

**REVIEW TO SUPPORT THE DEVELOPMENT OF THE HEALTH STRATEGY FOR
LONDON
CRIME AND DISORDER
DRAFT**

Crime Concern

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Contents

1	Introduction To Report	2
2	Research Evidence (1) – The Links Between Health And Crime	4
3	Research Evidence (2) - Identification Of Victims And Health Service Responses	19
4	Health And Crime In London	30
5	Strategic Action To Address Health And Crime Problems In London	46
6	Recommendations For Action	54

1 INTRODUCTION TO REPORT

- 1.1 The past decade has seen significant increases in crime; in the same period inequalities in health have widened and life expectancy in some groups has fallen. The poorest areas have become more rundown, more susceptible to crime and more cut off from the labour market. In these neighbourhoods the problems of crime, poverty and health are acute and intertwined. Unfortunately, there has been limited research in the UK exploring these relationships and this has led to a gap in policy responses. Most of the research that does exist concerns the impact of crime on victims; very little takes a wider view and considers the effects of crime and the fear of crime on populations and specific localities.
- 1.2 However, the debate is fast progressing from one based on intuitive knowledge and understanding of the relationship between health and crime and crime to one based on evidence which can inform policy decisions and action. In particular, significant research projects have begun to emerge which consider crime from a public health perspective. For example, work commissioned by the UK Public Health Alliance (Framing the Debate, 1997) emphasised the need for action research to develop local responses to health and community safety issues as well as for further substantive research into the impact of crime on public health.
- 1.3 The aim of this report is to inform the development of a London-wide health strategy by identifying:
- the research evidence concerning the health issues which need to be addressed in relation to crime and disorder and effective practice
 - current partnership activity in London concerning health and crime
 - further research needs
 - recommendations for action.

Structure of the report

- 1.4 Chapters 2, 3 and 4 of this report present a review of the literature in this field. The review is international in scope and provides a resume of current knowledge. Chapter 2 includes a summary of the key findings from the review as well as covering the impact of crime on physical and mental health; the links between health and fear of crime and substance abuse and offending. Chapter 3 covers the identification of victims; health service responses to the needs of victims; and the costs of crime and impacts on health services. Chapter 4 reviews research methods. This is followed by an overview of patterns of crime and disorder across the London Boroughs (Chapter 5); using this information alongside health data this chapter illustrates the correlation between health inequalities and crime. The strategic policy-making framework for joint consideration of these issues is then outlined (Chapter 6). Finally, recommendations are made for further research and action (Chapter 7).

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- the librarians of the London Regional Health Authority library at 40 Eastbourne Terrace for their advice and for making us welcome.

2 RESEARCH EVIDENCE (1) – THE LINKS BETWEEN HEALTH AND CRIME

INTRODUCTION

- 2.1 This chapter, and chapters 3 and 4 present the findings of a literature review to establish the current state of knowledge of the impacts of crime on health and health services. Most of the literature reviewed has been published, but in some cases authors have kindly made available unpublished papers.

METHODOLOGY

- 2.2 The review involved keyword searches of relevant computerised databases: MedLine; ASSIA; BMA. The search was restricted to English language material from books, journals and academic institutions. Search topics linked crime with: health, ill health and illness; fear, anxiety and stress; specific types of both personal and property crime; health and neighbourhoods. The research focused on the impact of crime on victims although there are some references to the health needs of offenders.
- 2.3 The search generated a substantial number of references and we have consulted abstracts and original publications. The review findings are organised using the following headings:

- impacts of crime on physical health (chapter 2)
- impacts of crime on mental health (chapter 2)
- fear of crime (chapter 2)
- substance abuse and offending (as this issue has been addressed by a parallel review this section provides only a very brief resume of the evidence of the association between drugs and crime) (chapter 3)
- identification of victims (chapter 3)
- responding to the health needs of victims (chapter 3)
- costs of crime and impacts on health services (chapter 3)
- research methods. (chapter 4)

RESEARCH EVIDENCE – KEY FINDINGS

- 2.4 There is a growing body of research concerned with the connections between crime and health. Much of the literature is from the US and focuses on violent crime; on the physical and sexual abuse of women and children; and on crime related PTSD. However, most of this work is of interest to the UK too. Where the body of literature is still relatively small but is growing; in particular there is an emerging interest in crime as a public health issue.
- 2.5 Crime is associated with social disorganisation, low social capital, relative deprivation and health inequalities, and the same social environmental factors which predict geographical variation in crime rates may also be relevant for explaining community variations in health and wellbeing. However, most of the large scale research exploring the inter-relatedness of these factors is from the US.
- 2.6 Crime can and often does damage the physical and mental health of victims. The effects of victimisation include acute as well as chronic physical and mental health needs.

- 2.7 It is not only the victims of personal crime who suffer psychological harm: the majority of victims of property crime also suffer some degree of psychological harm in the immediate aftermath of crime.
- 2.8 Crime may also impact on the health of those who are not directly victims themselves but who witness traumatic events or are affected by the victimisation of others close to them.
- 2.9 Domestic violence accounts for at least one quarter of all violent incidents in the UK and has long-term effects on the physical and mental health of its immediate victims as well as affecting the mental health of children who witness it. In many cases the perpetrators of domestic violence are also violent towards their children and many children who experience childhood abuse go on to become perpetrators themselves in later life. Domestic violence is a public health issue requiring a multi-agency public health approach to improve the identification of victims and prevention of incidents.
- 2.10 Some groups are at greater risk of victimisation than others, for example homeless people. It is important that services working with vulnerable groups address issues of safety and victimisation.
- 2.11 Health service staff are at greater risk from work-related violence than the general population. Many incidents are preventable and NHS Trusts need to implement risk management procedures.
- 2.12 Fear of crime is a very real and debilitating factor in many people's lives limiting their lifestyles in a way which is detrimental to good health and it is essential that the problem is properly assessed. However, this is a difficult issue and has attracted few researchers to date. Responses should be implemented at a local level, tailored to the local situation. Health services can play an important role in identifying the effects of fear of crime on health, and in implementing solutions.
- 2.13 Drugs and alcohol are key variables in crime and initiatives to reduce offending need to assess and address the relationship between drug/alcohol abuse and offending.
- 2.14 The identification of the victims of crime is inadequate; in particular the mental health needs of victims of crime often go unrecognised. There is an urgent need to improve the identification of adolescent victims and the victims of domestic violence and hate crimes. This has training and education implications for health staff.
- 2.15 Better co-ordinated approaches are important both to addressing the consequences and causes of crime. However, this does not necessarily mean that new 'specialist' structures are needed. Instead, it may be better to strengthen existing structures such as regeneration and community safety partnerships, ensuring the full participation of both health and criminal justice agencies and use the new opportunities created by Healthy Living Centres and Health Action Zones. It is important that multi-agency approaches concerning victims of crime pay attention to the ethics of confidentiality in the patient-health professional relationship.
- 2.16 Little is known about the impacts of crime on health service costs and the available data is often inadequate for the purpose. However, there is general agreement that the total costs are substantial. Accurate information is vital to develop strategies for reducing costs.

IMPACTS OF CRIME ON PHYSICAL HEALTH

Overview

- 2.17 Most of the literature on the physical health impacts of crime emanates from the US and is largely concerned with the effects of interpersonal violence, domestic violence and physical and sexual abuse.
- 2.18 The types of health effect victims are likely to experience vary. Violence may entail physical injury, permanent disability and even death as well as often resulting in time off work and financial losses which can materially affect health (Shapland et al. 1985:97). In general, victims of violent crime experience deterioration in both their actual and perceived health; they have more chronic limitations on their physical functioning and increased medical consultation (Resnick et al, 1993; Shepherd and Farrington, 1993; Ullman and Siegal, 1996).
- 2.19 The risk of victimisation is unevenly distributed: those most at risk are deprived young urban males who may suffer up to 60 years of incapacity as a result of injury through violence (Shepherd and Farrington, 1993). People living in deprived urban areas, homeless people, and people from ethnic minorities are also at increased risk. Women and children are most at risk of physical and sexual assault from people they know.
- 2.20 There is growing recognition that crime is an indicator of collective well being and that areas with high crime rates also tend to exhibit higher mortality rates suggesting that crime and population health share the same origins (Kawachi et al, 1999).

Findings

Income inequality and crime

- 2.21 Violent crime is associated with income inequality (Mesner, 1989). For example, recent US research found that the greater the degree of income inequality in a given state, the higher were the rates of homicide, aggravated assault and robbery. The only category of violent crime with which income inequality was not associated was rape; however, other research shows that domestic violence is also unrelated to income inequality. Income inequality is also associated with higher rates of burglary, but no other types of property crime (Kawachi et al, 1999).

Long-term health effects

- 2.22 Criminal injury is an increasing cause of temporary and permanent disability and even death in many countries and is increasingly considered as a public health problem meriting formal epidemiological research to establish causes and assist identification, management and prevention (Shepherd and Farrington, 1993). Much of the research in the US concerns firearm violence and homicide is now the second most common cause of death of Americans aged 15 to 24, and the most common cause among African American youth (Friday, 1995). Thankfully, this is not the case in the UK; however, violent injury is nevertheless a significant public health problem creating substantial health care demands. A study of patients with facial injuries attending 163 of the Accident and Emergency Departments in the UK during one week in 1997 found that 24% of these were caused by assault (the male:female ratio was 79:21) (Hutchison et al, 1998).

- 2.23 Injuries involving stolen cars are common in areas in which the activity has a high prevalence and can create significant demands on health services. Injuries tend to be severe and associated with a high fatality rate. Perpetrators are likely to be young and male (Marshall et al 1996). A study in the USA found that high rate of speed and police chase seemed to be related to the severity of the crashes involving stolen cars. The authors suggest that restricting police pursuit to only those instances in which other criminal activity is suspected may decrease the number of stolen car crashes (Livingston et al, 1998).
- 2.24 As well as the immediate and direct impact of physical violence a range of long term health risks are associated with victimisation. Increased rates of cigarette smoking, alcohol and other substance abuse, health care neglect, risky sexual behaviours and sleeping and eating disorders are associated with physical and sexual assault (Maguire and Corbett, 1987; Kelly, 1988; Resick et al, 1997; Smith, 1989; Thompson 1998). Domestic violence towards pregnant women is associated with poor foetal outcomes (Webster et al 1996). Women who experienced sexual assault, including rape, report more somatic symptoms complaints and have poorer perceptions of their physical health (Kimerling and Calhoun, 1994; Golding, 1994). Problems in respiratory, gastrointestinal, musculoskeletal, neurological and gynaecological functions are more likely to be experienced by women who have been abused in childhood (Leserman et al, 1996; Lechner et al 1993). In the US, victimisation in urban, poor, substance abusing women is associated with more medical disease and use of health care services (Liebschutz et al 1997).

