King's Fund

Community Safety and the NHS in London

Stakeholder views

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Introduction

Current legislation states that key agencies should work together to resolve complex problems. This report considers issues facing stakeholders in London who are working on two such problems: 'How do we build healthy and safe communities in the capital?' and 'What role does the NHS have in improving community safety?' This report is written for policy-makers and practitioners in the NHS and its partner organisations. It is intended to support improvements in current local arrangements.

Healthy and safe communities

The term 'community safety' is shorthand for a range of issues that affect the safety and well-being of individuals and communities, including fire, falls and accidents in and out of the home, access to safe green and play spaces, and urban design. In addition, community safety activities focus on the causes and effects of burglary, violence, sex and hate crimes, and crimes related to the misuse of drugs and other substances. It is also concerned with 'sub-criminal' and anti-social behaviours, such as truancy, noise pollution and vandalism. The connections with the public health agenda are apparent. For example, the WHO definition of health – 'as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity' – demonstrates clearly the conceptual synergies. The determinants of a 'healthy community' are not dissimilar to the 'upstream' factors that make a safe one. Holistic views underpin both. However, common usage of the terms often narrows their definitions. 'Health' is not simply the absence of disease, and 'safety' is not simply an absence of crime.

London: background data

London has the highest rate of violent crime (measured in terms of percentage of all reported crimes) in the country. An adult is three times more likely to be mugged in

London than elsewhere. Areas of high poverty and deprivation are usually areas of high crime. These are concentrated in inner London boroughs such as Tower Hamlets, Hackney, Islington and Newham. High crime and poor health are also linked. Westminster, Camden, Hackney and Islington, the four London boroughs with the highest total crime rates, also rate highest in the Mental Illness Needs Index. Wealthy boroughs, such as Kingston upon Thames, tend to enjoy low crime and good health. However, it is not unusual to find small areas of high poverty, poor health and high crime in relatively well-off boroughs. Conversely, poor boroughs may contain pockets of wealth (e.g. Lambeth).

The research

We undertook 38 interviews with stakeholders from local authorities, health authorities, the voluntary sector, the police, probation service and other associated organisations. Interviewees were involved in some way with multi-agency, community safety partnerships (either strategic or operational).

The interview questions focused broadly on: i) the relationships between community safety and health; ii) the role of health services in improving community safety; iii) strategies for improving the engagement of stakeholders across the 'health economy' in efforts to improve community safety; and iv) examples of good practice from which we can learn. The research summarises and analyses the opinions of a sample of individuals working at the interface of health and community safety issues. It is a snapshot of views expressed in London in Spring 2001. Further research is needed to validate the findings and to provide a fuller picture.

Stakeholder views

The links between community safety and health

The relationships between health and community safety were discussed. Overall, interviewees focused on the links between health and crime, which accounts for the bias in this report.

Interviewees took the view that criminal activity, like many other complex social issues, was a cause and a result of social exclusion. Ill health was also seen in those terms. They talked at length about recent mapping exercises in their localities which showed clearly that areas with high levels of deprivation, poverty and poor health were also areas of high crime and poor community safety. As one local authority officer claimed: 'Any community with a high score on Jarman (the deprivation/health index) is going to be an area of high crime.' Interviewees also noted that poorer people were more likely to be adversely affected. As one strategist summarised:

> *Children in social class five are up to 15 times more likely to die in house fires than children in social class one, and children in temporary accommodation are up to 70 times more likely to die. We think that about 30 per cent of all fires in London are started deliberately. The inequalities are so stark; it's really very shocking.*

Effective action to reduce social and economic inequalities would have positive effects for community safety and health, interviewees argued.

The disproportionate involvement of certain groups as victims and perpetrators of crime was also noted. These included vulnerable young people (including 'looked after children'), people with low educational achievement, people with severe and enduring mental illness, homeless people, and people from black and ethnic minority communities. It was noted that these people already experienced poor health, were likely to be in contact with statutory services and live in poor areas.

