Public Health England

Protecting and improving the nation's health

Protecting people and promoting healthy lives in the West Midlands

An evidence based public health response to support violence reduction across West Midlands police force area

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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1. Foreword

Violence is a public health issue. It blights lives, families and communities. Living without the fear of violence is a fundamental requirement for health and wellbeing.

Violence damages people and communities – not only at the moment it happens but also before and afterwards. Victims, their families and their friends are forced to live with the fear of violence being inflicted and repeated. It affects mental health and wellbeing and it prevents people from participating fully in society. Everyone has a right to live a life that is free of violence and the fear of violence.

There is nothing inevitable about violence. It can be reduced and stopped. Action can be taken by public agencies, the voluntary sector and by communities and individuals. However, to have the greatest impact we need to co-ordinate and target our actions where they will have the greatest effect. We will be guided by the evidence of where the problems are and the science of what works in tackling their root causes.

We have identified strong evidence of where violence is most likely to occur, who the victims and perpetrators are, and what the costs and consequences are.This new approach is the outcome of collaboration between West Midlands Police and Public Health England West Midlands over the past year. We have worked together to identify evidence of the links between violence and impact upon health.

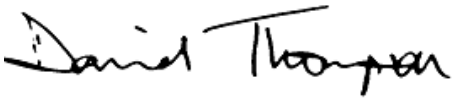
Reducing violence is one of seven priorities identified by the West Midlands Directors of Public Health. Reducing violence is also an ambition supported by a wide range of agencies including West Midlands Ambulance Service, West Midlands Fire Service, the local NHS, the Court Service and the Probation Service. I would like to pay tribute to the work done by West Midlands Police in particular and to Public Health England's Knowledge and Information Team in the North West which has helped enable the analysis in this report.

Our joint research has shown that the groups of people most likely to suffer violence are also people who are very likely to be affected by other factors that cause illness or poor health.

In supporting people to improve their health by providing the information necessary for them to make informed choices, we will help to create the conditions for healthy lives and contribute towards our ambition to reduce the numbers of people affected by violence. This will not only help individuals and communities, it will also save significant NHS, police and other public resources.

Public Health England will now work together with West Midlands Police, the Directors of Public Health and other stakeholders to take forward this work. This targeted support will make a real difference in stopping violence and reducing the blight it causes in the lives of our communities.

Sue Ibbotson
Centre Director
Public Health England West Midlands



David Thompson
Deputy Chief Constable
West Midlands Police

2. Executive summary

Six of the seven districts − Sandwell, Birmingham, Wolverhampton, Walsall, Coventry and Dudley − that make up West Midlands Police Force Area (WMPFA) fall within the 20% most deprived local authorities in England. Evidence shows that where there is deprivation, the risk of experiencing violence as a victim or as a perpetrator is much greater. Where there is increased violence, the likelihood of requiring emergency services is also increased.

2.1 Emergency admissions

Between 2008/9 and 2012/13 emergency admissions for violence showed a downward trend for all local authority areas with the exception of Coventry, Birmingham and Sandwell, which remained above the England average. Of the 63,200 victims aged 10 to 24 years, 72% required some form of medical treatment.

This is significant particularly as hospital emergency departments (EDs) are uniquely placed and can provide settings through which partner organisations can intervene much earlier to support, or refer young people and their families onto services that can reduce the risk of exposure to more violence. Services offered through such settings make a valuable contribution by reducing the impact of crime and could include evidence based interventions that have been shown to make a difference, eg victim support, diversionary activities, mentoring services for young people and brief interventions that support behavioural change.[1]

EDs can also implement systems to collect valuable information about the nature of crime and then share that intelligence with the police and other partners. This approach, as evidenced in the Cardiff Model,[2] shows how the collection of data on the location of assaults resulting in ED attendance can effectively contribute to local violence prevention. Advanced ED data can be used alongside police data to target policing and other violence prevention activity in nightlife environments through a multi-agency partnership. The Cardiff programme was associated with significant reductions in hospital admissions for violence, which compares with increases seen in similar areas that do not share data.

Responding to violence in this way will require all parts of the system to come together and work in partnership as no one single agency can make a significant difference by working in isolation. Sharing information must be a single partnership vision that will require a shared commitment from all to work together if we are to realise this challenging ambition.

2.2 Domestic violence

Domestic violence (DV) accounts for over a quarter of all violence reported to the West Midlands Police. Over a five-year period since 2005/6, an average of 10,759 offences were reported each year and categorised as either 'violence with injury' (66.9%) or 'violence without injury' (30%). Trend data show there to have been a steady decline during the period; however, importantly, while the volume of 'violence with injury' offences has fallen by 34.8%, levels of 'violence without injury' have risen by 13.7%.

This may suggest that although the injury was not classified as a physical one, psychological injury remains an issue, particularly where it is being viewed as a less serious offence given the absence of physical injury. If that is the case it is likely that the reported figures are a significant underestimate and the upward trend suggests a worrying increase in the mental health impact of domestic violence, the extent of which is not well described by the figures we have available. Of all violent domestic offending, 20.7% is recorded to have involved alcohol.

2.3 Sexual violence

Sexual violence is known to be widely under reported with only one in ten adult victims of serious sexual assault reporting the incidents at national level. Sexual offences make up 2.35% of reported domestic violence offending across WMPFA and reports of other sexual offences have continued to increase.

Of victims of reported sexual offences over the last five years, 89.2% were female. However, 10.6% of victims of other sexual offences were male, of which 9.1% were rape victims. More than six out of 10 victims of sexual offences were aged 10 to 24 years and young women were at greater risk of sexual assault than young men, particularly where the use of alcohol was involved.

Sexual violence can manifest through forced marriage, human trafficking, violence within same sex relationships and female genital mutilation (FGM). The extent of these forms of violence is largely not mentioned by the routine information available. Of note, rules of behaviour in some cultures or social groups can support violence against women.

Traditional beliefs that men have a right to control or discipline women through physical means make women vulnerable to violence by an intimate partner and can place girls at risk of sexual violence. Cultural acceptance of violence as a private affair often hinders outside intervention which can impact mental and emotional wellbeing. Therefore we need to support research to identify the effectiveness of social norms programmes that can effectively challenge stereotypes that support violence against women and support the development of service delivery models that are effective in supporting victims.

2.4 Young people

Of people who live in the WMPFA, 41% are under the age of 30 with 21% aged 10 to 24 years. More than two out of five (42.6%) of all victims who reported to have experienced violence against them during the 2008/09 to 2012/13 period were aged 10 to 24 years. This equates to an average of 17,703 offences per year. Of victims of violence over the last 5 years, 47% were male and the most common location for violent crime was on the 'road', that is outside in a public place. Pubs and nightclubs were in the top 10 most commonly recorded locations for violence with links made to alcohol use. Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have an important violence prevention impact from a public health perspective. For example, the National Institute for Health and Care Excellence (NICE) concluded that reducing the number of outlets in a given area would be an effective way of reducing alcohol-related harm.[3] NICE also advocates the use of identification and brief interventions (IBA) as a short, simple and cost-effective way to reduce alcohol consumption among risky drinkers.[4]

This report signals Public Health England's intent to work in partnership with West Midlands Police and support the wider public health system in its role as a public health advocate by providing the evidence base of what has worked in practice at reducing violence in a number of contexts (society, community and individual).