Alcohol and violent crime

- 2.25 There are strong associations between alcohol and violent crime. Consumption of alcohol is an important risk factor for injuries resulting from assault (Shepherd, 1994). Victims are likely to be male and have committed previous assaults themselves (Wright and Kariya, 1997). Alcohol related assault is also associated with unemployment and social deprivation (ibid). A UK study of patients with facial injuries caused by assault found that 55% were related to alcohol consumption and 8% were with bottles or glasses. The 15-25 age group suffered the greatest number of assaults and had the highest number associated with alcohol consumption. At least 22% of all facial injuries in all age groups were related to alcohol consumption within 4 hours of the injury. The commonest sites for assault were the street followed by public drinking establishments (Hutchison et al, 1998).

Domestic violence - women and children

- 2.26 There is a significant body of research concerning the extent, nature and effects of domestic violence:
- the BCS (1998) indicates that domestic violence accounts for 25% of all violent crime in the UK
 - a survey by Women's Aid in Scotland estimated that only 2% of violent attacks on women were reported to the police (West Glasgow Hospital University NHS Trust, 1995)
 - 50% of female homicides in the UK are committed by a partner or ex-partner (Morley and Mullender, 1994)
 - 69% of domestic violence results in injury (BCS, 1996)
 - 90% of domestic violence incidents are witnessed by children (Home Office, 1992).

- 2.27 Recent UK research (BMA, 1998) shows that domestic violence survivors are 13 times more likely than other victims of violence to sustain injuries to the breast, chest and abdomen than other victims of violence. Research in London (Stanko et al, 1997) found that a quarter of domestic violence incidents reported to the police in Hackney resulted in substantial physical injuries. These included attempted murder by fire, stabbing and strangulation and broken bones. The same study found that 10% of women at a GP surgery had been knocked unconscious, 7% had broken limbs or severe injuries to the face/head and each woman averaged four such incidents.
- 2.28 Research into physical symptoms associated with domestic violence has established that survivors are much more likely to suffer from irritable bowel syndrome, gastro-oesophageal reflux and chest pains (associated with stress and anxiety). They may also experience delayed recovery from surgery, multiple operations, recurrent vaginal infections, pelvic and abdominal pain, and backache (Stevens, 1998 and 1999).
- 2.29 It is known that domestic violence often begins or escalates during pregnancy. In its 1997 Position Paper on domestic violence, the Royal College of Midwives identified a range of common symptoms and injuries: gynaecological problems, pelvic pain, untended and different aged injuries (especially to the head, neck, breasts, abdomen and genitals), repeat/chronic injuries, chronic pain, physical injuries related to stress, self-harm and suicide attempts. Victims are also likely to experience higher levels of miscarriage and termination, stillbirth, pre-term labour, low birth weight of their children and unplanned/unwanted pregnancy.
- 2.30 There is also evidence to suggest experiences of placental separation, foetal fractures and uterus ruptures are more common amongst abused women (BMA, 1998). One study, in India, found that abused women were twice as likely to begin antenatal care after 32 weeks (Purwar et al, 1999).
- 2.31 Research into the increased risk of experiencing sexually transmitted diseases (STDs) showed a significant relationship between sexual and physical abuse and STD infection (Matza et al, 1999). The same study showed a smaller but still significant link between physical abuse alone and experience of STDs.
- 2.32 Medical conditions and psychiatric disorders are often inter-related in women who have experienced domestic violence: women with unrecognised depression have been shown to seek primary care help for a range of physical disorders rather than for mental health problems. (Betrus, Elmore and Hamilton, 1995). The American Medical Association's guidelines (1995) on the effects of family violence on mental health confirm that many medical conditions are more difficult to control in the presence of co-morbid psychiatric disorders which are often linked to abuse.
- 2.33 Domestic violence has also been demonstrated to affect the health of children who witness it. Effects can include stuttering, enuresis, insomnia and separation anxiety, together with headaches and abdominal pains (American Medical Association, 1995).

Physical and sexual abuse of children

- 2.34 Research suggests that there is a correlation between abuse of women and physical and sexual abuse of their children by the male partner. Several US studies have found an association of between 45-70% linking a father's violence toward the mother and his violence towards his children (BMA 1998).

- 2.35 Analysis of trends in intentional injury death rates in children and teenagers shows intentional injury causes 335 deaths of 0-19 year olds each year in England and Wales (a quarter of all injury deaths for this group). This represents 17% of all deaths from injury or poisoning for this group, over a third of which are classified as suicides, whilst 20% are classified as homicides. Although teenagers are very vulnerable the focus for health professionals tends to be prevention of child abuse. Evidence suggests many teenage homicides may be unrecognised as such. (Roberts, Li and Barker, 1998).
- 2.36 Irazuzta et al (1997) found that children who had been abused had the highest severity of injuries and the highest mortality rates amongst admissions to a paediatric intensive care unit.
- 2.37 A study of medical problems of adult women survivors of child sexual abuse showed that they were more likely to suffer from respiratory, gastrointestinal, musculoskeletal, neurological and gynaecological conditions (Lechner et al, 1993).

Rape and sexual assault

- 2.38 It is estimated that 70% of reported rape is committed by a man known to the woman of which 17% are spouses/partners and a further 17% are male family members ('Living without fear', Home Office 1999).
- 2.39 Rape and sexual assault victims suffer a range of long-term physical and emotional/psychological symptoms in addition to injuries sustained as a direct result of the attack. Physical and sexual assault are associated with increased substance abuse, healthcare neglect, risky sexual behaviour and eating disorders (Resnick et al, 1997).
- 2.40 Forty percent of known rape victims in the US are adolescents. Research has highlighted that adolescent physiologic and psychosocial changes make them more susceptible to genital trauma and STDs; they are also more likely to use denial as a coping mechanism and to delay contacting Accident and Emergency services (Pharris M. speaking at IAFN 6th Annual Scientific Assembly USA).
- 2.41 Victims of sexual abuse attending one gastroenterology practice were found to experience more pain, more non-gastrointestinal somatic symptoms and greater levels of functional disability than non-victims (Leserman et al, 1996).
- 2.42 Australian research by the Northern Centre Against Sexual Assault has identified Rape Trauma Syndrome which includes physical symptoms such as nausea, fatigue, headaches and loss of appetite.

Hate crime

- 2.43 Hate crime can be defined as physical or verbal assault or harassment which is directed at individuals or groups on the basis of their race, religion, sexuality, gender or other characteristics. There is, however, relatively little research into these issues in the UK, particularly in relation to homophobic-related crime. As with domestic violence, hate crime is thought to be significantly under reported.
- 2.44 The Metropolitan Police recorded 7790 victims of racial violent crime in London between March 1998 and April 1999. It is suggested that a black or Asian Londoner is 15 times more likely to become a victim of racially motivated attack than white counterparts (Metro, 16th June 1999).

- 2.45 In Southwark alone, between November 1997 and August 1998, the Metropolitan Police handled 57 cases of homophobic attacks (Southwark Homophobic Violence and Abuse Forum, 1998). In addition, the Forum highlights problems experienced by gay men, lesbians and bisexuals if they decide to 'come out', including physical assault by parents or family members, homelessness and denied access to children.
- 2.46 A survey of lesbians and gay men in Manchester (Truman et al, 1994) showed that 38% of men and 21% of women had experienced homophobic attack. A similar study in the US (Herek, 1998) found that 24% of gay and lesbian respondents had been victims of homophobic attack.
- 2.47 Research by Stonewall (1996) surveyed over 4,000 gay men, lesbians and bisexuals and found that 34% of men and 24% of women respondents had experienced homophobic violence, ranging from being hit, punched or kicked to being assaulted with a weapon (knife, gun). Respondents also cited rape and sexual assault. Half of all attacks were committed by an unknown group and 20% by an individual perpetrator. A quarter of those attacked had required medical attention; 79% suffered stress and fear and 18% had nightmares. Other symptoms following attacks included attempted suicide, 'nervous breakdown', HIV infection, sleeping disorder and physical disability. Over half of all black and half of disabled respondents had been harassed because of their sexuality. Overall, lesbians and gays under 18 were significantly more vulnerable to homophobic attack and harassment: almost half of all respondents in this age group had experienced a violent attack and 61% had experienced harassment compared with 32% of the total sample in both cases.

Other groups at risk of violent crime

- 2.48 The 1996 British Crime Survey found that health care staff are at greater risk from work-related violence than the general population. Ambulance staff are particularly vulnerable to violence. Information from UNISON concerning Criminal Injuries Compensation claims made by their members during 1997 (Leather et al, 1998) showed that:
- claims for all health care workers were 1.3 per 1,000 members compared with 0.7 per 1,000 for workers in local government (including social services, police and schools)
 - for health care staff within UNISON, the numbers of claims were 2.4 per 1,000 for ambulance staff and 1.4 per 1,000 for nurses (including psychiatric nurses).
- 2.49 Certain characteristics of community health care work have been identified as increasing the likelihood of violent incidents including:
1. providing care
 2. giving, or withholding, a service
 3. exercising authority
 4. working with people who are emotionally or mentally unstable
 5. working with people who are under the influence of drugs or alcohol
 6. working with people under stress
 7. working alone
 8. working outside normal hours, particularly at night

- 9. handling valuables (e.g. drugs)
 - 10. travelling in the community.
- 2.50 The first seven of these may render health care staff vulnerable to aggression from patients, or their relatives and carers; the last four may make them vulnerable to robbery. Several also apply to their interactions with colleagues, for example, exercising authority or working with people under stress (Leather et al, 1998).
- 2.51 The psychological consequences of non-physical aggression may be increased for community health staff. Adams and Whittington (1995) found that community psychiatric nurses (CPNs) reported experiencing lower levels of verbal aggression than hospital-based nurses but suffered higher levels of anxiety following such incidents. This is probably related to the fact that community staff regularly work alone remote from the support of colleagues and without the protection of the security systems in operation in most hospitals.
- 2.52 People working as prostitutes are particularly vulnerable to violent crime. An American study of 130 people working as prostitutes in San Francisco found that 82% had been physically assaulted; 83% had been threatened with a weapon and 68% had been raped while working as prostitutes. Victimization was associated with childhood abuse and over half of the study group had been sexually assaulted and just under half had been physically assaulted as children (Farley, M and Barkan, H., 1998).

IMPACTS OF CRIME ON MENTAL HEALTH

Overview

- 2.53 There is a growing body of research exploring the impact of crime on mental health. Much of this focuses on violence and, in particular, violence against women and children. Attention is also paid to the links between violent assault and subsequent substance abuse by victims.
- 2.54 There is widespread acceptance that victims of crime often suffer severe depression and mental health problems creating substantial demands on mental health services (Weaver and Clum, 1995; Mezey, 1996). Although symptoms may lessen over time this is not always the case and many victims of childhood abuse continue to experience harmful psychological effects into adulthood. The psychological impacts of crime are not always recognised by health care providers and several researchers indicate the need for improved identification of victims (see below, Identification of Victims).

Findings

Victims of property crime

- 2.55 The majority of victims suffer some degree of psychological harm in the immediate aftermath of crime (Lugrigo, 1987). In a UK study of burglary victims, Maguire found that 83% experienced strong reactions on finding that their homes had been invaded and 65% were still aware of some continuing impact on their lives four to ten weeks later (Maguire, 1982). When asked about the worst aspect of burglary, only 32% of victims spoke of loss or damage, while 41% cited feelings of intrusion and 19% feelings of emotional distress.

