April

2025

The Merseyside Violence and Community Safety (MerVCom) Survey

A representative household survey of adults to understand community safety and cohesion, violence victimisation, and adverse childhood experiences

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MERSEYSIDE Violence Reduction Partnership

LIVERPOOL JOHN MOORES UNIVERSITY
PUBLIC HEALTH
World Health Organization Collaborating Centre for Violence Prevention

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Acknowledgements

We would like to thank the following individuals and organisations for supporting the research:

- Merseyside residents who gave their time to take part in the MerVCom survey.
- The Merseyside Violence Reduction Partnership (MVRP) steering group and team, and Merseyside Community Safety Partnership (CSP) leads who advised on the focus of the MerVCom survey and question content.
- BMG Research who carried out the data collection on behalf of LJMU/MVRP.
- MVRP team members, CSP leads and local authority subject experts for reviewing draft reports, and LJMU staff for proof reading/supporting report finalisation.
- Image credits: Photo by Kenrick Mills on Unsplash.

Funding

The research was funded by the Merseyside Violence Reduction Partnership (MVRP).

Suggested citation

Quigg Z et al. (2025). *The Merseyside Violence and Community Safety (MerVCom) Survey. A representative household survey of adults to understand community safety and cohesion, violence victimisation, and adverse childhood experiences.* Liverpool: Liverpool John Moores University/Merseyside Violence Reduction Partnership.

Foreword: Emily Spurrell, Merseyside Police and Crime Commissioner

As Police and Crime Commissioner for Merseyside, I am proud to introduce the Merseyside Violence and Community Safety (MerVCom) Survey report.

This landmark research gives us an unprecedented insight into perceptions of safety, cohesion and violence across our communities in Merseyside, and the significant and long-lasting impact of childhood trauma.

Far too often, experiences of violence and trauma remain hidden, unreported and unspoken, preventing us from fully understanding the real picture. This survey delves beneath the surface of existing data, allowing us to hear directly from our communities and from those whose experiences of violence and trauma have never come to the attention of the police or statutory services before. These previously unheard voices shine a light on issues that may otherwise remain hidden and serve as a catalyst for urgent change.

We know trauma can manifest as a whole range of health and social problems in adulthood from mental and physical illnesses, poor socio-economic prospects, criminal justice exposure and addiction.

One of the most concerning findings of this survey is that almost half (49.9%) of adults in Merseyside have experienced at least one Adverse Childhood Experience (ACE), while more than one in ten (12.2%) have experienced four or more. This is significantly higher than the national average and warns us that too many children are being exposed to traumatic events as they grow up that could alter the course of their futures in devastating ways.

We now understand that those who experience four or more ACEs in Merseyside are more than nine times more likely to encounter violence victimisation as adults, and more than nine times more likely to have a lack of trusted relationships. They are also at substantially higher risk of engaging in risk-taking behaviours and suffering poor mental and physical health.

The profound and serious consequences of ACEs are not isolated to individuals – they are community-wide challenges that demand urgent and united action. This is why I remain absolutely committed to early intervention and prevention and will continue to prioritise an approach that puts communities first and at the heart of everything we do.

We must work harder and earlier to identify trauma as soon as it presents and to equip professionals with the skills needed to recognise and respond to the needs of children and families impacted by ACEs. This is the only way we will prevent these experiences from manifesting into poor life outcomes in the future, prolonging cycles of harm that hold back individuals, families, and entire neighbourhoods for generations.

Preventing violence and its lifelong impact requires a public health approach, and one that empowers our communities to actively contribute to and determine solutions.

While this report presents significant challenges, there is much to be positive about from our work and achievements to date. I would like to acknowledge the relentless commitment of our partners and communities in Merseyside whose efforts have already driven substantial reductions in violence.

The Violence Reduction Partnership has supported more than 121,000 young people to date – and over 7,000 young people this year alone. With the expertise and experience of more than 3,500 professionals in our trauma informed network, we are already improving life outcomes for children and young people across the region, but we can and will do more.

Alongside reducing risk, there is clearly more to do to build community cohesion and help people feel safer. While many people feel safe where they live, perceptions of safety across Merseyside are lower. Moreover, fewer than a third of people (29.4%) believe they have a say in local decisions. This must change. If people do not feel safe, or do not feel heard, they are less willing to engage with their communities, access vital support and develop the resilience that protects them from harm.

As Commissioner, I will empower our communities to take an active role in crime prevention, to support each other, to engage with services and to confidently take action as bystanders when they see harmful behaviours.

Interpersonal violence in Merseyside is a significant issue. Alarmingly, one in three adults (32.9%) have experienced violence since the age of 18, with women more likely to experience all forms of violence. We cannot watch helplessly as this continues. Together, we must collectively challenge the attitudes, stereotypes and behaviour that seek to legitimise any use of violence against women. This way, we will foster a culture where perpetrators are immediately held accountable for their actions.

Critically, this report reinforces the importance of a trauma-informed, whole-system approach, and demonstrates the need for systemic change across all agencies – police, education, justice and community services.

I will continue to champion this work, drawing on the data and insights from this survey to push for increased investment in early intervention, prevention and community-based support. I will also use every means at my disposal to ensure these responses are tailored to meet the diverse needs of our communities here in Merseyside and are fair and accessible to all.

Our region has come a long way, and our success will serve as a motivating force to achieve more. This report is a sobering reminder of the magnitude of issues we face but also gives us a clearer understanding of where and how we can make a positive difference. I fully welcome its recommendations, and I reaffirm my commitment to driving forward the change our communities need and deserve.

Only by working together – as communities, services, and leaders — can we create a safer, stronger, and more resilient Merseyside.

Foreword: Georgina Garvey, Director of the Merseyside Violence Reduction Partnership

Serious Violence impacts us all, regardless of whether we are affected directly as victims or not.

We know that the presence of violence in our communities significantly undermines confidence and our feelings of safety. Until now, the extent and scale of its influence has been difficult to measure as statistics only provide part of the picture. This research, however, seeks to lift the lid on the full range of feelings, experiences and perceptions of our communities to give us a truly comprehensive and unparalleled understanding of the realities of violence, community safety and Adverse Childhood Experiences (ACEs) across our region and importantly how these feelings and experiences influence people's lives.