This report offers an insight into violence across WMPFA seen from a public health perspective. It will assist local authorities and their partners in developing local responses to reducing violence, drawing on the key messages emerging from this collaborative work.

3. Introduction

Violence should not be the norm in our society neither should it be tolerated. Violence and the fear of violence is a major cause of ill health and poor wellbeing as well as being a drain upon health services, the criminal justice system and the wider economy. Violence impacts dramatically upon those who experience it.

3.1 Background

Violence is strongly related to inequalities, with the poorest fifth of our society suffering rates of hospital admissions for violence five times higher than those of the most affluent fifth.[5]

Categories that impose a considerable financial burden not only across the criminal justice system but across the health economy include:

- children who are maltreated
- women exposed to abusive relationships
- gang related youth violence
- violence involving alcohol or drug use

This report draws from and reinforces the recommendations contained within a wider collaborative project between Public Health England West Midlands and West Midlands Police.[6] That report previously set out a detailed exploration and analysis of violence as a major cause of ill health and reduced wellbeing. It also set the tone for this focused response which brings together public health practice and an evidence base which can be used by public health practitioners to drive the agenda forward.

The first key task within this partnership has been to understand what our data can tell us and how can we use our information more effectively.

This document is the result of the analysis of that data and contains in the first instance information to inform further debate and next steps. The potential for us as public health bodies to ensure local services take every opportunity to reduce violence has never been greater. Through this report we have presented the data, intelligence and evidence based practice required to assist us in taking appropriate action while identifying issues for further discussion and debate. These have been captured below as points of discussion along with recommendations. These issues and recommendations have set the direction for our partnership with West Midlands Police over the short and medium term.

3.2 General methodology

The following section draws from the data and intelligence as seen through a public health perspective. It focuses on specific areas where public health practice can make a significant contribution towards reducing crime and improving wellbeing. Topics included in this section include: violent crime and young people;reported crime; hospital admissions and attendances ate A&E; and domestic violence including intimate partner violence.

Both the collaborative project report and this focused public health report draw on data, collated locally by the West Midlands Police Force, covering its seven local authority areas: Birmingham, Sandwell, Wolverhampton, Walsall, Coventry, Dudley and Solihull.

This document also uses nationally available data from the Crime Survey for England and Wales (CSEW) (a useful guide to the differences between the CSEW and local police crime data has been published by the ONS[7]). Additionally data has been drawn from the Hospital Episode Statistics to help describe violent crime presentations to hospitals.

All data is presented on the basis of residency, and is limited to victims and patients resident within the West Midlands Police Force Area (WMPFA). While the HES systems capture all patients from the WMPFA irrespective of where treatment occurred in England and Wales, the police force data includes incidents which occur within their area regardless of where the victim lives and does not include information about local residents who have been the victims of violence in other police forces.

As much of this report uses the local police-recorded crime data, the data should be viewed in context of the national data from the Crime Survey for England and Wales. A particular issue to highlight is the under-reporting of crimes to the local police service when compared with the CSEW.

3.2 Key data and intelligence - population summary

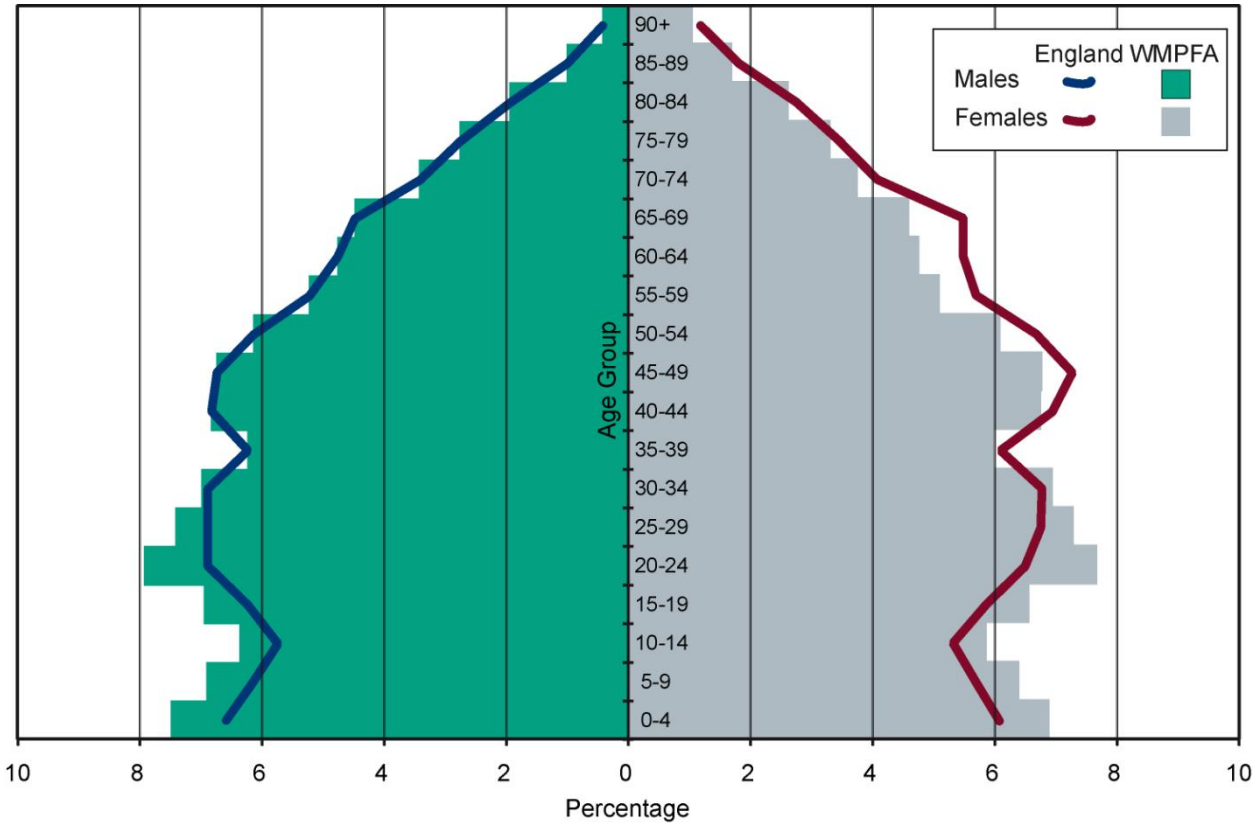
The population acrossthe West Midlands Police Force Area (WMPFA) has increased by over 7%[8] in the last ten years (2004 to 2013), with Coventry, Birmingham and Sandwell experiencing higher levels of population growth than the national average.

3.3 Key facts about the area

The population pyramid below shows there to be a higher proportion of 20 to 24 year olds in the West Midlands than the England average.[9] This is mainly due to students coming to study at the cities' universities.

In the West Midlands, 41.8% of residents are under the age of 30, compared with 37.4% for England. In contrast 15.5% of West Midlands residents are over 65 years, compared with 17.3% of people nationally.