Many interviewees argued that poor levels of community safety made people ill. However, the exact nature of this relationship was complex. One interviewee noted: 'The linkages remain poorly defined … especially where it is difficult to measure in concrete terms.' There were discernible physical effects, including injury from attack, from being hit by cars, or from fire. There were also diverse effects on individuals' mental health and sense of well-being. Several interviewees pointed out that poor mental health could result in poor physical health over long periods of time (for example, digestion problems, skin conditions and hair loss). This was especially true for people who were repeatedly victimised.

The fear of crime

The realities and perceptions of crime were seen to have considerable effects on the health of Londoners. For example, the fear of crime had significant impact on individuals' mental health and undermined their confidence. A public health consultant claimed: 'The fear of crime imprisons older people; they often feel incapable of leaving their homes.' By stopping them from leaving their homes, individuals reduced the amount of exercise they took. It stopped them from shopping or seeing family and friends. Worries about being accosted by street drinkers or drug dealers also affected individuals' behaviour. Often people's perceptions did not correspond with reality:

> *The way people see the situation can be very different from the reality; women are a great deal safer on trains than they are in their own homes … whereas young men are more likely to be attacked in public and are better off staying at home. This contradicts what we often think is true.*

This meant that services had to work with communities to identify needs and not rely on statistics alone to drive community safety-related activities.

Drugs and substance misuse

Several interviewees talked about drug misuse as an issue that exemplified the complex relationship between social exclusion, criminality and poor health. It also showed the problems experienced by partners in trying to join up responses across the system.

Preventing drug use had benefits for health, as well as for the safety of individuals. For example, one interviewee commented:

> *We need to prevent people from getting into hard drugs in the first place and we should make sure that those who are taking drugs should do so safely. For example, we know that 30 per cent of injecting drug users will get hepatitis C and 20 per cent of them will go on to get liver cancer as a result, and once you've got that there's not much we can do.*

Other tactics for reducing drug use included working with young people who were likely to become involved at early stages. For example, a drugs worker commented: 'To improve community safety, we've got to get education, social services and the police to work together to identify young people "at risk", to stop them getting into this mess in the first place.'

One interviewee asked us to consider 'young people who have been failed by the educational system, who live in poverty, perhaps have been in care, whose parents and grandparents lived in poverty, who use Class A drugs as a diversion from the tedium and despair of their lives, and who progressively become more dependent'. She went on to explain that as their drug use progressed and perhaps became more chaotic, theft became a potential source of money to pay for drugs. The costs of drug-related crime to the community were great. At this point, she argued that they started to lose contact with families and friends, isolating themselves from potential sources of support. Their mental health might suffer, as they became lonely, anxious and drug dependant. On occasion, their criminal behaviour would result in arrest.

After being arrested, they might be referred to drugs services, go into drug rehab and return from it to face eviction for rent arrears. Interviewees noted that the NHS provides and commissions excellent rehabilitation services for drug users in London. However, on leaving these services there was seldom adequate follow-through. For example, support services might be inadequate and they would fall back into drug use. ‘None of the services are joined up,’ she said. ‘We fail these people time and time again. We fail to identify who the kids are that face these problems and we fail to support them when they want to get off drugs and make their lives better.’ For those who did, ‘we have to work with the police, housing and health to make sure that they are supported in making a recovery. We can not allow people to fall through the net any more.’ The implications for developing the capacity of the NHS and its partners to achieve the goal were considerable.

Hate crime

Several interviewees discussed hate crime. Racist and homophobic violence were thought to deserve much greater attention, as were safety issues for disabled people. Such crimes were seen as isolating and they undermined individuals’ control of their own lives. They exacerbated inequalities in society. For example, crimes against gay men and lesbians might go unreported because of fears of being treated unfairly by statutory services, several respondents revealed. ‘There are still some gay men and lesbians who believe that they will be treated badly, that they live in a deeply homophobic society,’ one voluntary sector respondent noted. Others claimed that individuals who had been attacked for being gay might attend A&E but decided not to cite the reason for the injury. Racism was discussed at length, and it was noted that the long-term effects on the mental and physical health of black and ethnic minority communities were still not fully understood. Interviewees observed that little was known about the effects of violence on refugees and asylum seekers.