Personal crimes - general

- 2.56 Personal crimes such as physical and sexual assault commonly entail still longer-term effects. The psychological symptoms reported by victims of crime often accord with Post-traumatic Stress Disorder (PTSD) and include re-experience and intrusive memories, depression, sleep disturbance, memory impairment, hyperarousal, psychological numbing and withdrawal, guilt and avoidance of thoughts and stimuli associated with the trauma (Fischbach and Herbert, 1997). Victimization may be associated with subsequent substance abuse. For example, a US study of 96 low-income pregnant women who enrolled in a substance abuse treatment programme found that 72% had experience sexual assault, 67% had experienced physical assault and 62% had experienced indirect violent trauma. Sixty two per cent displayed symptoms consistent with PTSD (Thompson & Kingree 1998).
- 2.57 In a study of PTSD in victims of non-sexual assault, Riggs et al (1995) found that two to three weeks after the assault, 71% of women and 50% of men met the symptom criteria for PTSD. A UK study of bus crews who had been the victims of assault found that 23% developed PTSD symptoms (Fisher and Jacoby, 1992). Victims of terrorist attack have also been found to experience PTSD: a French study found that PTSD was present in 10.5% of uninjured victims and 30.7% of those severely injured; major depression was found in 13.3% of all victims (Abenheim et al, 1992).
- 2.58 An 'acute stress reaction' following trauma is common and, in the main, psychological distress will lessen in severity and symptoms will disappear over time, even with no treatment (Kirkland and mason, 1992; Riggs et al, 1995). However, Shapland et al (1995) found that 75% of victims of assault, robbery or rape were still experiencing psychological harm two and a half years after the offence.
- 2.59 One US survey of 168 mental health care professionals estimates that between 20-25% of the all mental health service clients in 1991 had been victims of crime. Furthermore, over half of these victims were adults being seen primarily for child sexual or physical abuse that occurred years prior to their victimisation (Cohen and Miller, 1998).
- 2.60 Scholle, Rost and Golding (1998) found women who reported physical abuse as adults had significantly more severe depressive symptoms, more physical illnesses and more psychiatric problems and were more likely to receive outpatient care for mental health problems. The authors conclude that the majority of depressed women experiencing abuse sought medical rather than mental health care.
- 2.61 A study of the extent of violence and symptoms of PTSD in the lives of people working as prostitutes in San Francisco found that 68% met the criteria for a diagnosis of PTSD and that PTSD severity was significantly associated with the total number of types of lifetime violence. As children, 57% had been sexually assaulted and 49% had been physically assaulted. As adults in prostitution, 82% had been physically assaulted; 83% had been threatened with a weapon and 68% had been raped (Farley, M. and Barkan, H., 1998).

Domestic violence

- 2.62 The British Medical Association (1998) provided an outline of the psychological effects of domestic violence. These included depression, anxiety, PTSD and suicide. Victims also experience panic attacks, demoralisation, shame, anger, fear, helplessness. Battered Women Syndrome (BWS) is a recognised psychological condition involving a range of psychological, emotional and behavioural deficits, particularly 'learned helplessness', passivity and paralysis. Traumatic Pathological Attachment has also been identified in association with domestic violence, characterised by bouts of fear and extreme co-dependency. Guidance issued by the American Medical Association (1995) stresses that victims with unrecognised depression will present more medical problems and receive symptomatic treatments as a result. Medical conditions can also be more difficult to treat if victims has 'co-morbid psychiatric disorders'.
- 2.63 Survivors of domestic violence feel that the psychological impact has been more profound than life-threatening and disabling physical violence (BMA, 1998). In her presentation to the Conference of the Royal College of Midwives (1997), Dr Lindsey Stevens of St Helier Hospital NHS Trust stated: 'Many of the medical and emotional outcomes of domestic violence are similar to those of people who have experienced/survived torture'. Her research in this area suggests that abused women account for a quarter of emergency psychiatric cases and a third of psychiatric inpatients. A further third are diagnosed with clinical depression, whilst known survivors make up a quarter of attempted and actual suicides.
- 2.64 Stark and Flitcraft (1996) found that survivors of domestic violence were 15 times more likely to abuse alcohol, nine times more likely to abuse drugs, and three times more likely to be diagnosed as depressed/ psychotic. They were also five times more likely to attempt suicide. The same study found that one in seven survivors were institutionalised in psychiatric hospitals or received psychiatric referrals, but that no domestic violence incidents were recorded in their referral notes.
- 2.65 The Royal College of Midwives (1997) identified self-harm, suicide attempts, increased use of prescribed tranquillisers/ pain medications, rape and sexual assault as key indicators of domestic violence.
- 2.66 A Swedish study (Hedin et al, 1999) of antenatal patients showed that a quarter reported threats/actual violence whilst the majority had experienced isolation and dominance. The report confirms a high correlation between sexual abuse and physical/verbal abuse and that depression and anxiety during pregnancy has links to domestic violence.
- 2.67 A US analysis of black women's responses to a national survey on women's health (Russo et al, 1997) showed that lower income women were more likely to experience domestic violence and suffered more from depression and low self-esteem. Abuse history and domestic violence led to depression, lower life satisfaction and lower perceived health status. There was also a correlation between experience of child abuse and domestic violence.
- 2.68 Australian research (Horsfall, 1997) highlights domestic violence (and childhood sexual abuse) as key factors causing depression in Australian women. Recommendations include nursing strategies which emphasise hope, use of group approaches and dealing with emotions and unconscious issues.

- 2.69 It is estimated (Hanmer,1989; Home Office, 1992) that between 75 – 90% of domestic violence incidents are witnessed by children. Short term impact includes disturbed behavior, withdrawal, depression, aggression, anxiety, fear. In the longer term, boys are likely to show increased aggression. A Canadian study (Silvern, Karyl and Landis, 1995) estimated that half of children living in refuges show signs of PTSD. In addition to problems associated with witnessing violence, children may also be manipulated by the perpetrator in his relationship with their mother and may suffer because her parenting abilities are affected by her experiences. They may also suffer indirectly through social isolation, change of address, poverty, disruption to schooling. (BMA 1998).

Childhood abuse

- 2.70 Sexual and physical abuse in childhood can have both short and long term effects on psychological health. Abused children often have a damaged sense of self and tend to see the world as unsafe due to loss of trust and security (AMA 1995). This can lead to relationship problems, gullibility, inadequate self-protectiveness, and an increased risk of victimisation/abuse by others. Children try to resolve the trauma through struggles with authority, use of play and re-enactment. Adults do so through close relationships and therapy. Both adults and children engage in self-harm (cuts and burns) and may appear hostile and difficult.
- 2.71 Short term effects of physical and sexual abuse may include increased incidence of depression, low self-esteem, learning problems in school and behavioural disorder (Stern et al, 1995). In the longer term, children's development and psychosocial functioning may also be affected (Kolko, 1992). Women who have been sexually abused (including rape) are pre-disposed to PTSD and other mental health problems in later life (Epstein et al, 1997; Saunders et al 1992).
- 2.72 Several studies have found that childhood victimisation is often associated with alcohol and substance abuse in later life as well as suicidal behaviour and emotional and interpersonal problems (Malinoskyrummell and Hansen, 1993; Kaplan et al, 1995). Montcrief et al (1996) found high reported rates of sexual abuse, particularly in childhood and adolescence, among men and women attending alcohol services.
- 2.73 Kitzinger (1989) found that obstetric/gynaecological interventions can make survivors of childhood sexual abuse feel violated and fearful, sometimes triggering traumatic recall/re-enactment of childhood abuse. This can lead to many survivors avoiding treatment which can have serious health implications, especially as childbirth is likely to be significant crisis point. Further research is needed on how medical intervention and hospitalisation affect abuse survivors and how examinations and childbirth can be made less threatening for these women.
- 2.74 Hanson et al (1997) found that abusive men reported high rates of violence during childhood (as victims/perpetrators), anti-social personality disorder, subjective stress, marital maladjustment, tolerance of spouse assault and a range of 'impulsive' behaviours (violence, substance abuse, car accidents).

Rape and sexual abuse

- 2.75 Rape victims and victims of sexual abuse have been found to suffer persistent effects for many years afterwards including the development of PTSD (Burgess and Holstrom, 1974; Resick, 1987). Symptoms associated with sexual assault include sleeping and eating disorders, feelings of insecurity, low self-esteem and difficulties with inter-personal functioning (Dansky et al, 1997; Maguire and Corbett, 1987; Smith, 1989; Kelly, 1988).

- 2.76 American Medical Association guidance (1995) states that sexual assault can lead to 'serious biological and mental health trauma' but that victims often delay seeking medical help making identification and treatment more difficult. Lasting emotional distress, self-destructive behaviour, interpersonal problems and behavioural disorders are cited. Adult survivors can present a range of sexual dysfunctions, or become involved in compulsive sexual behaviour and prostitution. STDs, and obesity are also common amongst victims of this type of crime.
- 2.77 The Australian Northern Centre Against Sexual Assault's research into Rape Trauma Syndrome, has identified emotional reactions such as anger, shame, guilt, flashbacks etc. Longer term reactions often involve depression, fear, loss of confidence, flashbacks, although victims may seem outwardly to be returning to 'normal'. Victims may also instigate major life changes such as moving house, changing job, ending relationships, with attendant relationship/ sexual problems, depression, phobias, and nightmares.
- 2.78 The impact of rape and sexual assault on adolescents includes PTSD, dissociative symptoms, eating disorders, substance abuse, prostitution, teen pregnancy, runaway behaviour and school performance problems (Duncan et al 1996; Fullerton et al 1995). A survey of French adolescents (Darves-Bornoz et al, 1998) found that girls who had experienced sexual assault reported nightmares, multiple somatic complaints and mood disorders more frequently whilst boys who had been assaulted reported repeated suicide attempts, violence, substance abuse and running away.

Hate crime

- 2.79 Little is known specifically about the impact of hate crime on the mental health of people from minority ethnic groups. However, research indicates that where racism is a factor this is likely to increase the impact (Fitzgerald and Hale, 1996).
- 2.80 A survey by Stonewall (1996) of over 4,000 gay men, lesbians and bisexuals and found that of the 34% of men and 24% of women respondents who had experienced homophobic violence, 79% suffered stress and fear and 18% had nightmares. Other effects on mental health included attempted suicide, 'nervous breakdown' sleeping disorders.

Exposure to violence

- 2.81 Exposure to violence as a witness of crime or living in communities with high levels of crime may also be associated with higher rates of mental health problems (Campbell and Schwartz, 1996). In particular, witnessing interparental violence is associated psychosocial adjustment problems in young adulthood including increased risks of anxiety, conduct disorder, problems with alcohol and criminal offending (Maxfield, M. and Wisdom, C. 1996).

