NORTHAMPTON BOROUGH COUNCIL

Overview and Scrutiny

Scrutiny Panel 1 – Serious Acquisitive Crime & Violent Crime and Community Safety

CORE QUESTIONS – ACCIDENT AND EMERGENCY DEPARTMENT, PUBLIC HEALTH

Serious Acquisitive Crime

1. WHAT ACTIVITY AS AN ORGANISATION/DEPARTMENT DO YOU UNDERTAKE TO ADDRESS/TACKLE ISSUES OF SERIOUS ACQUISITIVE CRIME (BURGLARY, ROBBERY, THEFT FROM/THEFT OF A VEHICLE)?

The A& E department is based within Acute Trusts as Providers, whilst the Public Health department resides within the Commissioner organisation, the Primary Care Trust.

The A& E department is a medical treatment facility that provides initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate life-preservation attention. The A& E department is also an important entry point to specialist, tertiary care, and often serves as the route to NHS-provided health care, and even social care, for those without other means of access to medical care, such as unregistered homeless, problematic drug users.

On arrival to A&E patients are assessed, prioritised, and treated as is appropriate to their clinical need. The A& E department also works to improve the patient experience by aiming to ensure that all patients are seen and treated within 4 hours from arrival.
There is also a dedicated area for children within the A&E department.

The A& E department operates 365 days a year, and is staffed 24 hours a day, thereby constituting a reliable gateway to multiple specialisms of health service provision for the entire community.

Figure 1 :Activity within the Accident and Emergency department

Public Health epidemiologists have increasingly recognised that situational and social crime prevention require multi-agency commitment and an understanding of the complex dynamics that operate within society. Public Health also acknowledges that different types of crime have different causes and it is thus essential to gain a better understanding of the nature and circumstances of the crime in order to begin to tackle it more effectively.

To this end, audit, research, policy formulation and translation, strategy development, implementation planning, monitoring and evaluation are all Public Health skills that can be brought to the table to assist the multi -agency work of successful crime prevention and management.

With regard to SAC i.e. serious acquisitive crime, which is a proxy term used by Police and Community Safety partners for problems relating to the use and abuse of illegal drugs such as Cocaine, Marijuana, Benzodiazepines, "legal highs" etc., some examples of the contribution of the NHS Northamptonshire and the Public Health department, are provided in the following non-exhaustive listed examples :

Public health -Analytical profiling and epidemiological resources, e.g. of hospital activity data, cause of death statistics, surgical activity profiles, all informing service commissioning and delivery and models of care e.g the establishment of the role of the accident and emergency alcohol liaison nurses. On a national level, the establishment of the VIPER database-Violence Indicator Profiles for England Resource, has been informed by significant Public Health input.,
Evidence-based Health improvement services have also been informed by Public Health, such as Substance misuse needle exchange programmes, and Alcohol awareness-raising campaigns, Fresher's week initiatives, the development of validated tools for identification of early alcohol misuse, the commissioning of individual brief advice (IBA) in primary care, and the introduction of detection tools and performance measures to encourage practitioners to raise the question of alcohol abuse during routine clinical consultations.

Treatment work-provided across both Acute Trusts of Kettering General Hospital Foundation Trust, and Northampton General Hospital, with gateways to access being the A& E departments, referrals in from GPs, and various speciality Clinics and Outpatient units, such as the Community Drugs' and Alcohol services within the County, supported by the NHS lead Mental Health providers, Northamptonshire Healthcare Foundation Trust (NHFT). Emergency management of wounds and injuries arising from violence precipitated by the use of these drugs, In-patient management at the Acute and Crisis management by the Response teams of the Mental Health Services' Trusts, including the provision of clinically managed detoxification services.

Rehabilitation work-Commissioning of services for the Clinical management and of complications such as strokes, liver disease, nutritional conditions, neurological complications such as bipolar mental illness, dental problems, management of blood borne virus infections and other blood infections (septicaemia) associated with injecting drug use, to name a few.

2. WHAT ACTIVITY AS AN ORGANISATION/DEPARTMENT DO YOU UNDERTAKE TO *PREVENT* ISSUES OF SERIOUS ACQUISITIVE CRIME (BURGLARY, ROBBERY, THEFT FROM/THEFT OF A VEHICLE)?

Prevention work by the Public Health department –This includes the provision of information, education and awareness resources , including those relating to psycho-social diagnosed that present as antisocial behaviour, alcohol-related injury and long term conditions arising from crime and disorder, and youth offending; contribution to school SRE –sex and relationships education-and

PSHE-personal, social health and economic education-which in brief can be described as 'learning to live life well'- curriculum delivery through School Nursing; leadership of designated Theme days such as providing the NHS Health Bus [at Corby] during the Alcohol week of action or the "Stop-tober" month focusing on smoking cessation; provision of school "Drop in" advisory clinics; provision of primary, community and tertiary care including maternity care and specialist drugs' and the design of care pathways and service specifications for alcohol harm prevention services at primary, secondary and tertiary levels of prevention.

We also contribute to activity reports to partners which inform planning and mitigating operations e.g. Minimum Alcohol Unit Pricing, Proxy purchasing, Drug-related death reviews, Prison health services' activity monitoring; National Treatment Agency performance monitoring, quality improvement and drug alerts.

3. WHAT DO YOU SEE AS THE MAIN ISSUES AND BARRIERS TO SUCCESSFULLY ADDRESSING SERIOUS ACQUISITIVE CRIME WITHIN THE BOROUGH OF NORTHAMPTON?

