their premises. We realised that there was some basis for moving things forward with them as well. This is a very positive thing. It can be thought of as Manchester PLC, and it does not concentrate on the problems; we know what the problems are. It aims to concentrate on solutions. To energise, to put the problems we do have into perspective, and to tell as many people as we can about it within our environment. If you try to change the social culture in this way you have to get people on side with you and have them believe in what is happening. We learned that “if you always do what you always did, you will always get what you always got.” Our aim was to move forward from that.

We think about the way we are working within the project as a sort of jigsaw puzzle. Our particular jigsaw puzzle aims to move us forward. It has, at the moment, about 20 component parts. We also work as consultants with other projects throughout the country that have similar problems to us. I (with my colleague Steve Greenacre) also work for the Home Office Violent Crime Unit. The areas that I work with in other parts of the country have similar problems, but sometimes they are slightly different. They therefore need slightly different pieces for their jigsaw puzzle. Some of the principals will always be the same. Things like how you improve management standards in licensed premises, how you deal with enforcement, how you make sure people can get home safely at the end of the evening. Some of those are going to be consistent, but some of the other ways that we deal with them will change slightly from area to area. Finally, each area should end up with their own jigsaw puzzle for their own area that meets their needs.

One of the key things for us was that we were not managing our public space at all. We propositioned the Home Office (actually in partnership with Merseyside) to ask if we could be allowed to trial an alcohol byelaw. After about a year they agreed to let us trial it for 12 months. We did and it was hugely successful. It allowed us to make the streets feel safer, and to take away the potential for weapons on the streets. This was important because a lot of injuries on the streets were being caused at that time by glass and bottles being used as weapons. We wanted to get out of vehicles and get back on foot; to actually have foot patrols. We identified our top 10 areas and we put foot patrols in those areas. We have sergeants who will move resources around to make sure that those hotspots are always covered. As you can imagine, when you have a hotspot, something is likely to happen there and unfortunately, sometimes something does happen and someone needs to take action but there is nobody there. We therefore try to manage our resources a lot better.

Here is an example: the Night-Time Security Blanket, which includes things like night-net
radio. Many city centres have night-net, but we wanted to make its use more widespread. We realised that many people were not taking part in the nighttime community because they were frightened. We had problems with parking wardens who were more than happy to ticket Mr and Mrs Bloggs who had been to the theatre and were two foot over the yellow line because they could hit them and run. However they were reluctant to ticket big BMWs parked on the pavement. This situation was intimidating for a number of reasons. For example, if you wanted to conceal weapons or drugs and did not necessarily want to take them into licensed premises it is quite handy to have a vehicle that is very close to the premises. It is almost like having a big handbag that you leave outside and come back to when you want it. Apart from the fact that such situations give a feeling of lawlessness, it is the beginning of losing control in that area. Basically, parking wardens were saying, “If we try to give them tickets and get them to move, we get threatened.”

We talked to local authority licensing officers who felt intimidated going into certain premises. We talked to street cleaners who were not going into certain areas because of the volume of people and, again, because they felt intimidated. We started to band them together. Door staff obviously have radios, but we started giving radios to lots of other people. What we found was the ability to talk to a Police Officer on the radio and to know that CCTV cameras were operating had an enormous impact. People were being spoken to, and they knew they were going to get a fast reaction. Consequently, little by little, what we had were people becoming confident enough to take small actions themselves and to get involved at a low level. We also do this with our nighttime buses where we have wardens provided by the bus company. They also have the same night-net radio. So you are starting to get people who are in the public space at night, and who are actually taking some control over the area themselves. It is like going back to the old days of having wardens in the park and toilet attendants. We did ourselves a big disservice when we removed those people because we stopped caring for those areas. This is an attempt to get back into that. It allows us to use our limited Police resources to better effect.

Previously we had about 20 different initiatives in our particular project. In American terminology, if you do bombard your problem and if you do try and look at it from a hidden, holistic focus you are far more likely to gain success because you are not just “cherry picking.” In other words, you are using more than just one or two ideas; you are attempting to move that whole project forward.

