

Towards integrated health care: a model for assault victims[†]

JONATHAN P. SHEPHERD and JONATHAN I. BISSON

The 1998 Crime and Disorder Act places a statutory responsibility on the National Health Service (NHS) to work in partnership with the police and local authorities to audit and tackle crime in their areas. One of the principal reasons for this partnership approach is that substantial numbers of offences that result in NHS treatment of physical and psychological injuries are not reported to the police. Nowhere is the 'dark figure' of unrecorded crime more obvious than in accident and emergency departments. In Bristol, only 23% of people injured in assaults who attended a local accident and emergency department appeared in police lists of woundings (Shepherd *et al*, 1989). Furthermore, because services for victims of crime have been organised in and around criminal justice agencies, services for those treated in the NHS are lacking.

MENTAL HEALTH IMPACT

The impact of assault on mental health is increasingly well understood. Around 20% develop post-traumatic stress disorder (Breslau *et al*, 1991; Kessler *et al*, 1995). Depression, anxiety and substance misuse are also commonly identified in this group. Violence and accidents cause similar levels of anxiety and depression during the first week or so, but those injured in assaults have much higher levels of anxiety and depression 3 months later than those injured in accidents (Shepherd *et al*, 1990). The important implication of this is that crime victims usually need longer-term support. Factors that exacerbate mental health effects include repeat victimisation, unemployment and low levels of innate resilience (Joy *et al*, 2000).

INTEGRATED SERVICES

The discoveries set out above indicate that integrated services for those injured in violence need to be developed that are accessible from both health services and the criminal justice system. The objectives of such services are principally efficient, early identification and treatment of psychological problems and alcohol misuse, and increased access across traditional trauma, mental health and criminal justice boundaries. Victim support services currently provided by the voluntary sector need to be integrated with mental health services for those with psychological and alcohol misuse problems. It is important that victims with these problems are identified early, not least because research has now shown that the early detection and management of symptomatic individuals can be beneficial and prevent the development of longer-term mental health difficulties (Bisson *et al*, 2003). With regard to alcohol misuse, getting injured in an alcohol-related assault (when noticeable face injury is very common) provides an important teachable moment at which to challenge and change drinking habits (Smith *et al*, 2003).

Initial attendance at the accident and emergency department is usually not the appropriate time or place for victims' mental health issues to be addressed at any length. The peak time for accident and emergency attendance for those injured in assaults is between 11 p.m. and 3 a.m., when the main priorities are medical treatment and getting home. Furthermore, many of those injured in assaults are intoxicated. There are also staffing problems at this time. Screening for psychological difficulties is best done during the next few weeks, when the physical injuries have been treated. At the first accident and emergency attendance, victims should be offered support, treated sympathetically and given opportunities and help to report offences to the police. They therefore must be

identified by reception and clinical staff as having been injured in an assault. Victim advice leaflets are available and no patients should leave the accident and emergency department without advice about how to contact Victim Support and mental health services if necessary.

We have been involved in two integrated service models. The first was developed in Bristol in the mid-1980s, when it was realised on the basis of published research that victim services were too narrowly focused. On a weekly basis, usually on a Monday, a medical secretary based in the city-centre accident and emergency department offers a meeting with a Victim Support volunteer by writing to all those reporting injury in an assault (15-20 people) who had attended the accident and emergency department in the previous week. The letters extend sympathy and state that a Victim Support volunteer will be present in a designated hospital outpatient clinic for a 2-hour period each Thursday afternoon. It is not necessary to make a formal appointment or even for the victim to call the hospital. In the event, between two and four victims usually attend and are supported by a rota of six volunteers trained for the purpose. Victim Support services are provided (emotional support, practical help with violence prevention and assistance with compensation claims). A higher proportion of victims of non-reported crimes, including domestic violence, attend than other groups of victims. Supported and funded by hospital management, and requiring no additional medical resources, this service has run on a weekly basis for some 15 years under the management of the coordinator of Victim Support Bristol.

The second service model was implemented in Cardiff in 2000. Here, assault patients are contacted by letter or telephone in the first fortnight after accident and emergency attendance by an accident and emergency nurse funded specifically for this role by the Cardiff Community Safety Partnership. They are advised about Victim Support and screened for the presence of mental health symptoms. If these are present, they are offered an assessment appointment with a psychiatric nurse and, if appropriate, offered evidence-based brief intervention for their symptoms. The psychiatric nurse is also funded by the Cardiff Community Safety Partnership and is a member of the local traumatic stress service.

[†]See pp. 63-69, this issue.

This referral network, in which the principal components are the accident and emergency department, local Victim Support scheme and traumatic stress clinic, currently screens more than 3000 victims per year. Current referrals to Victim Support are 18–20 per month; around five individuals per month are seen by the psychiatric nurse. Clearly, not all victims need or want help or treatment but evidence of effectiveness of screening and treatment now means that victims of violence should be aware of the existence of support and offered treatment as necessary.