The following are [not listed in any order of priority] some of the key considerations:

a) Family stability, structures and supports- Promoting stable family relationships and structures so that informal support systems are in place to cushion early problems and highlight issues sooner as problems identified earlier tend to be more amenable to easier or less costly solutions. It is a well-recognised fact that most drug abusers tend to isolate themselves from family, friends and others and may end up surrounded by enablers and toxic peers who are bound by the same addictions and challenges, which make it difficult to break away. Abuse within families may also lead to young household members abandoning the family for the streets. Homelessness and "rough sleeping" could ensue, and these in turn could lead to substance misuse and the downward spiral of a life of serious acquisitive crime.

b) Educational attainment-Full-time educational or other gainful occupation for children and young persons-Research has shown that truants have a significantly higher incidence of illegal drug use, underage drinking and smoking than non-truanting pupils, and rates of substance misuse increase over time. Also Pupils who have been excluded from school report a significantly higher incidence of illegal drug use, underage drinking and smoking than their non-excluded counterparts. Early intervention targeting health risk behaviours may have some part to play in diminishing truancy rates. However substance misuse is only one part of a complex set of behaviours and adverse circumstances associated with both truancy and exclusion. Gender differences may also be significant as research has found that patterns of truancy vary amongst the sexes, with early i.e. primary school truancy being predominantly a male activity and later truancy i.e. secondary school, principally a female activity.

c) Healthy neighbourhoods-Young people who come from deprived neighbourhoods are over-represented amongst truancy and school exclusion statistics. A range of community level, multi-agency strategies

aimed more broadly at the promotion of community safety, reducing the problems caused by youth crime, improving parenting skills, supporting families and addressing the problems posed by unemployment and social isolation would contribute to reducing the problem.

d) Teenage pregnancy reduction, sexual health and contraception initiatives-a drug mis-user with a family is more likely to scale up their "acquisitive" activities to meet the needs of their dependants.

e) Stemming the availability of drugs on the streets or within the community-which would include a combination of border and customs patrols and vigilance, international co-operation, immigration legislation and controls, police enforcement, specialist rapid response "substance" teams, and community awareness interventions, at least, for success.

f) Funded, rolling programmes of public education and awareness around substance misuse, particularly targeted at the young (under 25s), and delivering consistent messages about illegal drug use, underage drinking and smoking. Message content should be consistent around the fact that all drugs are "potential poisons", the safety window is individually variable, and with emphasis on an acknowledgement of the fact that abuse of drugs without apparent ill-effect does not necessarily imply that the abuser has not suffered damage to their tissues and organs because the damage caused may not manifest till later on in life. Furthermore, there is not necessarily a linear relationship between dosage used and resulting harm, and there may be no second chance to first time usage for some individuals who experience fatal initial reactions. Many illicit drugs are frequently taken together as "cocktails," often in conjunction with alcohol, and these combinations can have complex synergistic interactions, with potentially life-threatening effects. Therefore the "Just say No" message should be marketed as the best message.

g) Promoting population health and well-being and the availability of supports to ensure that healthy choices are more attractive options and are made easier for the community e.g. needle and syringe exchange and harm reduction services, vaccination against blood borne viruses healthy eating and anti-obesity services especially as low self-esteem and body image concerns have often led young persons to experiment with drugs of addiction;, physical activity promoting opportunities of exercise and sport in community infrastructural designs-as these potentially can effectively divert young people from initiating tobacco use and substance misuse; health checks which could lead to the identification of problems at earlier stages that are more amenable to less expensive treatments; and cardiac health services for substance misusers. The latter is important as- in addition to their effects on the central nervous system, many of these agents of abuse induce profound changes in the heart and circulation that are responsible for a significant proportion of drug-related morbidity and mortality; to name a few.

h) Funding to refresh professional education and achieve skills updates in practitioners, around appropriate prescribing to ensure that iatrogenic drug dependencies are avoided e.g. prescription drug abuse is not uncommon in those suffering from physical pain from car accidents, wartime trauma, cancer or a whole host of physical ailments?

i) Funding a range of rehabilitation options-For recovering abusers, long-term recovery is greatly assisted or catalysed by the availability of appropriate sheltered jobs or apprenticeships and employment, suitable supervised housing, alternatives to mainstream education such as evening classes, subsidised or cost-free access to legal advice-especially as many of them may be in the process of exiting lives of crime and may have residual obligations. Multi-agency support with transportation and ongoing health care, for instance to deal with the complications of lives of abuse such as blood borne virus infections, need to be available locally to meet existing need

4. WHAT ACTIVITY DO YOU UNDERTAKE IN PARTNERSHIP WITH OTHER ORGANISATIONS/ DEPARTMENTS TO TACKLE ISSUES OF SERIOUS ACQUISITIVE CRIME WITHIN THE BOROUGH OF NORTHAMPTON?

Crime affects the quality of life of every Northamptonshire resident. Therefore, reducing crime and building safer communities must be and is a priority for all public sector agencies in this county.

Public Health contributes in a specialist capacity to a number of multi-agency and multi-disciplinary working and strategic groups dealing with the root causes and consequences of drug and alcohol abuse such as:

a) Specialist Public Health support to the commissioning, delivery and monitoring of health care delivery in HM Prisons

b) Contribution to the County's Co-ordinated Community Safety Partnership Board agenda

c) Specialist support to the Substance Misuse Harm Reduction group, providing public health and infectious disease's control advice to the Drug and Alcohol Action Team (DAAT); informing the annual work programme; and lead the clinical review of the Drug-related Deaths at the periodic Review meetings

d) Contribution of Strategic NHSN Commissioner input to the Sexual Assault Referral Centre (SARC) –Serenity Commissioning Board

e) Strategic NHSN Commissioner input to the Interpersonal violence prevention and governance agenda

f) Provision of specialist Public Health advice to inform Commissioner procurement and various Clinical Provider contracts' specification

g) Funding and promotion of themed public information, awareness-raising and education events

h) Commissioning of research and evaluation of pilot projects and development of the local evidence-base.