Figure 1: Percentage of population within each gender, by age band, West Midlands Police Force Area, 2013



Data source: Annual Mid-Year 2013 Population Estimates for the UK, Office for National Statistics

There are strong relationships between deprivation and violence. Both the British Crime Survey (BSC) and West Midlands Police Force recorded crime data indicate that crime is not evenly distributed and that the risk of being a victim of crime was higher in the most deprived areas than the least deprived areas in England.[10]

Based on the 2010 Indices of Multiple Derivation[11] data, of the 329 local authorities in England, Sandwell is ranked the ninth most deprived, Birmingham the 13th, Wolverhampton 20th, Walsall 35th, Coventry 53rd and Dudley 113th. Based on the 66 LAs in each quintile, only Solihull falls into the second least deprived quintile. Sandwell, Birmingham, Wolverhampton, Walsall and Coventry are in the most deprived 20% of LAs in England.

3.4 Ethnicity

The ethnic profile of the WMPFA is shown below:

Table 1: Percentage of population by broad ethnic group (as reported in the 2011 census)

Area	All ethnic Groups (number)	% White	% Mixed	% Asian	% Black	% Chinese	% Other
England	53,012,456	85.4	2.3	7.1	3.5	0.7	1.0
West Midlands	5,601,847	82.7	2.4	10.2	3.3	0.6	0.9
West Midlands Police Force Area	2,736,460	70.1	3.5	18.0	6.0	0.8	1.5
Birmingham	1,073,045	57.9	4.4	25.4	9.0	1.2	2.0
Coventry	316,960	73.8	2.6	15.1	5.6	1.2	1.7
Dudley	312,925	90.0	1.8	5.8	1.5	0.3	0.6
Sandwell	308,063	69.9	3.3	19.0	6.0	0.3	1.6
Solihull	206,674	89.1	2.1	6.1	1.6	0.4	0.6
Walsall	269,323	78.9	2.7	14.9	2.4	0.4	0.8
Wolverhampton	249,470	68.0	5.1	17.5	6.9	0.6	1.9

Source: Office for National Statistics, 2011 Census: Ethnic group, local authorities in England and Wales

WMPFA is ethnically diverse having a larger proportion of the population from ethnic minorities than that seen across the West Midlands region or England. About 30% of the population described themselves as non-white and almost a fifth are of Asian heritage.

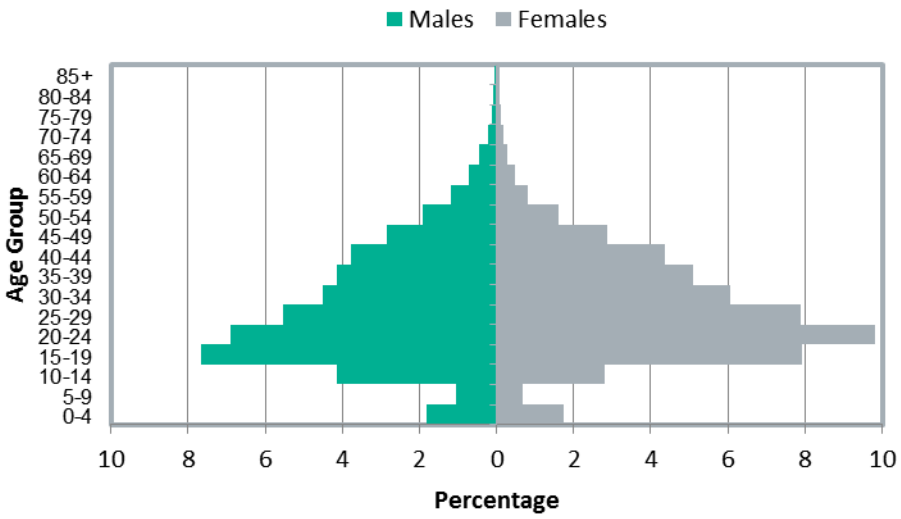
4 Violent crime across the West Midlands Police force area

4.4 Violence against the person

Violence against the person under English law is generally taken to mean offences which take the form of an attack directed at another person, which does not result in the death of any person. Where death occurs it is classified as homicide.

Data sourced from the West Midlands Police Force has been used to give a local picture of violent crime across the patch.

Figure 2: Proportion of all victims who were subject to 'violence against the person' offences, by age, sex, West Midlands Police force area, 2008/09 to 2012/13



Source: West Midlands Police force data, crimes where victim known to live in WMP force area, 2008/09 to 2012/13 averaged over five years.

Note the peak age is 15 to 24 years for both males and female.

Overall, 46.8%[12] of people subjected to violence over the last five years were male. However, the proportion fell to 38.7% when the offence was restricted to violence that had not resulted in serious physical injury requiring hospitalisation. Of the victims of violence, 5.4% (8,609) were under 10 years old. Almost two in five (39.3%) victims were aged 10 to 24 years. Of the 63,200 victims of violence who were injured aged 10 to 14, 72.0% required some form of medical treatment. Of 25 to 64 year olds who were victims of violence, 68.5% sustained an injury. Over half (113; 53.1%)[10, 12] of all homicide victims within the WMPFA were aged 10 to 24 years.

Table 2: Top 10 most commonly recorded offence locations for 'violence against the person' offences amongst victims aged 10-24 within the WMPFA 2008/09 - 20012/13

Primary Offence Location	Violence Against the Person inc Homicides			Total	Type of Location		
	Homicide	Violence w/o injury	Violence with injury		Dwelling	PPV*	Non-PPV*
Road	13	3768	15116	18884		17224	1660
Semi-Detached Dwelling	2	2533	4214	6747	6747		
Terrace Dwelling	3	2392	4216	6608	6608		
Flat Dwelling	6	1591	3968	5559	5559		
Outside Address	2	664	2446	3110		2679	431
Park	2	366	1939	2305		2170	135
Public Footpath	0	490	1732	2222		2068	154
Public House – Licenced Premises	0	254	1770	2024		1827	197
Educational	0	270	1128	1398		519	879
Nightclub	1	85	1146	1231		1115	116

Source: West Midlands Police, crimes where victim known to live in WMP force area and aged 10 to 24 years

Those offences identified as being child abuse have been excluded. 'Dwelling' relates to where the primary offence location is recorded as including 'dwelling' or 'home'. PPV and non-PPV relate to the presence of the PPV special interest marker or not.

*PPV (public place violence), When recording a crime there is the option to add flags or special interest markers to reflect details such as the vulnerabilities of the victim, factors that distinguish the offence or the circumstances which may have contributed. One such marker is PPV – public place violence – which can be used to denote that the violence occurred in a place to which the public has access or would expect to have access, at the relevant time, by payment or otherwise.

West Midlands Police data showed the most common location for a violent crime during 2012/13 was 'road' (31.5%). The CSEW,[13] however, found 'home' (30%) to be the most common place for violent crimes in 2012/13, followed by 'on the street' (22%). Links to the night time economy was influential, with both 'public house' and 'nightclub' featuring in the top 10 most commonly recorded locations.

