Violence and health

“Many who live with violence day in and day out assume that it is an intrinsic part of the human condition. But this is not so. Violence can be prevented. Violent cultures can be turned around.”

Nelson Mandela

How is this relevant to doctors?
Doctors have an interest in the prevention of violence for two key reasons: firstly, because of the adverse impact of violence on an individuals’ and the nation’s health; and secondly, doctors are in a unique position to detect the signs of violence among their patients and take preventive action (see in particular the section on the role of the medical profession).

Why are we working on it?
At the 2009 Annual Representative Meeting (ARM) BMA members highlighted the need for greater awareness of violence prevention among the medical profession. This signposting resource aims to provide doctors with an overview of the nature of violence and in particular how the medical profession can help prevent violence from occurring.

Further information can be found via the following links:

- definition and types of violence
- causes of violence
- consequences of violence
- violence in context
- what can be done to prevent violence
- the role of the medical profession
- guidance for healthcare professionals
- what is being done in the UK
- BMA work on violence and health
- further sources of information
Definition and types of violence

Violence is a worldwide institutionalised phenomenon, and a complex issue which includes many manifestations. There is no standard definition of violence. This reflects the subjectivity and difficulty in gaining a consensus on what constitutes a violent act or violent behaviour.

The terms ‘violence’ and ‘abuse’ are often used interchangeably as certain aspects of abuse can be of a violent nature. Violence is usually associated with abuse which has a physical element (eg sexual abuse, assault) but it also encompasses other forms of maltreatment (eg financial and verbal abuse and neglect by family and/or society).

The World Health Organization (WHO) defines violence in the following terms:

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

It is worth noting that this definition includes threatening behaviour, irrespective of whether the perpetrator acts on the threat. It also makes it clear that the outcomes of violence are far broader than simply physical injury, disability or death.

The WHO definition separates violence into three broad categories depending on where the act of violence is directed:

- **Individual violence** – self-directed violence (eg suicide and self-harm)
- **Interpersonal violence** – within families (eg child abuse, elder abuse) and within communities (eg gun and knife crime)
- **Collective violence** – armed conflict, terrorism, genocide and repression.

This framework is helpful to determine the best approach for addressing a particular type of violence (ie the relationship between the offender and the victim) and can also be broken down further to identify the nature of the act of violence (ie physical, sexual, psychological and deprivation/neglect).

Violence can take place in both the private and public domains:

- **Private space violence**: this relates to violence which occurs in private, often in the home, and usually between individuals who know one another, including incidents of domestic violence and almost all forms of sexual violence.
- **Public space violence**: violence taking place in public occurs between individuals and/or groups of people, and the victims and perpetrators are often not known to each other.

Risks of being a victim of violence

According to the 2009/10 British Crime survey, the overall risk of being a victim of violent crime was three per cent. The level of risk was found to vary by personal characteristics:

- men were more than twice as likely as women (4.2% compared with 1.8%) to have experienced violent crime
- the risk was highest for men and women aged 16 to 24 (13.3% and 4.3% respectively) and then decreased with increasing age
- unemployed people (7.7%), students (7.2%), single people (7.2%) and those of Mixed ethnicity (3.6%) all had a higher than average risk of being a victim of violent crime.

Risk of victimisation also varies by key household and area characteristics, with people living in social-rented accommodation and more deprived circumstances more likely to be victims.

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1 World Health Organization, Health Topics, Violence
One important exception to this general pattern is domestic violence, with women being more at risk of victimisation than men. It is also important to note that domestic violence is rarely a one-off incident, but commonly a pattern of repeated abusive or controlling behaviour (see Box 1).

### Box 1 – Domestic abuse

The 2007 BMA Board of Science report, *Domestic abuse*, aims to raise awareness of domestic abuse as a healthcare concern, in particular its impact on the health and wellbeing of the victim and family members. The report provides an overview of the nature and prevalence of domestic abuse, and considers the role of healthcare professionals in detecting and managing domestic abuse. It highlights that:

- there are four main types of domestic abuse: physical, sexual, psychological and financial abuse
- abuse within relationships is not easily preventable. Domestic abuse mainly occurs behind closed doors and therefore, for it to stop, the victim must seek help or refuge
- alcohol and drug abuse are frequently associated with domestic abuse. Alcohol and drug misuse do not cause domestic abuse, but it is acknowledged that they can both be contributing factors.
- around 30 per cent of domestic abuse begins during pregnancy
- partner abuse is as common and as prevalent among same-sex couples as among heterosexual couples. The risk of domestic abuse does not differ significantly by ethnic group
- it has been estimated that as many as half a million older people are victims of domestic abuse in the UK, although only a minority of such cases will be recorded. Neglect is the most common form of elder abuse
- the direct health impacts of domestic abuse can include: suffering from chronic pain, fractures, arthritis, hearing or sight deficits, seizures or frequent headaches. During pregnancy, domestic abuse increases the rate of miscarriage, low birth weight, premature birth, fetal injury and fetal death. Indirect health outcomes include self-harm and suicide
- children can be impacted by domestic abuse both physically and emotionally. It is estimated that children witness about three quarters of abusive incidents occurring within relationships where there is domestic abuse.

The report recognises that healthcare professionals are well placed to identify and support patients who are experiencing domestic abuse. It concludes by recommending that all healthcare professionals should:

- receive training on domestic abuse (which is implemented on a national scale within emergency medicine)
- take a consistent approach to the referral of patients to specialist domestic abuse services
- give the clear message that domestic abuse is unacceptable and not the victim’s fault, and that there are specialist support services which can provide essential information, advice and support
- ensure that they ask patients appropriate questions in a sensitive and non-threatening manner in order to encourage disclosure of abusive experiences
- recognise that men can also be victims of domestic abuse and should therefore be questioned if domestic abuse is suspected.

Full details and further information on this report can be found [here](#).

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The causes of violence

There is no single factor to explain why some individuals behave violently towards each other and why others do not.

Violence arises from a complex interplay of individual, relationship, and community factors, as well as social, cultural, environmental and political factors. It is important to understand how these factors are related in order to develop violence prevention strategies.

The WHO identifies four levels of risk factors for being a victim/perpetrator of violence (see Figure 1):

- **The individual level** – the characteristics an individual possesses that increase the likelihood of being a victim or a perpetrator of violence (eg a male adult with an alcohol problem is more likely to be a perpetrator of domestic violence). Other risk factors include: being young, having a behaviour disorder, having previously experienced abuse or violence.