In amplifying the voices of people across Merseyside, we see clearly - and for the first time - the magnitude of the challenges in front of us. But we are also able to better recognise collective opportunities for change - and have a new platform from which to initiative action.

Many of those we surveyed have never reported their experiences to the police or other services before. While the data may make for uncomfortable reading at times, it nevertheless illuminates the complexities of responding to serious violence which is imperative for designing effective solutions.

At the Merseyside Violence Reduction Partnership (VRP), we are clear that violence is preventable, not inevitable. To successfully prevent any unwanted or harmful behaviour, we must understand its root causes – and that can only happen by listening and learning from the communities where the behaviour is centred.

The high prevalence of ACEs among adults in Merseyside (49.9%) is undoubtedly cause for concern but serves to reaffirm that our investment and focus on a trauma-informed, whole-system response, is absolutely the right one.

Violence, health inequalities, and criminal justice outcomes are all interconnected. Those people exposed to violence and other ACEs are much more likely to experience poor mental and physical health and substance misuse in the future. And those with four or more ACEs are almost ten times more likely to experience violence and to lack trusted adult relationships - two factors that perpetuate harm across generations. This is evidence we cannot afford to ignore. Collectively, it reinforces the need for a public health approach, with all partners working together to tackle the root causes of violence, not just the symptoms.

Our work is grounded in the belief that early intervention and prevention are critical. The findings of this survey demonstrate that we must act earlier and more effectively to support children, families, and communities to break these cycles of trauma, violence, and poor outcomes. This means not only focusing on individuals but also addressing the wider community and societal factors that enable

harm to continue - poverty, inequality, lack of opportunity, and exclusion.

We must also strengthen community cohesion and resilience, as the survey highlights that while many people feel safe in their immediate area, far fewer feel safe across Merseyside, and less than a third feel they have a say in local decisions.

Communities are at the heart of everything we do as a partnership - and true violence prevention is only possible when communities are empowered, involved, and heard.

Positively, the findings around bystander intervention show there is a real willingness among residents to lead by example. It is important as partners we capitalise on this keenness by giving people confidence and the tools they need to intervene safely when they witness harmful behaviours. Building these skills, and strengthening the bonds within our communities, has been part of our strategy for a long time and will continue to be pivotal to the work we do in the future to reduce violence and promote safety.

Equally, this report reminds of the further work that is needed to respond to the enduring and disproportionate impact of violence against women and girls in our region. Aside from physical violence, women are more likely to experience all other forms of violence including sexual violence. These challenges are clearly beyond the scope of what the police can do alone. We remain committed to working with all partners to ensure gender-based violence and the attitudes that fuel it are challenged as early as possible through educational programmes in our schools to support our relentless efforts to make Merseyside safer for women and girls.

As Director of the Merseyside VRP, I am deeply grateful to everyone who took part in this survey and to all our partners who continue to work tirelessly to make a difference. The commitment across Merseyside to creating a trauma-responsive region is strong, but we know we must go further.

This report gives us the evidence we need to push for continued change and investment in our communities - ensuring that support is available where and when people need it, and that no one is left behind.

Contents

Preamble

The Merseyside Violence Reduction Partnership (VRP) aims to prevent and address the root causes of violence, to enhance the health, wellbeing, and life chances of children, young people, families, and communities across Merseyside [1]. It does this through adopting a public health approach to violence prevention [2], that works with and for communities to address the root causes of violence, intervening in a positive way to help children, young people, and families from before birth to young adulthood [1].

Taking an evidence-based approach is key to the work of the VRP, embedded through the development of the VRP evidence hub team who work with local (e.g. universities; communities) and national partners (e.g. VRU network; Youth Endowment Fund [3]) to understand the existing evidence on violence prevention, and where there are gaps, commission further research and evaluation. Over the past five years, the VRP has commissioned the Trauma and Injury Intelligence Group (at the Public Health Institute, LJMU) to develop a VRP Datahub that brings together data from multiple sources such as health (e.g. A&E attendances; ambulance call outs), police (i.e. recorded crimes), and fire and rescue (e.g. anti-social behaviour) services [4].[1] The VRP Datahub aims to enable a greater understanding of the extent and nature of violence across Merseyside, and at-risk groups and communities, to drive advocacy for investment in prevention, and support the targeting of violence prevention activity. Critically, it informs the VRP strategic needs assessment and subsequent response strategy.

Good quality data is critical to informing prevention and intervention activities which are tailored to meet the needs of local populations. Whilst administrative data systems such as police and health data provide crucial insight into the magnitude and characteristics of violence [5, 6], many victims of violence do not report the incident to police (e.g. Crime Survey for England and Wales [CSEW] data shows that only four in 10 crimes are reported to the police [7]) or present at healthcare services (e.g. CSEW data shows only 11% of victims of violence received medical attention [8]). Thus, such data needs to be supplemented with population-based surveys which are a vital method in determining the prevalence of violence (albeit may still represent an underestimate) and with use of standardised measures and indicators allow for comparison across regions and time [2].

To drive evidence-based policy and practice across Merseyside, the VRP, in collaboration with the Public Health Institute at Liverpool John Moores University, implemented the Merseyside Violence and Community Safety (MerVCom) Household Survey in 2024/25. The MerVCom survey is a population-level representative household survey of over 5,000[2] adults (aged 18+ years) which

[1] https://tiig.ljmu.ac.uk/Account/Login?ReturnUrl=%2FHubSelection

[2] n=5,395.

aimed to better understand community feelings of safety and cohesion, and perceptions and experiences of violence, including adverse childhood experiences (ACEs), and relationships of these with health and wellbeing and other public health and criminal justice outcomes (see Appendix 1 for the full survey methodology).

A series of outputs have been produced from the MerVCom survey to provide the VRP and wider stakeholders with comprehensive data and insights to inform violence prevention. This overarching report serves as the first in a series of these outputs and summarises key findings from the full suite of outputs, along with the study methodology. The report has three key sections:

Section 1: Perceptions of Community Safety, Violence and Neighbourhood Cohesion, and Bystander Attitudes.

Section 2: Adulthood Violence Victimisation.

Section 3: Adverse Childhood Experiences (ACEs).