In total 3,256 'violence against the person' offences plus one homicide were recorded as having occurred in public or at a night club and involved alcohol.

Although the national trend in homicide offences has generally been going down, gang and knife-related youth violence has become a key cause of concern both in England and the West Midlands.

During 2014 the CSEW reported the lowest number of homicides (532) since 1978.[14] Emergency hospital admissions for violence have also seen a downward trend both for

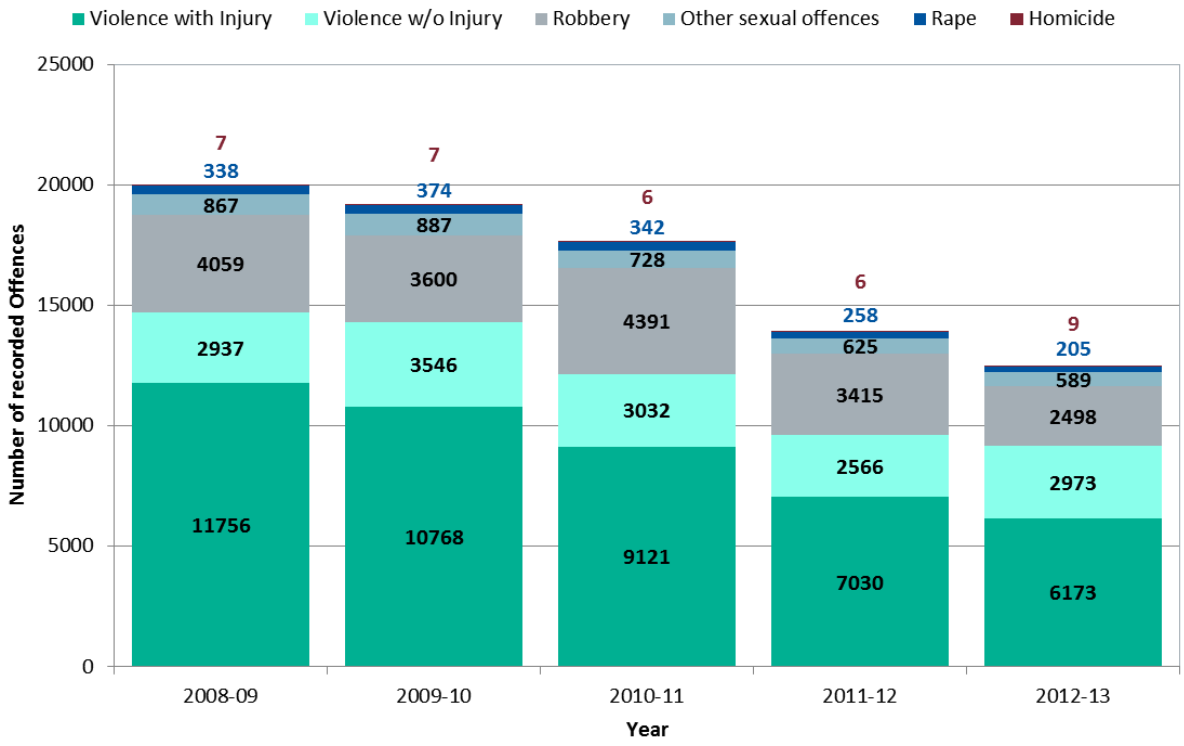
England and across all the LAs within the WMPFA, as reported in the Public Health Outcomes Framework.[15] Coventry, Birmingham and Sandwell LAs however have significantly higher rates of hospital admissions than England. [15]

What is noteworthy is that although 10 to 24 year olds represent 21% of the WMPFA population, 42.6% of this age group are recorded as being victims of violent offending.

4.5 Overview of recorded offences

More than two out of five (42.6%)[12] victims of all violence reported during 2008/09 to 2012/13 to the WMPFA has been against a young person aged 10 to 24 with an average of 17,703[12] offences per year.

Figure 3: Profile of violent offending committed against persons aged 10-24 resident in WMPFA, 2008/09-2012/13



Source: West Midlands Police, crimes where victim known to live in WMPFA and aged 10 to 24 years. Those offences identified as being child abuse have been excluded.

Since 2008 to 09, violent offending against people aged 10 to 24 years within the WMPFA has fallen by 37.7%,[12] which resulted in 7,517[12] fewer reported victims in 2012 to 13. This reduction has happened at a far greater rate than the reduction in violent offending across all ages, which has fallen by 29%.[12]

However, young people aged 10 to 24 years still account for 42.6%[12] of victims. Almost 5%[12] of 10- to 24-year-olds experiencing a violent crime had sustained a serious or fatal

injury requiring emergency hospital treatment. A total of 35[12] homicides where the victim was aged 10 to 24 years, were recorded in the last five years.

5 Reported crime and hospital admissions and attendance at A&E

Between 2008/09 and 2012/13, the rate of violent offending reported to West Midlands Police has fallen from 163.7[10] offences per 10,000 resident population to 112.2[10] – equivalent to 51[10] fewer offences per 10,000 residents over five years. During the same period the number of violent offences resulting in serious or fatal injuries has also fallen with 3.4 fewer offences per 10,000 people. Typically for every 18 violent offences reported to West Midlands Police by a local resident, one will result in a serious or fatal injury.

Although the reported police figures show reductions, the true level of violence is unclear as figures from the British Crime Survey suggest that nationally only 43%[16] of offences involving adult victims are reported to the police.

Table 3: Standardised Admission Ratios for Hospital admissions and Emergency Department (ED) attendances for violence related injuries, 2012/13

Area	A&E Attendances	Inpatient Admissions
England	**100.0**	**100.0**
West Midlands	99.6	95.0
West Midlands Police Force Area	110.4	122.7
Birmingham	124.8	120.4
Coventry	55.9	166.3
Dudley	107.7	96.7
Sandwell	108.6	153.8
Solihull	119.8	91.2
Walsall	157.2	100.2
Wolverhampton	70.5	109.7

Table key:

Significance comparison with respect to England		
Lower	**Similar**	**Higher**

Source: HES[17], Analysed by KIT(WM)

Health data provides a different reflection of violent crime. Table 2 above shows that A&E attendance and hospital admission rates for the WMPFA were worse than the England average. However, across the seven local authorities, there is some variation.

With the exception of Coventry and Wolverhampton, all other local authorities show higher A&E attendances following assault than the England average. Hospital admissions also showed some variation. The rates for hospital admissions following an assault during the same period were higher than the England average in Sandwell, Birmingham and Coventry while rates in Dudley and Solihull were lower than expected.

5.4 The cost of violence

Violence imposes major economic costs on victims, their families, public services, and wider society. The Home Office estimated the economic and social cost of violent crime in England and Wales in 2003/04 to be £26.9 billion. An independent analysis by the London School of Economics updated these figures for 2008/09 using a revised version of the Home Office methodology.[18] The analysis estimated the total annual economic and social costs of violence in 2008/09 to be £2.9 billion.[19] These costs are substantial.