Domestic violence

Violence against women was discussed by many of our interviewees. One noted that it should be recognised as a specific category of crime: ‘Women are more likely to be

attacked, to experience sexual assault, rape and harassment; it is an issue of gender and should be a priority.' In particular, domestic violence was a growing health concern that generally received too little attention. Victims were often left unsupported and felt unable to talk about their experiences until several years into a history of abuse. As one respondent from the voluntary sector noted: 'Domestic violence is more common than people think.' It was generally under-reported, which made providing specialist services difficult. In particular, repeat victimisation had cumulative negative effects on health. The coupling of physical effects with long-term consequences for mental health was considered to be a particular challenge. Women did not always use health services when they needed them, for fear of triggering an investigation into their situation. Unlike other community safety issues, domestic violence was experienced across all social classes and was not directly associated with poverty and deprivation.

Generally, NHS staff were keen to provide effective and appropriate services for the victims of domestic violence but remained uncertain about how best to do it. Nurses and doctors were not trained in identifying signs of domestic violence or in asking the right questions. According to several interviewees, GPs resisted asking questions about violence in the home, claiming that it was a matter of privacy and not up to them to make inquiries: 'They [GPs] will ask about the state of your bowels, but they can't bring themselves to ask if you are being beaten at home.' Midwives were often fearful of asking too many questions when they suspected violence in the home, because partners were encouraged to attend consultations and they felt that raising the issue in their presence might endanger the women. Once again, training was identified as a means of developing integrated responses.

Several interviewees questioned the legitimacy of codes of confidentiality. In cases where women and children were experiencing violence at home, interviewees said that it was unacceptable for GPs to resist passing information about individual cases to the police or social services. A health services researcher argued the point forcefully:

> *The fact that information should and could be disclosed, well, that's where the NHS becomes unhinged. We know women who live with violent partners are more likely to be attacked during pregnancy. GPs could have a vital role in alerting social services and helping protect the women and their unborn babies.*

However, others pointed out that women did not always want information to be passed on to other agencies, or for services to be alerted. They saw such actions as potentially threaten to their well-being, especially when pregnant. Sharing information might deter women from using services. It was important to develop services sensitively that would help women and their families, and not worsen their situations.

Children and young people

Violence experienced and witnessed by children and young people caused and contributed to trauma, exclusion and renewed patterns of violence, as well as threatened educational attainment in the long term: 'Kids are traumatised by street crimes … it affects their school careers … we need to build communities where children feel safe.' Interviewees called for a fuller investigation into the extent and effects of crime 'on young people by young people'. Several interviewees spoke about mobile phone crime in this regard. One local authority strategist called for 'a study into the ways in which very young people are introduced to crime and the effects it has on their development'. The association with poverty remained a strong one: 'And so they grow up to be unemployed, poor, excluded, and unhealthy, just as their parents were.' Ending child poverty would break this cycle of disadvantage, interviewees claimed. Others pointed to the importance of schemes like Sure Start.

‘Imagine London’ is a programme run by the King’s Fund that consults young people about issues that affect their health and well-being. Crime and safety is one of the five themes they are working on. A steering group of young people directed a conference on crime and safety for young Londoners. This event was organised in partnership with Safe in the City and the Metropolitan Police. They have recently launched multimedia work about crime by young people on the Imagine London web site, www.imaginelondon.org.uk

The role of the NHS

Overall, interviewees called for more ‘joining up’ of activities at strategic and operational levels. As one public health consultant noted: ‘We want to tackle inequalities, we want to improve people’s lives, and we want to reduce poverty and alleviate its effects. This is broadly the same as regeneration and community safety. So why is there such resistance to working together?’ However, interviewees recognised the formidable size of the task of raising awareness and building capacity in order to make this happen. It was recognised that the NHS is functioning under immense pressures and challenges in changing the way it works, demanding ‘a whole system rethink’.