More detailed data analyses and insights are provided in the following accompanying reports:

- Perceptions of Community Safety, Violence and Neighbourhood Cohesion, and Bystander Attitudes across Merseyside [9].
- Adulthood Violence Victimisation across Merseyside. Nature, prevalence, and associations with health and wellbeing, health risk behaviours, ACEs, and community safety and cohesion [10].
- Adverse Childhood Experiences (ACEs) across Merseyside. Nature, prevalence, and associations with health and wellbeing, health risk behaviours, violence and community safety and cohesion. [11].
- Local authority reports, one for each of the five local authorities in Merseyside (Knowsley, Liverpool, Sefton, St Helens, and Wirral). These reports offer an overview of the themes explored in the MerVCom survey, presenting data and insights specific to each local authority area (including selected data presented at ward level) [12, 13, 14, 15, 16].

Data have also been presented in a series of PowerPoint Presentations, disseminated across local (e.g. CSP steering groups) and regional (e.g. MSPPB[3] steering group)/VRP conference) events and meetings, and are available to partners for further dissemination via the authors.

[3] Merseyside Strategic Police and Partnership Board.

1. Perceptions of Community Safety, Violence and Neighbourhood Cohesion, and Bystander Attitudes

Community safety encompasses more than just feeling secure in your surroundings; it includes social norms, trust, and feelings of belonging within communities, all which impact wellbeing. Negative perceptions of safety can lead to social withdrawal and health problems, particularly among certain groups (e.g. women and ethnic minorities). While crime statistics offer an objective measure of safety, they don't always reflect residents' personal sense of security. The MerVCom survey aimed to address this gap by assessing residents' perceptions of safety, violence and cohesion, providing a more complete picture of community safety.

Examining ten diverse settings during both day and night, the survey provided a nuanced understanding of community safety. Most participants felt secure in familiar spaces like homes, streets, and workplaces, with daytime safety perceptions being notably higher than the nighttime (e.g. only 3.5% felt unsafe on their street during the day, rising to 9.1% at night). However, broader areas, such as Merseyside generally and town centres, saw a decline in perceived safety, especially at night; parks were considered the least safe at night. The survey also explored participants' concerns about their own, and children and young people's safety. While 13.9% felt personally unsafe in Merseyside, over four in ten felt children aged 10-17 (42.7%) and young adults aged 18-25 years (37.7%) were unsafe.

In addition to safety, the survey highlighted the importance of focusing on community cohesion. While most participants reported a positive sense of community, a significant proportion indicated a lack of influence over decisions in their neighbourhoods, with only three in ten (29.4%) agreeing that they had a say in local matters. The survey also examined attitudes towards bystander intervention, considering the potential positive role of communities in preventing violence. While nearly all (84.3%) participants acknowledged the importance of setting a good example in their own behaviour, less than half (47.1%) felt compelled to intervene in problematic situations. This points to a need for targeted initiatives to promote bystander engagement and foster proactive and safe responses to witnessing troubling behaviour in the community.

Overall, whilst most participants feel safe in the areas more local to them, they have poorer perceptions of safety in relation to Merseyside more broadly and there are key differences in residents' perceptions of safety across various settings. These results emphasise the need for targeted interventions to improve community cohesion, safety perceptions, and wellbeing across Merseyside.

Perceptions of Community Safety, Violence and Neighbourhood Cohesion, and Bystander Attitudes

Community Safety

64.7% of participants felt safe in Merseyside generally during the day, compared to **42.9%** during the night

Proportions of participants feeling UNSAFE in various settings during the day and night

Regional and local settings

Merseyside generally

10.8%

28.0%

The nearest town centre

11.0%

28.1%

Your neighbourhood
(within a 15-minute walk from your home)

5.4%

15.3%

In the street where you live

3.5%

9.1%

Recreational and transport settings

In your nearest park

10.4%

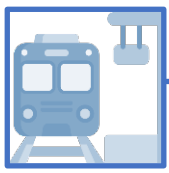
45.9%

In pubs, bars and clubs

13.0%

23.2%

On public transport or at public transport stations



7.3%

21.1%

At taxi ranks

8.6%

20.3%

Private settings

In your own home

1.8%

2.9%

At your place of work or education

2.0%

4.4%

Perceptions of Violence

34.8% of participants thought that violence is common in their neighbourhood, and **86.3%** thought that violence is common in Merseyside generally

13.9% felt personally unsafe from violence in Merseyside generally

42.7% felt that children aged 10-17 years are unsafe from violence in Merseyside generally

37.7% felt that young people aged 18-25 years are unsafe from violence in Merseyside generally

6.4% felt personally unsafe from violence in their neighbourhood

25.9% felt that children aged 10-17 years are unsafe from violence in their neighbourhood

23.3% felt that young people aged 18-25 years are unsafe from violence in their neighbourhood

Community Cohesion

Needs fulfilment

75.0% agreed 'I can get what I need in this neighbourhood'.

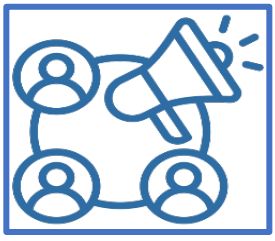
66.3% agreed 'This neighbourhood helps me fulfil my needs'.

Group membership

68.7% agreed 'I feel like a member of this neighbourhood'.

72.5% agreed 'I belong in this neighbourhood'.

Influence



29.4% agreed 'I have a say about what goes on in my neighbourhood'.

42.1% agreed 'People in this neighbourhood are good at influencing each other'.

Emotional connection

65.2% agreed 'I feel connected to this neighbourhood'.

68.1% agreed 'I have a good bond with this neighbourhood'.

Bystander Attitudes

84.3% agreed 'I need to set an example in my own behaviour for what I expect in others'.

47.1% agreed 'It is my responsibility to intervene when I notice a problematic situation'.

31.6% agreed 'There is no need to get involved in a problematic situation'.

There are significant differences by sex, age group, ethnicity, and deprivation in the proportions of participants who perceive violence as common, feel personally unsafe, report low neighbourhood cohesion, and have positive bystander scores (see the Community Safety report for further details [9]).