5.5 Emergency departments' contribution to violence reduction

Emergency Departments (EDs) can contribute towards violence prevention and a reduction in the financial burden to society. By working in collaboration with the police and other partners and by sharing information about the incident, type, location and time of crime, ED consultants have been shown to contribute towards effective targeted policing.[20]

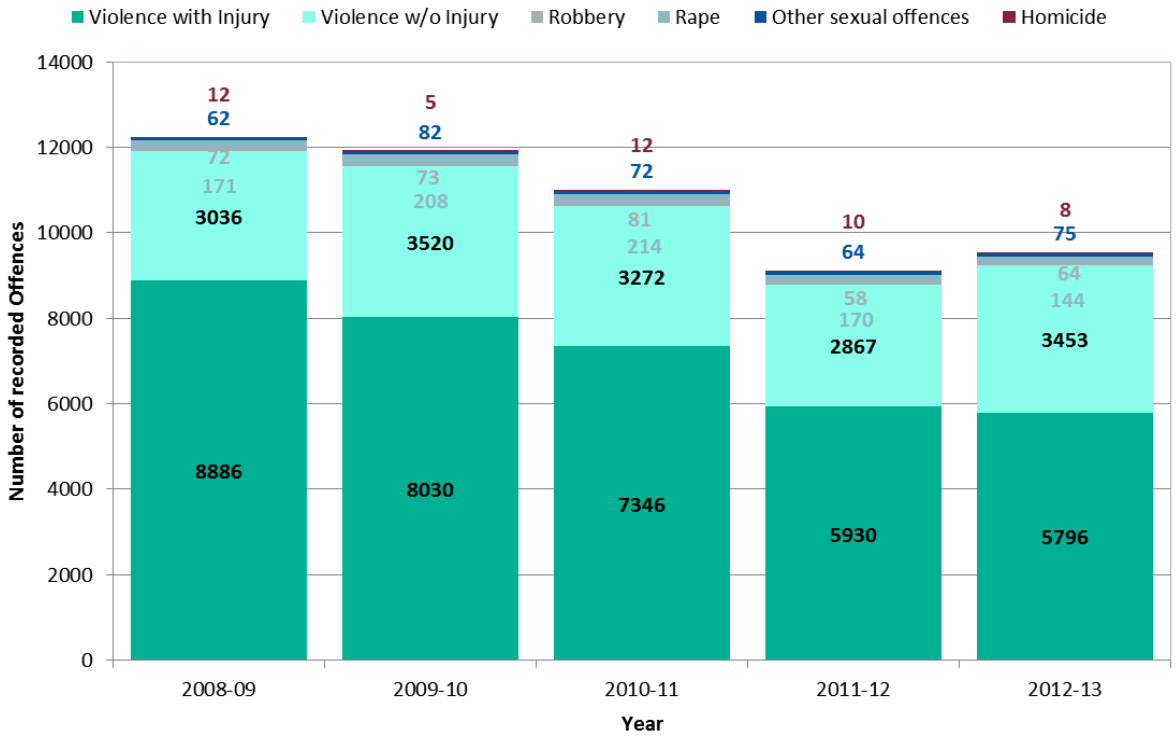
The Cardiff Model[2] is a good example of this approach.[21] Information/data about location and time of assaults is collected in EDs and shared with the police and local authorities enabling them to target their resources much more effectively.

Hospital settings can also provide opportunities for accessing and intervening with victims much earlier. Young people who present with injuries caused through violence can be provided with mentoring, brief interventions, counselling services, individual or family assessments and referrals to services.[22]

6 Domestic violence

Domestic violence accounts for over a quarter of all violence reported to the West Midlands Police over the last five years with an average of 10,759[10] offences per year.

Figure 4: Profile of domestic violence violent offending, committed against local residents, by offence sub-classification, 2008/09 to 2012/13



Source: West Midlands Police, crimes where victim known to live in WMP force area. Offences identified as being domestic violence – see technical annex for details of the search criteria.

As highlighted in Figure 4, the highest proportion of violent domestic violence offending is categorised as either 'violence with injury' (66.9%) or 'violence without injury' (30%). In each instance approximately a third of all offences classified under these sub-groups have been identified as being domestic violence.[10]

However, while the volume of 'violence with injury' offences has fallen by 34.8%, levels of 'violence without injury' have risen by 13.7%. This may suggest that psychological abuse remains an issue, particularly where it is being viewed and recorded as a less serious offence given the absence of physical injury.[12]

In the WMPFA, 2.7% of violent domestic violence has resulted in the victim sustaining serious or fatal injuries with a total of 47 homicides recorded in the last five years. [10]

Overall, 20.7% of violent domestic offending has been alcohol related, 80% of which has resulted in the victim sustaining an injury. Where the domestic violence was identified as occurring in a public place over the last five years, 26.2% have been alcohol related.[10, 12]

Sexual offences make up 2.35% of violent domestic violence offending with just over a quarter of all reported rapes being identified as domestic violence. Although there has been a 15.8% fall in the number of domestic violence related rapes over the last five years, the number of other sexual offences across the WMPFA has increased by 21.0%.[10]

7 Sexual violence

7.4 Sexual offences

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

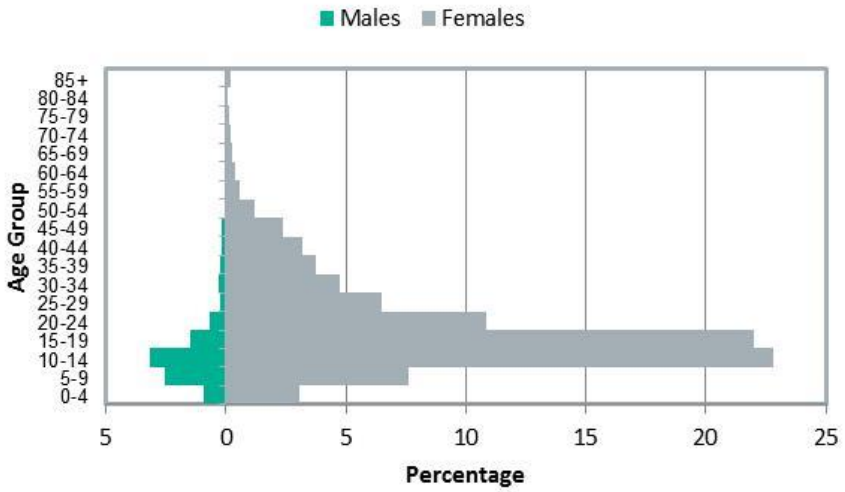
Overall, 89.2% of the victims of sexual offences as reported by WMP from 2008/09 to 2012/13 were female. An equivalent proportion where the offence has been classified as a rape were female (90.3%).[10,12]

Of the victims of other sexual offences, 10.7% were male of which 9.0% were victims of rape.

Overall, 14.1% of victims of sexual offences were under the age of 10 – equivalent to 1,696 victims over the last five years. Almost a third (32.9%) of these victims were the victim of a rape (558).[10]

More than six out of ten (61.0%) victims of sexual offences were aged 10 to 24 years. Of the 7,324 such victims over the last five years, 28.5% were victims of rape. The equivalent proportion of rape victims aged 25 to 64 was 32.5% (938 victims over five years).[12]

Figure 5: Age and gender profile of sexual offences (percentage of victims of sexual offences of persons, by age band)



Source: West Midlands Police, crimes where victim known to live in WMP force area, averaged over five years.