- **The relationship level** – the effect of close social relationships (eg with peers, intimate partners and family members) which increase the risk of being a victim or perpetrator of violence (eg a child living with an abusive parent has a high risk of repeated violent encounters). Other risk factors include: poor parental health and parenting style, adverse childhood/adolescent experiences (eg young offenders, teenage pregnancy).

- **The community level** – the characteristics of community environments which foster increased violence (eg risk factors include communities with high levels of unemployment, drug trafficking or social isolation). Communities which experience higher levels of violence tend to be culturally diverse, have a high population density, and tend to be places where people do not settle. Other factors include existence of gang cultures and lack of green spaces and community youth groups.

- **The societal level** – the larger societal factors that influence rates of violence. This includes factors which create an acceptable climate for violence, those that reduce inhibitions against violence, and those that create and sustain gaps between different segments of society or tensions between different groups or countries (eg societies which support the excessive use of force by police against citizens, which give priority to parental rights over child welfare or which regard suicide as a matter of personal choice rather than an act of individual violence).

Cultural or societal prejudices can often lead to violence against minorities groups or against those with lower social power (eg women).

In many societies, women and girls are disadvantaged by discrimination rooted in socio-cultural factors. Such discrimination, and also forms of societal neglect, can have a significant impact on their health.

Discrimination and neglect can occur as a result of traditions, beliefs, customs, values and religion, and includes the denial of rights and freedoms enjoyed by men and boys. This unequal power relationship between men and women can result in practices such as female feticide and infanticide. In some societies, women and girls are deliberately neglected within their families to advantage the male members of the family – for example, women may be forced to have a poorer diet and denied educational opportunities. Specific cultural practices can be inflicted on women, including forced marriages, ‘honour killings’ (ie murder due to perceived dishonour of the victim) and female genital mutilation.

Discrimination against women is not only confined to domestic settings but can also be supported by society and in some cases, the state itself – this ranges from attitudes towards rape and sexual abuse to the support of modern slavery, trafficking and forced prostitution.

Information on how current law and policy related to violence against women in England and Wales measures up to UK commitments under international law can be found in the 2010 Rights of Women

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report ‘Measuring up? UK compliance with international commitments on violence against women in England and Wales’.

Figure 1 – diagram of the ecological model for understanding violence:


It is important to note that not all risk factors are unique to a particular type of violence. Many will be shared between the different types of violence. There is therefore a need to identify interventions to prevent violence that are effective at addressing individual and shared risk factors.5

Factors which influence violence can begin in early childhood and exert their influence throughout people’s lives. Wider socio-economic and cultural determinants also play important roles in perpetuating violence. The main burden of violence is experienced by those living in greater socio-economic deprivation and by those in vulnerable groups and marginalised communities.6

Influence of alcohol and drugs

Alcohol misuse and the illegal use of drugs are strongly associated with crime, violence and anti-social behaviour, and can have a significant impact on individual, family and community life.

According to the 2009/10 British Crime Survey, victims believed the offender(s) to be under the influence of alcohol in half (50%) of all violent incidents, and in one in five (20%) of incidents the victim believed the offender(s) to be under the influence of drugs.7 Alcohol can also be a contributory factor in domestic abuse incidents. Approximately 50 per cent of cases of intimate partner violence involve alcohol. Parental alcohol misuse is also correlated with child abuse and impacts on a child’s environment in many social, psychological and economic ways.8

The inter-generational cycle of violence

There is evidence to suggest that inter-generational cycles of violence can occur.

Communities with high levels of violence, or having friends and family who find violent behaviour acceptable, can increase levels of violence in subsequent generations.9 This is based on social learning theory in that people learn by observing the behaviour of others and then imitate this behaviour.10 It is important to note, however, that individuals exposed to high levels of violence may not necessarily go on to be perpetrators.

Studies have identified an association between childhood experiences of violence and perpetration of violence. A 2008 review published in the Journal of Public Health found that childhood experience of violence was found to be a risk factor for intimate partner violence.\textsuperscript{11} A 2001 study by Glasser et al found that being a victim of child sexual abuse was linked to becoming a perpetrator.\textsuperscript{12}

The 2002 WHO Violence and Health report and the 2005 report Violent Britain describe in detail the various risk factors associated with becoming a victim or perpetrator of violence. Professor Mark Bellis, who is co-author of ‘Violent Britain’ and Director of the UK’s Centre for Public Health, describes the cycle of abuse in terms of the inter-generational patterns of violence that can develop (see Figure 2). For example, in the model below, a victim of child abuse has a higher risk of developing anti-social behaviour problems, which in turn leads to a greater risk of poorer performance at school and substance abuse. This means that he/she is more likely to become a victim of or perpetrator of youth violence. Anti-social behaviour and lack of education lead to poorer employment and housing prospects. Living in social housing in high crime areas can cause strain on intimate relationships and increases the likelihood of becoming a victim or perpetrator of intimate partner and/or sexual violence. Unintended pregnancy is often a direct effect of sexual violence and unwanted dependants becomes a risk factor in itself for becoming a perpetrator of child abuse. Thus the cycle begins again for the next generation.

**Figure 2 – simple cycle of violence:**

\[\text{Source: Presentation from Professor Mark Bellis, Department of Health} \text{ Violence and Abuse Prevention engagement event, November 2008.}\]


The consequences of violence

Violence has a significant impact upon individuals, families, communities and the wider society. For the individual there are many adverse health effects of violence:

- **Injuries and life-threatening injuries** – the most common consequence of a violent encounter is injury sustained to the victim. The degree of injury varies depending on the intensity of the incident from minor scratches and bruising, to broken bones and internal trauma.

- **Death** – death can result from the perpetrator’s intention to kill the victim (i.e., murder), as an unintentional outcome, as a result of intentional self-harm to kill (i.e., suicide), as well as death during armed conflict.

- **General physical health** – victims of violence may suffer indirectly as a result of the effects of the violent act on their general physical health. Such health impacts are varied and may be severe, depending on the nature and intensity of the violence that the victim has endured. Physical health effects include both short and long-term problems such as gastrointestinal disorders, reduced physical functioning, irritable bowel syndrome, ocular damage, chronic pain syndromes and disability. Sexual and reproductive health consequences include gynaecological disorders, pelvic inflammatory disease, infertility, sexual dysfunction, sexually transmitted infections (including HIV/AIDS), pregnancy complications/miscarriage, unsafe abortion and unwanted pregnancies.  