Conclusion and Recommendations

Conclusion

The MerVCom survey indicates that most participants feel safe in the areas more local to them, however, have poorer perceptions of safety in relation to Merseyside more broadly. Crucially, findings also highlight that certain sociodemographic groups are less likely to feel safe in different settings across Merseyside, and that there are stark reductions in participants' feelings of safety during the nighttime compared to the daytime (particularly in parks). Community members' perceptions of safety have important implications for their social participation, access to key sources of resilience (e.g. services and community spaces), and health and wellbeing. Across Merseyside there is a clear commitment to enhancing community feelings of safety across different settings, evidenced by the implementation of evidence and data-led interventions to prevent crime and antisocial behaviour (e.g. hotspots policing; Safer Streets). Local and national policymakers, services, practitioners, and communities should use the evidence in this report, alongside wider data and evidence to advocate for increased investment to enhance community residents' safety in different settings. Critically, policymakers and practitioners must ensure investment is tailored to the needs of local communities, aims to reduce inequitable experiences of safety across sociodemographic groups, and has a strong focus on early intervention.

Key recommendations

1. As part of broader community safety interventions, raise awareness of the high proportion of adults who feel safe in their neighbourhood and successes of violence prevention activities, to enhance perceptions of safety across Merseyside and within local authority areas.

2. Ensure that there is a strong strategic commitment across multi-agency partners to improving safety for women and girls and people living in the most deprived areas of Merseyside. Strengthen and fund the implementation of policies and interventions which aim to improve feelings of safety and prevent and respond to incidents of victimisation broadly, and specifically, for groups who are most at risk.

3. Increase the presence of factors which improve peoples' feelings of safety in different nighttime settings. Consider conducting further qualitative work to understand factors that influence different groups' feelings of safety across different nighttime environments, and design and implement interventions and approaches in line with this.

4. Improve understanding amongst community residents of how safe other groups (e.g. children and young people) feel and share local data on children and young people's views (e.g. Hope Hack).

5. Introduce activities to bring residents together to build community connections and give residents a stronger voice over what goes on in their local neighbourhoods. Consider targeting these activities towards groups with lower levels of community cohesion.

6. Engage with community residents to understand why there are generally poor attitudes towards acting as a positive bystander. Design and implement culturally relevant interventions for adults which aim to improve community residents' confidence, intentions, and skills to enable them to act as a positive bystander. Consider targeting these interventions towards groups with poorer levels of attitudes towards bystander intervention.

2. Violence Victimisation in Adulthood

Interpersonal violence is a major global cause of premature mortality and long-term trauma, extending beyond physical harm to poor mental and emotional wellbeing. Its cyclical nature is particularly concerning, as early exposure, especially in childhood, heightens the risk of future victimisation or perpetration. Generational patterns often emerge, reinforcing maladaptive behaviours and unhealthy coping mechanisms.

While preventable, effective violence prevention relies on accurate data, often limited due to underreporting. To address this, the MerVCom survey assessed the extent and nature of adult violence victimisation in Merseyside. It also analysed links between violence victimisation and health, health risk behaviours, criminal justice involvement, relationships, and perceptions of community safety.

Adjusting for population demographics, the study found that a third (32.9%) of adults in Merseyside had experienced violence since the age of 18 (4.5% in the past year). The adjusted prevalence of violence sub-types ranges from 3.0% experiencing rape or assault by penetration to nearly a quarter (23.9%) experiencing physical violence. Analyses showed that, aside from physical violence, women were more likely to experience all other types of violence. Perpetrator relationships varied by violence type. Friends or acquaintances were the most common perpetrators of rape, while ex-partners were responsible for most psychological abuse, and strangers stalking and harassment, indecent exposure and unwanted sexual touching. Strangers were also more likely to commit physical violence. A large proportion of violence goes unreported, and where it is reported it is mostly to family or friends, with much smaller proportions to police.

After adjusting for sociodemographic factors, compared to those who had not experienced violence, those who had were significantly more likely to engage in health risk behaviours (e.g. drug, alcohol, and smoking/vaping use; gambling-related harm), report poor general health and low mental wellbeing, and to have ever been arrested or incarcerated. Violence also impacted relationships, community bonds, and feelings of safety, with, for example, victims more likely to feel unsafe in their neighbourhood and in Merseyside as a whole, perceive that violence is common, and to report low neighbourhood cohesion. Concerningly, victims of violence were more likely to report not having close trusting relationships (who may offer a source of support). Experience of violence in adulthood was also significantly associated with history of ACEs, school exclusions, and lack of trusted adult support in childhood.

The survey highlights that a large proportion of adults have experienced violence, and exposure to violence is related to a range of other public health and criminal justice issues. Addressing the root causes of violence through early intervention is critical, and likely to have gains across several areas.

Violence victimisation in adulthood, and associations with health, health risk behaviours, and community safety and cohesion

Extent* and nature

Any violence - since age 18 years

32.9%

(Knowsley **28.4%**; Liverpool 33.4%; Sefton 28.8%; St Helens 30.1%; Wirral 39.4%)

- Intimate partner **11.1%**
- Sexual **11.0%**
- Night-time economy **10.6%**

Any violence – past 12 months

4.5%

(Knowsley **3.1%**; Liverpool 5.4%; Sefton 3.8%; St Helens 3.5%; Wirral 5.0%)

Physical violence

Since age 18 years **23.9%***	Male **28.3%***	Female **19.9%***
Relationship to the perpetrator[1]	Stranger	**51.5%**
Location of victimisation[1]	At home	**35.0%**
Reporting of victimisation[1,2]	**72.3%**	Of those reporting: **42.8%** to family/friends, **31.5%** to police

Psychological abuse and coercive control

Since age 18 years **9.4%***	Male **5.3%***	Female **13.3%***
Relationship to the perpetrator[1]	Ex-boy/girlfriend	**22.8%**
Location of victimisation[1]	At home	**83.5%**
Reporting of victimisation[1,2]	**65.0%**	Of those reporting: **45.1%** to family/friends, **19.1%** to police

Stalking and harassment

Since age 18 years **9.1%***	Male **5.0%***	Female **12.8%***
Relationship to the perpetrator[1]	Stranger	**34.8%**
Location of victimisation[1]	At home	**50.6%**
Reporting of victimisation[1,2]	**78.8%**	Of those reporting: **52.1%** to family/friends, **35.2%** to police

Indecent exposure

Since age 18 years **5.4%***	Male **1.3%***	Female **9.2%***
Relationship to the perpetrator[1]	Stranger	**84.8%**
Location of victimisation[1]	Public space	**64.7%**
Reporting of victimisation[1,2]	**71.0%**	Of those reporting: **42.0%** to family/friends, **20.5%** to police

Unwanted sexual touching

Since age 18 years **8.1%***	Male **2.3%***	Female **13.5%***
Relationship to the perpetrator[1]	Stranger	**45.6%**
Location of victimisation[1]	Night-time economy	**35.0%**
Reporting of victimisation[1,2]	**60.8%**	Of those reporting: **38.8%** to family/friends, **8.3%** to police

Rape or assault by penetration

Since age 18 years **3.0%***	Male **0.6%***	Female **5.2%***
Relationship to the perpetrator[1]	Friend/ acquaintance	**26.3%**
Location of victimisation[1]	At home	**54.5%**
Reporting of victimisation[1,2]	**46.2%**	Of those reporting: **28.2%** to family/friends, **10.9%** to police

* Adjusted for population level socio-demographics - sex, age, ethnicity and deprivation.

