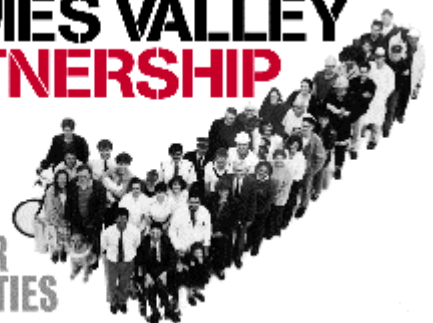


Community Safety and Health - A Compendium

May 2003

**THAMES VALLEY
PARTNERSHIP**

WORKING
FOR SAFER
COMMUNITIES



Contents

	<u>Page</u>
Foreword Nick Relph, Chief Executive, Thames Valley Health Authority	3
1. Finding the Common Ground Sue Raikes, Chief Executive, Thames Valley Partnership	5
2. Community Safety: The Forgotten Determinant of Health Richard Shircore, Manager – Health Promotion Services, Windsor, Ascot & Maidenhead Primary Care Trust	9
3. Community Safety and Abuse in Families	
a. Domestic Violence Training for Health Workers and the Links with Community Safety <i>Pat Wallace, Sunlight Project, Domestic Violence Co-ordinator, Buckinghamshire</i>	17
b. Changing Direction: Recognising Domestic Violence in Clinical Practice <i>Dr Fiona Duxbury, GP, Blackbird Leys Health Centre</i>	21
c. Meeting the Challenge: Developing a Public Health Approach to the Prevention of Child Sexual Abuse <i>John Brownlow, Central Co-ordinator, Stop it Now! UK & Ireland</i>	29
4. Early Intervention	
a. Never too Early <i>Patsy Townsend, Director of Youth Programmes, Thames Valley Partnership</i>	35
b. The Healthy Schools Award and its Contribution to the Community Safety Agenda <i>Angela Snowling, Healthy Schools Co-ordinator, Windsor & Maidenhead Primary Care Trust</i>	39
5. Mental Health: An Issue for Community Safety Sue Raikes, Chief Executive, Thames Valley Partnership	43

Foreword

During our first year the Thames Valley Health Authority has developed a constructive link with the Thames Valley Partnership and we have begun to explore how the Health Service can contribute to preventing crime and promoting community safety.

The NHS is affected by crime in a number of ways – in our surgeries and hospitals we respond daily to the health needs to victims of violent crime, we deal with symptoms of stress caused by the fear of crime, and we treat those whose mental health, drug or alcohol problems make them vulnerable to crime – or more likely to offend.

As an employer, the Health Service is affected by the crime and fear of crime experienced by staff both at work and at home. Our hospitals, car parks, and surgeries also suffer from thefts and vandalism.

This report demonstrates a number of ways in which we are already working together to the benefit of health practitioners and their patients. But the report also challenges us to get more actively involved.

The Thames Valley Health Authority will continue to work closely with the Thames Valley Partnership to strengthen our contribution to community safety. This report is part of that process and is relevant to health practitioners working in primary care, in our mental health services or in hospitals. I commend it to you.

Nick Relph
Chief Executive
Thames Valley Health Authority

Finding the Common Ground

Sue Raikes, Chief Executive, Thames Valley Partnership

The Purpose of This Compendium

This compendium builds on the Thames Valley Partnership's work over the last two years to strengthen the links between health and community safety. It draws from the experiences of Richard Shircore's secondment from the NHS to the Partnership and also brings together the views of practitioners in the health field who have supported and influenced our work.

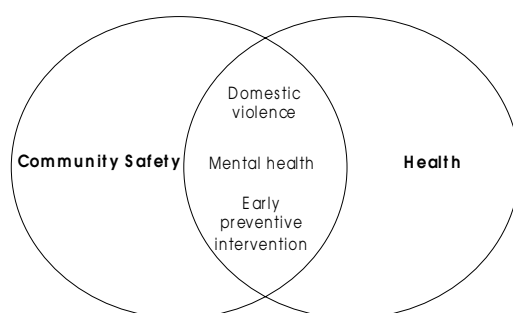
The process of developing links between the NHS and community safety structures since the introduction of the 1998 Crime and Disorder Act has not been an easy one. The first round of audits undertaken by community safety partnerships and resulting in the 1999 community safety strategies made only token attempts to engage health. Most areas described poor partnership involvement by the NHS in the local structures and a general frustration about the lack of involvement of health professionals. What we saw was a much more general lack of understanding about the purpose of working together – about whether there was a shared agenda and where you would find the common ground for joint work.

By the time crime and disorder partnerships were embarking on their second round of strategies in 2001/02 this problem had been more widely recognised and a range of organisations including ourselves were beginning to talk about the need for a more integrated approach.

In 2001 Oxfordshire Health Authority and Berkshire Health Authority supported a secondment to the Thames Valley Partnership which has enabled us to bring in health expertise.

The Thames Valley Partnership's work already involved health with our work on mentally disordered offenders and early intervention to prevent criminality and domestic violence. Our aim was to strengthen the links between the NHS and our own work but also to develop a stronger and more sustainable link between health structures and the emerging and developing community safety agenda at local level.

In order to do this we needed to discover and explore the shared agenda and find the overlap between the objectives of community safety and the objectives of the NHS. As in any form of partnership working, partnership can only exist where there is a genuine shared area of interest or concern. For example: -



Finding the Common Ground

Community safety is by definition about preventive upstream work. In the Thames Valley Partnership we describe our work as seeking to intervene to make crime less likely rather than picking up the pieces after crime has happened. Much of the work of the NHS is, by definition, about picking up the pieces. Intervening earlier, and in particular investing in earlier preventive intervention, is difficult both in the criminal justice system and in the National Health Service.

For both health and community safety however, there is an increasing acknowledgement that crime and poor health are focused in the same geographical areas. High levels of deprivation, poverty and poor health correspond with community safety concerns. Poor health and high levels of crime can be both a cause and a consequence of social exclusion. Crime and the fear of crime affects people's health and also affects their capacity to cope with their own ways of staying healthy.

The Health Case is Made

This overlap between crime, social exclusion and health inequality demonstrates that there is room for joint working a wider health improvement agenda. Crime and health can find common ground in their concern about social deprivation. Health is also an excellent access point for intervention at local level. Whether we are talking about families and children with difficulties, domestic violence or the early signs of drug abuse, local health practitioners often provide a natural and acceptable way of reaching those families affected – in a way that the criminal justice system often finds difficult. Recognising that those at risk of poor health are the same as those at risk offending is of benefit to both organisations.

In addition there is the direct impact of crime on the NHS itself – the levels of violence that it deals with day to day in Accident & Emergency departments, violence to its own staff and the costs of crime to buildings and the infrastructure.

So Why is it so Difficult to Change?

During our first two years of working to strengthen these links we have encountered directly many of the challenges that have faced colleagues in other areas. The structures of the NHS are extremely difficult to access from the outside. Is community safety a matter for Health Improvement Programmes, or for the public health agenda? Should we be talking to the new Primary Care Trusts and if so is this through managers, practitioners or clinicians?

Additionally there is a difficulty in identifying the right people. The NHS is divided into those with administrative roles against clinical roles. Which are the most appropriate for us to target? This has been a particularly difficult time because of the constant change within health service structures.

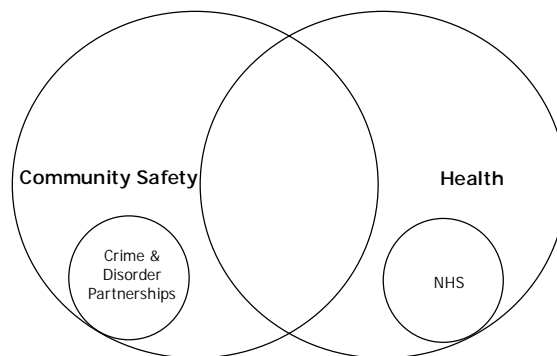
The targets and drivers, which determine what the NHS does, are not those of prevention. Talking to NHS managers about earlier preventive intervention usually elicits the response that they are driven by hospital waiting lists!

We have tried to influence both from the top down and from the bottom up, but without a clear policy lead from the Department of Health we continue to struggle to gain commitment to the shared agenda.

Wheels Within Wheels

Even when we can identify the overlapping agendas in terms of health and community safety we find that formal structures often have a narrower remit, which tends to respond to national targets and is often dominated by short term outputs. Community safety is a broad agenda concerned with wellbeing and social exclusion. The work of the statutory crime and disorder partnerships, is however much narrower, and is narrowing still further. Health practitioners attending meetings will find that increasingly they are talking about street crime, autocrime, burglary and targets set by the Home Office. It is therefore additionally difficult for health practitioners to find their place, make an impact and to establish joint work in the areas of overlap.

Equally health is a much broader concept than the remit of the NHS and while many health practitioners would sympathise with the need for more preventive work, again the NHS is dominated by targets on waiting lists, coronary heart disease, cancer and other diseases.



In this compendium however, we have tried to bring together some ideas and practical examples of the areas of overlap, and of joint work between Health and Community Safety. I would like to take this opportunity to thank all the contributors not only for the articles in this compendium but also for their help and support to our Thames Valley Partnership work.

Community Safety: The Forgotten Determinant of Health

Richard Shircore M.Sc. B.Sc. Dip H. Ed.,

Manager – Health Promotion, Windsor, Ascot & Maidenhead
Primary Care Trust

Introduction

Look at almost any Health Improvement (HImp), or NHS Modernisation Plan and reference will be made to the authors having carried out a “Health Needs Assessment”. There will then follow a listing of the accepted criteria for a health needs assessment. These will include Jarman Indices of Deprivation, population age and sex breakdowns, key figures for mortality and morbidity, especially concerning conditions covered by the National Standard Framework (NSF) documents for cancer, coronary heart disease, mental health and accidents. To round off there will be demographic assessment of ethnic diversity. Although these indices are important, one crucial measure will be absent.

What will be missing from this “Health Needs Assessment” will be any reference to community safety indicators. Community safety and its indicators is not a term routinely used by public health practitioners, and does not figure highly in the Department of Health’s agenda either. I argue that when discussing health and inequalities, a profound understanding and appreciation of local Community Safety issues is a prerequisite for health needs assessments.