i) Provision of regular and periodic public media, primary care and other public health service and policy guidance briefings and communications, proactively and in response to requests.

j) Provision of expert public health advice to workforce development programmes including research proposals, informing objective definition, research scope and methodologies as relevant to Northamptonshire

k) Leading different Vaccination and Immunisation programmes and developing, planning and specifying the provider service contracts and health care pathways in line with DH and appropriate guidance

l) Leading on Sexual Health and STI –sexually transmitted infection-prevention and management programmes and their commissioning, and developing the different agendas and work plans

m) Leading on Antenatal and Neonatal Screening programmes and infectious diseases in pregnancy screening, and informing contract specification, performance monitoring and service planning and for those at higher due to a "chaotic" lifestyle of substance misuse.

n) Contributing to the development of the evidence base to inform patient-centred care pathway developments, service improvements e.g. A& E Alcohol liaison work, and integrated partnerships.

o) Contributing to the overarching quality improvement agenda through service activity monitoring at different tiers of NHS healthcare provision, outcomes evaluation, care pathway reviews, operational research, and feedback to policy makers and Commissioners to deliver patient-centred improvements.

5. HOW CAN NORTHAMPTON BOROUGH COUNCIL FURTHER HELP YOUR ORGANISATION TO TACKLE SERIOUS ACQUISITIVE CRIME AND ADDRESS ANY BARRIERS, IN ORDER TO ACHIEVE POSITIVE REDUCTIONS?

An understanding of the nature of substance addiction is essential to informing positive reductions in SAC in the community.
Drug addiction has been defined (medically) as a condition characterized by an overwhelming desire to continue taking a drug to which one has become habituated through repeated consumption, because it produces a particular effect, usually an alteration of mental status. Addiction is usually accompanied by a compulsion to obtain the drug, a tendency to increase the dose, a psychologic or physical dependence, and detrimental consequences for the individual and society.

Common addictive drugs are barbiturates, alcohol, and morphine and other opioids, especially heroin, and identifying the specific drug combinations being abused such as through the commissioning of toxicological laboratory testing provides fundamental insights that will inform the development of effective solutions to the problem.

Based on the above definition, an addict will continue to engage in certain behaviours despite facing potential health risks, financial problems, shattered relationships or even arrest, and these consequences tend to become increasingly more serious.
Importantly, the addict's behaviour is out of their personal control, and unsupervised discontinuation of use of the abused drug in an addict may produce withdrawal symptoms or an abstinence syndrome which is the characteristic of opiate addiction, which require clinical intervention. This raises the question of whether drug addiction is to be considered a **crime** or a **disease**?

From a public health/NHS perspective, the most important actions would be:

a) Ensuring services and staff are well informed and increasing client awareness through education

b) Making every contact count and raising Public awareness to encourage and empower every individual and institution to take responsibility to recognise early signs of substance misuse and appropriately manage violence and its different causes.

c) Addressing lack of staff capacity, service funding gaps, and updating staff skills in line with evolving evidence.

d) Utilising appropriate technology to bridge manpower gaps or secure enhanced specialist input e.g. telemedicine can be more intimate than the in-person experience and can be used in sexual assault investigations to obtain expert professional opinion.

e) Investing in the development and strengthening of simple but effective collaborative working e.g. the benefits of four harm reduction strategies are well proven i.e. needle exchange (community pharmacy and shared care GP services), moderate drinking goals (primary and community care), methadone treatment (mental health and addiction services), and provision of free condoms to clients (sexual health services). These delivered in combination by integrated services could potentially achieve synergistic results and improved outcomes.

f) Being committed to strengthening the connection between the community and the individual through the promotion of community cohesion, e.g. by using intelligence derived from Police or analytical products such as the Vulnerable Localities Index (VLI) to target resources more effectively to

achieve the most impact. A caring, cohesive, healthy community is an important part of crime prevention and individual rehabilitation.

g) Investing in Innovation- supporting national models with potential for, prevention, treatment, recovery support e.g. the Kettering Dynamic Emergency Care Centre, law enforcement e.g Integrated Offender Management, social services, healthcare, judicial e.g. Court diversion schemes, education, faith and spiritual support e.g. Street Pastors, and networking to support programmes through shared resources, and skilled staff.

h) Supporting multi-agency collaboration to implement recovery advocacy by increasing access to research, policy, organisational and technical support; facilitating relationships among local and regional groups; improving access to policymakers and the media; and providing a local and regional rallying point for recovery advocates.

i) Promoting volunteering especially within the recovery community to foster peer-promoted recovery. Peer-to-peer recovery support services are support from people who've been there and are in a position to share their experience, strength, and hope in many ways, and have been proven by research evidence to be effective.

j) Improving options for Continuing Care/Personal budgets, and aiming to make available services appropriate to accommodate diversity, accessible regardless of ability to pay, ethnicity, race, gender, age or sexual/gender orientation.

k) Planning ahead using public health analytical data on trends and evidence, and taking account of the population demographics. For instance, an expanding population of older residents is forecast for the county. Some of these individuals will suffer from addictions which will be compounded by co-morbid conditions such as Diabetes, hypertension, and prostrate problems. These will create the need for much more complex care interventions and new models of service delivery, which would need to be tailored to support the affected individuals in coping with their addictions and chronic conditions. For instance, future service models need to be prepared to deal with increasing conflicts and stress in the elder addict , who may personally be unable to meet health demands aggravated by the addiction such as dementia or mobility problems.