[1] The highest response prevalence only is presented; [2] and police prevalence (a full list of responses is available in the main report [10]).

Increased risk of adulthood outcomes in those experiencing violence (since age 18 years) vs. not experiencing violence

(adjusted for age, sex, ethnicity and deprivation)

Health and health risk behaviours

Alcohol (current, 5+ drinks on one occasion at least weekly)	**1.4x**
Smoking and/or vaping (current daily)	**1.5x**
Use of any drug (past 12 months)	**3.3x**
Gambling-related harm (of those who gambled in past 12 months)	**2.5x**
Poor general health (current)	**1.2x**
Low mental wellbeing (current)	**2.0x**

Criminal justice exposure

Been arrested (ever)	**2.9x**
Been incarerated (ever)	**2.8x**

Neighbourhood cohesion

Low levels of overall neighbourhood cohesion	**1.2x**

Adulthood relationships

Does NOT feel close to adults that they live with	**1.2x**
Does NOT feel close to relatives that they do not live with	**1.3x**
Does NOT have close or good friends	**1.4x**

Perceptions of personal safety and prevalence of violence

Feel unsafe from violence in **Merseyside generally**	**2.1x**
Feel unsafe from violence in **their neighbourhood**	**3.0x**
Perceive violence is common in **their neighbourhood**	**1.7x**

Increased risk of violence in adulthood (since age 18 years) in those experiencing negative childhood experiences vs. not experiencing negative childhood experiences

(adjusted for age, sex, ethnicity and deprivation)

Adverse childhood experiences~

1 ACE	**2.5x**
2-3 ACEs	**4.4x**
4+ ACEs	**9.7x**

School exclusion

Excluded from school (up to age 18 years)	**2.8x**

Trusted adult support

No trusted adult support (up to age 18 years)	**2.1x**

~Based on nine individual ACEs included in the national England ACE survey

Conclusion and Recommendations

Conclusion

Interpersonal violence is one of the most preventable causes of premature morbidity and mortality and is a key target of the United Nation's Sustainable Development Goals. The MerVCom survey highlights that exposure to violence is common across Merseyside, with one third of adults experiencing some form of violence victimisation. Tackling violence and its root causes can improve the health and wellbeing of individuals and communities and have wider positive implication for the economy and society. Across Merseyside there is clear commitment to preventing and responding to violence across the lifecourse, with partners adopting a public health, whole system framework for violence prevention with interventions targeted at different levels (i.e. primary, secondary, and tertiary prevention). Local and national policymakers, services, practitioners, and communities should use the evidence in this report, alongside wider data and evidence to advocate for increased investment in lifecourse violence prevention (including both ACEs and adulthood violence). Critically, policymakers and practitioners must ensure investment is tailored to the needs of the local community, targeted towards those who need it most, and has a strong focus on early intervention.

Key recommendations

1. Use evidence from the MerVCom survey and wider data sources to advocate for increased investment in Merseyside to prevent and respond to violence across the lifecourse. Critically, this includes prioritising early intervention and building resilience and capacity in families and communities to mitigate the impacts of ACEs and trauma and break the intergenerational transmission of violence.

2. The availability of local data means that local partners are in a unique position to understand the impact of violence on individuals and communities, and which groups are most at-risk. The data presented in this report should be used to develop more nuanced and targeted prevention activity and direct provision towards areas and groups most at-risk.

3. Ensure current study findings on the extent and nature of violence across Merseyside (including by LA and Ward level) are used alongside the MVRP datahub system (VRP Hub - Merseyside) to provide partners with a comprehensive picture of violence across Merseyside to inform prevention and targeted intervention efforts.

4. Ensure local responses consider the existing evidence base and incorporate research and evaluation to build understanding of what works to prevent and respond to violence across the lifecourse in Merseyside, and beyond.

5. Given the protective role of the school environment and the potential for teachers and other school staff to provide trusted adult support for children, wider partners should ensure and support education providers in being key active partners in developing, implementing, and supporting local violence prevention activity.

3. Adverse Childhood Experiences

Across the last two decades, knowledge on Adverse Childhood Experiences (ACEs) and their potential long-term impacts on people's lives and the wider community has grown substantially. ACEs refer to potentially traumatic events that occur during childhood including all forms of child maltreatment and growing up in a household or community suffering from adverse harms [28]. There is now strong evidence that ACEs can have immediate negative effects on children's development, leading to potentially long-lasting and profound impacts into adulthood. Critically, the more ACEs a person experiences, the higher their risk of poor outcomes [17].

Given the diversity of communities across the UK, enabling local areas to understand the extent, nature, and impacts of ACEs across their local communities is vital for ensuring that preventing and responding to ACEs is high on the agenda. Thus, the MerVCom survey aimed to gather data on ACEs directly from adults, identifying those affected and assessing associated outcomes and risks.

Adjusting for population demographics, the study found that nearly half (49.9%) of Merseyside adults have experienced at least one ACE, with more than one in ten (12.2%) suffering four or more.[4] Individual ACE prevalence ranged from 2.8% (incarcerated household member) to 25.4% (bullying).

After adjusting for sociodemographic factors, compared to those who had not experienced ACEs, those who had experienced four or more were significantly more likely in adulthood to engage in health risk behaviours (e.g. drug, alcohol, and smoking/vaping use; gambling-related harm), report poor general health, low mental wellbeing, poor education and employment outcomes, and to have experienced violence and criminal justice exposure. Further, they were significantly more likely to feel unsafe, to perceive violence to be common in the community, and report low levels of community cohesion. Critically, they were also significantly more likely to report that they did not have a trusting relationship with other adults or friends during adulthood or childhood, factors that may promote resiliency against the impacts of ACEs and trauma.