It is argued here that when it comes to community safety and health inequalities, the level and degree by which individuals and communities can live their lives, free from risk and fear, is as important, as deprivation, age, sex, ethnicity or any other health determinant, biological or social. A sense of personal and community safety is a significant factor or influence on all other health determinants. A lack of community safety can nullify other health and educational efforts, as well as all personal endeavours and political initiatives.

The term “Community Safety” was first used in the Morgan Report (1991). The Morgan Report was commissioned by the Home Office Standing committee on Crime Prevention. It introduced the concept of ‘community safety’ and emphasised that crime reduction should be ‘holistic’ covering both situational and social approaches. It noted that crime reduction was a peripheral issue for many statutory agencies and a core activity of none of them and advocated the development of multi-agency crime prevention co-ordinated by local authorities.

Morgan reported that crime and social disorder was not simply a policing matter and that all statutory agencies and local people had a part to play. Since then local authorities in England and Wales have appointed a number of “Community Safety Managers” to focus attention on the prevention, and reduction of crime and social disorder. The content of such a programme falling amongst three headings, physical protection, policy development and social action.

- Physical Protection – such as improved street lighting, secure car parks, security fittings for old people, community wardens

- Policy Development – such as collaboration of agencies dealing with domestic violence, abandoned vehicles, protecting victims
- Social Action – such as early intervention to prevent offending, promotion of social inclusion

Since the Morgan Report, Government interest in community safety has been further strengthened in the Crime and Disorder Act (1998). This Act introduced “new statutory duties” on traditional community safety partnerships (local authorities and the police) and extended participation to the NHS and other agencies such as the Probation services and Education.

According to the Act, the involvement of the NHS being specifically related to: -

- a. Children’s Services Plans
- b. Area Child Protection Committee Annual Report
- c. Community Care Plans
- d. Annual Drug Action Plans
- e. Health Action Zones (where applicable)
- f. Anti-poverty Strategies (where applicable)

The Act’s guidance notes clearly state that the NHS “has a key role in any crime and disorder reduction strategy.” Its role being related to the fact that the NHS is a “universal service which reaches all sectors of the population”. As such it is suggested that the NHS can become involved in some forms of crime detection e.g. domestic violence, and crime prevention work such as behaviour modification programmes for drug and alcohol addiction and child behavioural support.

Although this guidance is helpful in describing the organisational position of the NHS and community safety, it is inadequate as a description of professional practice. Yet it is in the day to day professional practice of NHS staff that a real, lasting and positive contribution will be made to reducing crime and enhancing community safety.

Community Safety and Health

The professional practice element of the NHS and community safety becomes clearer if the concept of community safety and the NHS is viewed in the light of Seedhouse’s ideas regarding the purpose of health care activity. Seedhouse (1986) argues that all health work should relate to the pursuit of and maintenance of individual autonomy. For Seedhouse, working for health is not just about the provision of services but is about restoring the individual to health so that they can exercise “autonomy”. Autonomy is central to Seedhouse’s philosophy of health. Without health, or with limited or impaired health, independent action and the ability to make decisions in one’s own best interests becomes restricted and impaired.

It is at this point that the relevance of NHS participation in Community Safety begins to emerge. Community safety for the NHS and health work I have defined as: *The degree by which the environment¹ both physical and social, supports or detracts from an individual's or community's ability to exercise autonomy in the pursuit of ones own best interest.*

It is for the above reason that I believe that the lack of community safety is causal in the development and persistence of health inequalities, not simply symptomatic.

The Normative Use of Health Services and Health Information

Under conditions of positive community safety people are more likely to be free to voluntarily and individually make decisions in their own best interests to take advantage or not of NHS services or health information found in magazines, newspapers or TV.

It needs to be understood that for many in our society the lack of community safety severely restricts their lives, (NACRO 2001). There is much talk of social inequality leading to social exclusion. As a working definition I have defined social exclusion in terms of autonomy. *The inability of persons or communities to make autonomous health care decisions in ones own best interests.* Put simply you are excluded from mainstream society if you are unable to make your own decisions.

There is evidence, (Woodhead 2001) that for whole sections of contemporary Britain, the cumulative effect of the absence of community safety has denied them the foundation upon which to exercise autonomy of action. This is especially true of those living in the inner cities, sink housing estates, or experiencing poor local educational provision, unchecked drug or alcohol abuse or absent policing. Under these individual circumstances are thus unable to act in their own "best interest". In practice their autonomy of action becomes limited as to whether they can get through the day without harm.

There are women and children, for example, for whom action in their own best interests ie their own health, is not possible. Domestic violence victims by the very nature of their hostile and controlling environment are severely limited with regard to accessing health services autonomously. To visit their GP, family planning clinic, or accept an outpatient appointment is fraught with difficulty. Whether they attend or not is not their own decision. External pressure and forces colour and affect their every moment, (Nauman et al 1999).

For others living in an area of high crime, whether it is robbery, drug use, or social disorder, their lives become pre-occupied with self-protection, venturing out only if absolutely necessary and never carrying more money than they need to. These people become by default the socially excluded.

¹ The environment in this instance referring to both human and material influences. It would encompass both threats from violent partners and dangers from multiple occupancy.

Implications for the NHS

If health inequalities are to be reduced then engagement with the community safety agenda is essential. As can be seen from Diagram 1 “Health State Community Safety and Health Inequalities” (page 14), it is crucial in appreciating the relationship of community safety/coercive environments to health status. Positive community safety creates environments for positive health behaviour and attitudes. Negative community safety environments generate helplessness and neglect. Moreover it suggests that Community Safety can be a significant factor regarding persistent health inequalities in the UK.

Lack of community safety can explain why we have a significant differential death rate for children from household fires and road traffic accidents. It is not simply lack of parental care or concern, but is directly related to the immediate external and hostile environment. Similarly it explains some of the differential ante and postnatal morbidity and mortality rates. Pregnant women and their foetuses are more likely to suffer violence and harm at the hands of the woman’s partner or ex-partner than any other cause (RCM 1997).

What the NHS Needs To Do

Accept that: -

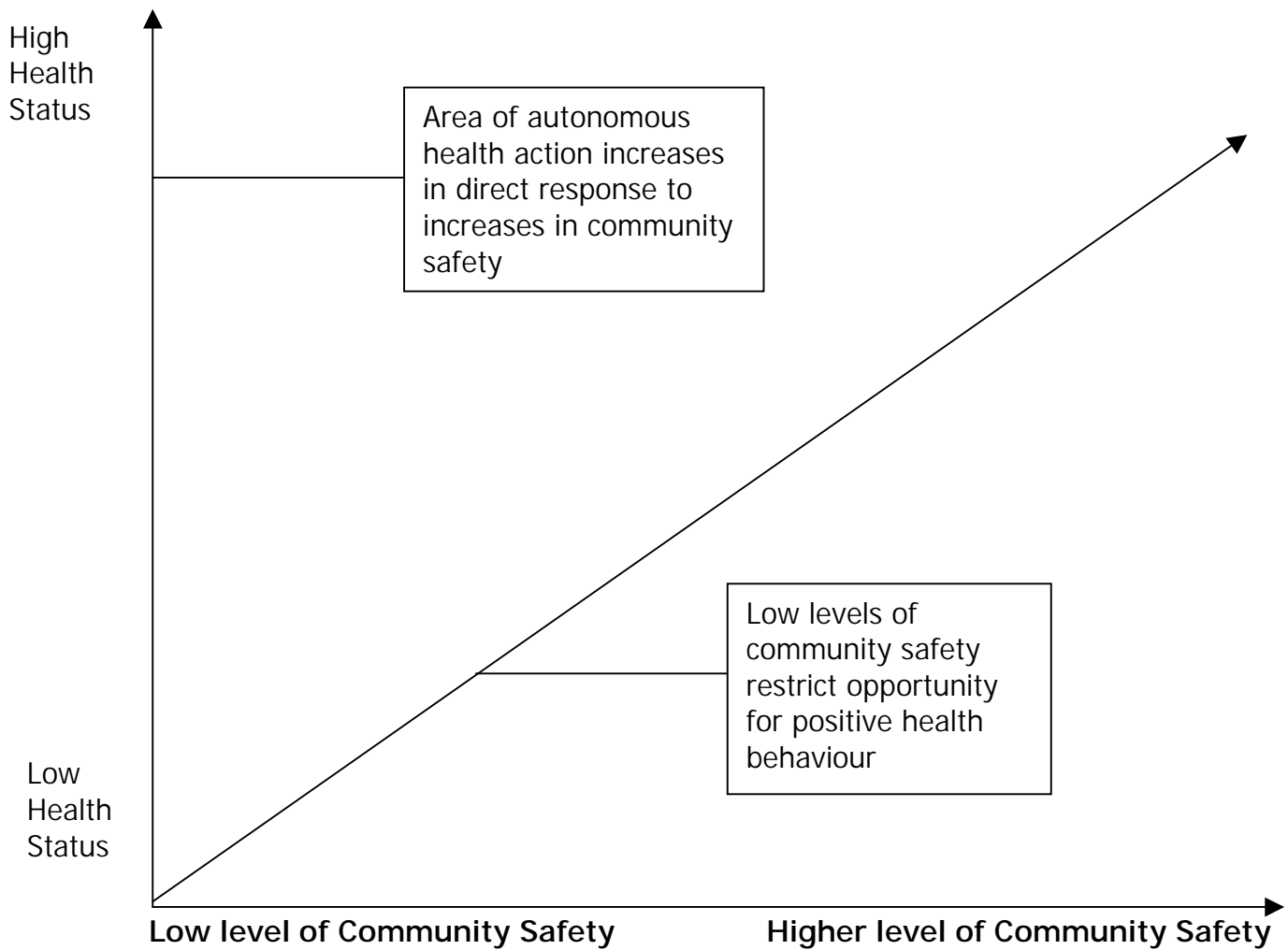
- Community safety is a health care issue because it is a determinant of health
- Socially threatened individuals and communities cannot access help freely and autonomously. They may need a different sort of health help, accessed in different ways and means than the rest of the population
- Seek to establish a professional knowledge base to inform professional practice for NHS professionals involved in community safety activity
- Community safety affects social competency and functioning and is therefore a health care matter similar to hypertension or diabetes, and community safety may well be a critical factor influencing whether patients can continue or maintain treatment regimes
- A humanistic person centred response to the socially excluded and those experiencing significant health inequalities should be developed. They need personal help and support even more than “facts and advice”. Health care staff cannot be police officers and keep the peace, but can help those afflicted find the energy and will to change their own circumstances.
- Actively participate in local community safety partnerships with the explicit objective of ensuring that the whole population is able to make their own health care decisions from a position of autonomy and freedom from fear or coercion.

