

Editorial

The public health approach to violence prevention

El enfoque de salud pública para la prevención de la violencia

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In the United Kingdom escalating incidents of street violence and death from knives in London and other cities has become a major issue over the past 2–3 years. It has in fact become one of the few things to push discussion of Brexit off the newspaper front pages. The response in recent months has been a growing call to adopt what is being called a “Public Health Approach” to the problem. Yet many politicians and commentators remain confused as to what this really means.

In 2002, the World Health Organization (WHO) published its *World Review on Violence and Health*.¹ This was a comprehensive, epidemiologically based study that has set the scene for much of the work that has taken place internationally since. The introduction quoted Nelson Mandela that the twentieth century would be remembered as a century marked by violence; the President of South Africa going on to point out that more widespread than the impact of war was the daily toll of suffering from violence in everyday life. The WHO report made two very important observations: firstly that the prevention of violence was an orphan, for whilst criminal justice systems and health services pick up the consequences of it, there is no clear lead agency for prevention. And secondly that despite pessimism, international and temporal studies indicate that violence is preventable.

Seven categories for prevention emerge from the WHO work: child abuse, youth violence, intimate partner violence, sexual violence, self-directed violence, abuse of the elderly and collective violence. For effective intervention action must be intelligence and evidence-based using epidemiological and sociological analysis with a focus on a partnership approach to the determinants of violence and a harm reduction approach once violence is already occurring.

Efforts at preventing violence using a range of methods have preceded the World Health report. In the 1980's high levels of street violence and disturbance in New York led to what came to be known as the ‘glass windows’ approach in which there was zero tolerance of low level nuisance on the streets.² This seemingly led to a culture change and lower levels of more serious crime including that of violence. Effective law enforcement together with building trust between citizens and the police is certainly part of the story.

On the other hand, also in the 1980's, in Cali, Colombia, then described as the homicide capital of the world, a classical public health approach led by the Mayor and professor of public health, Rodrigo Guerrero and his colleague, Alberto Concha-Eastman, led to a more than halving of the homicide rate.³ Classical public health methods including urban mapping for time, place and person paved

the way for systematic action at a policy level to address the root causes of violence including poverty and inequality, poor educational and work opportunities; action was taken in partnership with the key institutions and organizations including schools and employers; and at the front end there was work with neighborhoods and communities, including with the mothers of young men concerned that their son could be next in the mortuary. Efforts were made to build trust between the communities and the police and law enforcement was strengthened with special attention to access to alcohol, drugs and weapons in problematic areas. Homicide rates were more than halved over a period of years.

In the UK, work has been done in Glasgow and Cardiff, influenced by these approaches, with promising results⁴ and as a result of recent national political initiatives this will be rolled out across the country led by each of the Police and Crime Commissioners. In the City region based on Liverpool, I am working as public health adviser to the Police and Crime Commissioner, former MP and Minister for Northern Ireland Jane Kennedy to support the establishment of a partnership led Violence Prevention Unit.⁵ In the first months, this has been scoping the project and identifying key partners to establish a comprehensive coalition of the willing. We are in the process of establishing a strategy which will have 1, 5 and 10 year goals and which will challenge the two million people who live in the region to accept everybody's role in changing the culture in which violence can flourish. We are fortunate in hosting the Liverpool Public Health Institute in Liverpool John Moores University, which is a WHO Collaborating Centre for Violence Prevention with almost 20 year's experience of researching this field and reviewing the international evidence of effective interventions. The programme of work will be framed around a lifecycle approach building on current knowledge from neuro-developmental science on the first 1000 days of life beginning in utero, recent research insights into the importance of Adverse Childhood Experiences on future behaviour, health and wellbeing and the importance of achieving readiness for school for all children. During the school years there will be a commitment to supporting children in difficulties and avoiding school exclusions with strengthened school mental health services and support for classroom teachers and for parents to ensure that children have positive pathways for achievement that trump the temptations of the street gangs with their ready money, access to drugs and ritual violence. The evidence in these first few months is of an enormous fund of goodwill for this initiative to succeed from the citizens of the city region and its institutions.⁶

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