LINKS BETWEEN HEALTH AND FEAR OF CRIME

Overview

- 2.82 There is a significantly body of literature on the subject of fear of crime; however little makes any reference to its effect on health. This is probably because research in this area is fraught with difficulties:
- fear of crime is very difficult to define and measure, especially because it is a subjective emotional response, which is not constantly felt, but depends on the situation. The causes of fear of crime are also difficult to identify

- securing reliable data is problematic as many people may not identify fear of crime as a cause of ill health
- the causes of ill health may be multiple, including not only fear of crime, but other factors as well.

Findings

What is meant by 'fear of crime'?

- 2.83 Fear of crime is often talked about as if it is a simple, constant, concrete, easily quantifiable thing. However, in reality it is a subjective, emotional response that varies depending on the time, the person and the place. It is not purely related to rates of victimisation, but may be influenced by a complex web of inter-relating factors including:
- social identity: such as age (Pain 1995), gender (Pain 1997a, Stanko 1990), ethnicity (Webster 1996, Home Office 1996), motherhood (Hudson et al 1998). This is complicated by the fact that people have not simply one identity, but many
 - time: especially time of day (Taylor et al 1996)
 - environmental cues: for example lack of lighting (Painter 1991)
 - familiarity with people and place (Ferraro 1995, Loader 1996, Watt & Stenson 1997)
 - wider social context: such as worries surrounding economic and social change (Taylor & Jamieson 1998, Girling et al 1998).
- 2.84 Fear is not simply related to personal safety and belongings, but also to anxiety for the safety of others such as relatives and friends. Research suggests that fear of crime is associated with fear of things which are not truly crime, but impact on the quality of life such as living in an area where young people gather in gangs, or where there is environmental decay (Hudson et al 1998).
- 2.85 The British Crime Survey shows that a drop in crime does not necessarily reduce fear of crime (Robinson et al 1998). However, a long term reduction at a local level may have a more direct effect than a national reduction.

The impact of fear of crime on health

- 2.86 There is a particular lack of research concerning direct links between fear of crime and health. However, McCabe and Raine's survey for the Public Health Alliance (1997) of victims and non-victims¹ showed similar reports of feelings of stress, smoking, drug dependence, loss of confidence for both groups. This suggests that the fear of being a victim may induce ill health.
- 2.87 The impact of fear of crime is usually measured by examining the way people alter their lives as a result. In many instances these behavioural modifications are positive steps which reduce risks of victimisation and may lower fear of crime. However, behavioural modifications due to fear can reduce involvement in the local community, increase feelings of isolation, reduce quality of life and therefore have an adverse effect on health. Behaviour modifications due to fear of crime (Hudson et al 1998, Gilchrist et al 1998, McCabe & Raine 1997, Pain 1997a, 1997b) include:

¹ Non-victim is defined as not being a victim of crime in the last two years. However, it must be noted that the after-effects of victimisation may well last beyond two years.

- avoid going out alone
- watchful when walking
- stay at home more
- do not answer the door
- never go out after dark
- avoid certain streets/areas
- travel by different means
- move/planning to move house/area
- change locks
- change phone number
- fit security lights/alarms
- have weapon to hand
- nail down/brick up windows
- put up high boundary fences
- avoid wearing jewellery/carrying bags.

2.88 In addition, the behavioural modifications themselves may also induce fear of crime. For example, many young people have high levels of fear of crime and therefore go round in groups. However, large groups of young people are commonly cited as a cause of fear. High visible levels of security such as metal guards over windows, also make people fearful.

2.89 McCabe & Raine (1997) found that women and ethnic minorities were more likely to attribute their ill health to crime and fear of crime, whereas the elderly were less likely to do so. Just as the factors in fear of crime are multiple, so are the causes of ill health. Fear of crime is likely to be one of a range of contributory factors that will have a greater or lesser influence depending on the individual.

SUBSTANCE ABUSE AND OFFENDING

Overview

2.90 In addition to the research concerning victimisation and substance abuse, there are also several studies indicating a link between substance abuse and offending. A parallel review of health and substance abuse is being undertaken for the London Health Executive and, therefore, this section provides only a brief resume of evidence of the association between drugs and crime.

Findings

2.91 Concern about the illicit use of drugs, especially by children and young people probably receives more attention than any other related issue (NACRO, 1999). Much of the debate concerns the link between drugs and crime. Yet whilst research has established a correlation, whether drug use leads to criminality or criminality to drug use is contested.

- 2.92 Drug related crime is typically non-violent and acquisitive including theft, shoplifting, forgery, burglary or prostitution (Plant 1990, Goldstein 1979). More serious drug related crimes of violence, murder, large scale trafficking and money laundering occur and may be increasing in the UK although by comparison with the USA they remain relatively infrequent (South, 1994).
- 2.93 A Home Office study (Bennet 1998) surveyed five UK police forces over two years and found that 61% of people arrested tested positive for drugs excluding alcohol. Almost half of those arrested who admitted using drugs in the last year considered that their drug use and offending was linked.
- 2.94 Reported illegal income and number of previous convictions was also significantly correlated with substance misuse, especially of heroin and crack cocaine. The authors conclude that these two drugs may account for as much as a third of the criminal involvement of the sampled group of arrestees.

3 RESEARCH EVIDENCE (2) - IDENTIFICATION OF VICTIMS AND HEALTH SERVICE RESPONSES

Introduction

- 3.1 Having considered the research evidence concerning the impacts of crime and health this chapter focuses on the identification of victims by health services and responses to their needs as well as the costs of crime and impacts on health services.

Overview

- 3.2 Researchers agree that, in the main, health care workers fail to recognise the victims of crime and are therefore unable to respond adequately to their needs (Mezey et al. 1998).

- 3.3 Much of the research focuses on the identification of victims of interpersonal violence within the home directed mainly against women but also against older people. Key points highlighted by the research are:

- health care workers are insufficiently aware of the victimisation of patients
- patients are unlikely to freely disclose their experience of crime
- violence against women in particular and the impacts of crime on patients generally has not been seen as a matter of concern to medical professionals.

- 3.4 The literature makes various suggestions for increasing the rate of identification of victims of crime including:

- guidance for health workers (and GPs in particular) on appropriate questions about victimisation
- taking a thorough history from the patient
- collaboration with other agencies such as Victim Support and Women's Aid which are able to promote support, practical assistance and advice.

Findings

Identification of victims - general

- 3.5 In their study of adult attendees in a large group practice in London, Mezey et al (1998) found that most patients will tell their doctor about violence if asked directly but are reluctant to take the initiative to tell their GP. Other evidence suggests that victims of violence want their GP to recognise their plight and provide information and advice about what they can do and where they can go for help (Williams and McKenna, 1993).

- 3.6 When providing treatment for physical injuries doctors may fail to recognise, or see as relevant, that these result from violence. Doctors may also fail to recognise the evidence of psychological disorders in violence and abuse and may medicate depressive symptoms (Holtzworth, Murroe et al 1997). In some cases doctors may recognise the abuse but provide ineffective and even harmful treatment (Plichta, 1992). For example, a woman experiencing domestic violence may be prescribed tranquillisers which may reduce her abilities to respond to threatening situations and to take positive action (Fischback & Herbert 1997).

- 3.7 The main constraints concerning the identification of crime victims in Accident and Emergency Departments are the shortage of time, high staff turnover and unpredictable workloads. Furthermore, a survey in Camden showed that almost two thirds of victims delayed visiting their GP or Accident and Emergency Departments which led to problems in identification.
- 3.8 Particular consideration needs to be paid to the identification of victimisation amongst certain groups. For example, there is a high prevalence of victimisation amongst homeless people – a US study found that 44% of homeless people participating in a community care mental health programme had been victims of at least one crime during the two months before entering the programme. Women were significantly more likely than men to have been victimised and the more severe the clients' psychotic symptoms, alcohol abuse and criminal history, the more likely he or she was to have been victimised. The findings suggest a critical need for service providers working with homeless people to assess the extent to which they have been victims of crime and to address issues of victimisation and safety along with psychiatric and social adjustment problems (Lairn and Rosenheck 1998).
- 3.9 Shepherd & Farrington (1993) argue that the identification and prevention of interpersonal violence could be improved with formal collaboration between epidemiologists, Accident and Emergency doctors, family practitioners, criminologists and the police. Accident and Emergency Departments potentially have a key role to play in collecting detailed and systematic information on their patients who are the victims of assault. This information, the authors argue, is vital in developing appropriate prevention strategies and preventing repeat victimisation as well as increasing the rates of conviction of violent offenders through adequate clinical forensic documentation (Sheridan 96). In the US, health care workers have a duty to comply with laws governing the mandatory reporting of violent and abusive incidents (Tilden et al 1994, Scharnstein 1997). However this raises ethical issues about the victims role in choosing whether or not to report the incident and may deter some victims from seeking medical help (Mezey 1996).
- 3.10 Consideration also needs to be given to the identification of victims from minority ethnic groups including the training for health service staff and the use of interpreter services (Leman and Williams,1999). Attention has been drawn to difficulties faced in Accident and Emergency Departments by patients who can only communicate poorly if at all in English (Free and McKee 1998; Jones and Gill 1998).
- 3.11 French research into abuse of adolescents (Darves-Bornoz et al, 1998) suggests key symptoms of assault amongst youths are attempted suicide, substance abuse, violence and runaway behaviour and should prompt screening. In the UK, practice nurses may have an important role to play in the identification of adolescent victims. However, a study of their work with teenagers found that during practice nurses' consultations with teenagers, issues such as bullying, depression and relationship problems were rarely discussed (Greff et al 1998; Freeth and Blackie 1998).
- 3.12 A US study (Isely, 1998) indicates that sexual assault of men is under-reported and can cause serious biopsychosocial dysfunction, the authors recommend that future research into sex crime should sample male adults.

Identification of victims of Domestic violence

- 3.13 Scholle, et al (1998) found that the majority of depressed women experiencing abuse suffered significantly more mental health problems but sought medical rather than mental health care. They advocated that practitioners take a holistic view of women rather than focusing on somatic complaints and concluded that primary care screening for abuse is essential. In addition, Van Hook (1999) suggests that women reporting depression were significantly more likely to also report physical violence. Barriers to seeking help include stigma and a perceived split between general and mental health.
- 3.14 A US study estimates that doctors only identify injuries caused by domestic violence in 6% of cases (Scharnstein 1997). The low rate of identification is partly due to the low level of reporting by women themselves. There are a number of reasons why women may be reluctant to disclose this information: threats of violence from the partner; embarrassment; adherence to gender roles; concerns about police involvement, child protection procedures and lack of trust in health care workers (Robinson et al 1998).
- 3.15 Health providers' own attitudes and beliefs relating to domestic violence can also influence the level of detection and support offered to victims. Some GPs do not regard domestic violence as a relevant matter of concern to them even when they are aware that this has occurred (Stak and Flitcraft in Roseberg & Fewley 1991). In one study, Sugg et al (1999) showed that a high proportion of nurses, doctors and medical assistants believed domestic violence accounted for 1% or less of cases and that many had never identified abuse or questioned patients during examination. In addition, a quarter believed that victims' personality had led to violence. These findings have important implications for domestic violence training for health professionals and emphasise the need to change beliefs and attitudes as well as to increase clinical knowledge (Roberts et al, 1997; Varvaro and Gesmond, 1997).
- 3.16 A variety of suggestions have been made for improving the identification of victims. General practitioners should be more pro-active in questioning patients about victimisation. For example, Awerier et al (1997) recommend that brief trauma screening should be a routine part of general medical assessment procedures, especially for women. Research at a Hackney GP practice suggests active screening for domestic violence can increase identification five-fold and confirmed that women want their GPs to ask them about domestic violence. (Mazza and Deniers Stein (1996), argue that when prescribing psychiatric drugs for women, GPs should be aware of the possible association with domestic violence and sexual abuse and should incorporate questions about domestic violence into the consultation).
- 3.17 In the US, Caralis & Musialowski (1997) report that most female patients surveyed in a Miami medical centre felt that doctors should routinely screen for abuse and provide advice and assistance to victims. However, a major barrier to universal screening is the stereotyping of battered women and the perception of domestic violence as 'a disease of the poor'. This leads to the needs of women from higher socio-economic groups often being neglected (Poirer,1997).
- 3.18 The BMA's (1998) report on domestic violence identifies particular difficulties faced by women from minority ethnic groups in accessing help from health or other agencies.