Key Learning Points

- Community Safety Indicators should be included in Health Needs Assessments
- NHS involvement in community safety needs to encompass both organisation *and professional practice elements*
- Community safety and health services have a common interest in promoting individual and group autonomy to act in “their own best interests”

- Failure to create safe environments (physical and social) leads to coercive environments (physical and social) that reduce personal and community choices, options and possibilities.
- Living in coercive environments creates mental stress, a sense of hopelessness and anti-social behaviour
- The impact of domestic violence on women and children is a clear example of the effects of living within a coercive environment
- The NHS needs to embrace their local community safety agenda and ensure its own unique contribution is acknowledged and respected.

Health State, Community Safety and Health Inequalities



Richard Shircore
Thames Valley Partnership
17th March 2003

References

1. Crime and Disorder Act (1998) Home Office, HMSO or www.hmso.gov.uk/acts1998/19980037.htm
2. The Morgan Report. Safer Communities: The Local Delivery of Crime Prevention Through the Partnership Approach. Home Office Standing Conference on Crime Prevention. HMSO. August 1991
3. Better Health – Lower Crime, NACRO (2001), London
4. Women Battering in Primary Care Practice, Naumann P et al (1999), in Family Practice, Vol 16 N^o 4, OUP
5. Domestic Abuse in Pregnancy, Royal College of Midwives (RCM) (1997) Position Paper, London
6. Health: The Foundations for Achievement, Seedhouse, D (1986) Chichester Wiley
7. Community Safety and the NHS in London, Woodhead D (2001), Kings Fund, London

Richard Shircore
31/10/02 updated 25/3/03

Richard Shircore is Manager – Health Promotion at Windsor, Ascot & Maidenhead Primary Care Trust and was on secondment to the Thames Valley Partnership for 18 months until April 2003.

Domestic Violence Training for Health Workers and the Links with Community Safety

Pat Wallace, Sunlight Project, Domestic Violence Co-ordinator,
Buckinghamshire

Domestic violence is a serious criminal and social problem as well as having a huge impact on health and emotional well being. Traditionally the input from the statutory agencies involved has tended to run side by side rather than in an integrated manner. The Sunlight Domestic Violence Project was tasked with: -

- improving the services for women and children living with Domestic Violence in Buckinghamshire. This included researching the views of survivors as to "what worked"
- encouraging communication between agencies (statutory and voluntary)
- collecting and analysing data
- raising awareness amongst front-line workers
- developing policies and protocols which would lead to a more effective and consistent approach

The remit of community safety is essentially to reduce crime and the fear of crime through the promotion of Community safety initiatives. The Buckinghamshire Community Safety Strategic Objectives include: -

- Reducing perception of and actual numbers of crime/anti-social behaviour and increasing people's feeling of safety within the community
- A reduction of reported violent crime; information sharing and development of policies, practices and procedures. Domestic violence as a community issue fits in here

However domestic violence is also a health issue. The Department of Health states that "The impact of domestic violence on individuals' health and well being is substantial: psychological and psychiatric problems such as depression, anxiety, despair, suicide attempts etc are higher among those who have been abused, compared with those who have not,"(1). There is also the physical impact and the serious consequences that abuse in pregnancy can cause.

I was appointed to take the health lead in the Sunlight Project. I believed that the two most important issues that needed to be addressed were: -

- To ensure that health professionals had an understanding and awareness of domestic violence and its effects on health and therefore were more confident in their response.
- To encourage them to work collaboratively with other agencies.

My post included some pilot work within GP practices and for setting up a training package for health workers to enable them to be more pro-active in their approach to domestic violence. Midwives and Health Visitors across the county were identified as professional health staff who would ask their clients/patients routinely about domestic

violence. GPs and their practice teams, A & E staff and the GUM clinic were identified as needing raised awareness.

Awareness raising for health staff produced many benefits. It allowed people to think and talk about domestic violence and for many people attending this was the first time they had had this opportunity. It encouraged people to recognise that domestic violence affects people's health but that it is also anti-social behaviour and in many instances a crime. This was a painful process for some participants and several people revealed past experiences of domestic violence. This was not surprising because research shows that one in four women will experience domestic violence in their lifetime, (2) and the health service is staffed predominantly by women.

This training also included information on other agencies that are available to help, what help they offer, how to refer to them and what their confidentiality policy is. This incorporated the role of the police and of their Domestic Violence Officer as well as Women's Aid, Rape Crisis etc. This was deemed very important as it encouraged communication between agencies. Similar training was also offered to multi-agency groups and health workers could attend this training if they wished. This was intended to improve the services to women living with violence by improving referrals and subsequent responses to disclosure.

Documentation was another important topic covered. Full, accurate recording of disclosure was essential. Participants were informed of how this could be used beneficially not only within health but also in any future criminal or civil procedures. Information sharing between agencies was also discussed. This could be on a single identified basis if appropriate or as part of anonymous information sharing for community safety planning purposes. Health has signed up to the Countywide Information Sharing Protocol. Health workers were encouraged to develop their own policies for use in their specialities as well as to adopt the Countywide Multi-agency Code of Practice for dealing with domestic violence.

Training Midwives and Health Visitors to be pro-active and to ask all their clients routinely about domestic violence should have many benefits. It should enable the subject to be brought out into the open and thus raise community awareness about this issue. This reduces the stigma of disclosure and should make it more acceptable and easier to access help. It will also allow for earlier intervention of help and support. Therefore it may be seen as affecting some level of crime prevention or of repeated crime and victimisation.

The whole training package for health should have an impact on community safety. This will not, however, necessarily help them to meet their objectives. For example one objective is a reduction in reported crime. Domestic violence is recognised as being under reported. A woman is likely to be assaulted 35 times before she reports it to the police, (3). Health should be more pro-active, better able to support and refer, and able to share accurate information that may assist a case in going to court. If so, it is probable that not only will reported crime (domestic violence) increase but that people's perception of the incidence of crime will also increase. If earlier disclosure is encouraged and agencies work together to deal with perpetrators then repeated victimisation should decrease and people's feelings of safety within the community increase. Therefore the community and individual perspectives are entwined. A reduction in fear of crime and/or feeling safer improves an individual's emotional health or well being. It was important in

the domestic violence training, therefore, to show the many links between and community safety and health. Both of which are looking to improve quality of life for both individuals and communities and this can be achieved most effectively by working in partnership.

Key Learning Points

- NHS professionals should be more able to identify, support and refer their victims.
- Domestic Violence is a community safety and health issue.
- NHS professionals not aware of the health impact of Domestic Violence on patients. Need to be proactive.
- Collaborative working needs to be worked for.
- Multi-agency training can act as a focal point for better local collaboration.
- Documentation of Domestic Violence by health staff often neglected, but very important.

References

1. Domestic Violence: A Resource Manual for Health Care Professionals, Department of Health (2000)
2. The British Crime Survey England and Wales. Home Office Statistical Bulletin, Issue19/96, Mayhew P, Mirlees-Black C, Percy A (1996). Home Office, 1996
3. Violence Against Women, Bewley S, Friend J, Mezey G. (eds) (1997). Royal College of Obstetricians and Gynaecologists (RCOG)

Changing Direction: Recognising Domestic Violence in Clinical Practice

Dr. Fiona Duxbury, GP, Blackbird Leys Health Centre

Introduction

I am a GP and researcher interested in Post-traumatic Stress Disorder. This article describes the limitations preventing health workers from detecting domestic violence (DV), and describes opportunities for changing that.

Surveys confirm that DV is common, occurring at some point in the lives of 2/5 of women attending general practice (1, 2).

Apart from physical injuries, those in violent relationships have higher rates of: irritable bowel syndrome, chronic pelvic pain, gynaecological problems (some of which may be caused by rape) as well as what would be classified as psychosomatic problems with chronic pain, for example back pain. Violence escalates in pregnancy with consequently higher rates of miscarriage, foetal damage and low birth weight babies(3, 4).

Bradley reports that women who reported domestic violence were 32 times more likely to be afraid of their partner or to have experienced controlling behaviour than women who did not report this (5).

Campbell's Review (3) confirms that the specific name of the anxiety associated with DV is Post-Traumatic Stress Disorder (PTSD)(6).

In surveys, PTSD has been found in over 50% of those experiencing domestic violence(7, 8). Thus, people who are experiencing or who have experienced trauma past or present from intimates are likely to be your "thick file", "frequent-attenders", especially in Casualty, general practice or psychiatric settings. But GPs detect less than 20% of these victims, even when there is a physical injury present (1, 2).

The simple explanation for failing to detect DV is because we don't ask (1-3, 5, 9, 10).

What Prevents Us Asking?

Might guidelines help?

A Systematic Review on unsolicited guidelines confirms that they do not change practice(11), and are a waste of money. They sit forgotten on shelves in surgeries, if they are not binned.

Are health workers' beliefs about DV to blame?

Richardson et al. (10) surveyed the attitudes of 380 GPs, 180 Practice Nurses, and 140 Health Visitors. The paper found that the majority of us recognised that DV damaged health, and thought that we **did** have enough time to ask the questions. Forty five percent of GPs and 85% of health visitors handed out information leaflets to patients **if**

they uncovered DV. But of GPs only 10% of GPs thought they should routinely ask, and only 1 percent claimed to actually do this.

Screening?

This is unlikely to be effective (12, 13) and Richardson's study (10) confirms the impossibility of routine screening in health care settings until we've gained confidence in how to ask about domestic violence. There continues to be debate about whether other public health criteria for screening (14) can be fulfilled.

Clearly some more education of health care workers could be beneficial, but many recognise it doesn't take long to ask- we have got leaflets with useful telephone numbers and information to give to patients *if* the patient tells us, - and we recognise that domestic violence damages your health.