Note the heavy skew towards females and the generally lower age profile than for violence against the person

Sexual violence is known to be widely under reported, with only one in ten adult victims of serious sexual assault reporting the incidents to the police.[23] The CSEW includes a self-completed module to gather data on sexual assault experienced by adults. Based on aggregated data from the 'Crime Survey for England and Wales' in 2009/10, 2010/11 and 2011/12, around one in twenty females (aged 16 to 59) reported being a victim of 'a most serious sexual offence' (including rape and sexual assault) since the age of 16. Extending this to include 'other sexual offences' such as sexual threats, unwanted touching or indecent exposure, this increased to one in five females reporting being a victim since the age of 16.[24]

Between 2009/10 and 2011/12 it is estimated that around one in five women (19.6%) aged 16 to 69 and 2.7% of men had suffered a sexual assault since the age of 16.[25] In the previous year, 3% of women and 0.3% of men reported an actual or attempted sexual assault, equating to around half a million adult victims.[25]

Young women are at greater risk of sexual assault. National police recorded crime data as collated by the Home Office have suggested there has been a 20% increase in the number of reported sexual offences between March 2013 and March 2014.[26] Certain population groups can also be at increased risk, including sex workers and gay and bisexual men.[27] It is also worth noting the CSEW suggests that only 13% of sexual assault victims told the police. High profile cases may have led to increases in people coming forward and reporting sexual assault.[28]

Alcohol is a common feature of sexual assault. Over a third of offenders and a quarter of victims of serious sexual assault are thought to have consumed alcohol prior to the incident.[29] Surveys suggest that there is a negative attitude toward female victims among a sizeable minority of the population, particularly if they have been drinking, using drugs or flirting with the perpetrator prior to the assault.[30]

8 Female genital mutilation

Sexual violence can also manifest through forced marriage, human trafficking and female genital mutilation (FGM). The extent of all these forms of violence is largely unknown. However, police research in 2009 estimated that 2,600 trafficked women were involved in off-street prostitution markets across England and Wales.[31] A 2007 study estimated that 66,000 women in England and Wales had FGM and 33,000 girls were at high risk of existing or future FGM.[32] A more recent study carried out by London City University[33] and using 2011 census data estimated that around 170,000 women and girls were living with FGM in the UK, and that 65,000 girls aged 13 and under were at risk of being cut. The HSCIC reports that for the month of September 2014, 279 active cases and 467 newly identified cases of FGM were reported nationally.[34] Data on FGM are now being collected as mandatory to help tackle the problem.

9 The impact of violence

The burdens of violence fall heaviest on victims and their families, but also affect those who witness violence, live in violent communities and fear violence in public space. Addressing these burdens places significant costs on public resources, including health services, criminal justice agencies, education and social services.

The acute consequences of violence include physical and emotional injury, disruption to education, employment and housing, and restrictions to social behaviours.

Violence can cause significant physical injury to victims, which in the worse cases can be fatal or leave individuals with permanent disabilities or disfigurement. In 2008/09 to 2012/13, 52.4% of all violence recorded by West Midlands Police resulted in injury. The CSEW reported that across England and Wales 53% of violent crimes resulted in injury in 2012/13.[26]

Nationally, about a quarter (24%)[26] of partner abuse victims were estimated to have sustained a physical injury. Minor bruising or black eyes (16%) and scratches (13%)[26] were the most common injuries received. Data in relation to the WMPFA is unavailable.

Over a quarter (28%) of individuals who had suffered physical or emotional effects from intimate partner violence in the past year sought medical treatment.[25,26] GP or doctors' surgeries were the most common services accessed.

The 2009/10 CSEW measured the impact of serious sexual assault (since the age of 16). In addition to a variety of physical injuries reported, 4% of victims had become pregnant as a consequence of sexual assault and 3% had contracted a disease.[26]

9.1 Mental and emotional impact

All forms of violence can impact on mental and emotional wellbeing. The CSEW 2012/13 found that of those reporting partner abuse females victims were more likely to experience non-physical abuse (emotional, financial) (51%) than forceful abuse. Male partner abuse victims were also more likely to experience non-physical abuse (56%) than forceful abuse.[25]

Other consequences included victims stopping trusting people, having difficulties in relationships and stopping going out so much. Around one in twenty victims of past year intimate partner violence and those suffering serious sexual assault since age 16, had attempted suicide.

Self-harm and suicide can also stem from youth violence, including bullying. Children involved in bullying as either victims or perpetrators are at increased risk of self-injury and suicidal behaviours.[35]

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

9.2 Impact on employment and education

Individuals who suffer physical or emotional injury through violence will often have to take time out of education or employment as a consequence. The BCS found that one in ten individuals who had experienced intimate partner abuse in the past year had needed to take time off work, and 4% had lost their job or had given up working.[29]

Victims of bullying in schools and workplaces may also take prolonged periods of absence due to stress or fear, or feel forced to change schools or jobs. Further, violence in schools and workplaces can impact on victims' educational or professional performance. For example, ED nurses who have been exposed to violence at work can suffer stress and have difficulty remaining cognitively and emotionally focused.[37]

9.3 Social impact

Violence can affect the relationships victims have with family, friends and intimate partners. For example, individuals who are sexually assaulted may reject intimacy with a non-abusive partner, or be rejected themselves. Fear of violence in the community can also damage social cohesion and prevent individuals from going out and participating fully in society. For example, studies have shown that many children with learning disabilities are scared to go out due to fear of being bullied.[38,39]

Experience and fear of abuse also affects the lives of large numbers of adults with disabilities; for example it may prevent them from using public transport, going out at night or going to places where they fear abuse may occur.xxxviii

9.4 Homelessness

Victims of violence may be forced to leave their homes to escape intimate partner violence, child maltreatment, forced marriage or harassment, and abuse in the

community.[39] The CSEW found that 35% of intimate partner violence victims that lived with their abusive partner had left home for at least one night due to the violence.[25]

Family conflict and violence are among the key causes of homelessness among young people.[40]

10 Health behaviours

Violence can impact on a wide range of health behaviours, even in the short term. For example, victims of violence can suffer disruptions to eating or sleeping patterns, and may turn to alcohol or other drugs as a form of self-medication or as a coping mechanism.[41] Fear of violence in the community can also limit use of parks and other public places for physical exercise. For example, concerns around safety and crime may prevent parents from taking their children to playground areas and lead them to restrict outside play.[42]

11. Cultural and social norms

Rules and expectations of behaviour in specific cultures or social groups can support violence and maintain harmful traditional practices such as forced marriage, female genital mutilation and honour-based violence.