- 3.19 Initial findings from research by St Helier NHS Trust suggest that a domestic violence Liaison Worker is designated specifically to provide advice, support referral to external specialists, and to develop a multi-agency approach. The research also suggests that screening is acceptable and the best approach is by interview, not by questionnaire (Stevens, 1998).
- 3.20 Dienemann et al (1999) described how an Emergency Department changed its infrastructure to become more responsive to domestic violence survivors. The approach was based on national guidance which highlighted the need for a systematic approach to assessment, referral, intervention mainstreamed into care practices, and included staff training and raising patient awareness. The study concludes by stressing the need to 'institutionalise a responsive, non-judgemental climate'
- 3.21 The Royal College of Midwives (1997) calls for greater role for midwives in detection and management of domestic violence and recommends 'a systematic and structured framework', including a multi-disciplinary approach and the introduction of policies and guidelines within maternity units to support the midwife's role and routine screening. McGrath, Hogan and Peipert's (1998) study at an urgent obstetrics and gynaecology unit showed that although nearly half of the women surveyed reported a history of abuse and 10% reported recent abuse, only 18% recalled being asked about abuse by a practitioner and white women were significantly more likely to have been asked.
- 3.22 A survey of health visitors in two NHS Trusts in London and South East (Frost, 1999) confirmed that the majority had contact with families experiencing domestic violence. The report recommends that health visitors need to be more proactive in questioning and influencing policy, but also need more support and appropriate training.
- 3.23 Orthopaedic nurses also have an important role to play in the identification of victims of domestic violence and their role should include: acknowledging abuse, discussing safety planning, responding to denial, reassuring, referring to advice and support services. (Varvaro, 1998)

RESPONDING TO THE HEALTH NEEDS OF VICTIMS OF CRIME

Overview

- 3.24 Healthcare providers are often an early point of contact for victims of crime, however practitioners often fail to recognise and respond to their needs.
- 3.25 Much of the work concerning health service responses to crime emanates from the US and concerns the efficacy and merits of various psychological therapies. Researchers also stress the need for better identification of victims, appropriate responses, preventative work and a co-ordinated multi-agency response.

Findings

General

- 3.26 Crime is increasingly recognised as a public health issue which needs to be tackled by a rational approach involving: gathering information, problem definition, education and the development and evaluation of intervention strategies (Shepherd & Farrington 1993, McCabe & Raine 1997). The prevention of crime should be a key objective of public health strategies which should promote approaches such as risk reduction as well as early health interventions to minimise negative health consequences on victims (Kilpatrick et al 1997).
- 3.27 Researchers emphasise the need to develop combined responses to victims which address both their physical and psychological health needs. For example, the AMA (1995) recommend that doctors can help to reduce the risks of repeat domestic violence by adopting a preventive, public health oriented approach involving primary, secondary and tertiary prevention. Primary prevention involves efforts to prevent problems from occurring, and in the case of domestic violence, may include activities such as educating parents about the cycle and progression of domestic violence and making routine inquiries about any violence in the home. Secondary prevention involves, for example, making patients aware that the GP is interested in hearing about abuse (information in the waiting room, routine inquiry etc); screening for all forms of victimisation and making available information about other support and advice services such as Women's' Aid. Tertiary prevention involves providing medical care for injuries received by victims; identifying and referring for associated mental health disorders; monitoring of an on-going care plan for abuse; and notifying other agencies such as Child Protection teams.
- 3.28 These measures are also relevant to other victims of violence and Mezey et al (1998) stress the need for doctors to help victims of all crimes, including secondary victims, access other support and advice services to minimise the incidence of long term problems.

PTSD

- 3.29 There is considerable literature on the merits of various psychological therapies for PTSD including brief therapy, cognitive behavioural treatments and other interventions. However, much of the research lacks methodological rigour and is not conclusive on the efficiency of treatments indicating that there are major gaps in the knowledge of both PTSD and its treatment (Robinson et al, 1998).

Domestic violence

- 3.30 Researchers in the US (Varvaro, 1998) stress the important role for orthopaedic nurses in identifying the victims of domestic violence, assessing their needs and providing treatment and care. Key interventions and recommendations include: acknowledging the abuse; discussing safety plans; discussing the pattern of abuse; anticipating and respecting partial denial; informing the woman that no one deserves to be abused; telling her that help is available; telling her that domestic violence is a crime; referring to community services; and allowing her to decide about which support services and options are safe for her situation.

- 3.31 Health visitors in the UK have considerable knowledge of the abuse and violence experienced by women and domestic violence is clearly a feature of their work. However, the majority of health visitors have never received any training about domestic violence or support in dealing with it. Research concerning health visitors responses to domestic violence found that only one of the survivors of domestic violence who eventually talked to her health visitor reported a positive experience and was given considerable emotional support and practical information (Peckover, 1998/99).
- 3.32 Davina James-Hanman (1998/99) has identified several factors which impede change in health service responses to victims of domestic violence:
- logistical problems in accessing staff training
 - staff are over-loaded with change
 - some resistance from staff about their role in a 'social issue'
 - the lack of a nominated officer at corporate level within trusts
 - the lack of national policy direction.
- 3.33 Equally, James-Hanman argues, there are factors which help promote change:
- a local policy framework
 - commitment from the Health Authority or Board
 - inclusion in other projects such as the Health Improvement Programme
 - good relations with local women's' groups
 - the growing number of national and local initiatives.
- 3.34 James-Hanman emphasises the importance of approaches to domestic violence which remove the onus from women to stop violence and which rely instead on a systematic approach to prosecution in all cases of domestic violence. Such approaches depend on proper evidence collection which requires that doctors are knowledgeable about the collection of forensic evidence.
- 3.35 Multi-agency responses are critical to meeting the health needs of victims and preventing repeat victimisation (Shepherd & Rivar 1998). A recent report by the BMA (1998) suggests that Health Authorities should be required to include in all Health Improvement Programmes inter-agency agreements to provide for the recognition and management of domestic violence . The Glasgow Women's Reproductive Health Service may provide a model of good practice for a strategic approach to improving the health service responses to domestic violence including collaboration with other agencies (Hepburn and McCarthy cited in Bewley et al 1997).

Rape and sexual assault

- 3.36 Doctors also need to be knowledgeable about the acute medical and psychological management of sexual assault victims including the collection of evidence (Beebe, 1998; Sheridan,1996). Guidance is also given on the principles of chemical forensic documentation (for example, Burgess and Fawcett 1996).

Long-Term Violence Prevention and Risk Management

- 3.37 Health services, particularly health visitor and school nursing services, also have an important role to play in reducing both the risks of child abuse and the risks of children going on to offend in later life (Peckover, 1998; NACRO, 1999) (HMSO, 1998) .
- 3.38 American research also advocates the involvement of health services in violence prevention programmes with young people. For example, O'Donnell et al (1999), argue that when delivered with sufficient intensity, school programmes which couple community service by young people with classroom health instruction can have a measurable impact on reducing the violent behaviour of young adolescents at high risk for being both perpetrators and victims.
- 3.39 Health care staff face increased risks of victimisation; however they have a duty of care to their patients or clients, often within a continuing relationship, and may only withdraw care in exceptional circumstances. This creates particular pressures and some may feel that coping with a certain amount of aggression is "part of the job" even though professional codes of conduct, such as the UKCC Code of Professional Conduct for the Nurse, Midwife and Health Visitor, do not require health care professionals to put themselves or their colleagues at risk for the sake of their patients. Many violent incidents and assault related injuries are preventable and the NHS Executive and Royal College of Nursing have provided guidance on developing whole organisation approaches to risk management (Leather et al, 1998).

THE COSTS OF CRIME AND IMPACTS ON HEALTH SERVICES

Overview

- 3.40 Much of the research concerning the costs of crime and impacts for health services is from the US and mainly concerns violent crime. Very few studies have specifically considered the costs to health services; however, researchers are agreed that crime places a considerable financial burden on them and diverts resources (Robinson, 1998).

Costs of crime against health service staff and assets

3.41 The NHS Executive (1997) has issued guidance to NHS Trusts on identifying the costs of crime. Costs of crime to health services occur directly as a result of crimes involving their staff, property and people visiting their property. Costs associated with violent crime arise from:

- assaults to staff which lead to their taking time off work
- assaults on patients or visitors which require medical attention for injuries.

3.42 Costs associated with property crime arise from:

- burglary involving the theft of Trust property and damage to the fabric of the building
- theft of medical supplies, medical and other equipment by trespassers, visitors, patients or staff
- theft of and from vehicles, including the theft of and from private vehicles from Trust car parks as these involve staff time in dealing with the incident
- criminal and malicious damage such as graffiti, arson and breaking of equipment.

3.43 Crimes generate a variety of different costs in a Trust. These can be categorised in two main ways (NHS Executive 1997):

- cash costs: i.e. the additional expenditure incurred, or the loss borne, by a Trust as a result of a crime. This includes, for example, the costs of replacing stolen items, repairing damage incurred, temporarily replacing injured staff, call out charges for engineers, and overtime paid to staff.
- non-cash (or opportunity) costs: i.e. the value of the non-cash resources consumed. For example, this includes management time expended investigating and reporting incidents and the time spent on replacing goods (in the case of property crime) and arranging for staff replacements in the case of injury as a result of violent crime. Although these costs do not add to a Trust's expenditure as the time is paid for in any event they do, divert resources from their intended purposes and therefore represent additional work.

The wider costs of crime to health services

3.44 Violent crime has increased substantially in the last ten years in the UK, and whilst it is known that victimisation leads to increased utilisation of healthcare services (Solomon & Davidson 1997; Resnick et al 1997), little is known about the increased costs Accident and Emergency or other healthcare services experience as a result. In order to get a real sense of the costs of crime to health services (in addition to those directly resulting from crimes against their staff and assets) we need to assess the costs of treating the victims of crime including those arising from:

- acute medical care for injuries or neglect and their complications
- medical complications from injuries with enduring effects
- mental health and substance abuse care for victims, perpetrators and families
- inappropriate medical care for unrecognised mental health problems.