The major barrier to detecting DV is a reluctance to ask about trauma.

Opportunities

The work from research gives us pointers to ways forward.

Medical professionals need training in two areas :-

1. Feeling enabled to ask about trauma
2. In honing our diagnostic skills and "having a high index of suspicion" (9). Intimate abuse (childhood or spousal) should cross our minds when we see a patient with a "thick file", particularly if psychosomatic complaints predominate. We need to notice bruises and learn to recognise Post-Traumatic Stress Disorder or even just "anxiety/depression". If humans are not good at collating signs and symptoms, perhaps we could programme computers to flash reminders at us to ask about DV! But I do not think that this is truly the barrier to detecting DV.

This second type of training, honing our diagnostic skills, is consistent with the way we practice already, whereas asking people about their private lives does not feel comfortable. It is training in feeling enabled to ask about trauma that would be a major advance in detecting DV in our patients.

I think fears about asking about trauma in the lives of our patients include worries about: -

- "Opening the can of worms", and that doing this may harm the patient (15).
- Some may feel that the traditional British "stiff upper lip" is a good coping strategy, and that to interfere may reduce a patient's self-reliance. (I believe this displays ignorance about what is being endured and its consequences).
- It is not socially acceptable to ask about peoples' private lives. Traditionally such questioning has had nothing to do with medical diagnosis. We worry that we may cause offence.

Does it harm or offend people to ask about trauma?

In fact there is a tiny amount of worldwide research on whether we harm patients by asking about trauma. The five papers I have unearthed during a systematic electronic database search from 1985 till now (16) (17-19) (20) suggest that identifying types of trauma is not harmful, but that rehearsing details of specific traumas in the wrong context, may be harmful. This is almost certainly true for the technique of "debriefing" after a disaster (21) (22).

On the other hand, papers that have interviewed the traumatised, describe how they were calling out for health workers to ask them about *why* they were ill, anxious or depressed, not just give them pills for it (15, 23). In my personal experience, patients have not been offended if I have asked them, in the context of a presented distress, whether their relationships were okay. Patients seem to recognise that this might be a relevant question even if this does not apply to them.

In order to feel enabled to ask these non-medical questions, about private intimate traumas, I think we have to feel that we have "spotted the ticket" first. This is consistent with good diagnostic medical practice and allows us to step over this social boundary with justification.

So what would help us "spot the ticket" more and then feel it legitimate to pry into our patients' private lives?

Changing Practice

I advocate learning to recognise Post-Traumatic Stress Disorder (PTSD) (24). PTSD is a relatively new psychiatric diagnostic label, appearing after the Vietnam war. But its symptoms are as old as history itself, even if the name has changed. "Diagnosing" is the province of health workers. It is consistent with medical practice. Training in diagnosing PTSD enables health professionals to spot DV and other traumas because identifying the causative trauma is intrinsically part of making the diagnosis.

All other "calling cards" for DV, such as teenage pregnancy, smoking during pregnancy, episodes of deliberate self-harm, trouble with the police, drug or alcohol abuse, episodes of homelessness, frequent injuries, frequent attendance's at the surgery, recurrent anxiety or depression, are not specific to trauma alone.

All those groups also have higher rates of PTSD because they are often the traumatised (6, 25-39).

PTSD neatly summarises the experiences and symptoms people can have after life-threatening trauma. And of course this includes DV. Lifetime PTSD affects about 10% of women and 5% of men in the general population (40). The gender difference is probably accounted for by the fact that women were more often than men were the victims of civilian traumas of childhood sexual abuse, rape and domestic violence (40). Intimate abuse is commoner than combat trauma (40).

Experiencing intimate abuse is similar to experiencing war, as the following account demonstrates.

"... I can't remember a day when I wasn't afraid. My mother and I lived like wary animals, ever watchful, tense and waiting, ...for the next beating... It's the noise that people don't understand, the shouting, the menacing threats and the sound of punching fists making contact with flesh and bone. Even blood makes a sound when it sprays onto the wall" (41).

PTSD summarised

PTSD is diagnosed when: -

- The causative trauma results in injury or feels life threatening.
- Feelings of terror or helplessness are engendered.
- Symptoms diagnostic of PTSD must be present **at least 1 month after the trauma**.
- Symptoms must include at least one of five "intrusive symptoms/re-experiencing" symptoms, **plus** at least three of seven "avoidance" symptoms **plus** at least two of five possible "hyper-arousal symptoms".

"Intrusive" symptoms involve re-experiencing the trauma in forms such as nightmares, flashbacks, upsetting thoughts, emotional upset or physical reactions such as panic attacks or sweating when reminded of the trauma. "Avoidance" symptoms describe thoughts and behaviour that try to block out the trauma, leaving the sufferer with a sense of emotional numbness. "Hyper-arousal" symptoms mimic the physiological fight-or-flight response, general jumpiness.

- Symptoms interfere with life.
- PTSD is described as "chronic" if it endures for longer than 3 months.
- PTSD is of "delayed onset" if it starts over 6 months after the trauma.

Life-threatening traumatic events are common but any resultant PTSD is usually short term, "acute" PTSD. It is the chronic form of PTSD that is likely to result in the social and health costs outlined above (25). The types of trauma likely to cause *chronic* PTSD are abuse by intimates (42) and war experiences.

What To Do After Spotting Possible PTSD

When patients attend describing certain symptoms that I recognise as part of PTSD for example panic attacks, nightmares or poor sleep, I then feel enabled to ask the **key questions for detecting domestic violence**: -

- "How are things at home?"
- "Do you ever feel controlled by or afraid of your partner?" (5)
- "Have you ever been hurt by your partner?"

If the answer to either of the last two questions is "yes", the first priority is to discuss very practical issues of safety and give information leaflets with contact numbers for help.

If the patient has symptoms suggestive of PTSD, I may arrange for her to complete a fill-it-in-yourself questionnaire that diagnoses PTSD called The Post-traumatic Diagnostic Schedule (PDS) (43). It takes about 10 minutes to complete, and is easy to score. The patient can arrive at the surgery 10 minutes early and complete it before a follow-up consultation. I would not suggest leaving a patient unsupported to fill in the PDS as it inevitably brings up memories when identifying the trauma(s) that have led to PTSD. The PDS helps to formally diagnose PTSD and clarify how badly affected a patient is by PTSD. I use the PDS as a tool of communication. The link between the PTSD symptoms and the trauma suffered is then clear both to the health worker and the patient. The PDS illustrates to the patient that the PTSD symptoms they are experiencing are a recognised human response to severe trauma.

- A “diagnosis” helps the doctor and patient look at helpful ways forward. There are self-help books (44, 45), SSRI drugs and Cognitive Behavioural Treatments, EMDR and other therapies that can help cure PTSD (46) **once you are in a place of safety**. This point cannot be stressed enough. PTSD is the body's survival fight or flight response gone overboard. If you want to resolve PTSD you do need to be safe. We know that the life of our patients may depend upon it (47).

Another aid I use in my follow-up consultations with patients are two circle diagrams from America. One describes abusive relationships of power and control, the other non-abusive relationships of equality. They can help me in supporting the patient in what are often very complex decisions about what to do next. These circles sometimes help women see the reality of their situation and stop blaming themselves for being dominated and abused. This can allow them to decide to move on.

Key Learning Points

- Health workers need training to understand the health consequences of domestic violence, which includes developing an understanding of PTSD and how to diagnose it
- Having understood PTSD and learnt how to recognise its key anxiety symptoms, they need the courage to ask the three key questions about their relationship with their partner: -
 - “How are things at home?”
 - “Do you ever feel controlled by or afraid of your partner?”
 - “Have you ever been hurt by your partner?”
- Direct questioning regarding domestic violence and using a structured approach to diagnosing PTSD can help improve discussion with, and support of, the patient
- Health care workers should be able to offer accurate local help (written or verbal) regarding support services for domestic violence crime
- Domestic violence survivors want to retain a sense of responsibility for their own care and future. This must be respected

References

1. Richardson J, Feder G. Domestic violence: a hidden problem for general practice. *British Journal of General Practice* 1996;00(April):239-242.
2. Richardson J, Coid J, Petruckevitch A, Chung WS, Moorey S, Feder G. Identifying domestic violence: cross sectional study in primary care. *British Medical Journal* 2002;324(Feb 2):274--7.
3. Campbell JC. Health consequences of intimate partner violence. *The Lancet* 2002;359(April 13):1331-6.
4. Mezey GC, Bewley S. Domestic Violence and pregnancy. *British Medical Journal* 1997;314:1295.
5. Bradley F, Smith M, Long J, O'Dowd T. Reported frequency of domestic violence: cross sectional survey of women attending general practice. *British Medical Journal* 2002;324(Feb 2):271-4.
6. DSM-1V. Diagnostic and Statistical Manual of Mental Disorders. Washington, DC: American Psychiatric Association; 1994.
7. Roberts GL, Lawrence JM, Williams GM, Raphael B. The impact of domestic violence on women's mental health. *Australian and New Zealand Journal of Public Health* 1998;22(7):796-801.
8. Stewart DE, Robinson GE. A review of domestic violence and women's mental health. *Archives of Women's Mental Health* 1998;1:83-89.
9. Heath I. Domestic violence: the general practitioner's role. *Members' Handbook of the Royal College of General Practitioners* 1996;
<http://www.rcgp.org.uk/publicat/bluebks/domviol>.
10. Richardson J, Feder G, Eldridge S, al. e. Women who experience domestic violence and women survivors of childhood sexual abuse: a survey of health professionals' attitudes and clinical practice. *British Journal of General Practice* 2001;51(June):468-70.
11. Oxman AD, Thomson MA, Davis DA, Haynes RB. No magic bullets: a systematic review of 102 trials of interventions to improve professional practice. *Can Med Assoc J* 1995;153(10):1423-1431.
12. Ramsay J, Richardson J, Carter YH, Davidson LL, Feder G. Should health professionals screen women for domestic violence? Systematic review. *British Medical Journal* 2002;325(Aug 10):314.
13. Jewkes R. Preventing domestic violence. *British medical Journal* 2002;324(Feb 2):253-4.
14. Detels R, Holland WN, McEwen J, Omenin GS, Editors. *Oxford Textbook of Public Health*. Third ed. Oxford; 1997.
15. Nelson S, Phillips S. *Beyond trauma: mental health care needs of women who have survived childhood sexual abuse*. Edinburgh: Edinburgh Association for Mental Health; 2001 June, 2001.
16. Gidron Y, Peri T, Connolly JF, Shalev AY. Written disclosure in Post traumatic Stress Disorder: Is it beneficial for the patients? *The Journal of Nervous and Mental Disease*. 1996;184(8):505-507.
17. Pitman RK, Altman B, Greenwald E, al. e. Psychiatric complications during flooding therapy for post traumatic stress disorder. *Journal of Clinical Psychiatry*. 1991;52:17-20.
18. Jacomb PA, Jorm AF, Rodgers B, Korten AE, Christensen H. Emotional response of participants to a mental health survey. *Social Psychiatry psychiatric Epidemiology* 1999;34:80-84.