Another thing we are developing is Safe Havens. This is an idea taken from London and uses the big white help points, usually in underground stations. We have put help points around the city centre using common walkways that people will use when they go to bars, pubs and clubs. If you hit the help point, CCTV cameras move onto you straight way and you have immediate communication with an operator. We can get a response to you quickly. We have some serious issues in the city centre. For example, we have young, lone females who have had a lot to drink and therefore run a high risk of becoming victims of crime. What we would like to do is to develop the Safe Haven system further. For example, getting a Starbucks to open late at night in order to create an area where people who are potential victims can go and be out of harm’s way. Such areas could have phones for potential victims to call for assistance or to get a taxi home.

We are constantly looking at ways to reduce risk. Lone females who have consumed a lot of alcohol are certainly potential victims. We are starting to see an increase in sexual assaults and other associated issues. This gives you an idea of some of the things that we have to think about. We have our night-net system that we use to protect our taxis as well as buses. Our taxi safe scheme has
been going for about two and a half years and it works on a number of different levels. It replicates some of the principals that we have for our night bus scheme; the idea is to have a limited amount of bus stops protected by CCTV, with wardens. In this particular case we actually use marshals that we were able to get from Neighbourhood Renewal Fund funding; our partners in the council arranged that. If you are going to wait for any length of time we want people to use, and to have the availability of, safe late night transport. If you choose to take a bus, you want to know that the area in which you will be waiting is protected. Manchester Piccadilly (the area of the bus station) used to be dark, scary and not very pleasant at night. But because we now have about 10 or 12 bus marshals working in that area (easily identifiable in their yellow jackets) we now get a lot of people, especially women, using the bus service to get home because drunks are not allowed on. The wardens also check to see that people have got money for the fare so the bus drivers also feel comfortable. The whole area has an air of safety about it, so we have started to encourage other people to wait in that area. People now use it as a meeting point; waiting for people to pick them up or to meet up with friends. We need such places. If it feels a bit scary then people are not going to use these systems.

It was the same with taxis. We needed to have more taxis in the city centre. Audits of taxis in city centres usually find what sounds like a reasonable amount. However, many of them do not work during the nighttime for a variety of reasons; they do not want the fights, they do not want the drunks, and they do not want to be intimidated. Consequently, we put together a lists of options; a package to encourage them to work, and also make people feel more secure about actually using taxis at night. We have taxi marshals at the taxi ranks, so there is a queuing system for the first time. We found that big males were coming to the front of the queue. We have had some serious fights as a result of this. It can be very intimidating for females to wait by themselves at taxi ranks at night, yet we need to encourage women to take safe forms of transport home. It is not safe to wander around in the middle of the road, opening car doors and climbing into any car that happens to stop at the traffic lights. Unfortunately this still happens.

We have to make sure that they are running to standard, so we have taxi enforcement nights at least once a month. Again, this involves working with lots of other agencies. On average, we will stop over a 100 vehicles a night. We are checking to make sure vehicles are safe and roadworthy, that they are not running on illegal red diesel, and that the people who are driving them are who they are supposed to be; it is like a roadside mini MOT. In some areas we are still taking vehicles off the road because they are dangerous. We have had the occasional driver who is actually drunk, along with a number of other issues. It is a two-way thing. We provide support, but we also have enforcement. We have a taxi marketing campaign to support all this. We do a lot of education. Another system we have in Manchester is to have the Manchester crest on the bonnets of our taxis and also the firm that they are from. We can pick this up on CCTV. This means we have an indication if there is a bogus taxi in operation and we can check it out.

One of the big issues we identified was poor management of licensed premises. When we set up the project we did not know a lot about what was happening in licensed premises; we were concentrating on what was happening on the outside. We certainly had some very bad operators; but we also had many good operators. We needed to start having some clear policies. We also realised that if we wanted to start any policies of mixed usage, it was another reason for us to really get to grips with the standards in licensed premises. I am told by some of the big operators that safety influences choice; up to 70% of people base their decision on where they go to drink on this factor. A lot of people perceive that premises are unsafe and
will not go there, but how do you know if a premise is safe or unsafe? We need to get all these things right if we are going to have a vibrant and safe city centre. We really needed to know what was going on, and make things a great deal cleverer. I believe we have got much cleverer about collecting our data and working out what is really happening (crucial if you want to be able to use legislation effectively). By clearly defining our problems and our direction, it has become easier to make clear distinctions between good and bad operators. We now have a better understanding of the impact that crime and issues of safety have on the city centre.