3.45 US studies have found that:

- in 1987 physical injuries to people aged 12 and over resulting from rape, robbery, assault and murder caused an estimated \$10 billion in health related costs including some unmet mental healthcare needs (Miller et al 1993).
- between \$5.8 and \$6.8 billion a year is incurred by mental health services on treating victims of crime.

3.46 In the UK research has found that:

- the costs of providing treatment for injuries and psychological harm - excluding the costs of medicines and hospitalisation - were estimated at £540,000 for the London Borough of Hackney and £189 million for Greater London (Stanko et al 1998)
- the costs of examinations and initial investigations of children in a Liverpool hospital stemming from allegations of child abuse amounted to £31,739 for 181 investigations over a six month period (63,500 annually) (Summers and Mouneaux 1997).

4 RESEARCH EVIDENCE - RESEARCH METHODS

Overview

- 4.1 It is widely acknowledged that crime is generally under-reported and only a small proportion of some types of crime (for example, domestic violence and sexual assault) are ever reported (Bewley et al 1997). This makes assessing the extent to which crime impacts on the health of populations problematic.
- 4.2 The measurement of health impacts is also complex and into a 'simple' causal equation between crime and health come a number of complex but influential variables: gender, race, disability, geography, inequality, access to power and resources, the extent to which individuals and communities feel socially included or marginalised (McCabe and Raine, 1997). It is even harder still to measure the fear of crime.

Findings

- 4.3 Raine (1996) identified particular methodological problems in trying to establish crime as a public health issue including :
- how do we assess the invisible health effects of crime - stress, anxiety and quality of life factors?
 - what do we actually measure?
 - how do we measure the fear of crime as against the impact of actual crime?
 - how can we best assess health effects?
 - at what point should health effects be measured - it may be possible to measure the effects immediately after a person has experienced a crime; but what about enduring effects of crime on health?
 - where should data be sought from? Should it be sought in GPs surgeries, hospitals, victim support services; or, if we are to address the problems caused by under-reporting do we need to develop different sampling strategies?
- 4.4 Fundamentally, a very real issue in progressing research in this field is overcoming the problems of definition and understanding. The variety of interpretations of the term 'public health' and variety of measures being applied to the terms 'crime' and 'fear of crime' highlight the difficulties in quantifying the impact of crime on individual and public health.

Sampling strategies

- 4.5 Sampling strategies affect the ways in which the research has been conceived and carried out as well as the conclusions reached (Fry, 1993 cited in Robinson et al, 1998). Many studies have been based on populations or samples attending health care facilities and already labelled as 'ill' (e.g. McCauley et al 1995, Mezey et al 1993). In some studies the population or samples consist of those with specific health problems which, it is suggested, are associated with victimisation, such as psychiatric symptoms or substance abuse and are unlikely to be representative of the wider population (Robinson et al, 1998).

- 4.6 A study commissioned by the UK Public Health Alliance (UKPHA) (McCabe and Raine, 1997) combined surveys in GP surgeries in four culturally diverse and differing neighbourhoods in West Bromwich and Bristol with broader community based research involving eight group interviews attended by 132 residents. Particular attention was paid to ensuring diverse participation in terms of age and cultural background. This combination of approaches attempts to address the issue of representativeness; nevertheless, the community based research sample is small and may omit some groups such as homeless people.

Research approaches

- 4.7 Most of the research undertaken in this field has been quantitative research and has involved a variety of research methods. Survey and interview methods have included structured or semi-structured face to face interviews, self-administered questionnaires and telephone interviews. A wide range of standard inventories have been used to measure depression, anxiety, self-esteem, anger, behaviour and general health. Many of these have been developed and validated in the USA and care needs to be taken in utilising them in different cultural contexts (Robinson et al, 1998). For PTSD, the Diagnostic Statistical Manual definition has been widely used (ibid).
- 4.8 Qualitative research has included the use of focus groups to explore experiences and views from victims' perspectives (Rodriguez et al, 1996). McCabe, A and Raine, J. (1997) used focus groups to examine the impact of crime on health in specific localities and included research instruments in their report for use with focus groups as well as questionnaires for use in GPs surgeries.
- 4.9 Researchers exploring the impact of crime on public health uses epidemiological techniques to analyse data at a community level. Research by Kawachi et al (1999) used a range of measures covering social capital, poverty and relative deprivation and crime to explore whether the social environmental factors which predict geographic variation in crime rates may also be relevant to explaining community variations in health and well-being.
- 4.10 Researchers attempting to measure the costs of the impacts of crime on health and health services have used a variety of quantitative and qualitative data and techniques. A key problem however is a lack of data or unreliability of data. In the US, Rice and Howard (1996) have attempted to develop an economic model to estimate costs associated with domestic violence, including those to the health care services, suggesting sources of data which could be used and how they might be improved.

Analytical techniques

- 4.11 Most of the quantitative research projects in this field use standard statistical techniques of correlation, regression and modelling to analyse data and establish connections between being a victim of crime and health experiences, often based on questionnaire or interview survey data.
- 4.12 Robinson et al (1998) stress that whilst statistical analyses in this field may be helpful in the development of causal explanations they do not in themselves demonstrate a causal link. For example, the high incidence of mental health problems among the survivors of childhood abuse may be linked to a general pattern of childhood neglect, rather than specifically with the abuse. Causal links may also be difficult to establish because the retrospective nature of the accounts reported to researchers creates difficulties in disentangling the chronology of events and health experiences.

5 HEALTH AND CRIME IN LONDON

Overview

- 5.1 This section draws together some of the data on health and crime in the London Boroughs, using NHS and police statistics, and information from local Crime and Disorder Audits. The official crime statistics enable the mapping of the distribution of crime. These maps show that areas that have poor health also have high crime rates. The Crime and Disorder Audits provide a limited amount of data on local crime victims, however using this along side national information we can see that there is considerable variation in victim profiles across the Boroughs.

Patterns of crime

- 5.2 The maps pages 33-42 illustrate official crime rates in the London Boroughs. The rates have been calculated using crime figures from the Metropolitan Police Service for the financial year 1997-1999 and population statistics from the Office for National Statistics. In addition, health data maps have been reproduced from the 'Pocket guide to the NHS in London'. In spite of the varying data sets the maps allow broad comparison between the distribution of crime, health and deprivation.
- 5.3 The maps cover: total crime; violent crime; street crime; motor vehicle crime; residential burglary; cancer; coronary heart disease; Mental Illness Needs Index (MINI); Jarman underprivileged area score.
- 5.4 When considering the maps the following data limitations should be born in mind:
- a large number of crimes are neither reported nor recorded
 - some areas of London have a large visiting population (commuters/tourists) which may increase the crime figures in those areas²
 - the crime statistics are for 1997-1999, whilst the health statistics are from 1994-1996, and the Mental Illness Needs Index (MINI) and Jarman underprivileged area score are from 1991
 - the health maps centre around a national average figure, while the crime maps are in relation to the London Borough average.

² The City of London is not included in the maps due to the low number of residents.

Findings

- 5.5 Comparison of crime, health and deprivation indicators demonstrate that the worst crime rates for all types of crime are concentrated in the inner London Boroughs – in particular Westminster, Camden, Hackney, Islington. Overall, the same is true of mortality rates. Conversely, the lowest crime rates and the lowest mortality rates are generally focused in the outer London Boroughs.
- 5.6 The four Boroughs that rate highest on the MINI also have the highest total crime rates (table 1).

Table 1

Rank	Crime rates per 1,000 population	MINI index score
1	City of Westminster 385	Islington 122.4
2	Camden 221	Hackney 122.2
3	Islington 180	City of Westminster 121.1
4	Hackney 179	Camden 120.9
	London 129	England 100

- 5.7 The MINI scores areas on the basis of variables that have an established association with mental illness such as social isolation, poverty, unemployment, sickness and quality of housing. This suggests that whilst there is an association between health and crime there is no 'simple' causal explanation and that there are a number of complex and influential factors centred around disadvantage that must also be considered.
- 5.8 The recent report of the Independent Inquiry into Inequalities in Health (the 'Acheson Report' 1998) shows that poor neighbourhoods are characterised by poor health and tend to have higher rates of crime and accidents in and around the home; lower levels of educational achievement and high levels of school exclusion and truancy. This is reflected in a comparison of the Jarman underprivileged area scores map and the crime maps, both of which highlight the inner London Boroughs such as Tower Hamlets, Hackney, Camden, Islington and Newham.

Victims of crime in London

- 5.9 Patterns of crime usefully show us the distribution of offences, but do not tell us anything about the people affected by crime – the victims.
- 5.10 As part of this research project a rapid consultation exercise was carried out with Victim Support Schemes across London. Victim Support staff were asked how in their view, being a victim of crime affected their clients' health. The most frequently offered responses highlighted a variety of potential direct effects on health, and reactions that could indirectly impact on health:
- **Physical effects:** insomnia, panic attacks, headaches, weight loss/gain, skin rashes, asthma, nausea, exacerbation of ill health

- **Mental health effects:** depression, obsessive behaviour (such as re-checking doors and windows to make sure they are locked after property crime and repeatedly washing after violent crime), anger, fear, guilt, loss of confidence.

5.11 Victim Support Schemes were also asked how, in their view, the NHS could respond more effectively to victims. Suggestions included:

- greater availability of counselling services particularly in key locations such as Accident and Emergency Departments
- Increased awareness on the part of health professionals of services for victims and improved referral procedures to make sure victims have access to them
- greater availability of information in health service premises about services for victims
- training for GP's and other health professionals to improve the identification of victims and responses to their needs
- improved awareness of the mental health impacts of crime on victims.

5.12 The potential health impact of crime can evidently be severe. However, collecting data on the risk of victimisation is not a straightforward task. The police can produce victim profiles from their records. But this excludes the estimated 50% of crimes that are never reported to the police (BCS 1998), and so the figures need to be viewed with caution. A review of the London Borough Crime and Disorder Audits found that they provide very little information on victims and those that do usually rely on police data. Nevertheless, some have also undertaken local victimisation surveys, which include crimes unreported to the police. These have been used in Audits particularly for profiling victims of poorly reported crime such as racial incidents.

5.13 The British Crime Survey (BCS) is a national household survey which collects information about the characteristics of victims throughout England and Wales. The survey shows that there is considerable variation of the risk of becoming a victim of crime amongst different groups of the population and that the nature of the risk alters depending on the offence. The following sections highlight the BCS findings on the profile of victims in relation to burglary, violent crime and ethnicity – crimes which are the focus of victim reports in the Crime and Disorder Audits as well as the main findings from the audits.

Burglary

5.14 The BCS reveals that the highest risks of burglary are for households where:

- the head of the household is relatively young
- one adult is living alone with children
- the head of the household is unemployed
- the home is rented privately or from a council or housing association
- the home is a flat or end of terrace property
- the home is left empty during the day for three or more hours.