19. Parslow RA, Jorm AF, O'Toole BI, Marshall RP, Grayson DA. Distress experienced by participants during an epidemiological survey of Post traumatic Stress Disorder. *Journal of Traumatic Stress* 2000;13(3):465-471.
20. Martin J, Perrott K, Morris E, Romans S. Participation in retrospective child sexual abuse research: how women feel six years later. In: conference PotITaM, editor. *Trauma and Memory*. Thousand Oaks, California: Sage; 1996.
21. Rose S, Wessely S, Bisson J. Brief psychological interventions ("debriefing" for trauma-related symptoms and prevention of post traumatic stress disorder (Cochrane Review). *The Cochrane Library* 2001;2.
22. Solomon SD. Interventions for acute trauma response. *Current Opinion in psychiatry* 1999;12:175-180.
23. Burton P. Women's Health and Domestic Violence- Breaking the silence. *Social Services Research* 1996;4:39-45.
24. DSM-1V., American PA. Post traumatic Stress Disorder (p.424-429). In: Chair-of -task-force-Frances A, Vice-Chair-Pincus HA, Editor-First MB, editors. *Diagnostic and Statistical Manual of Mental Disorders-DSM 1V*. 4th ed. Washington, DC: American Psychiatric Association; 1994. p. 886.
25. Kessler RC. Post traumatic Stress Disorder: The Burden to the Individual and to Society (a review). *Journal of Clinical Psychiatry* 2000;61(supplement 5):4-14.
26. Kukla L, Hrubá D, Tyrlik M. Typical differences between smoking and non-smoking pregnant women. (Results of ELSPAC study). *Hygiena* 1999;44(2):67-77.
27. van der Kolk B, McFarlane AC, Weisaeth LE. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*. New York: Guilford Press; 1996.
28. Zlotnick C, Mattia JI, Zimmerman M. Clinical correlates of self-mutilation in a sample of general psychiatric patients. *Journal of Nervous and Mental Disease* 1999;187(5):296-301.
29. Chu JA, chapter in Jacobs,D.G (Ed.). *The Harvard Medical School guide to suicide assessment and intervention*. 1st ed. San Francisco: Jossey-Bass; 1999.
30. Davidson JRT, Hughes D, Blazer DG, George LK. Post-traumatic stress disorder in the community: an epidemiological study. *Psychological Medicine* 1991;21:713-721.
31. Giacona RM, Reinherz HZ, Silverman AB, Pakiz B, Frost AK, Cohen E. Traumas and Post traumatic stress Disorder in a community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry* 1995;34(10):1369- 1380.
32. Najavits LM, al. e. Cocaine dependence with and without PTSD among subjects in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *American Journal of Psychiatry* 1998;155(2):214-219.
33. Chilcoat HD, Breslau N. Post traumatic Stress Disorder and Drug Disorders. *Archives of General Psychiatry* 1998;55(Oct):913-917.
34. Brown PJ, Ouimette PC. Introduction to the special section on substance use disorder and post traumatic stress disorder comorbidity. *Psychology of Addictive Behaviours* 1999;13(2):75-77.
35. Brady KT, Dansky BS, Sonne SC, Saladin ME. Post traumatic stress disorder and cocaine dependence: Order of onset. *American Journal on Addictions* 1998;7(2):128-135.
36. Jacobsen LK, Southwick SM, Kosten TR. Substance Use Disorders in patients with Post traumatic Stress Disorder: a review of the literature. *American Journal of Psychiatry* 2001;158(8):1184 -1190.
37. Davis J, Kutter CJ. Independent living skills and Post traumatic Stress Disorder in women who are homeless: implications for future practice. *American Journal of Occupational Therapy* 1998;52(Jan. 1):39-44.

38. Smith EM, North CS, Spitznagel EL. Alcohol, drugs and psychiatric comorbidity among homeless women: an epidemiological study. *Journal of Clinical Psychiatry* 1993;54(3):82-87.
39. Bassuk EL, Buckner JC, Perloff JN, Bassuk SS. Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry* 1998;155(11):1561-4.
40. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Post traumatic Stress Disorder in the National Comorbidity Survey. *Archives of General Psychiatry* 1995;52(12 (Dec)):1048-60.
41. Doughty S. Independent 2002 24.2.02.
42. Boney-McCoy S, Finkelhor D. Is youth victimisation related to Trauma symptoms and Depression after controlling for prior symptoms and family relationships? A longitudinal prospective study. *Journal of Consulting and Clinical Psychology* 1996;64(6):1406-1416.
43. Foa EB, Cashman L, Jaycox L, Perry K. The validation of a self-report measure of post traumatic stress disorder: The Post traumatic Diagnostic Scale. *Psychological Assessment* 1997;9 (Dec)(4):445-451.
44. Herbert CW, Ann. *Overcoming Traumatic Stress*. London: Robinson; 1999.
45. Kennerley H. *Overcoming Childhood Trauma - a self-help guide using Cognitive Behavioural Techniques*. London: Robinson; 2000.
46. Bisson J. Post traumatic Stress Disorder. In: Stuart Barton JP, Richard Smith, editor. *Clinical Evidence*. 5 ed. London: BMJ Publishing Group; 2001. p. 688-694.
47. Brock K, Stenzel A. *When men murder women: an analysis of 1997 homicide data - females murdered by males in single victim/single offender incidents*. Washington, D.C.: Violence Policy Center; 1999.

Meeting the Challenge: Developing a Public Health Approach to the Prevention of Child Sexual Abuse

John Brownlow, Central Co-ordinator, Stop it Now! UK & Ireland

Child sexual abuse is currently high on the agenda for professionals, the media and the public alike. But it is easy to forget that, until the mid-eighties, it was an issue that even child-care professionals were only marginally aware of. And we know that those who were most acutely aware of it, the children involved, had little or no chance of being heard and believed even if they tried to tell someone. This situation has changed little over the years; a major NSPCC study, published in 2000, found that about 75% of sexually abused children tell no one about their abuse. The proportion that come to the attention of the police, health and social service is less than 5%.

Our knowledge and skills have moved on a great deal since those days; joint police and social services investigative techniques are well developed; therapeutic help is available to victims and survivors (although there is still far from enough of it), and we have one of the most advanced networks of sex offender treatment in the world, although again many of those who need treatment do not receive it for one reason or another.

There is also some cause for optimism in the increase in public awareness about child sexual abuse, however distorted some of the information provided by the media may be. A MORI poll, commissioned by Stop it Now! last year, found that nearly 60% of respondents recognised that children are most likely to be abused by an adult they know and trust. This is encouraging in the light of the high profile media coverage of children abused or killed by strangers. There is also cause for hope in recent reports from ChildLine that children appear to be calling to talk about their sexual abuse much earlier than used to be the case.

However, the NSPCC study found that about one in six children are sexually abused before the age of 16, a figure broadly comparable with similar studies in the UK and the USA. If we are to accept the scale of the problem, then we must also accept the scale of the response.

Stop it Now! is a child sexual abuse prevention campaign, founded in the USA in 1993. A key element of the campaign is to promote child sexual abuse as a public health issue that demands broad-based prevention, similar to the approaches taken to smoking, drink-driving and domestic violence. The central question posed by Stop it Now! is: "Can we successfully challenge adults to take responsibility for preventing and stopping child sexual abuse?"

This is not a radical idea – most would agree that it is the responsibility of adults to protect children. But it requires a radical change in the way that we think about child sexual abuse. A change for all adults, from thinking about sexual abuse as somebody else's problem, as an evil, but as an essentially unavoidable fact of life. This is not to say that all of us involved in working with sexually abused children and their families are not doing our utmost to help children within the current structures and systems, but that as a society we are failing our children.

The personal, social and financial costs of child sexual abuse are incalculable. The criminal justice, child protection and health systems all commit significant resources to investigating, prosecuting and treating the perpetrators of sexual abuse. Social services and health help children and their families in the aftermath. The far-reaching effects of child sexual abuse on the physical and psychological health of victims as children and adults are well documented.

But the services that we now provide nearly all come after the event, in an attempt to punish those responsible, to prevent further harm and to ameliorate the worst effects on children. In public health terms, they are almost all concerned with tertiary prevention – preventing further harm.

Addressing child sexual abuse as a public health issue challenges us to look seriously at prevention at all levels and to develop approaches in primary and secondary prevention where currently there is little or no activity. The only current examples of primary prevention that are widely available are self-protection programmes for children. These are very valuable, but we should not place the responsibility on children to protect themselves. There is a pressing need for accurate information to be widely available and to encourage open dialogues and recognition of what child sexual abuse really means.

Current work in secondary prevention is represented by services for children and young people with sexually inappropriate or harmful behaviour. In some areas this is very effective, but in others there is a lack of consistent policies and procedures and the services to back them up. There is also a real challenge in identifying the young people and adults who are most at risk of going on to abuse children. Work with offenders has identified risk factors in the background of people who abuse, but can we find ways to provide appropriate interventions before it is too late?

Stop it Now! is developing approaches to develop primary prevention by providing information to all adults about how to recognise the warning signs of abusive behaviour in people they know, and secondary prevention, by calling on those most at risk of abusing to seek help before they abuse a child.