This study underscores the widespread prevalence of ACEs in Merseyside, with levels exceeding the national England average. These findings highlight the urgent need for a concerted effort to prioritise ACE prevention through an ACE and trauma-informed response, which requires the active involvement and commitment of political leaders, key stakeholders, and crucially, the community.

[4] The survey included 13 individual ACEs. ACE count only includes the nine ACEs included in the England ACE survey i.e. verbal, physical, and sexual abuse; household mental illness; alcohol and drug abuse; incarceration; witnessing domestic violence; and parental separation.

Adverse Childhood Experiences (ACEs)

Nature, prevalence, and associations with health, health risk behaviours, and community safety and cohesion

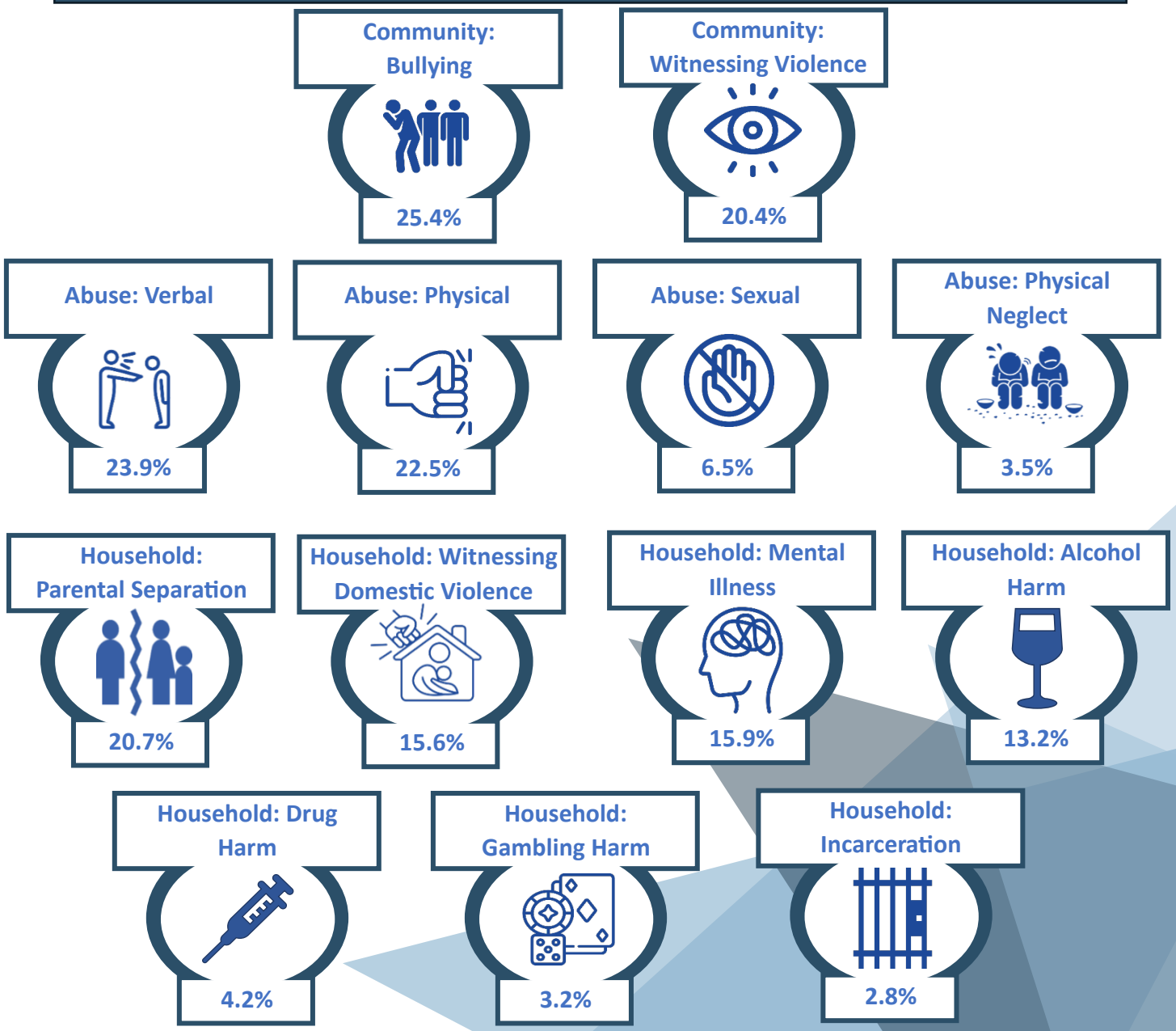
Extent and nature

Adjusted ACE count for adults in Merseyside*^

0	1	2-3	4+
50.1%	18.9%	18.8%	12.2%

(4+ ACEs: Knowsley **11.6%;** Liverpool 14.0%; Sefton 12.6%; St Helens 7.9%; Wirral 11.9%)

Adjusted prevalence of thirteen individual ACEs for adults in Merseyside*



* Adjusted for age, sex, ethnicity and deprivation. ^ Based on the 9 ACEs used in the national England ACE survey.

Increased risk in those experiencing 4+ ACEs^ vs. experiencing 0 ACEs

(controlling for age, sex, ethnicity and deprivation)

Health and health risk behaviours

Alcohol (current, 5+ drinks on one occasion at least weekly)	**1.4x**
Smoking and/or vaping (current daily)	**2.0x**
Use of any drug (past 12 months)	**8.4x**
Gambling-related harm (of those who gambled in past 12 months)	**4.0x**
Poor general health (current)	**1.5x**
Low mental wellbeing (current)	**2.6x**

Criminal justice exposure and violence victimisation

Been arrested (ever)	**5.2x**
Been incarerated (ever)	**6.2x**
Violence victimisation (since age 18 years)	**9.7x**
Violence victimisation (past year)	**6.8x**

Perceived prevalence of violence

Violence is common in **their neighbourhood**	**1.8x**
Violence is common in **Merseyside**	**1.3x**

Employment

Unemployed (current)	**1.9 x**

Adulthood relationships

Does NOT feel close to adults that they live with	**1.9x**
Does NOT feel close to relatives that they do not live with	**2.5x**
Does NOT have close or good friends	**1.9x**

