

THE ROLE OF EMERGENCY DEPARTMENTS IN COMMUNITY VIOLENCE PREVENTION

This is an update of a paper commissioned by the Department of Health in 2004.

Summary

Emergency Departments (EDs) can contribute distinctively and effectively to violence prevention by working with Crime and Disorder Reduction Partnerships (CDRPs) and by sharing, electronically wherever possible, simple anonymised data about precise location of violence, weapon use, assailants and day/time of violence. These data, and the contributions of consultants in CDRP meetings, enhance effectiveness of targeted policing significantly, reduce licensed premises and street violence, and reduce overall A&E violence related attendances - in Cardiff, by 40% since 2002. The city has moved from mid table to safest city in its Home Office family of 15 similar cities now, a position which had been maintained for over three years. In the recent *Reform* study, Cardiff was 51st out of 55 towns and cities with more than 100,000 population in terms of all assault and robbery. Evaluations have been published in the *Emergency Medicine Journal* and the *Journal of the Royal College of Surgeons of Edinburgh*.

This protocol for Emergency Medicine involvement in community violence prevention sets out the reasons for contributing, how contributions can be made, what contributions have been found to be effective, who should contribute and when contributions are best made. Misconceptions and barriers to working with local violence reduction agencies are listed, together with ways of overcoming them which are consistent with ethical guidance to doctors and data protection legislation.

Reasons for Emergency Medicine involvement in Community Violence Prevention

- Large numbers of violent offences which result in ED treatment are not detected by the police.^{1,2}
- Information about location and time of assaults, which can easily be collected in EDs can help police and local authorities target their resources much more effectively.^{3,4}
- ED professionals, particularly senior doctors, can be powerful and effective advocates for community safety particularly when they work in local crime prevention partnerships.^{3,4}
- ED health professionals act from the patient/victim perspective: most crime prevention activity is orientated towards offenders/offending.
- Burdens on EDs can be reduced, particularly late at night at the weekend when services are stretched and alcohol-related disorder is commonplace, including in the ED itself.

- Involvement can lead to improvements in local transport services, pedestrian safety and alcohol licensing all of which are important in violence prevention.^{3,4}
- Involvement can help other agencies to realise the seriousness of violence from a health standpoint, particularly the numbers and seriousness of injury sustained.
- EDs are the only sources of information about serial (repeat) injury: a recognised precursor to homicide in the home and elsewhere.
- This approach can identify trends in weapon use: the use of glasses and bottles as weapons was first recognised not by police but by ED services.^{5,6}
- Even very serious violence, knife and gun crime, may not be reported to the police, for example in drug – related gang crime.⁷
- Legislation includes the NHS as a statutory partner in local crime prevention (e.g. Crime and Disorder Act 1998): emergency medicine is able to contribute a great deal in this context.
- Data sharing provides a new objective measure of community violence which helps the public, the police, local government and the Home Office to understand the true size of the problem.^{8,9}
- ED staff can facilitate increased reporting of violence to the police by those injured who are not in a position to report.¹⁰
- ED doctors have an ethical responsibility, in the public interest, to report serious violence if the patient or other people are at continued risk,¹¹ for example with regard to knife and gun crime, with regard to people who have been injured previously at the hands of the same person and with regard to locations of violence such as particular nightclubs.
- ED patients who have been injured in violence support routine questioning about the circumstances of injury, police reporting and whether they need help to report or to prevent future harm.¹³

How can Emergency Medicine contribute to community violence prevention?

- By leading EM efforts to contribute to local violence prevention.
- By ensuring the collection of information from assault patients with regard to location, time and other circumstances of assault.^{3,4}
- By sharing anonymised information promptly with the police and other local crime reduction partners.^{3,4}
- By working with public health and local crime reduction/community safety partnerships to measure community violence.⁸
- By identifying serial (repeat) attenders and referring them to agencies, for example to womens' safety units, who can intervene to reduce the chances of further harm.

- By providing EM representation at consultant level to local crime reduction/community safety partnerships.
- By auditing hotspot locations for violence such as particular bars and nightclubs.
- By providing local clinical experts for drinks license hearings in local courts, to make sure that licensing takes account of safety/injury risk.
- By being committed to decreasing community violence as well as treating the injured.
- By initiating and participating in local safety campaigns, working with local media.
- By providing facilities and encouragement – leaflets and opportunities for patients to report to the police without interference, in the safe haven of an ED.¹⁰

Who in Emergency Medicine and NHS Hospital Trusts can contribute to community violence prevention?

- Receptionists, who have been identified as in the best position to record, electronically wherever possible the necessary information.¹² This obviates the need for busy doctors and nurses to carry out this task.
- Managers and IT staff, who can anonymise information, adjust local software and share data electronically with analysts working in local crime prevention partnerships.
- Nurses, who can supplement information collected by clerical staff, enquire routinely about the circumstances of injury, and contribute to secondary prevention, for example with regard to alcohol brief interventions.
- Consultants, who can contribute to local prevention as persuasive advocates for community safety acting as ambassadors in this regard for their hospital Trusts. ED doctors can be persuasive witnesses in alcohol license hearings and can contribute effectively to conferences with other agencies.