- **Mental health** – victims and witnesses of violence commonly suffer mental health problems. This can range from mild emotional disorders to severe mental illness. Post traumatic stress disorder (PTSD) is a complex condition which develops following a stressful event or situation of an exceptionally threatening or catastrophic nature. Around 25-30 per cent of people experiencing a traumatic event may go on to develop PTSD. The most common symptoms include re-experiencing aspects of the traumatic event in a vivid and distressing way (e.g., through flashbacks or nightmares) and avoiding reminders of the trauma (e.g., people, situations or circumstances resembling or associated with the event). Individuals may also experience symptoms of hyperarousal (including hypervigilance for threat, irritability and sleep problems) and emotional numbing (such as feelings of detachment and amnesia for significant parts of the event). This condition is commonly associated with armed conflict, serious road accidents and violent personal assault (sexual assault, rape, physical attack, abuse, robbery, and mugging).

- **Health risk behaviours** – violence can lead victims to adopt health risk behaviours such as unsafe sexual practices, and smoking, drug-taking and/or excessive drinking.

Violence can also indirectly affect health through a number of mechanisms:

- lack of good nutrition (for example as a result of the deliberate neglect of women and girls) leads to generations of women with poorer health, growth and development.
- denial of educational opportunities inevitably leads to poorer health outcomes for all of the family members – a good education is a major factor in the mother providing optimal care for all of her family.
- youth and other violence can have an indirect economic impact on entire communities if high rates of violent crime cause businesses to fail and reduce local investment.
- children who do not experience direct physical abuse but witness violence in the home may suffer indirect effects such as bedwetting, bad behaviour at school (including bullying), lying, stealing and illegal substance misuse.

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Violence in context

There are many different types of violence that can occur in a whole range of contexts. The WHO estimated in 2000 that 1.6 million people were killed through acts of violence: approximately half to suicides, one-third were homicides, and over one-fifth casualties of armed conflict.\textsuperscript{15}

The majority of violence, however, is non-fatal and results in short- and long-term physical or psychological problems (see ‘The consequences of violence’ section). Violence is also associated with substantial social and economic costs.

There is no overall figure for the level of violence in the UK. The following provides an overview of the extent of individual, interpersonal and collective violence in the UK and an indication of where to find further information.

Individual violence

Self-harm

Self-harm (also known as self injury or self mutilation) is an expression of personal distress, usually made in private, by an individual who hurts him or herself. The nature and meaning of self-harm vary greatly from person to person. The reason a person harms him or herself may be different on each occasion. People may harm themselves as a way of coping with an overwhelming situation or feelings.\textsuperscript{16} For some people, self-harm may be a way of preventing suicide.

The methods of self-harm can be divided into two broad groups: self-injury and self-poisoning.

- The most common method of self-injury is by cutting oneself. Self-poisoning involves overdosing with medicine(s), or swallowing a poisonous substance. The majority of people who attend emergency departments after self-poisoning have taken over-the-counter medication. Alcohol may also play a part.
- It may also take less obvious forms, including taking unnecessary risks, staying in an abusive relationship, developing an eating disorder (such as anorexia or bulimia), or substance abuse.
- Young women and those with mental health problems are most likely to self-harm. Self-harming behaviour is also significant among minority groups discriminated against by society and those who are dependent on drugs or alcohol, or who are faced with a number of major life problems.
- The UK has one of the highest rates of self harm in Europe, at 400 per 100,000 population.\textsuperscript{16}

Suicide

Suicide rates are not distributed evenly throughout the population – the likelihood of committing suicide tends to increase with age, and is more common among men than women:

- in 2000 the WHO estimated that 815,000 people died from suicide worldwide. This represents an annual global mortality rate of 14.5 per 100,000 people\textsuperscript{15}
- in 2007 the suicide rate in the UK was 16.8 per 100,000 population for men and 5.0 per 100,000 for women
- suicide rates are declining across the UK overall (although there is some variation among the devolved nations) and have reached their lowest level since 1991
- in England and Wales, suicide is the most common cause of death in men under the age of 35, and also for men between the ages of 15-44 in Scotland.

Interpersonal violence

A number of sources provide information on the prevalence of different types of interpersonal violence in the UK. These data are not directly comparable and in the majority of cases are under-representative due to under-reporting.

\textsuperscript{16} Mental Health Foundation website – statistics on mental health
The 2005 Centre for Public Health report *Violent Britain: People, Prevention and Public Health* provides the most comprehensive overview of the levels of collective violence in the UK. The following is a summary of the key data from this report:

**Youth violence**
- Youth violence committed by or against young people (aged 10 to 30 years) accounts for an estimated 60 per cent of all violence committed in England and Wales
- Nearly three quarters of firearms offences (71%) and incidents of alcohol-related violence (72%) are committed by youths under the age of 30
- Over 5 per cent of all 12-30 year olds report fighting in the previous year and almost half of 10-14 year olds have been bullied at school at some time
- Those most likely to be involved in youth violence are males between the ages of 14 and 17.

**Intimate partner violence**
- A quarter (25.9%) of women and 16.6 per cent of men in England and Wales have experienced some form of intimate partner violence since the age of 16
- Female victims outnumber males when numbers of incidents per victim are compared. In England and Wales in 2001, female victims suffered on average, an estimated 20 incidents of non-sexual intimate partner violence in the 12 preceding months compared to seven incidents in the same period for men; women are also more likely to be victims of intimate partner homicide
- Young women aged 16-34 years are most at risk of intimate partner violence, with both prevalence and gender differences decreasing with age.

**Child maltreatment**
- Almost a fifth (16%) of 18-24 year olds report some serious maltreatment by parents during their childhood, with seven per cent reporting serious physical abuse
- A reported 16 per cent have suffered some form of sexual abuse by an adult during childhood, with four per cent reporting that this is committed by their parents, carers or other relatives
- Over a third of children have experienced absence of care at some period, while three per cent were frequently left to fend for themselves due to parental problems with substance use
- Boys are most at risk of physical abuse while girls are most at risk of emotional and sexual abuse.