Perceptions of personal safety

Feel unsafe from violence in **Merseyside generally**	**2.4x**
Feel unsafe from violence in **their neighbourhood**	**2.9x**

Neighbourhood cohesion

Low levels of overall neighbourhood cohesion	**1.8x**
Low levels of neighbourhood influence	**2.1x**

Negative childhood experiences

Excluded from school (up to age 18)	**8.4 x**
No trusted adult support (up to age 18 years)	**9.6x**
NOT engaged in any extracurricular/ community activities (up to age 18 years)	**1.2x**
NOT have a trusted friend (up to age 18 years)	**3.9x**

Conclusion and Recommendations

Conclusion

The MerVCom survey highlights that ACEs are common in Merseyside and likely experienced at higher levels compared to England. Critically, ACEs are significantly associated with increased risks of a range of negative outcomes across the lifecourse, with impacts on health and risk-taking behaviours, socio-economic prospects, community safety, violence, and criminal justice exposure. ACEs and trauma are cross-cutting issues that require responses from political leaders, the community, and multi-agency partners who support children, families, and communities. Across Merseyside there is clear commitment to preventing and responding to ACEs and trauma, evidenced in the accompanying review of current ACE and trauma-informed practices (McCoy et al, 2025 [20]). Local and national policy makers, services, practitioners, and communities should use the evidence in this report and the review, alongside wider data and evidence to advocate for increased investment in preventing and responding to ACEs and trauma. Critically, policymakers and practitioner must ensure investment is tailored to the needs of the local community, targeted towards those who need it most, and has a strong focus on early intervention.

Key recommendations

These recommendations should be read alongside the recommendations for developing a trauma responsive Merseyside presented in McCoy et al, [20].

1. Establish clear leadership and buy-in for developing an ACE and trauma-responsive Merseyside from political leaders, key partners (with director, strategic, and senior roles), and critically the community. This includes statutory and non-statutory partners across health and social care, public health, safeguarding, education, youth and family services, criminal justice, and academia.

2. Set up a Merseyside multiagency task and finish group, to develop a strategy and action plan for becoming a truly ACE and trauma-responsive region (using findings from this report and McCoy et al, [20]). This group should identify clear roles and remits for stakeholders across the system, and accountability for actions to drive the agenda forward.

3. Develop local authority level ACE and trauma-responsive task and finish groups, to enhance place-based approaches that meet the needs of the local community, whilst contributing to Merseyside becoming a truly trauma-responsive region.

4. Use evidence from the MerVCom survey and wider data sources to advocate for increased investment in ensuring the children of Merseyside are given the best start in life. This includes prioritising early intervention and building resilience and capacity in families and communities to mitigate the impacts of ACEs and trauma and break the intergenerational transmission of ACEs.

5. The availability of local data means that local partners are in a unique position to understand the impact of ACEs on individuals and communities, and which groups are most at-risk. The data presented in this report should be used to develop more nuanced and targeted prevention activity and direct provision towards areas and groups most at-risk.

6. Ensure local responses to ACEs and trauma consider the existing evidence base on what works to prevent and respond to ACEs (see box 2 in main report; [21]) and incorporate research and evaluation to build understanding of what works to prevent and respond to ACEs and trauma across Merseyside, and beyond.

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5. Appendix: MerVCom Survey Methodology

A cross-sectional survey of adults aged 18+ years who were residents of households across the five local authorities in Merseyside was carried out from November 2023 to April 2024. The study was conducted collaboratively by Liverpool John Moores University (LJMU) and the Merseyside Violence Reduction Partnership (MVRP). LJMU designed the study and survey (with input from the VRP and local partners). A private market research company (BMG Research[5]) was commissioned to carry out the data collection. The key aims of the study were to measure community feelings of safety and cohesion, perceptions and experiences of violence (including Adverse Childhood Experiences [ACEs]) across Merseyside, and relationships of these with health and wellbeing, to inform the activities of the VRP and wider partners [18]. Ethical approval was granted for the study by Liverpool John Moores Research Ethics Committee (23/PHI/050).

Sampling

The study utilised quota sampling to select 110 Lower Super Output Areas (LSOAs; small geography areas of similar population size with around 1,500 residents) stratified by English Index of Multiple Deprivation quintile (IMD; [19]), age, and sex, from the five local authorities in Merseyside (Table A1). The number of LSOAs selected from each local authority were calculated according to the relative population size of each local authority (Table A1). The IMD provides official measures of relative deprivation for LSOAs in England [19] and is comprised of a combination of 39 indicators across seven different domains of levels of relative deprivation, including income; employment; health deprivation and disability; education, skills and training; crime; barriers to housing and services; and living environment. An overall measure of deprivation is calculated for each LSOA in England, LSOAs can then be categorised into deprivation quintiles for an area based on their ranking in the IMD. The achieved sample size was 5,395 (Table A1). This sample size was selected as approximately 500 individuals with four or more ACEs were needed to meet the wider aims of the project, and other studies [17] suggested that this sample size would be adequate for this.

[5] More information about BMG Research can be found on their webpage: https://www.bmgresearch.co.uk/

Table A1: Total number of LSOAs and total population aged 18+ years by study area, and number of LSOAs and number of participants in the study sample by study area

Study area	Number of total LSOAs in each study area	Number of LSOAs in the sample from each study area	Total population size aged 18+ years[6]	Number of individuals in the sample from each study area
Knowsley	100	12	122,295	597
Liverpool	302	36	402,288	1,752
Sefton	191	23	227,592	1,113
St Helens	121	14	147,828	697
Wirral	209	25	256,763	1,236
Merseyside	923	110	1,156,766	5,395

Recruitment

Using the Postcode Address File,[7] postal letters were sent to up to 500 randomly selected households within each selected LSOA. Contacted households were given information about the study, including that participation was entirely voluntary, that all data collected would be confidential and anonymous, and how to opt out of the study. Contacted households were given the option to take part in the survey online. If a member of the household did not complete the survey online, and had not opted out of the study, then a trained interviewer would visit their household so that they could take part in the survey in-person. Household visits were made on all days of the week and at varying times of day from 9am to 9pm. Interviewers would call back up to five times on different days and different times if they did not receive an answer on the first time visiting a household. If an individual was ineligible or declined to participate in the study, the interviewer recorded the outcome of the contact then moved on to the next randomly selected household.

