GUEST EDITORIAL

Violent crime and victim support

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Accident and Emergency research has demonstrated that more than three-quarters of victims of violent crime who attend hospital are not recorded by the police (Shepherd *et al.*, 1987, 1989). This has important implications, particularly in a climate of steadily increasing violence. The British Crime Surveys (Hough, 1983; Hough & Mayhew, 1985) have confirmed the magnitude of this 'dark figure' of unrecorded crime, though medical data may indicate more accurately the true incidence of severe injury resulting from domestic and street violence.

The British Crime Surveys (BCS) were initiated principally because of an increasing awareness of the inadequacy of Home Office crime data to reflect overall crime rates: these data only include crimes reported to and recorded by the police. Designed and carried out by Home Office Researchers, the BCS comprises interviews of one person over the age of 16 years in each of 11 000 randomly selected households in England and Wales and 5 000 homes in Scotland. The purpose is to record crimes committed during the previous 12 months, to record details of particular offences and to investigate how respondents' life-styles affected their chances of becoming a victim (Hough, 1983; Hough & Mayhew, 1985). Though the BCS depends upon respondents reporting all offences affecting them, and therefore still tends to undercount crimes, results demonstrate that police crime statistics include only one quarter of woundings and sexual offences, and only about one in ten robberies (Hough & Mayhew, 1985). There is thus the potential for artificial 'crime-waves' to be brought about by changes in police administrative practices. The BCS represents one of the most accurate sources of information concerning crime rates in the U.K., and has also demonstrated that those most at risk of victimization are young, single males living in inner city areas, those who travel to work by public transport, and those who regularly visit public houses and discotheques late at night and at weekends. Heavy drinkers and those with criminal

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records (particularly involving violent offences) are also at higher risk (Gottfredson, 1984).

The principal agencies concerned with the wider support of victims of crime in the U.K. are the Victims Support Schemes, which rely very heavily upon the police for referrals. In 1986 only 4% of Schemes regularly received referrals from other sources (Maguire & Corbett, 1987). After the first Scheme was established in Bristol in 1974, rapid expansion took place, so that 350 were in existence by December 1987. A central advisory body, the National Association of Victim Support Schemes was formed in 1979 and in 1987 a Government Grant of £9m enabled individual Schemes to appoint paid co-ordinators. This support is continuing. These developments, a Council of Europe Recommendation (European Committee on Crime Problems, 1985) and a United Nations Declaration (United Nations General Assembly, 1985) reflect increasing concern for victims of all kinds of crime. Though some Schemes are closely associated with the Probation Service and with the Police, independence is highly valued and the need for this, and for confidentiality is recognized in the continuing provision of separate local authority and Governmental support.

Research funded by the Home Office has indicated that, in addition to medical treatment, victims needs include emotional support and reassurance not available from other sources such as the family, information about compensation, assistance with approaches to the Criminal Injuries Compensation Board, Social Services, DHSS, Crime Prevention Officers, Legal Advice Centres and practical help to repair or recover property in the case of robbery (Maguire & Corbett, 1987). The principal aim of Support Schemes is to assess and meet individual victims needs through visits, correspondence or telephone calls from trained volunteers. The resources of the Support Schemes are unavailable to victims of assault and more serious violence who seek treatment of physical injuries simply because there are few or no links either with A&E departments or with general practices. This may stem from an assumption on the part of medical staff that the police know about most crimes of violence and from ignorance of sources of wider support. Furthermore, there is little time to discuss or initiate this support, or an application for compensation for the majority of victims, who are out-patients, particularly as most assaults occur late at night and at weekends (Shepherd *et al.*, 1988). A&E Departments and General Practices should therefore forge links with Victims Support Schemes.

Though the incidence and duration of psychiatric distress following assault and robbery is not clear, there is growing evidence that this is an important problem, and includes many features of the post traumatic stress disorder prevalent in victims of disasters and war. (Raphael & Middleton, 1988). Criminologists and psychiatrists have begun to address this problem, and assaults at work and resulting in loss of earnings seem particularly likely to be followed by psychiatric distress (Shapland *et al.*, 1985). Moreover, a recent study found that anger, difficulty in sleeping, uneasiness, confusion, fear, shivering, inability to perform ordinary tasks and loss of interest were experienced by more than 40% of victims following robbery or assault (Maguire & Corbett, 1987). Conversely, many victims clearly suffer little distress and for some:

'past victimizations often do not seem memorable enough to be recalled for survey interviewers, and even those which are remembered are frequently trivial and of little importance; they are part of life's vicissitudes, not ineffectively coped with by victims with help from family, friends and insurance premiums.' (Mayhew, 1984).

It is probable, however, that at least a substantial minority of victims of assault who attend A&E Departments will suffer some degree of psychiatric disorder, and will need specialist assessment and care (Shapland *et al.*, 1985; Hamilton, 1987). In contrast to most other types of violence, the serious psychiatric sequelae of rape are well documented, and psychiatric services have been developed to deal with them (Martin *et al.*, 1983; Mezey 1985). Similar services should be made available to assault victims, though research is necessary to clarify short and long-term needs in more detail. Oral and maxillofacial surgeons and plastic surgeons as well as A&E staff and general practitioners should be aware of these potential problems, given the high incidence of facial injury in assault (Shepherd *et al.*, 1988, 1990).

A further implication of the absence of Police involvement in many assaults is that medical records represent an important source of data of potential use to criminologists, the police and to legislators. The 'dark figure' of violent crime could be estimated more accurately, crime prevention measures, such as the policing of particular locations could be improved, and the use of various weapons could be more accurately monitored. None of these developments need compromise confidentiality.

In a wider context, information from hospitals and general practices about the epidemiology of urban and rural violence could be used to investigate the causes of violent behaviour in relation, for example, to alcohol, affluence and deprivation, the media and unemployment (Shepherd *et al.*, 1986). Police derived crime figures are clearly of limited value. This is an area ripe for research. Most importantly though, doctors should join with the police to initiate the wider care of victims.

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