**Elder abuse**
- Elder abuse can be defined 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 an older person’. 17
- It has been estimated that half a million older people in the UK are experiencing elder abuse at any one time (excluding older people living in institutional settings)
- While female victims of elder abuse outnumber male victims, there is little difference in rates between the sexes as females have a longer average lifespan than males (ie the population is larger).

**Sexual violence**
- A quarter (24.1%) of women and 4.7 per cent of men have experienced some form of sexual violence during their lifetime
- Serious sexual violence is most likely to be committed by perpetrators known to the victim, and in almost half (47%) of cases the offender is an intimate partner (current or ex husband or partner)
- Young women are at greatest risk of sexual violence, with women who are single or separated, living in private rented accommodation, and living in inner city areas also more likely to be victims. Sex workers are at particular risk of sexual violence, with a quarter of prostitutes working outdoors in England and Scotland having been raped by clients.

Up to date data on different forms of police-recorded interpersonal violence can be found via the following sources:
- [British Crime Survey (England and Wales)](www.elderabuse.org.uk)
Collective violence

The WHO defines collective violence as ‘the instrumental use of violence by people who identify themselves as members of a group – whether this group is transitory or has a more permanent identity – against another group or set of individuals, in order to achieve political, economic or social objectives’.\(^8\) This definition includes wars, terrorism, state-perpetrated violence (eg repression and genocide), gang warfare and mass hooliganism.

From an international perspective, the last century has seen a high level of collective violence. This includes conflicts between states or involving organised groups within a specific geographical area, civil wars and the various forms of state-sponsored violence against individuals or groups.

It has been estimated that approximately 190 million people lost their lives directly or indirectly in the 25 largest instances of collective violence in the 20th century, 60 per cent of which occurred among people not engaged in fighting (commonly as a result of famine related to conflict or genocide).\(^9\) Since the Second World War, armed conflicts have increasingly been fought internally rather than between States (eg in Bosnia and Herzegovina and in Rwanda), however, conflicts between States still occur (eg the war between Eritrea and Ethiopia between 1998 and 2000). There have also been coalitions of multinational forces engaged in conflict such as the recent Iraq war and ongoing operations in Afghanistan.

Significant changes have occurred in the type of conflict since the 19th century, shifting from warfare taking place on the ‘field of battle’ to mobile warfare using submarines, fighter/bombers and laser-guided missiles, which have created battlefields without geographical limits. Torture and rape have also become common practice in many conflicts in order to terrorise and undermine communities, to force people to flee, and to break up community structures.

Since the start of the 21st century, new forms of collective violence have emerged involving organised but highly dispersed terrorist groups and networks of organisations without a ‘fixed address’. These groups commonly seek to use conventional explosives, missiles and suicide bombings to create both mass destruction and widespread fear. There is also increasing concern regarding the potential use of new technologies such as biological and chemical weapons.

Terrorism has traditionally been associated with men, yet increasingly, women are participating in such acts of political violence. In Iraq for example, an increasing number of female jihadists are being recruited as suicide bombers.

Further information on the use of chemical and biological weapons can be found in the BMA Board of Science reports Biotechnology, weapons and humanity I & II (1999, 2004) and The use of drugs as weapons (2007).

The UK has a long history of involvement in armed conflict, particularly overseas, as well as being subjected to the threat and effects of terrorist activity.

According to statistics provided by Defence Analytical Services and Advice:

- between 1998-2007, the overall Armed Forces age and gender standardised mortality rates fluctuated between a low of 66 per 100,000 in 1999 and a high of 105 per 100,000 in 2007.


there was an increase in Army fatality rates from 94 per 100,000 in 2006 to 128 per 100,000 in 2007 which was mainly accounted for by operations in Iraq and Afghanistan at this time.\footnote{Defence Analytical Services and Advice - UK Defence Statistics 2008.}

The threat of terrorism as a form of collective violence is not new to the UK. In the past, the principal domestic threat was from dissident Irish republican groups and loyalist paramilitary groups in Northern Ireland. In recent years this has been replaced by other terrorist threats, such as those in July 2005.\footnote{Home Office – counter terrorism (archived webpage)}

The most common forms of collective violence in the UK today are those that do not have political objectives, such as gang violence and mass hooliganism. Although traditionally perpetrators of collective violence have tended to be young men, it is becoming increasingly common for young women to be involved in such acts of violence. In 2007/08, for example, of the 1.3 million assaults in England and Wales, more than half a million were either directly perpetrated by women or involved women as part of a gang.\footnote{Home Office Statistical Bulletin, Crime in England and Wales 2007/08 Vol 1 Findings from the British Crime Survey and police recorded crime}

**Hooliganism**

Collective violence is often associated with sports, in particular the hooliganism (destructive behaviour such as brawls, vandalism and intimidation) sometimes displayed by football club fans. Although hooliganism is not as common today as it used to be, when it does occur it is a serious threat to the safety of other fans and the general public. Violence is now less likely to take place within football grounds, instead, gangs who associate themselves with certain clubs will organise fights between supporters of rival teams at pre-arranged locations away from the stadiums.\footnote{Home Office – reducing crime webpages – football disorder (archived webpage)}

**Gang violence**

Gang cultures are present in many parts of the UK and are closely associated with youth crime. The Home Office defines a gang as ‘a group of people who may be involved in crime and violence’. Being in a gang is not illegal, but young people who are part of a gang are more at risk of committing a crime or being a victim of violence\footnote{Directgov – gangs and gang crime: the facts}. The majority of Anti-Social Behaviour Orders (ASBOs)\footnote{Anti-social behaviour orders (ASBOs) are court orders which forbid specific threatening or intimidating actions. They are in effect for a minimum of two years, and can be longer. They are designed to protect specific victims, neighbours, or even whole communities from behaviour that has frightened or intimidated them, or damaged their quality of life. For further information see Home Office - anti-social behaviour orders (archived webpage)} are given to young people between the ages of 15 and 18, and in most cases, anti-social behaviour is conducted not by solitary perpetrators, but as part of a larger group or gang.
What can be done to prevent violence?

In 1996, the World Health Assembly (WHA) declared violence a leading worldwide public health problem and committed the WHO to deliver a plan of action for progress towards a science-based public health approach to violence prevention. The need for an evidence-based public health approach to violence prevention was strongly supported by BMA members at the 2009 ARM.