- 5.15 Amongst the London Borough Audits the focus on victims of burglary is on repeat burglary victimisation and burglary artifice. Identified levels of repeat victimisation vary considerably, from low levels such as 4.2% in Richmond upon Thames and 6% in Merton to 17% in Waltham Forest and 23% in Lewisham. Burglary artifice (bogus caller) victims are most likely to be female, and the rates of victimisation increase with age (Hackney, Harrow, Kingston upon Thames).

Violent crime

- 5.16 Nation-wide, risks of violent crime are higher for:

- young men and young women
- single adults
- one adult living alone with children
- unemployed adults
- those with a low income
- adults in rented accommodation
- adults who go out more often.

- 5.17 Within types of violence there are distinctive patterns:

- men are most likely to be victims of street violence
- women are most likely to be victims of domestic violence.

- 5.18 The London Borough Audits generally reflect these findings. Many have carried out special surveys with young people that confirm they suffer high levels of victimisation, and that, unlike with offending, the gender profiles are similar.

Ethnicity

- 5.19 The BCS does not consider the ethnicity of victims, but a number of the London Boroughs examine this issue. Generally ethnic minorities are more likely to be victims of crime, for example, in Southwark, black people are almost twice as likely to be victims of crime than their white counterparts. There are exceptions to this in the Outer London Boroughs, such as Kingston upon Thames, where ethnic minorities are no more likely to be victims than white people (excluding racial crimes). However, as these profiles come from official crime figures they must be treated with caution as many crimes may go unrecorded.

Summary of findings

- inner London Boroughs have the highest crime and mortality rates and the highest scores on the MINI and the Jarman Index suggesting that crime and public health share the same origins.
- consultation with Victim Support Schemes in London indicate their clients experience a variety of mental and physical health effects.
- Victim Support Schemes highlighted the identification of victims and knowledge of local advice schemes as key areas for improvement by health services.

6 STRATEGIC ACTION TO ADDRESS HEALTH AND CRIME PROBLEMS IN LONDON

Introduction

6.1 This chapter:

- outlines the main inter-agency structures and strategies for developing joined-up approaches to crime/disorder and health inequalities
- identifies a range of other initiatives and strategies being implemented in London which aim to both improve health and reduce crime and disorder
- identifies key national initiatives linking crime and health issues.

6.2 There is no partnership with a specific remit to address health and crime as a cross-cutting issue, but, there are three for whom it is critically important:

- Crime and Disorder Reduction Partnerships
- Health Improvement Programme Partnerships
- Health Action Zones.

6.3 As part of this research project a review was carried out of these partnership strategies to identify the links being made between health and crime. The review found that some partnerships are planning a sizeable amount of work in this field; however, most of them are still overcoming problems of joint-working and information sharing.

HEALTH-CRIME LINKS MADE BY THE CRIME AND DISORDER REDUCTION PARTNERSHIPS

6.4 The Crime and Disorder Act (1998) requires the Police and Local Authorities to establish borough level partnerships to reduce crime and disorder in the local area. The partnerships were tasked with:

- auditing local crime and disorder problems
- publishing and consulting on their findings
- designing and implementing a 3 year strategy with clear targets to reduce crime and disorder in the area.

6.5 The first audits were undertaken for the end of 1998. After consultation, this information was used to draw up a three year Crime Reduction Strategy which runs from April 1999.

6.6 Whilst Police and councils are the 'responsible authorities' tasked with this work, they are required to act in co-operation with other bodies including health authorities. The review revealed that few of the audits and strategies specify who from the Health Authority (HA) is actually involved. Of those that do, six identify the Chief Executive, two the Director of Public Health, one the Assistant Director of Public Health, and one the Director of Partnership Development. The majority of strategies simply display a HA logo, or mention the HA as 'working in partnership', or list them as data providers. In general, it is difficult to identify the level of commitment and input from any of the partner agencies, including the HA. In some instances the partnership seems to have been dominated by the Police and Local Authority.

- 6.7 This issue of health participation in Crime and Disorder Partnerships is not limited to London. A report by the Home Office (1999) reviewed the partnership processes of 12 Crime and Disorder Partnerships (Crime and Disorder Pathfinder areas) in England and Wales. The review found that engaging Health trusts in the partnerships was particularly problematic; one of the main stumbling blocks was identifying the benefits of participation for them. Nevertheless, where health services had engaged in the process their input had been extremely valuable.

Review of crime and disorder audits and strategies – key findings

- 6.8 Although the majority of audits and strategies do not provide clear statements of the health-crime links at a local level, there are exceptions; for example, the Brent Crime and Disorder Strategy clearly sets out the links between crime and disorder reduction and the work of Brent and Harrow HA.

A clear and high level of involvement in the local Crime Reduction Strategy – Brent and Harrow HA

Strategic links are identified between crime and disorder reduction and:

- The local Health Improvement Programme (HIMP) on cross-cutting themes such as domestic violence and fear of crime.
- The Health Action Zone (HAZ).
- The Youth Offending Team (YOT) focusing on offenders inappropriately caught up in the Criminal Justice System due to mental illness/substance misuse.
- The development of Arrest Referral Schemes.
- The development of Child and Adolescent Mental Health Strategy, which will include examination of issues of school exclusion, deliberate self harm, and aspects of offending behaviour.

- 6.9 In addition it is possible through content analysis to identify the relevance of health issues, and examples of joint working. The links between crime and health are most evident in the following issues:

- drug/alcohol misuse
- domestic violence.

Drug/alcohol misuse

- 6.10 All the Boroughs provide official statistics on drugs in their audits. However, much more crime may be indirectly related to drug or alcohol misuse:

- “Half of local arrests are alcohol related and nine out of ten disorder cases are associated with alcohol. The Borough also suffers three times the national average for death by cirrhosis” (Hammersmith & Fulham).

- 6.11 The London Boroughs all cite reducing drug-related crime as a priority. In many instances the Drug Action Teams (DAT) or Drug and Alcohol Action Teams (DAAT) are identified as the lead bodies for this work. DATs are statutory, multi-agency groups with a specific remit to look at drug related issues; they comprise senior officers from a range of local organisations including probation, Youth Offending Teams, local authorities and the voluntary sector, and are led by HAs. All DATs are tasked by Government with developing three-year action plans. Their work has clear links with community safety as well as health and they are required to establish arrest referral schemes in partnership with the police by April 2000. These schemes are intended to help reduce substance abuse related offending by making sure people taken into police custody are offered access to rehabilitation services.
- 6.12 The DATs are most frequently cited as lead agencies around drug action. However, in a minority of instances, the HA is listed as the lead.

Examples of clear HA involvement in crime-health related action:

City of London: HA is the lead partner in collecting additional audit data on drugs and health.

Croydon: HA is the joint lead partner with Police in carry out the drug and alcohol related crime action plan.

Kensington and Chelsea: HA is the lead partner to raise awareness of local residents on drug/alcohol misuse, including the availability of support services.

Merton: HA is the lead agency in providing accessible, suitable and effective treatments for drugs and alcohol mis-users, and promoting their use.

Sutton: HA to assist in promoting a co-ordinated approach to issues around underage drinking.

Waltham Forest: HA to help examine drug and alcohol related driving issues.

Domestic violence

- 6.13 Domestic violence is also a priority for action by all the partnerships. Where multi-agency groups are not already in existence, many are being established, and specific domestic violence strategies are being drawn up. Assessing the extent of domestic violence locally has proved problematic and most of the strategies make this observation. A minority of the Crime and Disorder Reduction Partnerships provide very detailed information on their domestic violence strategies in separate action plans. One example where the HA is involved in a joint planning partnership is Croydon.

Crime Reduction Action Plan on Domestic Violence: Croydon

Examples of the 18 measures to be undertaken:

- Improve reporting and recording of incidents
- Central collation of information
- Set up domestic violence resource library
- Produce a leaflet in 4 community languages of services in the borough
- Develop service provision specific to the needs of certain groups
- Ascertain the cost of domestic violence crimes

6.14 In addition to drug misuse and domestic violence other health issues identified in the audits and strategies include:

- fear of crime
- prostitution
- road safety.

Fear of crime and health: Bromley and Ealing: Bromley's HealthQuest Survey in 1996 asked about fear of crime, and showed that during the previous three months 38% of those questioned had felt anxious or stressed about burglary in their area, 33% had felt stressed about theft from cars, and 31% about violence towards themselves. Generally the percentage of people feeling stressed is greater in the higher age groups. There was a slightly higher level of stress felt among Black-African and Indian respondents to the survey.

The Ealing audit showed that the fear of crime was high and existed across all age groups, but particularly amongst older people and school children. The audit also revealed high levels of fear amongst women surveyed. Of those people who responded to the audit, 47% indicated that their experience of crime had affected their health or lifestyle. A loss of confidence, anxiety, fear or depression was reported by 25% of respondents. As a result, Ealing is planning to improve communications about crime patterns, undertake targeted fear of crime reduction work and promote personal safety.

Lambeth's Strategy: action around prostitution: Lambeth Crime Reduction Partnership will be undertaking a range of action around prostitution, including targeting young people/women working in the sex industry for health/social support/education. As part of this, a project is being led jointly by the Health Authority, the Youth Service and the Health Action Zone to conduct a needs assessment to determine the most effective intervention strategy for young people involved in the sex industry.

Road Safety: Kingston upon Thames: Kingston is a major communications centre. Heavy volumes of traffic use the local road network. Traffic accidents (personal injury) increased by 8% between 1995 and 1996. The local Health Authority has been working in partnership with other stakeholders since 1994 running a yearly campaign of 'Road Accident Free Days' to promote road safety awareness.

HEALTH-CRIME LINKS MADE BY THE HEALTH IMPROVEMENT PROGRAMMES

- 6.15 The 1997 White Paper 'The New NHS: Modern and Dependable' introduced the Health Improvement Programmes (HImPs). The first plans cover the period 1999-2002, and have been drawn up by multi-agency partnerships with the aim of improving health, tackling inequalities and raising standards. The lead agency regarding the HImPs is the HA. Typically, the other partners are NHS Trusts, Primary Care Groups, Local Authorities, Police, Probation, the voluntary sector and TECs.
- 6.16 The HImP guidance is not prescriptive, so there are variations in the priorities identified by different partnerships. However, every HImP makes some mention of the link between crime and health.

"Crime and the fear of crime can have a major impact on health. Fear of crime plays a major role in people's perceptions of their safety in the community. It affects older people, women, Black and ethnic minority communities and people who have already been a victim of crime. It contributes to anxiety, psychological ill health and social isolation. The links between crime, drugs and alcohol and their impact on health are significant." (Brent and Harrow)

- 6.17 Many of the HImPs outline the governmental priorities of crime reduction, youth offenders and Sure Start as complementary initiatives. As with the Crime and Disorder Reduction Partnerships, there are two issues which the HImPs emphasise as linking health and crime:
- drug/alcohol misuse
 - domestic violence.

Drug/alcohol misuse

- 6.18 The HImPs identify the DATs as taking forward local multi-agency action on drug use, although with little clarity on which member agencies will be involved. Rarely, the HA and Police are specified. An example of a clear, detailed plan that includes joint working led by the Police and HAs is Barking and Havering.