Public health campaigns are concerned with prevention. This means providing accurate and accessible information to raise awareness and it means encouraging dialogues across society that challenge our current ways of thinking and doing. Many of these campaigns draw on social marketing techniques, which have their roots in advertising commercial products. This approach involves the development of media campaigns to raise awareness of the issue, community action to model alternative dialogues and behaviours, and structural changes that motivate adults to take action and to consolidate changes in behaviour.

These target groups of Stop it Now! are: -

- Adults who have abused or are thinking about abusing a child, to encourage them to recognise their behaviour as damaging, both to children and themselves and to seek help to change
- Family and friends of abusers or potential abusers, to help them recognise the warning signs of abusive behaviour and seek advice about what action to take

- Parents of children and young people who sexually abuse other children, to recognise the signs and to seek help

Perhaps the greatest challenge lies in encouraging people to come forward for help with their own sexual thoughts or behaviour towards children. At the very least, this requires them to admit the most shameful thoughts and behaviour and for those who have committed an offence it may mean facing prosecution. Many people have been sceptical that people in this situation would come forward. However, between the launch of the Stop it Now! helpline in June 2002 and April 2003, nearly a third of 224 callers have fallen into this category.

The next challenge is to equip people close to abusers and those at risk of abusing, whether they are adults or young people, with the information and confidence to recognise the warning signs of abusive behaviour and to seek help – preferably before abuse occurs. This means providing everyone with this information. People who sexually abuse children live within communities – they are fathers (and some mothers), brothers, uncles, aunts, neighbours and friends. They come from all sections of society. They are not the monsters of the popular press - though they may do monstrous things – but they may well be people we know and love.

We then need to give people the confidence to take responsible action, if they suspect that someone they know is abusing or preparing to abuse a child. More than half of the respondents to the MORI survey said that in this situation they would contact the police, another 20% would contact social services and 7% would contact the NSPCC. But this rarely happens – a very small percentage of sexual abuse is reported to the authorities. Either people are failing to identify abuse or they lack the confidence to act on their suspicions.

In order to promote a better understanding of child sexual abuse, Stop it Now! is producing a series of information leaflets, three of which are currently available. A further leaflet is in production for those who are themselves abusing or thinking about abusing a child – perhaps using the internet as a distribution channel to target people seeking to access child pornography.

The development of Stop it Now! in the United Kingdom and Ireland is led by the Lucy Faithfull Foundation and overseen by a national steering group, chaired by Baroness Valerie Howarth. The steering group comprises representatives of the leading children's charities, NOTA, survivor groups and government and statutory agencies. In 2000 the Home Office and Department of Health agreed to provide 3-year core funding for the initiative, which enabled the recruitment of a central co-ordinator.

In its first phase of its development in the UK, Stop it Now! is developing a number of local projects to test out our approach and to develop our key messages. The first project, managed by the Lucy Faithfull Foundation, was launched in Surrey in September 2002. A second project, funded and managed by the NSPCC, was launched in Derby and Derbyshire in November 2002 and is a particularly good example of partnership in action.

Funding has been secured for the appointment of a development co-ordinator in Thames Valley, through an inter-agency initiative led by the Thames Valley Partnership – another

good example of the diversity of support on which Stop it Now! depends. Each of the Stop it Now! projects is typified by strong local partnerships and there are groups looking at developing local initiatives in the West Midlands and Northern Ireland and many other areas, including Wales and Scotland, have expressed an interest.

In addition to the development of local initiatives, Stop it Now! is continuing the development of a website as a source of information for the public and as a link to help and advice and is seeking to influence people at all levels, to promote a public health approach to the prevention of child sexual abuse and to lobby for improvement in treatment resources for adults and children, whether they are potential or actual abusers, victims or survivors.

Diversity is another important issue for Stop it Now! in seeking to challenge people from all backgrounds to change the way they think and act towards child sexual abuse. The campaign is looking at ways of putting across its messages in a way that people with widely varying constructions of childhood and sexuality can accept. It is also embarking on a programme to translate information leaflets into a variety of languages and investigating resources to ensure an appropriate response to diverse Helpline calls.

A particular challenge is to ensure that child sexual abuse secures a place on the national and local public health agendas from which it is almost entirely absent at present. The placement of child protection under the responsibility of the Director of Public Health in most Primary Care Trusts is an encouraging step, but it remains to be seen whether it remains more than an administrative convenience. Many health visitors would like to see it become a mainstream public health issue.

It is a priority to develop a common language to talk about child sexual abuse – one that is understood by professionals and the public; one that is frank and to the point, but that also helps us to develop a more informed approach. The use of the word paedophile, for example is often used inaccurately and has become a kind of shorthand for a wide range of abusive behaviours and a label for the ‘demons’ of our society. This involves challenging public perceptions of sex offenders and working with and through the popular media

References

Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect. Cawson, P, Wattam, C, Brooker, S and Kelly, G (2000), London: NSPCC

For further information contact: -

UK Stop it Now! UK & Ireland
PO Box 9841
Birmingham B48 7WB

Tel: 01527 598184
Email: office@stopitnow.org.uk
Website: www.stopitnow.org.uk
Helpline: 0808 1000 900

For information on Stop it Now! in the Thames Valley contact: -

Thames Valley Partnership
Townhill Barn
Dorton Road
Chilton
Buckinghamshire HP18 9NA

Tel: 01844 202001

Email: admin@thamesvalleypartnership.org.uk

Never Too Early

Patsy Townsend, Director of Youth Programmes,
Thames Valley Partnership

The Case is Made – Isn't It?

There is now a broad consensus that earlier intervention is an effective tool in preventing crime. This government is investing over £1 billion in Sure Start in recognition that positive intervention in the first four years will give a child the best chance in life and will in the longer term achieve social and economic outcomes in the form of improved health, less crime, and a more skilled and educated workforce. Gordon Brown and Oliver Letwin are both on record in support of preventive intervention. The public and media, too, take the view that poor parenting and teenage motherhood are to blame for many of our social ills.

But what do we really know? Research consistently highlights a range of risk factors associated with future criminality including poor parental supervision, harsh or erratic discipline, parental conflict, and separation from a biological parent.¹ Domestic Violence and a parent in prison are also well documented. (The gender of the child - statistically the most significant "predictor" is rarely explored!) Also significant are low income, poor housing, deprived neighbourhoods and socially disorganised communities. Educational risk factors predictably point to low attainment and aggressive and troublesome behaviour².

These risk factors do not individually cause crime, but when they cluster around a particular individual the risk of involvement in criminality is substantially increased. Programmes such as those delivered by Communities that Care and the Youth Justice Board continue to refine our understanding of risks associated with youth crime.

We need also to consider inadequacies in statutory provision, for example the failure of some schools to make accurate assessments of children's cognitive abilities, or to have a relevant curriculum or to engage effectively with parents, the failure of local authorities to provide and adequately maintain housing stock, or the failure of the NHS to engage with marginalised groups.

In terms of long-term research, protagonists of early intervention have had to rely on the High/Scope Perry Pre-school Project³ longitudinal research in the USA which showed that enriched nursery education achieved savings in terms of crime, drug abuse and teenage pregnancy over a 15 year period. It was seen to provide more relevant, timely, early education appropriate to parents' and children's needs. Now, investment in Sure Start is to be backed up by a national evaluation in the UK.

¹ Bright, J. (1992) in *Family, School and Community, Crime Concern*, Swindon

² Utting, D. (1996) *Reducing criminality among young people: a sample of relevant programmes in the UK*, Home Office Research Study 161, London

³ Schweinhardt, LJ, Barnes, HV and Weikart, DP. (1993), *The High/Scope Perry Pre-school Through Age 27*, High/Scope Educational Foundation. Ypsilanti, Michigan

The Question of How

There are still plenty of questions about how earlier intervention should take place, and what measurable effects we can expect. How far can we predict long term changes in the risk of criminality based on short-term improvements in family functioning, educational achievement or engagement? How do we provide relevant and accessible support to families in the most deprived areas? How can we use the pooled knowledge of various agencies working with these families and communities (health services, the police, probation service, social services, and education) to target earlier work without stigmatising individual families or children and breaking professional codes of confidentiality or ethical standards? How can we engage community members both as volunteers and users and providers? How can programmes working with parents genuinely reflect cultural diversity when they continue to be based on white middle class notions of good parenting? Parenting programmes should be based on thorough assessment and this should include cultural relevance.

The Thames Valley Partnership's Early Intervention Programme

These are some of the questions that the Thames Valley Partnership addresses through its Early Intervention Initiative. We seek practical, low cost solutions. Our work centres on our experience of community safety and our own research on early intervention.

In 2001 we published *Never too Early: An Evaluation of Methods of Early Years Intervention*, based on an examination of eight early intervention programmes working with families in disadvantaged communities in Oxford and Slough⁴. The quantitative and anecdotal evidence suggests that the younger the child, the more pronounced the effects on behaviour. The most successful programmes were age specific and targeted pre-school children. Programmes for school age children also had an impact, but it was less marked. We looked at a range of programmes including structured cognitive behavioural-based work, play therapy, whole school behaviour programmes and literacy. Programmes using cognitive and social learning approaches showed the greatest effects.

We discovered that motivation for parents to participate comes not just from a concern about their children, but because involvement in a programme provides company, support and activity outside the home. Being part of the group was, for many, the first time parenthood had produced social opportunities instead of limiting them. The recognition that parenting is a difficult, wearing job was enough to keep some parents coming, even when they felt there were few changes in the child's behaviour. The programmes were not generally seen as stigmatising in the way that professional interventions in family life often are. The use of volunteers and community members added local links and lessened any embarrassment parents may have felt about taking part.

Our conclusion is that an ideal strategy offers a layered approach to the provision of services. It would include universal support for all children in the early years and a more targeted approach for those who continue to have problems. Targeted programmes such as parenting support groups are most successful when offered through a universal access point – an acceptable place where parents would naturally seek support and guidance - somewhere it is OK to admit that parenting is hard and children can be problematic.

⁴ Thames Valley Partnership. (2001) *Never Too Early: An evaluation of methods of early years intervention*

Parallel work on reducing exclusions from school revealed striking similarities. The report⁵ again suggested a layered approach with interventions that needed to be taken in the classroom, by the school as a whole, by specialist services and by the local education authority. Again, the method of reaching out to children and families who need support seemed more important than the type of programme on offer. The method used, whether dramatherapy, work-based learning or cognitive behavioural group work, was less important than the offer of real engagement and individual attention.