By understanding the causes of violence at a population level, and identifying the different settings and risk factors which increase the likelihood of becoming a victim or perpetrator of violence, a public health approach can prevent and reduce the effects of violence.

There are three levels of public health prevention:
- primary (aims to prevent violence before it occurs)
- secondary (focuses on the more immediate responses to violence such as improving emergency services)
- tertiary (focuses on the long-term care following violence such as rehabilitation and reintegration).

Violence prevention responses could include interventions targeted towards the general population, selected groups displaying particular risk factors, or be aimed at those who have already displayed violent behaviour in the past.

The 2002 *WHO World Report on Violence and Health* outlines nine recommendations for preventing violence:

1. **Create, implement and monitor a national action plan for violence prevention**
   Such a plan would need to be developed in consultation with government and non-governmental groups as well as stakeholders. This should take into account human and financial resources and could involve: reforming existing legislation, improving data collection and research, strengthening services for victims and developing prevention activities.

2. **Enhance capacity for collecting data on violence**
   Robust data is essential in order to set priorities, guide programme design and monitor progress. Systems need to be cost-effective and accessible, as well as conforming to national/international standards.

3. **Define priorities for, and support research on, the causes, consequences, costs and prevention of violence**
   Research is important to gain a better understanding of the problem of violence, and to influence the actions taken. Research should be planned at both the national and local levels, and the international level where appropriate.

4. **Promote primary prevention responses**
   Preventing violence from occurring in the first place requires interventions to remove the risk factors. Some of the key interventions are designed to bolster early development, such as prenatal care for mothers, good parenting training and social development programmes for children and adolescents. In addition, interventions can also include improvements to the urban infrastructure eg identifying locations where violence commonly occurs, and modifying the environment to reduce the risks of violence occurring.

5. **Strengthen responses for victims of violence**
   Improving health systems to provide high-quality care and support services for victims. A key priority is to develop better recognition of signs of violent situations and ensuring that victims are referred to the most appropriate agencies. This could also include incorporating violence prevention modules into the national curricula for medical and nursing students.

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6. **Integrate violence prevention into social and educational policies, and thereby promote gender and social equality**

   Violence is linked to gender and social inequalities therefore interventions to reduce violence should take this into consideration. Governments need to ensure that their social protection policies and programmes are robust as this will minimise the risk factors for a large proportion of the population.

7. **Increase collaboration and exchange of information on violence prevention**

   Improving working practices between organisations and groups involved in violence prevention will achieve a stronger co-ordinated approach and avoid duplication. This should include advocacy groups.

8. **Promote and monitor adherence to international treaties, laws and other mechanisms to protect human rights**

   Many international legal agreements are directly relevant to violence and its prevention. National Governments need to ensure that these are adhered to.

9. **Seek practical, internationally agreed responses to the global drug trade and the global arms trade**

   The global trade of drugs and arms is strongly related to problems of violence in both developing and industrialized countries. Public health strategies need to be developed at local and national levels to reduce their health impacts.

In England, the Department of Health (DH) has developed in 2008 a draft violence prevention framework, *Towards healthier, fairer and safer communities – connecting people to prevent violence*, which outlines the need for interventions in four key domains:

1. **Ensure a positive start**

   - **Ensure good antenatal and post natal mental health** – this helps to build protective factors of attachment, bonding, emotional regulation and empathy formation.
   - **Promote good parenting** – to reduce abusive and damaging parenting and enhance protective parenting styles.
   - **Younger children - targeted parenting programmes with high risk mothers** – enhanced home visiting led to lower rates of physical abuse of children (4% compared with 26%).
   - **Older children - later targeted parenting programmes with children with emotional and conduct disorders** – for example the ‘Positive Parenting Programme’ or Functional Family Therapy - 20-30 percent lower repeat rates for antisocial behaviour.
   - **Intervene early with conduct and emotional disorders** – the total value of benefits of prevention from treating a one year cohort of children with conduct disorder is estimated at £5.2 billion.

2. **Skills for safe, connected relationships**

   - **Promote good mental health as well as social & emotional skills in childhood (especially with children with a conduct disorder)** – Interventions showed an 11 percent improvement compared to controls.
   - **Universal, multi-component programmes in schools** – showed a 15 percent reduction in violence. Teacher training to reinforce pupil self management showed benefits.
   - **Multimodal programmes of social skills training for children** – for disruptive boys, results showed twice the level of graduation and about half the risk of having a criminal record as controls.
   - **School-based youth violence prevention programmes** – resulted in a 36 percent reduction in aggression.
   - **Dating violence reduction programmes** – reduced perpetration and victimisation at a four year follow up.
   - **Bullying Prevention programmes** – led to a 50 percent reduction in student bullying at two year follow up.
• **Family Intervention Programmes** – led to a reduction in the proportion of domestic violence issues from 26 to 6 percent. It led to a halving of the proportion of families with child protection issues.

• **Cognitive Behaviour Therapy** – showed significant reductions in aggressive behaviour at 1-year follow up.

### 3. Creating safer, green connected communities

• **Create Safe, green spaces especially in urban areas** – this was found to result in up to a 50 percent reduction in violence indicators in urban areas with green spaces, compared to those without, including child and domestic abuse and community violence.

• **Provide contact with nature for high-risk groups** – wilderness programmes with intense physical activity and a therapeutic component, led to a reduction in youth re-offending rates from 37 to 29 percent.

• **Improved street lighting** – has shown a 20 percent reduction in violent crime

• **To create safe green spaces, they need to have good visibility, and encourage human participation** – methods to increase use of green space include: employing park rangers, designing green spaces for all sectors to use, developing community interaction points and use of social marketing. Green gyms, allotments and participatory community environmental projects aide in maintenance of green spaces and develop community cohesion.

• **Green the NHS Estate** – to improve urban greening and encourage multiple health benefits.

### 4. Working together for safer communities - connecting professionals

• **Collect and share anonymous assault data across partnerships to prevent violence and inform strategic action** – accident & emergency feedback to Crime and Disorder Reduction Partnerships (CDRPs) led to a 40 percent reduction in assaults presenting to accident & emergency over a five year period.

• **Share individualised information and work in partnership** – if child protection concerns or risk of harm to others is identified, particularly following knife or gun violence.