Barking and Havering substance misuse actions

- Review services and develop protocols for shared care (HA joint lead)
- Identify and develop options for targeting chaotic users (HA joint lead)
- Develop arrest referral scheme (HA joint lead, lead partners include Police and Probation)
- Develop education response for high risk groups.
- Develop information-sharing protocols/systems.
- Collect effectiveness evidence base (HA sole lead)
- Agree and implement alcohol strategy (HA joint lead)
- Contribute to Community safety partnerships (HA supporting partner).

Domestic violence

- 6.19 Three of the HlMPs prioritise action on domestic violence: Brent and Harrow, Croydon, and Kensington & Chelsea & Westminster. Brent and Harrow specifically identifies actions for health services as members of the Domestic Violence Forum.

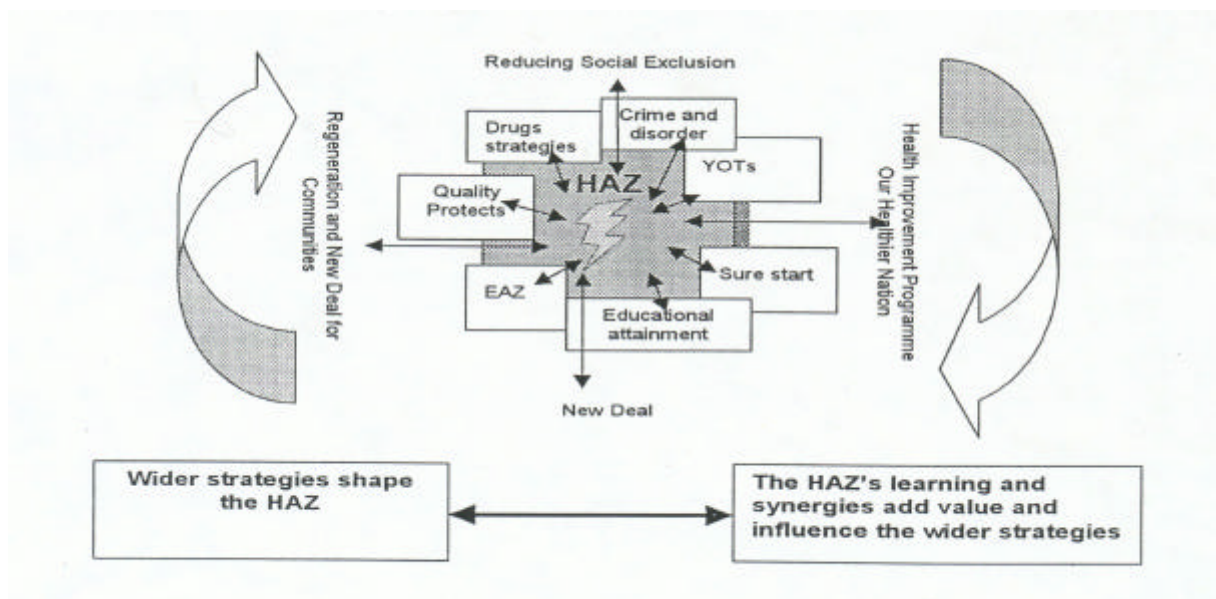
Brent Domestic Violence Forum

This multi-agency forum has aims including:

- Improve the ability of health professionals to identify, record and monitor domestic violence
- Increase the awareness and commitment of health agencies
- Provide guidelines/protocols and support for health professionals.

HEALTH-CRIME LINKS MADE BY THE HEALTH ACTION ZONES

- 6.20 Health Action Zones (HAZ's) are established by multi-agency partnerships bidding for funding to improve health by tackling the social, economic and environmental determinants of health. The HAZ work should add value to other local strategies. These factors are also known to increase the risk of offending, and action to improve parenting, reduce school exclusions and substance abuse, tackle unemployment and poor housing should lead to health gains as well as reductions in crime and disorder.
- 6.21 There are four HAZ in London: Lambeth, Southwark and Lewisham, East London and the City, Camden and Islington, and Brent.
- 6.22 The HAZ partnerships all involve HAs, Health Trusts, and Local Authorities. In addition some have community representatives (Brent, Camden), University representatives (Lambeth, Southwark and Lewisham), and Voluntary Sector representation (East London and the City). All identify local Crime and Disorder reduction action.



The HAZ: working at a local level to support other strategies and to create synergies and add value

6.23 All the London HAZ's focus on the following areas for action which have close links to crime:

- young people, including parenting and exclusions
- reducing drugs misuse
- tackling unemployment
- improving housing
- improving mental health
- encouraging social inclusion.

OTHER LONDON INITIATIVES AND STRATEGIES

6.24 Consultation with the Crime and Disorder Review Topic Group (a reference group for this research project) identified a range of initiatives in addition to the Crime and Disorder Partnerships, the HImPs and Health Action Zones which aim to both improve health and reduce crime and disorder:

- the Joint Steering Group for Community Safety in London - includes the London regional Office of the NHS Executive
- the Pan-London Mapping Project led by MPS - aims to draw together and analyse de-personalised data from a range of agencies and provide a central data base
- data base and information exchange between ELIPS (Probation) and MPS - supports the risk management of potentially dangerous offenders
- Mental Health Strategy for London – relevant to mental health needs of perpetrators as well as victims of crime and recognises that perpetrators are often victims too
- London Children's Strategy
- MPS Three-Year Drug Plan - includes: work with young people through schools; reducing levels of acquisitive and violent crime by stifling drug markets; identifying and targeting drug-impaired driving; implementing arrest and referral schemes in each of the 32 London Boroughs linked in with Youth Offending Teams and other diversion schemes; targeting prolific offenders who are involved in drug-related crime
- MPS have established 32 Community Safety Units across London to focus on domestic violence, racial and homophobic crimes.

NATIONAL INITIATIVES LINKING CRIME AND HEALTH ISSUES

6.25 The Government has developed several cross-cutting strategies that link the issues of crime and health. It is beyond the scope of this research project to review these in any detail; however, some of the main programmes/initiatives are outlined below.

6.26 The **Sure Start Programme** has a fund of £450 million to develop and add value to services for children under four in England over the next three years. Most of the new work emphasises an expanded role for health visitors

6.27 An **Innovation Fund** has been established by the Ministerial Group on the family to explore new ways of working for health visitors and School Nurses, involving new partnerships and multi-disciplinary working

- 6.28 **'Living without Fear'** is the new Government strategy which sets out an integrated approach to tackling violence towards women. It will be supported with funds from the Crime Reduction Programme (see below)
- 6.29 The **Crime Reduction Programme** aims to reverse the long-term rise in crime by investing in projects that offer a significant and sustained impact on crime. The Programme is supported by £250 million over three years (1999 - 2002) which will be used to develop evidence-based approaches to crime reduction.
- 6.30 **New Deal for Communities** (NDC) is co-ordinated nationally by the Department of Environment, Transport and the Regions (DETR) and provides funds (£800m between 1998/99 and 2001/02) to develop and implement local community-based plans covering everything from jobs and crime to health and housing.
- 6.31 **Best Value** is a central part of the Government's strategy for strengthening and renewing local government. The aim is to deliver measurable improvements in the quality and value for money of local authority services at a price residents are willing to pay. Pilot authorities are currently exploring approaches to best value including developing cross cutting approaches to community safety.
- 6.32 **Healthy Living Centres** (HLCs) are new local community-based projects to improve the quality of life, promoting social inclusion and encouraging community participation. They will be supported with funds from the Lottery new Opportunities Fund. Proposals for at least 40 HLCs are currently being developed across London

7 RECOMMENDATIONS FOR ACTION

This chapter makes recommendations for action based on the research findings.

Research needs

7.1 The literature review highlighted the need to enhance our understanding of the interaction between crime, fear of crime and public health. Research is required to identify:

- the impact of hate crime on the health of minority ethnic communities
- the financial and social costs of crime to health related services through the collection and analysis of standardised data from primary health care teams as well as Accident And Emergency services
- good practice in the identification of victims paying attention to the ethical, resource and policy implications
- models for high quality, holistic multi-agency working which combine community safety/public health agendas.

7.2 Action research is required in those areas with the highest crime rates and the greatest health inequalities to understand the inter-actions between crime, health and other variables. Research should aim to:

- promote high quality and holistic local partnership working
- improve the identification of victims
- improve health care responses to victims.

Policy and service development

7.3 Clear policy frameworks (including policy statements, guidance, inter-agency protocols and staff training plans) are missing in the areas of:

- the identification of victims and subsequent responses to their health needs; particular attention needs to be paid to victims of domestic violence (including children who witness domestic violence) and to victims of hate crimes such as racist and homophobic crimes
- reducing the risks of victimisation of staff in hospitals and primary care
- information exchange with other agencies in particular:
 - the London Regional Office of the NHS Executive should participate in the Pan-London Mapping Project being led by MPS
 - information on health inequalities, substance abuse and data from Accident and Emergency services should be included in Crime and Disorder Audits; equally, Health Improvement Programmes should be informed by MPS crime and victimisation data as well as data from Victim Support Schemes
 - information sharing protocols should be established between the Metropolitan Police Service (MPS) and other agencies including health services to help increase convictions of perpetrators of violent (including sexual) crimes. Protocols need to be informed by careful consideration of the ethical implications and the need to preserve the victims rights to privacy.

- 7.4 Joined-up action between health services and MPS is needed to make sure that those referred for treatment by MPS Drug Arrest and Referral schemes receive help quickly. This is likely to be a major resourcing issue for health services and is an area where joint training between MPS, NHS staff and voluntary agencies would be beneficial.

Workforce development and training

- 7.5 Health professionals in hospitals and primary care settings (including Health Visitors and School Nurses) need training and guidance on the development of routine victimisation assessment including appropriate questioning about victimisation and on how they can collaborate with other agencies able to provide support, practical assistance and advice. Particular attention needs to be paid to domestic violence and hate crimes including racist and homophobic crimes and the victimisation of adolescents.
- 7.6 Attitudes and beliefs of staff are an important factor in the identification of victims of domestic violence in particular and influence the support they receive; therefore training also needs to address these issues.
- 7.7 Hospital staff in particular need training and guidance in the principles of clinical forensic documentation, evidence collection, forensic photography, accurate wound identification and on working with the police and testifying in court.
- 7.8 Health services need to develop procedures for reducing the risks of victimisation of their own staff; this should include training and guidance for staff.
- 7.9 More joint training should be provided for health staff, social workers, police and ambulance service staff to improve multi-agency responses to situations involving people with mental health needs.

Strategic inter-agency action

- 7.10 The London Regional Office of the NHS Executive should participate in the Joint Steering Group for Community Safety in London
- 7.11 Health services should participate in Borough Crime and Disorder Partnerships at both strategic and operational levels. Consideration needs to be given to which NHS service area/s should be involved and at what level.
- 7.12 Health service participation in YOTs should be reviewed to identify and share good practice and make sure that the health needs of young offenders are being addressed consistently.

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