When can Emergency Medicine services contribute to community violence prevention?

- During contacts with assault patients.
- At attendance of every serial (repeat) assault patient/victim. Serial attendance should prompt enquiries about police reporting, as well as referral to other agencies. A further example is when, during the night, several injured people attend from the same night club, when this fact should be promptly reported to the police.

- When those who have been injured in very serious violence attend: when patients are brought in unconscious or have been injured in gun or knife crime when the police should be informed promptly whether or not the patient's consent can be obtained.
- Frequency of information sharing with crime reduction partnerships should be agreed locally.

What can Emergency Medicine contribute to the prevention of community violence?

- Anonymised data/intelligence, with regard to violence location, time, date, weapon, and assailants.
- Advocates for local prevention and safety: particularly consultants contributing to multiagency meetings.
- Expert witnesses and witnesses of fact in court hearings.
- Safe havens for patients to report to the police and explain to them what has happened.
- Partners in local crime prevention: crime reduction and community safety partnerships want to work with EDs.
- Evidence based attitudes. The evidence based culture is more advanced in medicine than it is in crime prevention: ED doctors can bring greater objectivity to violence prevention effort.
- Commitment to safety in the town/city served by their ED.

Misconceptions and barriers to ED contributions to community violence prevention

- **Patient confidentiality.**

There are some misconceptions about confidentiality: although it is, of course, important to respect the confidential nature of personal information, data protection and crime prevention legislation and General Medical Council guidance makes specific provision for data sharing to detect, investigate and prevent community violence, of which all violence which results in A&E treatment can be considered from a lay perspective to be a serious example. Indeed, Hospital Trusts may be in breach of data protection legislation by, for example, not instituting processes through which doctors and nurses can know when patients are repeat attenders after injury in violence. Responsibility with regard to data, a key principle underpinning data protection legislation, means identifying repeat attenders, and responsible sharing of data with agencies able to increase community safety. It is important to ensure that patients have access to means of reporting violence to the police whilst in the ED. In the context of recent murder enquiries, public services have been criticised for not sharing data when, potentially, lives and serious injury may have been prevented by so doing.

With regard to the most serious cases, the GMC has advised that all firearm injuries should be reported promptly with the patient's knowledge but, if necessary, without their consent.

- **A blinkered attitude to injury which focuses only on treatment.**

Prevention and wider issues of justice and safety are also important. Involvement in community prevention has in the past even been criticised, wrongly, as 'unacceptable medical paternalism'. Hospital Trusts and EDs are of course, central in local communities.

- **Unreasonable demands for evidence by police officers.**

Some antagonism on the part of ED staff towards police officers has been generated as a result of unreasonable demands for evidence. Police approaches should take account of the rights of the injured and responses by ED personnel should, taking issues of confidentiality into consideration, take account of the need to detect and prevent serious violence so that further violence can be prevented and offenders brought to justice.

- **Over-regulation.**

In the past, guidelines have been published which recommend disclosure of information by senior ED doctors to senior police officers. In practice, most violence occurs late at night and at weekends when senior staff in both services may not be present. Appropriate disclosure of information about the circumstances of violence should take place promptly, with regard for example to gun shot and knife wounds and all ED doctors should be ready to contact the police when appropriate. In the past, concern about the consequences of a formal approach has led junior doctors to provide police informally with tip offs in relation for example to drug related offences.

- **Logistic barriers to collection of evidence.**

These include lack of appropriate software in ED reception and elsewhere, and lack of electronic links with crime analysts working in crime reduction partnerships. These barriers can be overcome by receptionist training, simple adjustments to software by Trust IT staff, and establishment of formal links between ED consultants and local crime reduction partnerships.

- **Funding.**

Relevant data collection, IT support and links with crime reduction partnerships can be achieved at no extra cost to local EDs.¹⁰ Unjustified concerns about funding can get in the way of responsible practice. Solutions are however available from local crime reduction partnerships who are all funded to facilitate data sharing.

- **Time constraints.**

Evaluations indicate that whilst doctors and nurses may be too busy to collect information about the circumstances of violence, reception staff have opportunities during waiting room waits and also have access to appropriate IT systems. Data collection by reception staff obviates the need for clinical staff to collect information, but responsible clinical care should still include enquiry about cause of injury, police reporting and finding out whether one injury may be part of a series of attendances after injury at the hands of the same attacker.

- **Lack of relevant legislation.**

This problem has been largely overcome with the Crime and Disorder Act 1998, the Police Reform Act 2003 and Data Protection and Human Rights Legislation, which facilitate responsible data sharing in the context of the prevention, detection and investigation of community violence. Government departments have also published guidance on data protection.¹⁵

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Professor Jonathan Shepherd FMedSci FCEM Hon FFPH

Cardiff

02920 742442

shepherdjp@cardiff.ac.uk

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