6. WHAT DO YOU SEE THE ROLE OF THE POLICE CRIME COMMISSIONER TO BE IN PREVENTING AND TACKLING SERIOUS ACQUISITIVE CRIME AND VIOLENT CRIME?

a) Serving as Strategic Champion and leader supporting multi-agency partnership teams working to prevent and manage crime.

b) Committing financial and other resources to enable the development of measures and interventions that are evidence-based, and cost-effective.

c) Lending the weight of their support to the development and implementation of a comprehensive violence prevention strategy in the county, which integrates the different types of interventions of proven effectiveness.

d) Being receptive to and respecting the advice of professional colleagues, and protecting more effective frontline policing, strengthening intelligence and enabling the frontline to work smarter to prevent, as well as tackle, crime and to deliver effective and safe services to the public.

e) Forging links with the new public sector organisations and architecture, thus leading to the provision of appropriate resource support to achieve the maximum possible gains for the community's health and well being.

f) Acting as the principal advocate and communicator, responsible for raising the awareness of and securing the commitment of corporate executive leads towards their potential contribution to violence reduction in Northamptonshire.

g) Serving as county Ambassador to Central government and promoting the work of the county to ensure that funding streams continue to flourish, leading to a thriving community of residents free from the limitations of violence or fear of its consequences to individual residents.

h) Supporting Public Health professionals especially, as partners in their role of coordinating and leading programmes on violence prevention across all tiers.

i) Supporting the "Troubled Families'" agenda, and prioritising the prevention of gang violence, Violence can be used by gangs, for example, to generate and maintain respect, defend territory, obtain resources and punish transgressions. Gangs tend to be concentrated in areas of high deprivation and attract disadvantaged and excluded youths, many of whom experience problems at home and school. Alcohol and violence can be linked in many ways, and focusing on promoting more responsible use of alcohol at all levels, would minimise the contribution of alcohol to violence in this county, and go along way towards reducing or eliminating different types of violence including domestic, and assault with injury.

j) Tackling issues such as under-age drinking, minimum price per unit for alcohol, a restriction or ban on the sale of multi-buy alcohol discounting, provision of stronger powers for local areas to control the density of licensed premises, and the piloting of sobriety schemes to challenge alcohol related offending, are examples of interventions of proven effectiveness that come readily to mind.

k) Addressing social inequalities, which constitute risk factors, not only for youth violence, but for individual and public health.

VIOLENT CRIME

1. WHAT ACTIVITY AS AN ORGANISATION/DEPARTMENT DO YOU UNDERTAKE TO ADDRESS/TACKLE ISSUES OF VIOLENT CRIME?

Some of these have been highlighted in the foregoing sections. Examples of activity are listed below:

a) **Investment in Analytical public health-** Public Health analyses gathers intelligence about violence and enables us to profile the risks, target effective interventions, and objectively evaluate outcomes.
It cannot be over-emphasized that Violence is a major public health issue that affects millions of people across England.

Several characteristics of violent crime have been revealed by public health enquiry, some of which are enumerated in the following section, and should inform integrated efforts at reducing or preventing violence in the county:

VIPER: the Violence Indicator Profiles for England Resource is an online Public Health resource that provides access to local authority level data on violence, and is hosted by the North West Public Health Observatory.
At a local level, the collation and sharing of multiagency data on violence is critical to understanding the impact of violence on local populations, which groups or communities are most at risk, what types of interventions are needed and ultimately how effective they are at preventing violence.

The Department of Health (October 2012) estimated that Violence causes around 35,000 emergency hospital admissions and over 300,000 emergency department attendances in England each year. The burden of violent crime is therefore not an insignificant contributor to health service cost pressures.

The Home Office's Drug Treatment Outcomes' Research study (DTORS) has estimated that a drug user will commit an average of 10.24 crimes per month before entering treatment. In 2010/11, 1780 drug misusers were engaged in effective treatment in Northamptonshire (NCC's BIRT,September 2012).Partners in the Police, Criminal Justice and Probation services will recognise the effects of repeat offending on their workload.

Drug treatment also has a positive impact on criminal conviction rates.

Alcohol misuse often co-travels with substance misuse. Locally in Northamptonshire, analytical work (NCC 's BIRT, September 2012) has revealed that there are an estimated 146,000 binge (over 6/8 drinks per day) drinkers and a further 37,000 higher risk (over 35/50 drinks per week) drinkers in the county with a population of 691,952 individuals. This equates to approximately 1 in every 3.8 individuals in this county!

During 2010/11, there were 2118 Alcohol-related admissions in this county.

For every hospital admission for violence, studies have shown that a further ten assault victims require treatment at accident and emergency departments (A & E).

We also know that A & E assault attendances peak at weekend nights, and are often related to alcohol. It has also been estimated that 35% of all A& E attendances (2003 Cabinet Office MORI poll) were attributable to alcohol consumption.

Rates of both hospital admissions and A & E attendances for violence are highest in young males from deprived communities.

Offender insights also assist prevention efforts. For instance with regard to Homicides, the evidence shows that Child victims were most commonly killed by parents or step parents and adult victims by friends and acquaintances (for male victims) or current or ex-partners (for female victims.