• **Establish systems and protocols to identify and manage violence and abuse** – include treatment and referral pathways to appropriate partners and agencies.

• **Reduce alcohol misuse, refer and treat alcohol misuse problems across health and CJS systems for perpetrators of violence**

• **Connect Communities to Prevent Sexual Abuse** – for example through ‘Stop it Now’ campaign and the Child Exploitation and Online Protection Centre (CEOP).
The role of the medical profession

The World Medical Association (WMA) confirmed its policy on violence and health in 2003 stating that ‘there is one feature common to all forms of violence: the health effects suffered are a direct concern for the medical community.’

Traditionally, acts of violence have been addressed through the law and criminal justice systems. Since the 1980s, there has been growing awareness and emphasis on the need for a public health approach to tackling violence. This approach requires collective action from many different sectors such as health, education, social services and justice.

Doctors have a responsibility to safeguard the wellbeing of individual patients affected by violence. They also have a unique insight into the connectedness of social, cultural, economic and political environments and the effects they have on wellbeing. By working together through medical associations and special interest groups, doctors can therefore be powerful and effective lobbyists in informing and influencing public health policy. The WMA recommends that the medical profession should deliver more systematic approaches to address violence. These include:

- **Advocating effective strategies to prevent violence and limit its impact on health**
  Victims of violence are usually the most vulnerable in society and often powerless. The medical profession should advocate a zero tolerance approach to violence and neglect by promoting violence prevention strategies on their behalf at local, national and international levels.

- **Collecting routine, robust data in order to inform public health policy**
  The medical profession should play a central role in ensuring routine and useful data collection occurs.

- **Improving medical training by ensuring the integration of injury and violence protection into the medical school curriculum**
  Violence and injury as a threat to health is largely absent from the medical school curricula. Its inclusion would help the medical profession to understand the connections between violence and health and advocate primary intervention strategies more effectively.

- **Using clinical encounters to counsel patients and families to create safer, less violent household environments**
  The medical profession has a unique opportunity to detect victims of violence or potential victims, intervene and direct them to appropriate support services (further information can be found in [Guidance for healthcare professionals](#)).

- **Coordinating victim assistance**
  Doctors can play a role in ensuring victims receive appropriate referral to deal with any related health conditions or the physical, psychosocial or long-term disability associated with injury.

- **Improving research into violence to better understand the causes and consequences**
  The medical profession should encourage and contribute research which will improve understanding of the effectiveness of various violence prevention strategies. This includes encouraging medical journals to publish work in this area and stimulate relevant research.

- **Leading by example and denouncing violence in its various forms**
  The medical profession should contribute to the creation and reinforcement of social norms by not participating in or tolerating various forms of violence.

- **Encouraging and assisting the development of violence prevention policies and action plans**

27 World Medical Association (2003) Statement on violence and health
The medical profession should encourage the development of local or national violence prevention policies/plans of action and in some cases should take a leading role in developing them.

Further information can be found on the World Medical Association website. Please note that the WMA will be publishing a further statement on violence against women and girls in 2010.

In March 2010, the UK taskforce established to consider the health aspects of violence against women and children published its report examining the role of the NHS and other institutions. The report describes the key issues (identified by women and children, NHS staff, and experts from a wide range of interested bodies) and sets out a number of recommendations in relation to:

- improving the early identification of victims
- enhancing the quality of and access to services
- raising awareness of violence against women and children
- training and development
- and partnership working.

Further information can be found in the 2010 taskforce report Responding to violence against women and children – the role of the NHS.
Guidance for healthcare professionals

“Since healthcare professionals frequently come into contact with victims of all types of violence, they are ideally situated to identify individuals who would benefit from local services to help prevent repeat victimisation.”

As a doctor we have a responsibility to identify and support patients who are victims of violence.

This involves recognising when patients present with injuries which could have been inflicted as a result of violence, and working to encourage them to refer themselves to the authorities and support services. Only in exceptional circumstances should you take action on their behalf (for example if the patient is a minor or if the patient does not have the capacity to take this decision as a result of their injuries).

The General Medical Council (GMC) guidance document Confidentiality provides the following advice for protecting the patient:

- it may be appropriate to encourage patients to consent to disclosures, and to warn them of the risks of refusing to consent
- a doctor should usually abide by a competent adult patient’s refusal to consent to disclosure, even if their decision leaves them, but nobody else, at risk of serious harm. In this situation, patients should be provided with the information and support they need to make decisions in their own interests, for example, by arranging contact with support agencies (see Helplines for patients)
- disclosure without the patient’s consent may be justified if failure to disclose may expose others to a risk of death or serious harm (for example incidents of domestic violence where children or others are at risk).
- if it is believed that a patient may be a victim of neglect or physical, sexual or emotional abuse, and they lack capacity to consent to disclosure, such information should then be given promptly to an appropriate responsible person or authority, if it is believed that the disclosure is in the patient’s best interests. If it is believed that such disclosure is not in the best interests of a neglected or abused patient, the issues should be discussed with an experienced colleague.

The BMA Medical Ethics Department has developed a Confidentiality and disclosure of health information tool kit to help identify the key factors which need to be taken into account when such decisions are made. This guide highlights that in the absence of patient consent a doctor can decide to make a disclosure in the public interest (based on the common law) where such a disclosure is essential to prevent a serious and imminent threat to public health, national security, the life of the individual or a third party, or to prevent or detect serious crime.

Information on the ethical issues surrounding the confidentiality of an abused patient can also be found in Medical ethics today: the BMA’s handbook of ethics and law (second edition, 2004).

Seeking further advice

Disclosing patient information, with or without patient consent, often involves complex scenarios and requires difficult decisions. Doctors are increasingly being asked to explain and justify such decisions. If in doubt further advice can be obtained from:

1. Your medical defence body
   1.1. Medical and Dental Defence Union of Scotland
   1.2. Medical Defence Union

30 For further information see Medical Ethics Today - The BMA’s handbook of ethics and law, second edition
1.3. **Medical Protection Society**

2. The legal department in your healthcare organisation (if applicable)

3. Your organisation’s **Caldicott Guardian** who is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing

4. Your BMA – BMA members can access individual legal and medical ethics advice from askBMA on 0870 60 60 828 and via email at askBMA@bma.org.uk

There are also many sources of information which may be of practical use for healthcare professionals. These range from risk assessment checklists such as the HCR-20 (commonly used by psychiatrists to assess various risk factors for violent behaviour) to guidelines for recognising and managing different forms of violence:

**Self-harm/suicide**

- **Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care** (National Institute for Health and Clinical Excellence) provides information on the care people who harm themselves can expect to receive from healthcare professionals in hospital and out of hospital and outlines which services provide the best help.