The need for clear leadership was discussed at length. As one NHS middle manager argued:

> *Senior managers put the responsibility onto middle management and practitioners to do all the so-called ‘joining up’, yet we don’t have the power to really change anything. They do have the power and they should get up off their seats and think outside of their precious little boxes.*

It was not widely understood why the NHS was not doing more. An interviewee from a non-statutory agency wryly observed: ‘If the NHS was clever it would realise that people

who walk through the doors of hospitals with injuries caused by street violence or bar-room brawls are using up their precious resources.'

Interviewees noted that health services were not always taking their place in local Crime and Disorder partnerships. One local government officer noted: 'It's a miracle if they turn up, and it's an even bigger miracle if they make a contribution.' There were exceptions reported, for example in Southwark and Camden, where health authority representatives had taken considerable roles in shaping responses.

Several respondents made the point that there should be clearer direction from Whitehall about the incentives for working together, and recognition that small advances required large organisational changes. Indeed, many respondents called for more evidence of joining up activities at the Centre, to 'lead by example'. As one local authority employee commented: 'Get the Department [of Health] to talk to the Home Office; that would be a start.' Others acknowledged that there was increasing 'joining up' at the Centre, but that its impact was often limited on local work. Another commented that national initiatives with allocated resources encouraged local action:

> *Look at [the national strategy] 'Tackling Drugs Together'. It set out the must dos and came with some money, and real progress has been made, because it had to be made, the Government said so … real money encourages real engagement.*

But one respondent noted: 'Nobody spells out what the carrots are, all we see are sticks; it causes resentment.' Lessons should be learned from other relevant attempts to join up action at local levels, including Drug Action Teams and Health Action Zones. In addition, health services would do well to invite community safety agencies to be partners in relevant health initiatives, such as the Local Implementation Groups for Mental Health Services.

Sharing information

The issue of sharing information across agencies recurred throughout the interviews. Interviewees recognised that in order to measure achievements, robust and shared systems for measuring performance had to be developed. Central to the strategy development was the issue of sharing information across organisations. There were several potential sources of relevant data, but management information systems were incompatible. In addition, interviewees pointed out that there were extensive problems in making information systems harmonious between, and across, relevant agencies.

A&E departments could make a very useful contribution. By recording the number and origin of injuries resulting from violence, they could provide valuable information for police and crime prevention agencies. For example, young men rarely reported being attacked to the police. Therefore, police records were often incomplete. Clear ideas about what types of injury were coming from which areas would be beneficial, allowing others to focus activities effectively. As one strategist noted:

> *We could focus our efforts more effectively, perhaps even know which pubs were producing the highest number of attacks or which families were experiencing domestic violence. If we had this kind of information, we could do much more.*

It was also pointed that the benefit for the NHS was not always immediately apparent. It would take time to see a pay back:

> *Everybody has ideas about what the NHS should be doing, but tell me how will we develop the systems for collecting more information? Where are we going to find time and money to train staff? Who's going to analyse it? We're under pressure to show improvements now. We can't think how wonderful the world will look in 20 years time.*

Close monitoring of the provision of services in response to community safety and crime-related issues would enable the NHS to estimate more accurately the costs of it as a result of crime. It would also enable it to demonstrate how NHS involvement in community safety could be beneficial over time. One health authority employee observed: 'We need to look at local areas, where services are, analyse them and understand how our agendas all feed in.'

Regeneration, community safety and health

Most action to improve the health and safety of communities was led by local authorities, through their roles in providing education, housing, maintaining the environment, promoting local economic development and engaging the community in decision-making. However, many interviewees argued that health authorities and local community-based health service providers should take an active role in local regeneration initiatives that had strong community safety elements; this would help tackle the 'upstream' determinants of health and promote community safety. The NHS could also improve the health of local populations through its role as a major employer of local people, procurer of local goods and developer of land and property. It could invest in local people, improve their lives and thereby reduce the problems associated with poverty and disadvantage. The potential of the NHS in this way was not fully understood.