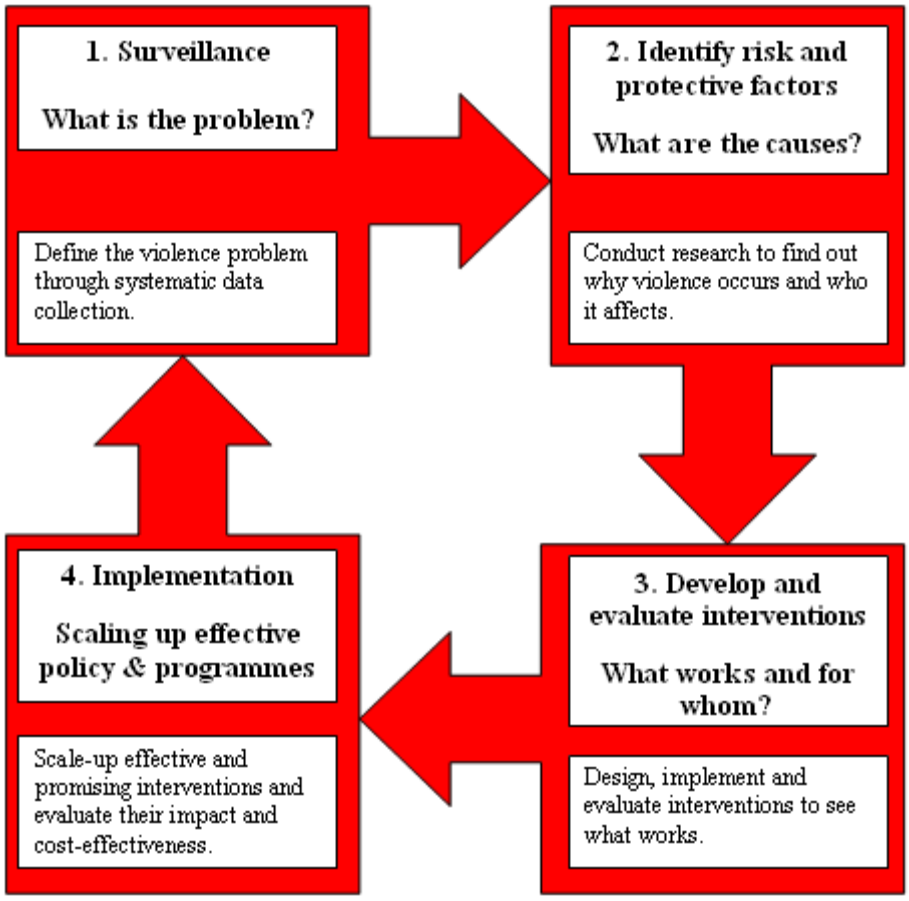
Alcohol costs to the Northamptonshire county have been estimated at £139m a year, collectively to the NHS, Crime, Social services, and the workforce and wider economy. In financially austere times any savings made through effective prevention and management efforts could fund other vitally important services.

The Cabinet Office Strategy Unit estimated in 2011 that alcohol related harm costs every household in England and Wales approximately £925 a year (including costs relating to health, police, fire, un-employment and community cohesion). The opportunity costs per household are likely to include loss of health and well-being.

The above have highlighted some of the principles of public health and provide a useful framework for both continuing to investigate and understand the causes and consequences of violence, and for preventing violence from occurring through primary prevention programmes, specialist clinical screening, diagnostic and therapeutic service input, rehabilitation, policy interventions and advocacy.

The public health department also adopts a stepwise approach to tackling issues such as violent crime.

Figure 2: The stepwise public health approach



Source: WHO-Violence Prevention Alliance. http://www.who.int/violenceprevention/approach/public_health/en/index.html 5th December 2012

Violent crime is recognised to be a complex subject and its scope and nature is influenced by a broad range of factors, some of which (like the wider determinants of health) are amenable to intervention, whilst others are less so.

The public health input seeks to understand the distribution, determinants and deterrents i.e. epidemiology, to inform effective prevention and management.

Public health recognises that there may be significant overlap between different categories of violence, thus making differentiation, the targeting of effective interventions, and the assessment of successful outcomes quite complicated. Some of these will be teased out in the following sections, and should serve to inform the efforts of partners at effectively mitigating the problems of .violent crime in Northamptonshire.

The World Health Organisation defines violence as: *"The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation"*.

The context of the violence is also of relevance, for instance in Domestic Violence, which has been defined by Women's Aid (Voluntary sector partners) as: "Physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of co-ercive and controlling behaviour"

The term **sexual violence** covers a wide range of abusive acts directed towards an individual's sexuality, including sexual assault, rape, sexual coercion, sexual bullying and female genital mutilation.

Also, adult sex offenders are more likely than non-sex offenders and non-offenders to have suffered childhood sexual abuse themselves. Family and Community structures have a role to play in the aetiology of childhood abuse.

In other instances, the cause of the violence is key and readily presents a number of options for solution, such as alcohol-related violence.

Particularly worrying dimensions of violence also relate to the stages in the life course when they occur e.g. Child and Elder abuse, and these demand specialist and often more intensive supports and remediation.

Child abuse or maltreatment includes all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power.

DH commissioned research has revealed that a significant proportion of children suffer abuse and neglect. Also all forms of child maltreatment are underreported, and only a small proportion of cases are likely to come to the attention of services.

Examples of risk factors for child abuse revealed by Public health profiling include:

- Unplanned pregnancy
- Single parent household
- Young, poor parents
- Socially isolated parents
- Parental alcohol consumption and drug use
- Domestic violence in the home
- Child disability or illness
- Child behavioural problems

A wide range of studies have shown that children who suffer violence and other adverse childhood experiences are at increased risk of further victimisation and of becoming perpetrators of violence in later life.

At the other extreme of life is Elder abuse.

Elder abuse has been defined as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, which causes harm or distress to an older person.

- DH research has shown that one in forty older patients seen by the average general practitioner or family physician will be suffering from abuse or neglect.
- The prevalence of maltreatment of older people was highest in those aged 85 and over, at 4.1%.
- Overall, females were more likely to report maltreatment (3.8%) than males (1.1%).
- The most common form of maltreatment reported was neglect (1.1%), followed by financial abuse (0.7%), psychological abuse (0.4%), physical abuse (0.4%) and sexual abuse (0.2%).