The transition from primary education to secondary school emerged as a crucial point for positive, inclusive intervention. All children find this transition a challenge. The most vulnerable and those already failing educationally in primary school may never effectively re-engage with education unless they are offered additional support at this crucial transitional stage. Universal support at this point from older students in a 'buddying'/mentoring role has been seen to be an effective support mechanism for the young pupils transferring from primary to secondary. A more targeted service to those youngsters identified as requiring additional specialist help can then supplement the peer support. This model supports the 'layered-approach' referred to above and is currently being promoted and supported with training in several schools across the Thames Valley as part of the Early Intervention Initiative.

Our Early Intervention Initiative

Our aim is to apply some of that learning and experience and to link it with the broader community safety agenda. We wish to demonstrate our commitment to early intervention as an important aspect of community safety, relevant not just to the most deprived areas, but to estates and neighbourhoods where young people's behaviour is a source of concern. Disadvantage in the Thames Valley, as in many areas, is characterised by pockets of deprivation concealed by the general affluence of the area as a whole. Because they are hidden, these areas are not eligible for Sure Start or neighbourhood renewal funding. New initiatives must rely on redirection of existing money and the improvement of existing services. Our emphasis is on promoting collaboration between professionals and community organisations working in these neighbourhoods so they can develop the layered approach and the combination of universal and targeted services that our work suggests is important. This requires bringing together the statutory agencies, voluntary organisations and the community. In the case of earlier years work, the focus is on positive support for children under 11 and their families.

Our Experience So Far

The Neighbourhood Renewal Strategy⁶ suggests that across the country it is the poorest, most disadvantaged and needy communities that receive the poorest local services. For years we (and others) have suggested that community safety would be more effective if it focused on individual geographical areas, harnessing the commitment and resources of the key agencies in developing a vision and strategy with the community.

Our work is at a relatively early stage but we can already speak with experience on the different features of disadvantage and the need to develop all these initiatives from the

⁵ Thames Valley Partnership. (2001) *Mind the Gap: A model for school inclusion*.

⁶ Social Exclusion Unit. (1998) *Bringing Britain Together: a national strategy for neighbourhood renewal*

bottom up. An interim evaluation of the initiative⁷ has just been produced which, in illustrating this bottom-up approach states that “(The initiative) is seeking to inform strategy through practice and if the practice is lost then the authority to recommend is diminished.”

We have been welcomed as an honest broker because of our commitment to working through existing locally based structures and our ability to pull in the key strategic players. “The Partnership is particularly valued for its brokerage, independence, expertise, responsiveness, pragmatism and funding.” “The Partnership was applauded for its brokerage skills and its ability to act as a catalyst”. “They have no vested interests. They are independent but have the clout to get things done.” These comments reflect our unique position as a partnership of statutory and voluntary organisations in the Thames Valley.

We have learned that the small amount of money we bring can go a long way when used sensitively as pump-priming for getting things off the ground and harnessing ongoing commitment from statutory agencies. An example of this is the baby clinic set up in response to the concerns of local teenage mothers. Very small amounts of funding for a launch and basic equipment was matched by the offer of premises and a reorganisation of the working practices of local midwives and health visitors. Again quite a small amount of funding to provide expert peer mentor training for 45 year 9 students who in turn support 250 11 year-olds moving up to secondary school is indeed good value for money.

It is becoming clear that in both Unitary and two-tier authorities there is poor communication and a distinct lack of joining-up of thinking, policies or strategies. Initiatives introduced to achieve the co-ordination are in some cases struggling to achieve any connectedness and for some are only serving to make the picture more complex. More and more layers of partnerships whether around Crime and Disorder, Primary Care, Children's Services, or local strategy are struggling to fit together or to keep in touch with the providers of services on the ground.

We are learning through the Early Intervention Initiative that by focussing on work within small neighbourhoods and providing co-ordination, enthusiasm and pump-prime funding we can effect change. The challenge is how to sustain that development and secure greater ownership of early intervention work within the planning frameworks of the major service commissioners and providers.

⁷ Spafford, J (2003) *Thames Valley Partnership Early Intervention Project – An interim evaluation*

The Healthy Schools Award and its Contribution to the Community Safety Agenda

Angela Snowling, Healthy Schools Co-ordinator, Windsor & Maidenhead Primary Care Trust

The first objective for this article is to give an overview of the national framework that enables national policy makers, local health and education strategy groups, community safety partners and healthy school task groups, within schools, to tackle community safety issues in a co-ordinated way. Secondly some examples of the wide range of community safety work implemented in schools and communities are outlined.

The National Healthy School Standard (NHSS): a framework for linked policy, planning and action

The NHSS is an excellent schools based programme within which educational, child, family and community related community safety issues can be addressed. Focusing as it does on facilitating and empowering children and adults to create the environments and facilities most relevant to their needs in a democratic and open manner the NHSS promotes inclusivity and democracy at the heart of learning.

Inclusivity and democracy are fostered by: -

- The use and development of schools councils and the creation of opportunities for children to meet and discuss issues of personal concern.
- Creation within each participating school of a "Healthy Schools Task Group" which comprises teaching staff, parent, community and pupils representatives.

To participate in the NHSS schools need to develop activity within the following nationally agreed categories: -

- Personal, Social and Health Education (including Citizenship)
- Drug Education
- Emotional health and wellbeing
- Healthy Eating
- Physical Activity
- Safety
- Sex and relationship education

Alongside the above categories, local schemes can identify other categories of particular interest or relevance.

As can be appreciated, under the heading of "Citizenship, Drugs Education, Emotional Health, Safety, Sex and Relationship Education" there are clear opportunities for both health and educational staffs to engage in, and be supported by a community safety agenda.

History

The work of individual healthy schools programmes in the UK was consolidated with the launch of the National Healthy School Standard (NHSS) in October 1999. It is a key part of the current Government's drive to "improve standards of health and education and to tackle health inequalities" (NHSS 1999). The NHSS provides a comprehensive standards framework for monitoring strategic and operational partnerships, local programme management and operational work implemented in schools.

The programme is based on a model of health promotion inspired by Caplan and Holland (1990) which involves two fundamental dimensions of healthy living. The first concerning the "nature of knowledge" such as what do we know, and the second concerns the nature of social living and behaviour, "the nature of society" (Naidoo and Wills 2000). Such a model of working enables national and local strategists, both statutory and non-statutory, to integrate their policies and targets into practice whilst maintaining a supportive, and validating ethos when working with Healthy School Task Groups. (Task Groups self evaluate their progress towards the National Standard, aided by local healthy school co-ordinators who facilitate access to a range of co-ordinated partnership support and training).

The programme in Berkshire is administered by a Healthy Schools Co-ordinator (employed by the NHS), who are responsible for liaison with the Department of Health and the DfEE, programme promotion, monitoring and evaluation. Local development work with individual schools is the responsibility of the locally based education consultant, who is employed by the Local Education Authority (LEA).

All local programmes are now accredited to the National Standard. Every Local Education Authority (LEA) and Primary Care Trust (PCT) in the country participates in a local, strategic, health and education partnership and employs one or more local healthy school co-ordinators to support local programme management, partnership links and work in schools. For details of your local co-ordinator and local health and education partnerships please see the national website (www.wiredforhealth.org.uk)

One of the functions of the local health and education partnership is to set targets for the direction of local healthy schools programmes and thus ensure that NHSS work is fully integrated into the action plans of a range of partners. Inter agency working is aided by sharing action plans and funding, which ensures that the operational work in schools is linked to joint objectives.

A typical action plan (monitored nationally) will identify work in schools and with pupils being educated out of school linked to a range of local strategies such as: - teenage pregnancy, community safety, drugs education, Children's Fund, Sure Start, Connexions, Health Improvement and Modernisation Plans (which include a range of action plans working towards the National Service Frameworks), Education Development Plans and Quality Protects plans, etc.

In practice this co-ordinated approach means that partners from a wide range of agencies can use the National Standard in support of their work at an operational level in schools.

Partners are encouraged to help with joint planning, training or delivery of interventions either across the whole school population or in targeted work with at risk groups.

How Do Schools Achieve Recognition as Healthy Schools?

Following attendance at training offered through the local programme, each school is encouraged to establish a local healthy school task group as described earlier. External agencies must represent the local community as well as the usual support staff from the statutory agencies. The work of the task group must be seen as part of the school improvement plan and they must become learning organisations, in which for example the needs of the whole school community with regard to community safety can be addressed.

In this respect the NHSS is able to incorporate other local and national initiatives. Within the Thames Valley area (Berkshire, Oxfordshire, Buckinghamshire), the Schools in Action (SiA) programme of the Thames Valley Partnership has been used as part of a wider NHSS programme but focusing particularly on community safety related issues.

An audit process follows in which the task groups self evaluate their progress towards the Standard and identify key themes they want to prioritise. Here the role of the local co-ordinator is key in facilitating awareness of access to national guidance or best practice, funding or local support for interventions.

Work then commences on all or part of the eight key themes (according to the needs of the school and how the local programme is designed) comprising: PSHE, Citizenship, drug education, emotional health and well being, healthy eating, physical activity, safety, sex and relationships education (SRE).

Examples of work implemented by local task groups in schools that reflect community safety concerns

- Whole school support for a continuing programme of policy and practice improvements in areas such as PSHE and citizenship, emotional health and well being, behaviour management, drugs education, health and safety etc. The participation of families, staff, governors and young people was key in developing this whole school approach owned by the community. The sharing of school facilities with lifelong learning programmes such as family education/literacy programmes.
- Young peoples' involvement in redesigning safer entrances, play areas, toilets and other buildings
- Ensuring adequate provision for quiet areas, active areas and covered areas that benefit both the school and community.
- Inset training for all staff (paid and voluntary) in behaviour management with improvements linked to styles of learning, special educational or medical needs.
- Training for school pupils in peer mentoring and peer mediation.
- Improved access to counselling and other family support services.
- Promotion of active participation by pupils in schemes, which benefit the community such as the Duke of Edinburgh Award or peer drugs education.
- Citizenship training for young people on running effective school councils.
- Improving links with local support agencies by ensuring representation on task groups by the local police, members of local youth offending teams, school nurses, educational welfare services etc.