We also re-examined the problem again in its entirety. We knew that, certainly from a police perspective, we shouted at people an awful lot for the bad things. One operator told us, “I am trying to invest a lot of time, money and effort into my premises. I would like to think my premises were well run, but what difference does it make? The guy down the road is running on next to nothing. He never runs staff training. He doesn’t do a thing with his premises, but you treat us both the same. We are in the same road, we all get shouted at.” Consequently, we realised what we needed to do was to identify good practice and start to reward it. We started the Best Bar None awards in 2002/2003. We did a lot of consultation with the trade and other organisations to define exactly what we meant by good practice. We looked at what awards were out on the market place at the moment. It was quite interesting looking at the ones from the trade. There are thousands of them, but basically most of them are along the lines of “the smiley barman awards”. There is no criterion for safety. If you ask them what social responsibility is, the licensing industry until recently thought this meant giving to charity. We were talking in two completely different languages, so we needed to establish exactly what we were talking about. We now have a national standard, the programme is supported by government and industry and is part of the UK Tackling Violent Crime programme. It is in the process of being rolled out around the UK and will be in over 50 towns and cities in the UK by April 2006 with a management unit to support the programme and to spread and support high standards and good practice. We have also had interest in the programme from other countries.

Our strategy involves the premises filling in a quite detailed application form. This is testing that they have the processes and the management structure in place, to reduce crime and reduce the risk of harm to people using those premises. We then have trained assessors who go back into the premises to check that all those policies are in place. If they reach the required standard (only about two-thirds of our operators do), then they are given the award. It is basically a large badge that they can place outside. We also have a big award night, and we have “best of” categories.

We have judging nights for people who have met all the agreed standards. We are trying to encourage them to look for better solutions for things, to be more creative. We have a really good night; a big black tie event. We actually make money from them that we can plough back into other initiatives that we are working on to reduce crime and make the city centre more vibrant. We are just in the process of developing this year’s application form. The application form asks for information on all the issues that should be considered as part of an operating plan by those with licensed premises. So there should be a structure there to minimise the risk of harm in any licensed premises. The information in the form should tie in nicely with the way the police should be looking at new applications through the new Licensing Act.

As we go into more and more city centre licensed premises, we find that the public are starting to understand more about what the Best Bar None award is about. We hope that more people will choose safety and premises that take more care of their welfare rather than premises that are badly run and where
there is a higher risk of crime and other problems.

We also deal with licensing and enforcement. We have a “top ten enforcement team” which identifies our ten worst licensed premised on a monthly basis. They are brought in and we identify exactly what the problems are. We also bring in people from head office because we want them to understand how important this is. We sit down with them and we agree on an action plan of the things that they need to do within their premises to reduce these problems. With one exception we have had a 100% success rate in the whole time we have been doing this, which is about three years. Everybody we have worked with has had the crime within their premises drop considerably.

We conduct multi-agency targeted visits in which we go into licensed premises with other agencies, including the local authority licensing team. Visits are recorded on video camera. Visits are conducted in a prescribed way so that every visit is pretty much standardised. We collect evidence as we are going through; this is necessary so that we have clear proof if we see an offence being committed.

The following week we bring somebody in from head office who has been maintaining how well their premises are run. When watching the video of the visit showing how their premises were running at one o’clock in the morning they tend to become very silent very quickly. You can actually get some really meaningful exchanges from them.

We carry out risk assessments as well. If an event is going to happen in particular premises we expect them to come in with us and go through all the issues that they need to have thought about before they put on a particular event. We are constantly looking at minimising risk. We use other crime reduction techniques, such as alcohol arrest referral schemes, with the community alcohol team. This is a project that has been proven to work in other areas and is certainly something we want to develop further. Again we are looking to try and break that cycle of alcohol and people committing offences.

We developed our own social marketing range. This is partly to keep the cost down and partly because some of the products we have been offered from commercial organizations did not meet our needs. We produced the “Think Safe Drink Safe” campaign. A lot of things come under that banner. It comes from an American idea called social norms marketing. It works on the principal that most people actually do come into town and get home safely; how did they do that? It involves using people’s own simple coping strategies. These can be as simple as thinking about how you are going to get home before you go out, or staying with your friends to stay safe. Amazingly enough two and a half million people visit Manchester a week which is phenomenal. That amount of people use the city centre every week and yet we have less than three and a half serious assaults a week. In the last year we have reduced assaults in Manchester by 30%, so our strategies are working. Ours is a long-term project but already we are seeing some success.