Examples of risk factors for elder abuse revealed by Public health profiling include:

- High levels of dependence
- Mental and cognitive disorders
- Carer alcohol consumption and drug use
- Carer financial problems
- Carer burnout
- Social isolation
- Lack of social support
- Age discrimination

Public Health also acknowledges that violence can be categorised in alternative ways which would change the emphasis of the findings, such as under the four broad headings of:

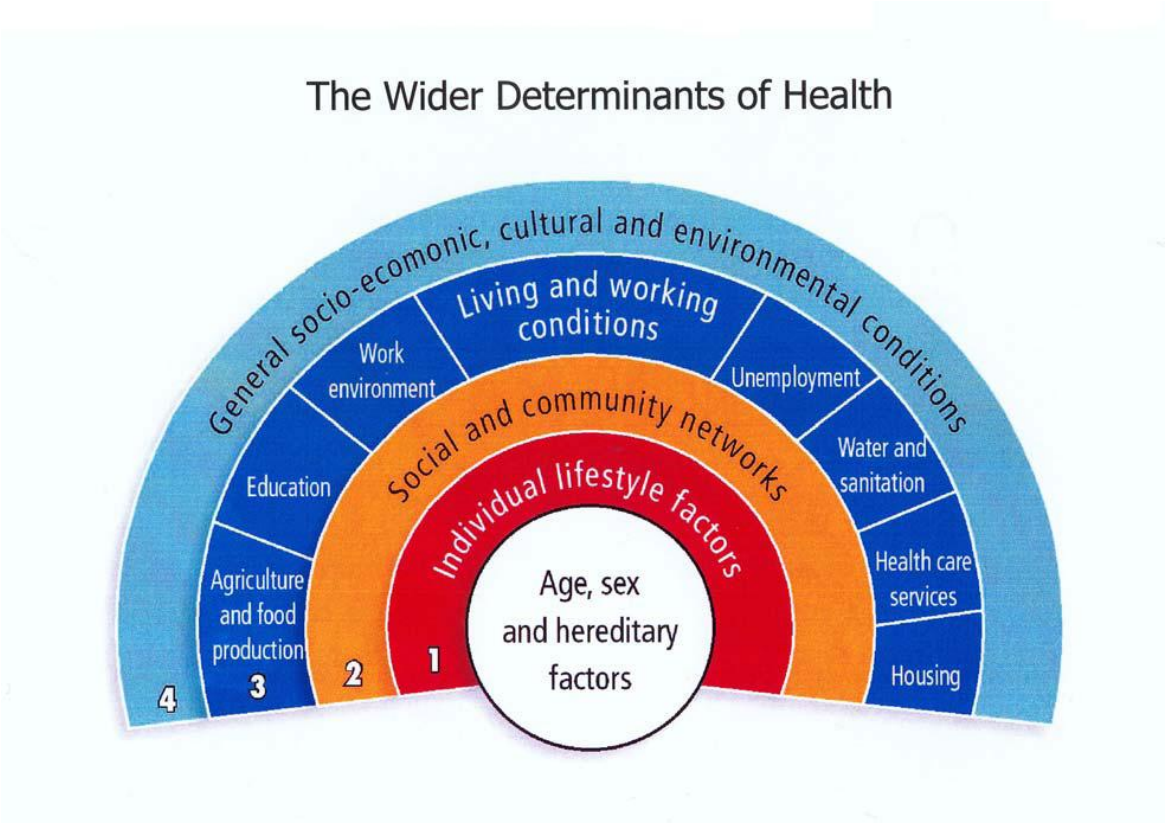
- Physical
- Sexual
- Psychological
- Deprivation

Public health has a major role to play in providing the in-depth analyses that informs the most effective and high-impact interventions, whichever perspectives are being considered across the different categories.

Much in the same way as we recognise the different social determinants at play in the manifestation of “health status” of an individual, violence, as a key Public health concern is also influenced by multi-factorial issues, which in turn could serve to inform efforts to successfully prevent and effectively manage violence.

As evidence in the foregoing, there are wider determinants of violence,much in the same way as there are wider determinants of health:

Figure 3: The Wider determinants of health:



Source: Dahlgren and Whitehead (1991)

The successful prevention of violence requires attention to pertinent community issues such as poverty, inequalities, education, housing, employment and crime. These issues in turn represent determinants of health, strongly contribute to health related societal inequalities, and therefore remain key priorities for public health. Indeed the DH's 2012/13 public health outcomes' framework highlights inequalities as a continuing priority for public health.

From a health service utilisation perspective, research shows that the poorest fifth of society suffer rates of hospital admissions for violence five times higher than those of the most affluent fifth (Source: Protecting people: Promoting Health- A public health approach to violence prevention for England, DH and NW PHO, October 2012).

Disadvantaged groups therefore suffer higher rates of violence, and this can reduce economic participation, social well-being and health outcomes

for people in these groups and contribute to increasing inequalities. Interventions targeted specifically at these groups are therefore likely to achieve greater gains for the wider community.

Research has proved that abuse in childhood increases risks of violence in later life, but also risks of cancer, heart disease, sexually transmitted infections, substance use, and a wide range of health conditions that are currently stretching health care resources..

Safeguarding and Child protection teams bear testament to the cross-cutting problems arising from the different dimensions of violence listed above, and those teams need to be prioritised for resource allocation.

The development and ongoing clinical governance of the county sexual assault referral centre (SARC)-Serenity has been made possible with significant public health contribution.

Psychological violence manifests itself in a number of conditions-ranging from behavioural deviations, lack of mental health and well-being, to different levels of offending behaviour leading in turn to criminal activities, custodial sentences, and sadly, sometimes even homicides/suicides. Again the contribution of health to prevention and management programmes cannot be over-emphasised. These skills will also be required when Domestic Homicide Reviews are being conducted at the request of the Police and Crime Commissioner.