Promoting health and preventing crime

Interviewees argued that the NHS should support local crime prevention efforts and integrate them into community development and health-promoting activities: 'Invest in the preventative interventions rather than the front end.' Opportunities presented by healthy living centres and other community initiatives galvanised local resolve, bringing community members together to identify needs and ways of meeting them, and to initiate action. Several interviewees suggested pooling resources to identify issues that had similar causes and to take action on them. For example, one interviewee called for life skills programmes with young people that would build confidence, self-esteem, respect for others and basic living skills, and increase knowledge about sexual health, parenting,

and how to minimise risk in the misuse of drugs and substances. She hoped that action of this type would meet several objectives at once.

‘Health Benefits Regeneration’ is an SRB 6 Programme operating in Greenwich. Its outcomes are measured totally in health terms. As part of the programme, they are working with three disadvantaged communities. Initial consultation with communities in the areas shows how residents relate the effects of crime and the fear of crime with their ill health. They have asked that the money intended for health improvement should be used to improve community safety as a ‘determinant’. For example, secure door systems in high-rise flats actually enable residents to allow entry to drug dealers and takers. Once they are inside, they are effectively protected from outside interference. Residents are fearful and suspicious about drug-related crime on the estate, intimidated by drug dealing in stairwells, and worried about abandoned drug paraphernalia. The programme manager has coordinated a partnership made up of local residents, managers of housing, youth work, education and social services departments, the police, and public health practitioners as a means of improving the health and well-being of the residents.

It was widely acknowledged that staff in the health service were committed to providing high-quality and effective services. However, a review of current roles and responsibilities of NHS employees working on the front line was discussed. They should be trained in how to promote community safety, for example by assessing the risks faced by individuals, in order to work effectively with those in greatest need:

> *Let’s be really radical, let’s get community nurses, midwives, health visitors in on the community safety work; they know more about what it really means than anyone ever gives them credit for.*

The training implications of such changes were seen as extensive. It was reported that work of this type was underway in Redbridge and Waltham Forest and Camden, and although it was still in its early stages, preliminary evaluations were positive.

Accidents in Peckham – It was widely acknowledged that Peckham is a dangerous place to live, with high levels of accidents both within and outside the home. However, developing a joined up response was difficult because there was not one place where data could be found to get clear picture. Public health developed a partnership of local practitioners and policy-makers who managed disparate local data sources: for example, housing, A&E, primary care, police and the fire authority. In addition, they commissioned local research and consultation exercises with local people to paint as full a picture as possible. As a result, they developed a fuller picture about the rates and types of accidents, where they occurred and which communities were most affected. The partnership was able to develop programmes that improved the safety of local residents. These included developing specifications to ensure all houses are designed to be secure and safe, and routine health impact assessments on road changes, new crossings and play areas.

Protecting NHS staff from harassment, abuse and attack was identified as another area where there were opportunities for prevention. The Department of Health is currently considering this widespread phenomenon, and guidelines have been published. However, safety in hospitals and GP surgeries remained a strong concern for many of our interviewees. As one policy manager noted:

> *It's about seeing the NHS as part of the community, not something outside of it. Safety issues in hospitals are really very important, whether it is about protecting nurses from being hit or preventing drug dealers getting onto psychiatric wards to get hold of patients' medication; it is all part of the same picture and we should be doing more.*

Several interviewees discussed work undertaken by Crime Concern that audited community safety issues within hospitals (for example, staff members' experiences of attack), and offered training and support to hospitals to reduce associated problems.

'Picking up the pieces'

The NHS as a provider of health services that 'put people back together' and 'picked up the pieces' after they experienced crime was a strong theme in our interviews. The NHS usually provided high-quality services for their patients. NHS staff were commended for their commitment and professionalism. However, all interviewees concurred that more could be done.