ORAL AND MAXILLOFACIAL SURGERY

In the UK, and indeed in most developed countries, the face is the most frequently selected target for blows in an assault. This tragic fact does, however, provide an opportunity for targeting integrated services because the treatment of face, jaw and mouth injuries is the province of one particular specialty: oral and maxillofacial surgery. Very often, facial and dental injuries are checked in oral and maxillofacial out-patient clinics 5–10 days after initial treatment in the accident and emergency department. All accident and emergency departments are linked to these specialist injury services. The most cost-effective way to tackle alcohol misuse is for the clinic nurse to combine wound care with a brief alcohol intervention (Smith *et al*, 2003). It has been found that, in itself, injury often alerts patients to their alcohol misuse and leads them to reduce their heavy drinking. This nurse-led brief intervention, however, resulted in a further 20% of victims changing their behaviour from hazardous to safe levels of drinking. It has been shown also that maxillofacial senior house officers working in accident and emergency departments are able to predict which individuals are most likely to develop further mental health difficulties (Bisson *et al*, 1997).

JONATHAN P. SHEPHERD, PhD, FMedSci, Department of Oral Surgery, Medicine and Pathology, University of Wales College of Medicine, Cardiff; JONATHAN I. BISSON, MD, Department of Liaison Psychiatry, University Hospital of Wales, Cardiff

Correspondence: Jonathan Shepherd, Professor of Oral and Maxillofacial Surgery, Department of Oral Surgery, Medicine and Pathology, University of Wales College of Medicine, Heath Park, Cardiff CF14 4XY, UK. E-mail: Shepherdjp@cardiff.ac.uk

(First received 22 May 2003, final revision 29 August 2003, accepted 1 September 2003)

CONCLUSIONS

The voluntary sector, in this case Victim Support, has an outstanding record of extensive service provision with sparse funding. However, on the basis of new evidence of effectiveness the NHS must also contribute mental health services to the care of victims of violence who may or may not be identified as such in the criminal justice system. The NHS has provided facilities for the hospital-based Victim Support 'clinics' described in this article. In Cardiff, funding for new nurse posts has come from Home Office 'targeted policing' funds and also, more recently, from the Cardiff Community Safety Partnership. This non-traditional source of funding has been achieved by the Cardiff Violence Prevention Group, a blueprint for integrated services in the UK, whose twin objectives are to prevent violence and to provide holistic services for the injured (Home Office, 1998). Such funding opportunities seem likely to be greater in the future, because there is consensus that criminal justice systems should be more victim oriented. This network of services needs to be developed more widely, to contribute not only to the care of the injured but also to safer and more just communities.

DECLARATION OF INTEREST

None.

REFERENCES

- Bisson, J. I., Shepherd, J. P. & Dhutia, M. (1997)** Psychological sequelae of facial trauma. *Journal of Trauma*, **43**, 496–500.
- Bisson, J. I., Roberts, N. & Macho, G. (2003)** The Cardiff traumatic stress initiative: an evidence-based approach to early psychological intervention following traumatic events. *Psychiatric Bulletin*, **27**, 145–147.
- Bisson, J. I., Shepherd, J. P., Joy, D., et al (2004)** Early cognitive-behavioural therapy for post-traumatic stress symptoms after physical injury. Randomised controlled trial. *British Journal of Psychiatry*, **184**, 63–69.
- Breslau, N., Davis, G. C., Andreski, M. A., et al (1991)** Traumatic events and post-traumatic stress disorder in an urban population of young adults. *Archives of General Psychiatry*, **48**, 216–222.
- Home Office (1998)** *The Cardiff Violence Prevention Group: Cutting Crime, Building Communities*. London: Home Office.
- Joy, D., Probert, R., Bisson, J. I., et al (2000)** Post traumatic stress reactions after injury. *Journal of Trauma*, **48**, 490–494.
- Kessler, R. C., Sonnega, A., Bromet, E., et al (1995)** Post-traumatic stress disorder in the national comorbidity survey. *Archives of General Psychiatry*, **52**, 1048–1060.
- Shepherd, J. P., Shapland, M. & Scully, C. (1989)** Recording of violent offences by the police: an accident and emergency perspective. *Medicine, Science and the Law*, **29**, 251–257.
- Shepherd, J. P., Qureshi, R., Levers, B. G. H., et al (1990)** Psychological distress after assaults and accidents. *BMJ*, **301**, 849–859.
- Smith, A. J., Hodgson, R., Bridgeman, K., et al (2003)** A randomised controlled trial of a brief intervention after alcohol-related facial injury. *Addiction*, **98**, 43–52.