The following non-exhaustive list summarises the Public Health initiatives directed at addressing the issues of alcohol-fuelled violent crime/violence:

- The implementation of year three (£460K) of the alcohol treatment business case, funded by NHS Northamptonshire (NHSN) to provide community based alcohol treatment services. These have been recognised by the National Treatment Agency as high quality evidence based interventions.
- The collection of assault data at Accident and Emergency Departments has supported partnerships in their local planning to mitigate the problems of alcohol and violence.
- The delivery of the alcohol social marketing campaign targeting young people. The alcohol harm reduction campaign, *'Another Night Wasted'* aimed at under 25 year old, binge drinkers involved TV advertising, website development of www.likeadrink.com, outreach activity with young people in clubs/pubs in the county and the production of various merchandise including survival guides and alcohol-test cards.
- The partnership joint approach to dealing with alcohol harm in Northamptonshire supports cost effective community based treatment and advisory services which is contributing to the success of the Northamptonshire Alcohol Harm Reduction Strategy.

Other broader Public health actions directed at tackling crime include the following:

- Working collaboratively with wider partners such as the Police, Criminal Justice, Probation, and Fire and Rescue service, and third sector agencies.

- Informing policy and corporate and partnership strategic plans such as the Joint Strategic Needs' Assessment and the county Health and Wellbeing Strategy.

- Contributing to public education and targeted prevention interventions such as Suicide prevention, Teenage rape prevention, Alcohol awareness, "Choose well", "Right Care" and similar funded/commissioned schemes.

- Commissioning the provision of clinical care including acute surgical intervention, health promotion, and longer-term specialist input e.g. maxillofacial surgery to correct "bottling injuries", delivery of "IBA-Initial Brief Advice" to alcohol mis-users via GP surgeries, and the management of acute intoxication and chronic abuse through specialised substance misuse management services.

2. WHAT ACTIVITY AS AN ORGANISATION/DEPARTMENT DO YOU UNDERTAKE TO *PREVENT* ISSUES OF VIOLENT CRIME?

Much of this has been covered already in the foregoing sections-understanding the problem and its determinants is essential to effective prevention and management. The below sections further emphasize and summarize the vital contribution of public health to the crime prevention agenda.

a) Understanding patterns and enquiry

Public health as one of its core functions seeks to understand the distribution, determinants and deterrents of conditions or issues of interest to the public health.
All societies experience violence, but its context - the circumstances in which it occurs, its nature and society's attitude towards it - varies greatly from one setting to another. Wherever prevention programmes are planned, public health facilitates an understanding of the context of violence by the application of tools and methods of enquiry which inform policy, strategy, and improve understanding in order to tailor the intervention to the targeted population.

Violence is not something that just happens, nor is it normal or acceptable in our society. Also it is well recognised that a wide range of factors relating to individuals, their relationships, and the communities and societies in which they live can interact to increase or reduce vulnerability to violence.

Public health research has confirmed that many of the key risk factors that make individuals, families or communities vulnerable to violence are changeable.

Understanding these factors means we can develop and adopt new public health based approaches to violence. Such approaches focus on the primary prevention of violence through reducing risk factors and promoting protective factors over the life course.

Some cross-cutting risk factors for violence for individuals, communities, and society at large, have been elaborated upon in foregoing sections, and include but are not limited to:

Cross-cutting risk factors for violence:
- Poverty
- High unemployment
- High crime levels
- Local illicit drug trade
- Inadequate victim care services
- Economic inequality
- Gender inequality
- Cultural norms that support violence
- High firearm availability
- Weak economic safety nets
- Poor parenting practices
- Marital discord
- Violent parental conflict
- Low socioeconomic household
- Delinquent peers or “NEETs”
- Victims of child maltreatment
- Psychological/personality disorder
- Delinquent behaviour
- Alcohol consumption/drug use

The above are discussed in greater depth in the Department of Health’s commissioned publication titled ”Protecting people Promoting health -A public health approach to violence prevention for England” .by North West Public Health Observatory at the Centre for Public Health, Liverpool John Moores University (October 2012).

b) Prevention effort

A range of different interventions throughout the life course can reduce individuals’ propensity for violence, lower the chances of those involved in violence being involved again and ensure that those affected by violence get the support they require.

The Adverse Childhood Experiences (ACE) Study in the USA has provided strong evidence of the enduring effects of childhood violence on health. Individuals with ACEs were found to have increased risks of a wide range of harmful behaviours and health conditions.

Public Health has commissioned Home visiting programmes to provide intensive early years support for vulnerable parents whose children are at risk of poor outcomes. This is the Family Nurse Partnership (FNP) programme, whereby visits are conducted by public health nurses or other health professionals and typically start during pregnancy. They promote healthy child development by improving parenting skills and helping parents to find jobs or pursue other opportunities to improve the family's circumstances. The FNP model has also been found in the USA to reduce child maltreatment, criminal behaviour and welfare service use by mothers, as well as serious criminal behaviour by children (particularly girls) in adolescence. Savings are greatest when FNP is targeted at high risk groups.

As stated previously, exposure to violence in childhood also increases individuals' risks of further victimisation and of becoming perpetrators of violence themselves in adolescence and later life.

Sure Start Children's Centres provide preschool children (up to age five) and their families with child education, childcare services, support for parents, family health services and employment support. Broader Sure Start services cover children through adolescence.
Some services are available universally, while others are targeted at disadvantaged families. An evaluation found that three year old children from deprived Sure Start areas had more positive social development and social behaviour than children from equivalent non- Sure Start areas, while their parents had less risk of negative parenting.

c) Integrated and Cross-over services

Violence prevention is a critical element in tackling other public health issues, as Violence impacts on mental wellbeing and quality of life, prevents people using outdoor space and public transport and inhibits the development of community cohesion

Changes to NHS public health systems and other public service organisational structures should help facilitate violence prevention because Public health is being embedded into local government structures, thus allowing stronger connections between Directors of Public Health and local services aimed at addressing poverty, inequalities, education, housing, employment and crime- all determinants of inequalities.