Primary care and A&E services were seen to occupy a central role in disseminating information relevant to victims of crime, and referring them on to specialist support services. As one front-line worker noted:

> *I sit for hours in my GP surgery waiting to be seen. It is an ideal opportunity to be reading leaflets about where to find help and what to do if you live with a violent partner.*

In addition, practitioners working in primary care and A&E could develop their capacity to refer victims of crime on to support agencies. However, one interviewee, a health services researcher, observed:

> *It's not just about referral, it's about the NHS taking some responsibility and providing services, or at least training staff in how to respond appropriately.*

But, as one primary care manager noted:

> *We can't refer if we don't know where to refer to, can we? We need more information about where to send people. What do the agencies do? Where are they? We just don't know.*

It was important to work in partnership at operational levels.

In Cardiff, Professor Jonathan Shepherd was concerned by the high number of young people who were arriving in A&E after being attacked and 'glassed' in the city. He began collecting information about when and where these incidents took place. He coordinated a partnership response to tackle the cause of the injuries at source. He worked with local police and landlords to reduce levels of violence by targeting police activity in specific bars and clubs and encouraging the use of plastic 'safe' glasses. The scheme has been successful and the incidence of such violence and associated injuries has dramatically reduced.

Working with vulnerable people

Several interviewees pointed out that vulnerable people in the community, such as drug users and the homeless, needed support, and called for community safety strategists to see them as people with health needs rather than just as criminals:

> *We need to remember that drug users are part of our communities. Treating them like the scum of the earth will not in itself make things safer.*

Others observed that young offenders were at risk of depression, experiencing disturbed lives in a culture of violence. They needed support, as did mentally ill people, who might be homeless or spend time in public places with nowhere else to go. For the latter, it was more important to find them appropriate support and health services than to criminalise them or pander to those who sought to sweep them off the streets (or as one local authority interviewee noted: 'It's not so much sweep them off the street, its sweep them into another borough, and make them someone else's problem!').

Conclusions

All interviewees recognised that the complexity of the situation would not be addressed through the efforts of any one agency working in isolation. Community safety and health

needed to be seen ‘in the round’ and action had to taken in partnership. It was important to consult communities about their needs and engage them in the process, especially those that were disproportionately affected by ill health and poor community safety.

There was deep frustration at the disjointed relationships between community safety agencies and the NHS in London. As one voluntary sector employee commented: ‘The structures don’t meet … and the issues don’t come together.’ There was also considerable enthusiasm about improving those relationships – and ‘joining up’ – at every level. First, the NHS should work closely with local authorities and police, supporting them in strategies for improving community safety and achieving neighbourhood renewal. Second, the NHS should invite community safety agencies to work closely with it on issues that would benefit from input from a wide range of partners, for example in improving community mental health services.

It was recognised that the NHS would not be able to do everything immediately. It was important that it communicated clearly with its partners: ‘Tell us what you can do, tell us what you can’t do.’ Similarly, it was important for local authorities, police and others to be explicit about what they expected from the NHS. Progress was more likely to be achieved once defined areas had been identified and partners were clear about what was expected of them.

Overall, there was a need to integrate community safety concerns into planning and performance management for the NHS and put them at the very heart of its strategies to reduce inequalities. As one public health specialist said: ‘It should be part and parcel of almost everything we do.’ Interviewees suggested ways of bringing the two agendas closer together: ‘Let’s embed some health targets in Crime and Disorder Strategies and get some crime targets into the HImPs [Health Improvement Programmes].’ Similarly, interviewees called for health questions to be included in the three-yearly crime audits that local authorities have a duty to undertake as part of the development of Crime and Disorder Strategies. If partners were accountable for joint targets, greater cooperation would follow, driving common agendas and increasing the chances of each partner taking

its role. The opportunities brought by the National Strategy for Neighbourhood Renewal were discussed at length. It was agreed that it would support effective working at local levels.

There were calls for building the evidence base in the area, to fully understand the synergies between the two areas and find out ‘what works’. Examples of good practice were useful in designing local initiatives. Identifying areas where greater research could take place to inform the development of joint responses was a priority. It was important to develop standardised tools to identify needs, gaps and duplications, assess progress and build on best practice.

The enthusiasm and commitment of the individuals interviewed for this study could be nurtured and deployed productively to increase professional awareness and stimulate action to improve the safety and health of London’s disadvantaged communities.

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