- **Healthcare worker factsheet** (FirstSigns) provides healthcare professionals and practitioners with a practical introduction to self-injury and the treatment and care of people who self-harm.

**Domestic violence and rape**

- **Domestic violence: recognition and management in emergency departments** (College of Emergency Medicine) provides guidelines for recognising signs of domestic violence and steps to take when a patient discloses domestic violence.

**Child abuse**

- **Safeguarding Children and Young People: A Toolkit for General Practice** (Royal College of General Practitioners) is intended to increase awareness and skills regarding child protection in general practice. The main objective is to promote a change in the behaviour of doctors, and enhance the ability of primary care teams to support young patients at risk.

- **When to suspect child maltreatment** (National Institute for Health and Clinical Excellence) covers the alerting features in children and young people (under 18 years) of physical, sexual and emotional abuse and neglect.

- **Safeguarding children** (The College of Emergency Medicine) outlines the steps emergency departments should take to ensure adequate awareness and safe management of child protection issues on two levels: safety net systems and management of individual cases.

**Assault and community violence**

- **Violence: The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments** (National Institute for Health and Clinical Excellence) sets out guidelines for managing disturbed/violent behaviour covers how people in the NHS should try to prevent violent situations from happening, and what they should do if someone becomes violent.

- **Information-sharing to reduce community violence** (College of Emergency Medicine) provides guidelines to assist emergency physicians in sharing data with Crime and Disorder Reduction Partnerships (Community Safety Partnerships in Scotland and Wales) to reduce community violence.

**Helplines for patients**
There are a range of organisations which provide support, advice and counselling for victims of violence and abuse. These include:

**Domestic Abuse:**
- National Domestic Abuse Helpline – 0808 2000 247 (for women and children)
- Men’s advice line – 0808 801 0327
- Men’s aid – 087 1223 9986
- Broken Rainbow – 08452 604460
- Respect (support for domestic abuse perpetrators) – 0845 122 8609

**Rape:**
- Survivors UK – 0845 122 1201
- National Domestic Violence Helpline – 08457 023468
- Refuge’s 24-hour National Crisis Line – 0990 995 443
- Samaritans – 08457 909090
- Shelterline – 0808 800 4444
- Womens Refuge – 0845 702 3468
- Rights of Women - sexual violence legal advice line - 020 7251 8887

**Child abuse:**
- Childline – 0800 1111
- NSPCC – 0800 800500

**Elder abuse:**
- Action on elder abuse – 0808 808 8141

**Suicide:**
- National Suicide Prevention Lifeline – 1 800 2738255

**Bullying:**
- National bullying helpline – 0845 22 55 787

**Sexual Assault Referral Centres**

Sexual Assault Referral Centres (SARCs) are currently being rolled out across England and Wales – these bring together all of the different legal and medical agencies and departments in one place, which helps both the victims and those investigating the crimes. Victims of sexual assault can either self-refer, or be referred to the service, for example through a GP or accident and emergency department.

SARCs offer victims of sexual crime an integrated service where victims can receive medical care, psychological counselling, legal advice and other support, all in one place from professionally trained staff. Many centres are located in hospitals, as this allows access to medical staff and equipment.

Referral centres relieve some of the pressure on police service resources by providing centralised facilities where they can meet with the victim, conduct forensic examinations and gather evidence.

Victims who receive good immediate care and counselling are found to recover more steadily, and are less likely to need ongoing counselling and long-term mental health care.

At present there are 29 SARCs in England, with a further nine in development. More information can be found on the [Home Office](https://www.homeoffice.gov.uk/) website, including a list of [contact details](https://www.homeoffice.gov.uk/) for current centres.
What is being done in the UK

There is no overarching body responsible for violence prevention in the UK. The responsibility for violence prevention policy falls under many different sectors, including but not limited to the Police and the Home Office, as well as the UK Health Departments.

The following provides an overview of key strategy documents for violence prevention and management in the different parts of the UK:

**England**
- **Towards healthier, fairer and safer communities - connecting people to prevent violence: a Framework for Violence and Abuse Prevention (draft)** (Department for Health) outlines the impact of violence and abuse upon health and inequalities. It takes a life-course perspective in understanding why violence and abuse happens and makes links between the different forms of violence and abuse. It also provides an evidence-based framework for the best areas to intervene to prevent violence and abuse from occurring in the first place.
- **Youth Crime Action Plan – one year on** (Home Office) provides a cross-government analysis of what action is being taken to tackle youth crime.
- **Cross-government action plan on sexual violence and abuse** (Home Office) outlines the government’s strategic approach to addressing sexual violence and abuse.
- **National domestic violence delivery plan 2007/08** (Home Office) outlines the progress that has been made by the Inter-Ministerial Group on domestic and sexual violence in 2007/08.
- **Women’s National Commission (WMC) – violence against women** – the WNC ‘Violence Against Women Working Group’ was established to develop a cohesive, powerful and more effective voice to Government on action needed to address violence against women.
- **The Way forward: final strategy 2010-2013** (Mayor of London) – sets out the strategy to end all forms of violence against women in London.

**Wales**
- **All Wales Youth Offending Strategy: Delivery Plan 2009-2011** (Welsh Assembly Government/Youth Justice Board) sets out a holistic approach to end-to-end youth justice in Wales, with a focus on prevention.
- **Tackling Domestic Abuse: The All Wales National Strategy** (Welsh Assembly Government) sets out the Welsh Assembly Government’s strategy to tackle domestic abuse.
- **Talk to Me** (Welsh Assembly Government) is the national action plan to reduce suicide and self harm in Wales 2008-2013.

**Scotland**
- **Safer Lives: Changed Lives: A Shared Approach to Tackling Violence Against Women in Scotland** (Scottish Government/Convention of Scottish Local Authorities) provides a shared understanding and approach which will guide the work of all partners to tackle violence against women in Scotland.
- **Domestic Abuse: A National Training Strategy** (Scottish Executive) focuses on identifying training and development activity required to support improvement in services to women and children who are experiencing domestic abuse and men who use violence.
- **Choose Life** (Scottish Executive) is the ten year national strategy and action plan to prevent suicide in Scotland. The strategy includes a target to reduce suicide in Scotland by 20 per cent by 2013.