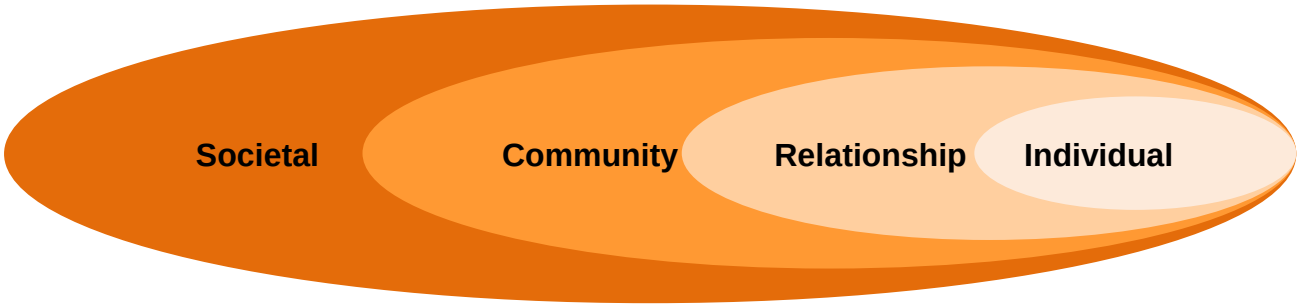
There are many different cultural and social norms that can contribute to violence.[43] Traditional beliefs that men have a right to control or discipline women through physical means make women vulnerable to violence by intimate partners and can place girls at risk of sexual abuse. Cultural acceptance of violence as a private affair hinders outside intervention and prevents victims from gaining support, while in many cultures victims of violence feel stigmatised, stopping incidents from being reported. Cultural intolerance, dislikes and stereotyping of 'different' groups within society based on nationality, ethnicity or sexual orientation, can also contribute to violent or aggressive behaviour towards such groups.

Cultural and social norms persist within society because of individuals' preferences to conform, given the expectation that others will also conform.

A variety of pressures can maintain harmful norms with individuals experiencing both the threat of social disapproval or punishment for norm violations, and guilt and shame where norms do not necessarily reflect an individual's attitudes or beliefs, although they may well influence them.

12. Evidence on the effectiveness of violence prevention

Figure 6 Cross cutting risk factors for violence



Society	Community	Relationship	Individual
Economic inequality	Poverty	Poor parenting	Victim of child maltreatment
Gender inequality	High unemployment	Marital discord	Psychological / personality disorder
Cultural norms that support violence	High crime levels	Violent parental conflict	Violent parental conflict
High firearm availability	Local illicit drug trade	Low socioeconomic household	Low socioeconomic household
Weak economic safety nets	Inadequate victim care services	Delinquent peers	Delinquent peers

Source: adapted from World Health Organization 2004

The World Health Organization uses an ecological model to show the interaction between risk factors for violence at the individual, relationship, community and societal levels as shown in figure 6 above.

Many of the factors that affect individuals' risk of violence arise through their circumstances and experiences in early life. For example, children can be at greater risk of experiencing or observing violence if they are born to parents that are young, single, who suffer from mental ill health, misuse substances or that have violent relationships. The links between these early life risk factor and childhood experiences can arise from poor bonding between parents and children and poor parenting skills and resources. Violence damages physical and emotional health and can have long-lasting negative impacts across a wide range of health, social and economic outcomes and reduce life prospects in terms of education, employment, social and emotional wellbeing.

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

There are a wide range of strategies and partnership approaches that can be used to address risk factors for violence and promote protective factors across the life course. Some can be implemented universally and others are targeted specifically towards at-risk groups. This section summarises evidence on the effectiveness of violence prevention.

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

12.1 Early years

12.1.1 Home visiting programmes

Home visiting programmes provide intensive early years support for vulnerable parents whose children are at risk of poor outcomes. Visits are conducted by public health nurses or other health professionals and typically start during pregnancy. There is strong evidence that these programmes can promote positive outcomes including better parenting practices and maternal mental health, reduce child maltreatment and result in fewer child behaviour problems.

One of the most widely used and researched home visiting programmes is the Family Nurse Partnership (FNP).[44] The FNP programme is implementing this model across the West Midlands where family nurses provide intensive home visiting for vulnerable first time mothers. We have a number of Family Nurse Partnerships which provide pre-natal health advice and support, child development education, and life coaching for vulnerable first time mothers.

12.1.2 Adverse childhood experiences in early life

Many of the factors that affect individuals' risk of violence arise through their circumstances and experiences in early life.[45] For example, children can be at greater risk of maltreatment if they are born to parents that are young, single, who suffer from mental health conditions or substance abuse, or have violent relationships. The links between these early life risk factors and child abuse can arise from poor bonding between parents and children and poor parenting skills and resources.

The experiences that children have early in life also impact on their risk of involvement in violence in adolescence and childhood. Abuse and neglect in childhood can contribute to children having lower self-esteem, poorer social skills, and poorer mental health and to consider violence as a normal way of resolving conflict. Children who suffer adverse experiences as they grow up are at increased risk of violence later in life. The Adverse Childhood Experience Study (ACE) has shown that individuals who have been abused or who lived in dysfunctional households in childhood (for example with domestic violence, family breakdown or substance use) have higher levels of health harming behaviours. A study of English residents aged 18 to 69 years found that those who had suffered ACEs were more likely to perpetrate health harming behaviours such as bullying, fighting and dating violence, and to have self-harmed and attempted suicide than those who had not.[46]

The ACE score can be used as a guide to a person's risk for health consequences in much the same way a person's blood pressure or cholesterol communicates risk for heart disease or stroke. The ACE score was originally derived from the Family Health History and Health Appraisal questionnaires (http://www.cdc.gov/ace/questionnaires.htm), which collect information on childhood maltreatment, household dysfunction and other socio-behavioural factors examined in the ACE Study. The 10-question ACE screener (http://acestudy.org/ace_score) may be useful as part of programme recruitment or an assessment protocol.

12.1.3 Positive parenting programmes

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

12.1.4 Pre-school programmes including Sure Start children's centres

Sure Start children's centres provide pre-school children up to age five and their families with child education, childcare services, support for parents, family health services and employment support. Broader Sure Start services cover children through adolescence. Some services are available universally, while others are targeted at disadvantaged families. An evaluation found [47] that three-year-old children from deprived Sure Start areas had more positive social development and social behaviour than children from equivalent non-Sure Start areas, while their parents had less risk of negative parenting.[47]

12.2.Working with high risk young people and gangs

12.2.1 Bullying prevention programmes

All schools including academies are required to implement measures to prevent bullying. One of the most widely researched bullying prevention programmes is the Olweus programme, developed in Norway. This uses a whole-school approach which includes: implementation of clear school rules and management structures for bullying; training of staff, a classroom curriculum for students; awareness raising for parents; improvements to the physical school environment; and the use of evaluation tools.