Only one individual from each household was eligible to participate in the study. If more than one individual in a household was eligible the interviewers would ask for the person whose birthday is next to take part. Interviewers gave potential participants a copy of the study information sheet which outlined the purpose of the study, provided information regarding confidentiality and anonymity, and information on informed consent for participation. It was made clear to potential participants that participation in the study was entirely voluntary and that they were free to withdraw at any point during the interview and that this would not affect their rights, any current or future

[6] Total population size according to mid-2022 LSOA population estimates found at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/lowersuperoutputareamidyearpopulationestimatesnationalstatistics

[7] For more information on the Postcode Address File see: https://www.poweredbypaf.com/

health treatment, or services received. Further, due to the sensitive nature of some questions participants were told that they should only complete the survey in a setting whereby nobody else could see or hear their answers, participants also self-completed sensitive questions (i.e. on ACEs and violence), and questions on health and wellbeing, and health risk behaviours. No personally identifiable details were collected from the individual during the recruitment process or interview. For face-to-face survey completion, consent was taken for participation in the study verbally and using a tick box. For online survey completion, implied consent was given by participants submitting a completed survey, this was made clear to participants in the participant information sheet. Signposting to relevant support services for anyone who may feel distressed by taking part in the survey was provided in the participant information sheet, at the end of the survey, and by trained interviewers.

The study inclusion criteria were:

- Resident of Knowsley, Liverpool, Sefton, St Helens, or Wirral.
- Aged 18+ years.
- Cognitively able to provide informed consent and participate in the study.

The study utilised computer assisted personal interviewing (CAPI) technology, and computer assisted self-interviewing (CASI) for parts of the survey that required self-administered methods. Using CAPI/CASI methodology has a variety of advantages. For example, data are collected electronically minimising errors, time delays, and security risk to respondents' data; and CASI interviewing allows participants to self-complete sections of the questionnaire which may be more sensitive, increasing privacy and improving the extent to which participants respond to these questions.

Response rate

54,761 postal letters were sent to households in randomly selected LSOAs. From these letters, 467 households opted out of participating in the research. There were 6,040 households that were visited where an eligible participant answered the door, of these 4,180 completed the survey, giving a response rate of 69.2%. Overall, 1,215 participants (22.5%) completed the survey online and 4,180 participants (77.5%) completed the survey face-to-face with trained interviewers.

Measures

The MerVCom survey included questions on a number of different areas including:

- **Participant sociodemographics**: age; sex; ethnicity; sexuality; qualifications; school exclusions; employment status; relationship status; number of children; time spent living in the area; household income and perceptions of current household and community wealth; and, neurodivergence status.
- **Relationships and neighbourhood factors**: measures on 1) of feeling close to others, 2) community connectedness/cohesion, 3) bystander attitudes; measures of feelings of safety in the community – at day and

night, and for men/women/children; perceptions of how common violence is in the community.

- **Lifestyle and health risk behaviours**: alcohol consumption; drug use; tobacco, e-cigarette, or vapes use; gambling; engagement with criminal justice system (i.e. being arrested or incarcerated).
- **General health and wellbeing**: validated scales on general health and mental wellbeing.
- **Childhood experiences**: sources of resilience; perceptions of household and community wealth in childhood; Adverse Childhood Experiences.
- **Adulthood experiences of violence**: experiences of different types of violence and abuse in adulthood.

For full descriptions of the measures used see individual reports on: Adverse Childhood Experiences [11], adulthood violence victimisation [10], and perceptions of community safety, violence and neighbourhood cohesion, and bystander attitudes [9].

The final survey took approximately 15 minutes to complete.

Data analyses

Quantitative analyses were undertaken in SPSS (v.28) using descriptive statistics. Chi-square for Independence (with Continuity Correction) and binary logistic regressions were used to explore associations between different outcomes of interest and sociodemographics. To estimate the prevalence of ACE count, individual ACEs, and different types of adulthood violence victimisation, at Merseyside, local authority, and ward level, best fit binary logistic regression models were used. These generate modelled risks (estimated marginal means) for each outcome for all combinations of individual characteristics (age, sex) and LSOA of residence properties (ethnicity profile,[8] quintile of deprivation, local authority). These modelled risks were applied to the resident population of each geography according to its demographic and LSOA characteristics.

Sample characteristics

Table A2 shows the demographics of survey participants compared to the Merseyside population. Overall, the final sample included an over-representation of individuals living in the most deprived areas compared to population estimates. The sample also had an over-representation of individuals from the oldest age groups compared to population estimates. There were no significant differences between the sample and population estimates on sex or ethnicity.

[8] Ethnicity profiles at LSOA level were assigned by calculating whether an LSOA had a proportion of Black and Asian populations that were more than one standard deviation above the average % of Black and Asian populations across all LSOAs. The following cut off points were utilised: low Black 3.9% or lower; high Black >3.9%; low Asian 6.2% or lower; high Asian >6.2%; to assign LSOAs into four LSOA ethnicity profile categories (low Black, low Asian; high Black, low Asian; low Black, high Asian; high Black, high Asian).

Table A2: Comparisons between sociodemographics of study participants and Merseyside population

Sociodemographics		Study participants		Merseyside population aged 18+ years		χ^2	*p*
		%	n	%	n		
Sex	Male	47.4	2,553	48.0	554,894		
	Female	52.6	2,828	52.0	601,872	0.665	0.415
Age group	18-24	9.5	508	11.9	137,496		
	25-34	14.8	797	16.8	194,044		
	35-44	17.6	945	15.5	179,103		
	45-54	14.0	751	15.0	173,689		
	55-64	18.9	1,017	16.8	193,760		
	65+	25.2	1,352	24.1	278,674	75.331	<0.001
Ethnicity	Any White background	93.0	4,985	93.1	1,304,819		
	Other ethnicities	7.0	377	6.9	96,823	0.143	0.705
Deprivation quintile	1 (most deprived)	46.0	2,480	47.2	545,538		
	2	15.8	854	16.3	188,390		
	3	15.6	840	15.9	183,828		
	4	15.5	835	13.9	161,267		
	5 (least deprived)	7.2	386	6.7	77,743	14.157	<0.01

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