As can be appreciated the above reflect re-occurring community safety and health themes. These being, social inclusion, action against bullying, promotion of personal and community respect, active citizenship, promotion of personal autonomy, responsibility and achievement.

To see further examples of the nature of the work implemented in local schemes go to the national website www.wiredforhealth.org.uk and select a local programme website. Further information on Schools in Action activity can be accessed via the Thames Valley Partnership website www.thamesvalleypartnership.org.uk.

Key Learning Points

- The National Healthy Schools Scheme (NHSS) provides an excellent opportunity for health staffs to focus on health issues that also have a significant community safety aspect
- Healthy School Task Groups would welcome positive external collaboration with groups with a community safety brief such as Schools in Action
- The NHSS is a flexible scheme able to respond positively and quickly to local issues and concerns.

References

DfEE The National Healthy Schools Standard. Getting Started – A guide for Schools (1999), HMSO

Naidoo J. and Wills J. (2002) Health Promotion: Foundations of Practice. Bailliere Tindall London

Mental Health – An Issue for Community Safety

Sue Raikes, Chief Executive, Thames Valley Partnership

During 2002 Criminal Justice Agencies and the NHS in the Thames Valley have engaged in a radical rethink of the way in which services are provided to those with mental health problems who come into contact with the criminal justice system. This positive initiative grapples with a problem that has challenged the health and criminal justice services for many years. At the centre of this work is a commitment to see mental health as part of the broader community safety agenda, and a recognition that improving the way in which we deliver services to those at the interface of mental health and criminal justice is an essential ingredient in our work for safer communities and public protection. This paper explains why, and how key agencies have come together to develop a more coherent approach to service delivery.

The current initiative builds on work by the Thames Valley Partnership over the last five years which has brought together practitioners and managers from the criminal justice agencies (particularly the Police, Probation and Prison Services) alongside those working in the NHS and Social Services. In 2002 the new Thames Valley Strategic Health Authority (TVSHA) and the Area Criminal Justice Strategy Group (ACJSG) both made a clear resolve to work together to improve the way in which services are delivered to this demanding and vulnerable group.

Few would argue that there are too many people caught up in the prison system who have mental health problems. Whilst precise definitions of mental disorder continue to elude the strategists, anyone who has worked directly within the NHS or in the criminal justice system will have no difficulty in recognising the client group that we are talking about. They will talk of chaotic lives, complex needs and the vulnerabilities of those whose mental health problems contribute to repeated patterns of offending and lead to the revolving door syndrome of police cell, court, prison and hospital. Revolving Doors, a mental health charity working in London and the Thames Valley, in their report "Mental Health, Multiple needs and the Police", identify a group of people with mental health and multiple needs who come into contact with the police and who fall through the net of housing and social care. Of these: -

- 80% had significant mental illness requiring psychiatric treatment
- 29% showed evidence of sole personality disorder
- Almost two thirds also had problems associated with drug or alcohol misuse

It is worth remembering that a national debate continues over the definition, status and treatability of a range of mental illness categories especially Personality Disorder. Over the last 20 years, numerous inquiries into tragedies have assigned responsibility - and blame - to other agencies for their failures of care or treatment. Meanwhile this group of shared clients/patients continues to make demands on primary care services, accident and emergency departments and Community Mental Health Teams. They present a daily challenge to police officers, courts and the Prison Service and in the end frequently fall between our complex structures and services.

In a more recent Revolving Doors report "Young People, Mental Health and Criminal Justice", they identified the problems had started at a young age, for example: -

- 83% of their client group had no mental health diagnosis before 22
- 21% had committed more than 100 crimes before turning 23

To respond positively to this challenge a new spirit of collaboration in the Thames Valley has come up with a radical agenda for change. We seek to ensure that this topic is seen as an important aspect of the broader community safety agenda, recognised by the crime and disorder partnerships across the Thames Valley as a legitimate focus for collaboration. It is nothing less than a new vision for the mentally ill.

A new vision for the Thames Valley

In 2001 the ACJSG and the TVSHA together prepared a radical solution to the intractable problems described earlier. Both started from a recognition that the services had been inadequate and inconsistent for too long and recognised a need for a greater understanding of the interaction between mental health needs and offending. The consultation document resulting from joint work "A Mental Health and Community Safety Vision" published in May 2002 recognises that the existing system does not always deliver positive outcomes for the client or the community in terms of reducing offending or provide a prompt service in reducing re-offending or relapse.

The strategy which is emerging from this work is based upon: -

- A multi-agency approach where shared responsibility is the key
- A commitment to social inclusion
- A recognition of the importance of community safety and public perception

The strategy recognises the problems and definitions of mental disorder that have beset this work for many years. It agreed its own remit to consider "the needs of those with some degree of mental illness, personality or other disorder, psychological disturbance or learning disability which leads to behaviour which may bring them into contact with the criminal justice system".

The strategy therefore encompasses a broad range of people with the following features and characteristics: -

- Complex multiple needs
- Long-term and repeating patterns of behaviour
- A possible deterioration over time exacerbated by the criminal justice system itself
- A continuum of need and a dynamic pattern of change, problems and behaviours
- Offending across the full spectrum from the relatively trivial to the very serious
- Often difficult to help through existing channels
- Known to a wide range of agencies and services
- In some cases a connection between mental health problems complicated by substance misuse

In attempting to identify the size of the problem the working group collected information from the criminal justice agencies and mental health services across the Thames Valley -

recognising that only when a fully integrated service was available could the full extent of need possibly be known. The information collected suggested that there was a reasonably constant demand in those areas where services had attempted to provide a more integrated approach.

A History of Mental Health and Criminal Justice

The development of services to people with mental health problems at the interface with the criminal justice system has, in the past received little government attention. In 1992 the Reed Report attempted to co-ordinate policy, highlighted the shortfall of services and made a total of 276 recommendations. The main thrust was the call for diversion of those with mental health problems away from the criminal justice system, in favour of treatment within the NHS. Implicit in this was a need for greater inter-agency co-operation between criminal justice and health at local levels. In 1997 the NHS again stressed the importance of multi-agency activity in "A Healthy Nation: A contract for Health" (1997).

In 1998 The Crime and Disorder Act set up a statutory framework in the same year for partnership working to reduce crime – involving health as a key partner. The report "Modernising Mental Health Services: Safe and Supportive" (1998) recognised that people with mental health problems often had complex needs, which crossed traditional organisational boundaries.

So What is The Link With Community Safety?

Community safety is a broad, partnership approach to preventing crime, reducing the fear of crime and improving the quality of life and well being. Precise definitions of community safety do not exist but this includes the remit of the 16 crime and disorder/community safety partnerships in the Thames Valley established by the Crime and Disorder Act 1998.

In April 2002 all crime and disorder partnerships published their next three-year strategies based on local audits of crime and disorder for each local authority area. Whilst mental health is rarely identified as central to the strategy, most partnerships would recognise the importance of the link through: -

- Public protection – risk assessment and intervention with those who have mental health problems that constitute a risk to the public.
- Community safety concerns – the perception of the public that those with mental health problems and particular those visible on the streets, are responsible for some kinds of crime, disorder and nuisance.
- Mentally vulnerable people – the recognition for the need for services to support mentally vulnerable people to live safely in the community and to reduce their vulnerability as victims of crime and harm by themselves or others.
- The mental health needs of young people – the importance of tackling risk factors including mental health and other behavioural problems in young people to prevent criminality.

Diversions and Networks

The Thames Valley Partnership has been working to support multi-agency initiatives in this field for the last five years, bringing managers and practitioners together, hosting

seminars and discussion groups and working with the key criminal justice agencies to improve their services. In 2000 we conducted a review of the services for those with mental health problems and complex needs who come into contact with the criminal justice system. Our report, "Diversion and Networks" (2001) showed that local statutory and voluntary agencies had often worked well together to find imaginative ways of improving services but that these local schemes are ad hoc, they operate with insecure funding and a heavy reliance on the voluntary sector. The good practice that had developed in some areas was not supported by any strategic commitment to develop a comprehensive service. The report went on to identify the key components for a comprehensive service for assessment, referral, support in the community and for those detained in custody. It also identified the need for significant work in some areas of the Thames Valley where very few of these services were in place. In 2002 joint work with Revolving Doors on "Pilots into Policy" formed the basis of a national seminar for key policy makers last year identifying the key elements of what works in practice: -

- A range of different interventions
- Flexible delivery of service
- Good assessment of risks and for treatment
- Good links between agencies
- A seamless service that can stay with people through the system

Where Are We Going?

The Thames Valley Mental Health and Community Safety Vision is proposing a new multi-agency structure for the delivery of service. It is proposed to implement the new structure over a three-year period starting in two selected areas. The proposal draws from the experience of managers and practitioners in the NHS and in the criminal justice system and presents an exciting and radical proposal for the future. The jigsaw however is not complete. Community safety partnerships and crime and disorder structures have not yet grasped the importance of this issue for their own agenda. The problems of anti-social behaviour, low level disorder and the fear of crime which are so much the concerns of community safety partnerships need to see the new community safety and mental health proposals as a real contribution to improvement of community safety. The new arrangements for public protection developing rapidly through the multi-agency public support the protection panels (MAPPPS) also need to link in with the new multi-agency structures focus on those with mental health problems as a real contribution to improving public protection.

We believe that the proposals in the Thames Valley are groundbreaking work. Whilst we have links with what is happening in other parts of the country there is no doubt that the commitment to joint working, the recognition of the complexity of the problem and the willingness to look for radical solutions puts this initiative at the front of national developments. There is a visionary lead coming from strategists and policy makers in the Thames Valley, which seeks to break through these longstanding barriers and look at the problem from the position of those who desperately need a better and more integrated service.

Key Learning Points

- The contested nature of what constitutes mental illness is not a bar to successful multi-agency working between health and other criminal justice partners
- Those experiencing mental illness (including Personality Disorder) are uniquely vulnerable from inadequate services and their own pathology
- Failure to tackle child and youth mental health concerns exacerbates their mental illness status in later life
- Mental Illness is a Community Safety issue in which the NHS can play a leading role
- New multi-agency service provision is possible with commitment & vision from senior management