The programme has shown benefits including a reduction in the number of children reporting bullying.[48]

12.2.2 Family therapies and life skills programmes

Family therapies aim to address family problems, increase communication and interaction, and improve family conflict resolution. They can reduce anger, bullying and delinquency in young people.[49] In older children and young adults, life skills programmes can focus on healthy relationships and gender norms with the aim of preventing sexual and intimate partner violence. Evidence for their effectiveness is mixed but some positive results have been seen. For example, the Safe Dates programme in the USA targets 12 to 18 year olds and aims to develop relationships skills (such as conflict resolution), address social norms (eg dating violence, gender stereotypes) and raise awareness of support services for those affected by violence. It has been found to reduce perpetration of sexual, physical and psychological violence against dating partners, with some benefits also seen in reducing victimisation.[50]

12.2.3 Family interventions – multi-systemic therapy

Multisystemic therapy (MST) is an intensive community intervention for high risk 11 to 17 year olds and their families to prevent out-of-home placements and re-offending. Therapists use approaches such as cognitive behavioural therapy, and work with families to improve parenting skills. Talking therapies can be used to address emotional and behavioural problems, strengthen family cohesion, increase young people's engagement with education and training and tackle underlying health problems in the family. A study in the USA found that young offenders who had received MST in adolescence had lower rates of arrest and there was less of a tendency for them to lapse into previous patterns of criminal behaviour over 20 years later when compared with those who had received individual therapy.[51]

12.2.4 Gang-focused strategies

Youth gangs can be associated with high levels of violence. Strategies that address gang violence, encourage gang members to change their behaviours and prevent young people from joining gangs can be important in preventing violence. Research on effective approaches to preventing gang involvement is limited in the UK; however, in the USA multi-agency strategies that have targeted police activity at high risk gang members and provided these individuals with social support and opportunities for education, training, employment and health services (eg substance use services) have reduced violence.[52]

12.2.5 Mentoring programmes

Mentoring programmes partner at-risk youth with an older peer adult who can provide emotional, social and academic support. The evidence for their effectiveness on violence is limited, but some programmes have shown positive results. For example, an evaluation of a school-based mentoring programme in the USA focusing on self-esteem, relationship building, goal setting and academic enrichment has reported positive effects on bullying, physical fighting and depression.[53]

13. Hospital based programmes

Hospital settings can provide opportunities for accessing and intervening with high risk youths injured through violence. This can include providing mentoring, briefing interventions, counselling services, and individual or family assessment and referral to services. Although more evidence on the effectiveness of such programmes is needed, positive results have been reported.[54] For example, a programme in the USA provided mentoring for 10- to 15-year-old youths attending emergency departments with assault injuries, combined with parent home visits. This was found to have benefits in reducing aggression and delinquency.[55] Also in the USA a study delivering screening and brief intervention among youth attending EDs found this reduced peer violence and alcohol consumption.

The South East London Violence prevention model is piloting an ED-based programme to address violence through data sharing, capacity building and focused activity with high risk young people. The model incorporates a youth service, provided by specialist staff, through which vulnerable young people presenting at the ED are identified, assessed and referred to appropriate support services such as one-on-one mentoring and peer group support. The youth service also provides training for ED staff in youth risk assessment and referral, and works with other agencies to promote an evidenced-based approach to violence prevention.[56]

14. The role of alcohol

Individuals who start drinking at an early age, who drink frequently and who drink in large quantities are at increased risk of becoming involved in violence as both victims and perpetrators.[57]

Alcohol and violence can be linked in many ways, such as:

- alcohol consumption can affect physical and cognitive functioning, reducing self-control, the ability to process information and the ability to recognise warning signs for violence
- beliefs that alcohol causes aggression can lead to the use of alcohol as preparation for violence, or to excuse violent acts
- poorly managed pubs, bars and nightclubs (eg through crowding, poor staff practice, poor cleanliness, cheap drinks) can create environments where violence is more likely
- alcohol can be used as a coping mechanism by victims of violence
- alcohol and violence can be linked through shared risk factors that make people vulnerable to high risk behaviours

The availability and accessibility of alcohol contributes to levels of violence. Measures to limit access to alcohol and reduce alcohol consumption among hazardous and harmful drinkers can have important violence prevention impacts from a Public Health perspective. For example, the National Institute for Health and Care Excellence (NICE) concluded that reducing the number of outlets in a given area would be an effective way of reducing alcohol-related harm.[58] NICE also advocates the use of identification and brief interventions (IBA) as a short, simple and cost-effective way to reduce alcohol consumption among risky drinkers.[59]

The majority of people who drink above the recommended guidelines do not have an alcohol problem, but may be at increased risk of developing health problems or dependency. These ‘at risk’ drinkers are therefore suitable for simple ‘brief advice’.[60] Brief advice highlights the risk of drinking at that level and the benefits of cutting down.

NICE has produced guidance which is aimed at those responsible for helping people to change. IBA does not require advanced training, just some basic knowledge of alcohol consumption levels and common risks, some simple resources and some key delivery skills.

By using systematic approaches such as ‘Making Every Contact Count’[61] to deliver IBA, a wide range of frontline public sector workers, including police, can support behaviour change.

15. Conclusion

Violence is preventable and public sector services including health services across our region have a major role to play in its prevention. Over the last decade, an increasing body of research, intelligence and experience has developed our understanding of the wide range of risk factors that can and will contribute to violence as well as what can be done to prevent it.

We now have a sound knowledge of how violence affects our population across the West Midlands Police force area, and which groups are most at risk. This work has helped to give us an insight into what the effectiveness of different violence prevention strategies is likely to be and what we might do from a public health perspective to help to reduce it. The following recommendations have been put forward for and should form the basis of an integral work programme as the partnership moves forward.

16. Recommendations

Recommendation 1

Public Health England West Midlands to work in partnership with West Midlands Police and wider stakeholders to establish West Midlands Violence Prevention Alliance.

Tackling violence effectively requires multi agency action based upon evidence of what works. The Alliance would bring together representation from the wider system, not only to articulate the collective challenge, but to set out a commitment to work together to deliver against a joint action plan to reduce violence.

Recommendation 2

Establish an injury surveillance programme

By adopting an evidence based approach, the Violence Prevention Alliance will oversee the establishment of information sharing protocols allowing for crime related intelligence to be collected and shared among partners. An evidence based approach will assist the West Midlands Police, local authorities and other stakeholders to target their resources much more effectively, engage earlier with victims to reduce the risk of more violence and position ED health professionals as powerful and effective advocates for community safety.

Recommendation 3

PHE to review the evidence and present the science that will support the partnership in its role as advocate.

Traditional beliefs that men have a right to control or discipline women through physical means make women vulnerable. Where there is a shift from physical to non-physical violence, this may result in a reduction in those presenting at EDs while those requiring mental health support will increase.

Cultural acceptance of violence as a private affair often hinders outside intervention but is a known factor in the development of depression, anxiety and other mental health disorders including self-harm, suicide, eating disorders and substance misuse. Therefore the West Midlands Centre will review the literature to support partners in their roles as advocates and ascertain what works in challenging prevailing social norms and in providing emotional support for women to help them recover from violent experiences.

Recommendation 4

Support partners in their role as advocates to ensure that all children and young people get the 'Best Start in Life'.

Stressful or traumatic childhood experiences (such as witnessing domestic violence or growing up with substance abuse) can increase the risk of young people's involvement in violence. Interventions, especially those in early childhood, not only prevent individuals developing a propensity for violence but also improve educational attainment, employment prospects and long term health outcomes.

By taking a life course approach and by focusing on the initiatives that are evidence based, we will support partners to understand the impact of Adverse Childhood Experiences and to co-design their responses for early intervention.

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