**Northern Ireland**

Protect Life (Northern Ireland Office/Department of Health, Social Services and Public Safety) is the Northern Ireland Suicide Prevention Strategy and action plan 2006-2011.
BMA work on violence and health

The BMA has published a number of reports that cover different aspects of violence and health. These include:

Interpersonal violence

- **Alcohol misuse: tackling the UK epidemic** *(2008)*
  This report examines the patterns and trends of alcohol consumption in the UK, and considers the range of adverse effects both on the individual and society that are associated with its misuse. Included in the report is an analysis of alcohol-related crime, disorder and anti-social behaviour.

- **Domestic abuse** *(2007)*
  This report is intended to lead the way in encouraging the healthcare professions to raise awareness of domestic abuse and makes recommendations for tackling the problem. The impact of domestic abuse can vary from person to person, but there is growing evidence to confirm that it has serious and long-lasting consequences on the health and wellbeing of the victim and family members.

- **Violence in the workplace: the experience of UK doctors** *(2003)*
  This report presents the findings from a national survey of 3,000 doctors on the incidence and impact of violence in the workplace. This study is set against the background of increasing incidence of violence against the UK healthcare workforce in recent years.

- **Injury prevention** *(2001)*
  Injuries are a major cause of death and disability in the world today. This report presents a comprehensive overview of the current challenges for government in improving injury surveillance and prevention in the UK. The report covers unintentional and intentional injuries including homicide and interpersonal violence, forms of collective violence, as well as suicide and other forms of self-harm.

Collective violence

- **The use of drugs as weapons** *(2007)*
  This report draws attention to governments’ interest in the use of drugs as weapons. The key purpose is to consider the role of healthcare professionals as frontline staff who potentially will have to manage and treat the consequences of their use, as well as considering the use of biomedical knowledge in the development of drugs as weapons.

- **Biotechnology, weapons and humanity I & II** *(1999, 2004)*
  The BMA has published two reports on biotechnology, weapons and humanity in 1999 and 2004 respectively. These reports describes the alarming gap between the quickening pace of scientific discoveries that could be misused and the desperately slow development of international arms control. The second report reviews current concerns about biological research which might easily lead to dangerous malign applications.
Further sources of information

The following reports provide further information on violence and violence prevention strategies:

  This eight-part series provides information on violence prevention and the evidence for interventions to prevent interpersonal and self-directed violence. The series looks at increasing safe, stable and nurturing relationships between children and their parents and caregivers; developing life skills in children and adolescents; reducing availability and harmful use of alcohol; reducing access to guns, knives and pesticides; promoting gender equality; changing cultural norms that support violence; and victim identification, care and support.

- **Women and health: today’s evidence, tomorrow’s agenda** (2009) World Health Organization
  This report focuses on both women’s health needs and their contribution to the health of societies, and also looks at the impact of violence and deprivation. It highlights how gender inequalities can increase women’s exposure and vulnerability to risk, limiting their access to health care and health information, and ultimately impacting on their health outcomes.

- **Manual for estimating the economic costs of injuries due to interpersonal and self-directed violence** (2008) World Health Organization
  This manual provides a standardised set of recommendations to estimate the direct and indirect economic costs of interpersonal and self-directed violence. It is intended primarily for economists, public health experts and researchers interested in conducting studies of this nature.

- **Preventing violence and reducing its impact: How development agencies can help** (2008) World Health Organization
  This document makes the case that violence seriously hampers the development of low- and middle-income countries. It calls for increased attention to, and investment in, violence prevention by development agencies and identifies gaps in their current programming.

  This report reviews the progress that has been made in the field of violence prevention since the 2002 World report on violence and health and the Global Campaign for Violence Prevention. It sets out what WHO and its partners can do over the next 5 years to expand violence prevention programming and to demonstrate the impact of violence prevention.

  This guide provides tools and information for governments, civil society and international organisations in their efforts to prevent and respond to violence against children.

  This report describes the many activities that have been organised as part of the Global Campaign for Violence Prevention, since its launch in 2002. The document reviews global activities coordinated by WHO and its collaborators, provides regional reports on recent developments and promising new programmes, and surveys the work of the Violence Prevention Alliance and its progress in building global commitment to violence prevention.

  This report analyses the costs and consequences of violence in the UK and brings together information on youth violence, intimate partner violence, child maltreatment, elder abuse and sexual violence. It aims to promote a public health approach to violence by focusing the attention of health, education, judicial and other public sector agencies on violence prevention.
  This handbook describes how to systematically identify and document violence prevention programmes, including attributes such as their target populations, interventions, evaluation methods and evidence of effectiveness.

  This report describes the one year follow-up to the release of the 2002 *World report on violence and health*, using the nine recommendations as a reporting framework.

  This document provides conceptual, policy and practical suggestions on how to implement each of the six country-level activities, and promotes a multi-sectoral, data-driven and evidence-based approach.

• **The economic dimensions of interpersonal violence** (2004) World Health Organization
  This report strengthens the case for investing in violence prevention by highlighting the enormous economic costs of the consequences of interpersonal violence, and reviewing the evidence for the cost-effectiveness of prevention programmes.

  The guide, which reflects the work of 15 United Nations agencies on preventing and addressing the consequences of interpersonal violence, describes related programmes, publications and databases and provides contact information for focal points for interpersonal violence prevention within each agency.

  This report analyses different types of violence and explores the magnitude of the health and social effects, the risk and protective factors, and the types of prevention efforts that have been initiated by Member States.

• **Co-ordinated action against domestic abuse (CAADA)** – is a national charity supporting a multi-agency response to domestic abuse. CAADA provides practical tools, training, guidance, quality assurance, policy and data insight to support professionals and organisations working with domestic abuse victims. Their aim is to protect the highest risk victims and their children – those at risk of murder or serious harm.

• **Measuring up? UK compliance with international commitments on violence against women in England and Wales** (2010) Rights of Women
  This report provides an assessment on how current law and policy related to violence against women in England and Wales measures up to UK commitments under international law.