The Public Health approach is also Science-based; Public health policies and activities must be backed by research, and Public Health is also multi-disciplinary.

The NHS provide social marketing and health promotion interventions e.g. provison of University and Further Education students with awareness and resources and signposting to prevent and deal with problems e.g.teenage rape

prevention and alcohol awareness during Fresher's fairs and other designated weeks of intervention.

Public Health commissions Service activity and performance monitoring to provide early warning signals for targeted intervention.. For instance input via Children's Centres, enables family nurses to work closely with other health visitors, midwives and professionals from other agencies where needs are identified.

Clinical care and case management work by specialist teams such as addiction and alcohol misuse services.

Support to low level interventions in primary care such as brief advice and Motivational Interviewing to deal with alcohol problems; Resourcing of staff training and education; Public communication through media briefings and reports e.g. in response to fois or public complaints; and Board and specialist level scrutiny and external quality assurance; are other public health activities directed managing the prevention of violence.

The NHS provide School nursing input to PSHE and SRE curricula and drop-in sessions. Programmes that develop life and social skills in young people can help protect them from violence by building their social and emotional competencies, teaching conflict avoidance skills and providing broader skills to help them find employment and avoid poverty and crime
Funding of Parenting programmes for teenage or young parents such as "Ladz to Dadz", also aim to develop parental skills, improve parenting styles and strengthen relationships between parents and their children, especially when targeted at high risk families and children with conduct disorders, where they can have the greatest benefits..

Prison in-reach work also addresses secondary prevention and contributes to the reduction of re-offending e.g. Health Champion pilos and Pathway projects.

3. WHAT DO YOU SEE AS THE MAIN ISSUES AND BARRIERS TO SUCCESSFULLY ADDRESSING VIOLENT CRIME WITHIN THE BOROUGH OF NORTHAMPTON?

Resourcing, especially as funding has been cut for many support services and projects recently, in a prevailing climate of national austerity.

Sustained capacity and ongoing efforts at profiling, needs' assessment, access to alcohol and drug prevention and treatment, running in parallel with policing and enforcement, and regulatory effort are essential requirements to the successful prevention of violent crime, and must be adequately funded to achieve the desired effects.

There is currently no national system for recording ambulance data, thus its content and availability will vary, yet key data items can include call out location, patient demographics, assault type and outcome, and enrich insights that could inform more effective intervention..

Secondary, non-fatal, or consequential effects of violence also merit more investment. Violence damages physical and emotional health and can have long-lasting negative impacts across a wide range of health, social and economic outcomes. It increases individuals' risks of a broad range of health damaging behaviours – including further violence – and reduces their life prospects in terms of education, employment and social and emotional wellbeing.
Additional resources to commission personalised, longer term, and holistic interventions, directed at not only the victim, but also witnesses, and their wider families, would go along way towards reducing the problems of violence in those individuals and also the associated significant costs to the community and public resources, including health services, criminal justice agencies, education and social services.

4. WHAT ACTIVITY DO YOU UNDERTAKE IN PARTNERSHIP WITH OTHER ORGANISATIONS/ DEPARTMENTS TO TACKLE ISSUES OF VIOLENT CRIME WITHIN THE BOROUGH OF NORTHAMPTON?

Most of these activities have already been discussed in foregoing sections, and include the contribution to Community Safety Partnership Boards including the different agendas relating to Offender Management, Domestic Abuse/Sexual Violence, Violence and Alcohol Harm, Offender Management, and Domestic Abuse/Sexual Violence; ongoing data capture and analyses to profile trends in A& E utilisation, clinical outcomes including maternity reviews, and mortality profiles across the county; informing service development and care pathway resourcing and configuration; and the investigation of serious incidents and contribution in death reviews to learn lessons and share best practice.

5. HOW CAN NORTHAMPTON BOROUGH COUNCIL FURTHER HELP YOUR ORGANISATION TO TACKLE VIOLENT CRIME, AND ADDRESS ANY BARRIERS IN ORDER TO ACHIEVE POSITIVE REDUCTIONS?

a) By continuing to work collaboratively to identify those at most risk of lacking physical, mental and social health and wellbeing, and supporting measures to assist them through the health and social care system, whilst providing them with available tools to enable them to take more control over, and improve their own health and well-being such as supervised employment and training opportunities and provision of parenting and family support.

b) Also by actively contributing to surveillance, outcomes' monitoring, governance and the quality improvement agenda, and also supporting timely and relevant public and community information and health promoting efforts. The latter particularly needs to be directed at the most vulnerable i.e. families and children, those NEET, looked after children, young offenders, and those who through physical or social disadvantage/deprivation, learning disability or mental illness, who may find themselves more vulnerable to being victims or perpetrator's of crime.

c) Investing in the provision of shelter/appropriate Housing and places of safety and long-term care for victims who need it.

d) Monitoring public places such as Schools, workplaces, and neighbourhoods, and taking steps to prevent or address earlier, any problems that might lead to violence.

e) Investment in social support, prevention programmes and other services to protect families at risk of violence and reduce stress on caregivers.

f) Strengthening responses for victims of violence by putting in place policies to positively improve the status of vulnerable individuals such as women, the disabled, and children, and to reduce social discrimination through a range of interventions including legislative and judicial reforms, campaigns aimed at raising public awareness of the problem, training and monitoring of the workforce and supporting educational or economic incentives for disadvantaged groups.

g) Enhancing collaboration and the exchange of information on violence prevention across stakeholders in the public sector.

To conclude, there is a tendency worldwide for authorities to act only after violence has occurred. But by investing in public health collaboration towards prevention – especially primary prevention activities that operate ‘‘upstream’’ of problems – investments are likely to be more cost-effective and have greater impact and longer- lasting benefits.