



Improving the mental health of the population: towards a strategy on mental health for the European Union

[EU green paper 14 October 2005]

Victim Support's response

Victim Support is the national charity for England and Wales for people affected by crime. Staff and volunteers offer free and confidential information and support for victims of any crime, whether or not it has been reported and regardless of when it happened. Victim Support works to increase awareness of the effects of crime and to achieve greater recognition of victims' and witnesses' rights. The organisation operates via a network of affiliated local charities, the Witness Service and the Victim Supportline (0845 30 30 900). Scotland and

Green Paper

Improving the mental health of the population: towards a strategy on mental health for the European Union.

Introduction

We welcome this opportunity to contribute to the development of a mental health strategy for Europe.

This response is based on Victims Support's work with victims and witnesses of crime in England and Wales.

A significant proportion of Victim Support's funding comes from the government. In 2004/05 Victim Support's community-based services helped 1.3 million victims of crime.

Victim Support staff and volunteers offer victims information about the legal process, dealing with the police, and their rights as victims of crime, as well as links to other sources of help. They also importantly offer emotional support – someone to listen, reassure and empathise - and practical help, such as clearing up after a burglary, applying for criminal injuries compensation, and advocacy in relation to meeting their wider needs including any health, housing, financial, employment or educational issues arising from their victimisation. In 2004/05 we received more than 7,000 referrals of victims of rape and 14,500 crimes with a sexual element. We also helped more than 700,000 victims of burglary, theft and criminal damage and supported almost 1,200 bereaved relatives of homicide victims.

In 2003/04, 90,575 referrals to Victim Support services were recorded as domestic violence, an increase of 22% on the previous year. Victim Support's national telephone help-line (Victim Supportline) took just over 2000 calls from people affected by domestic violence. Again referrals rose in 2004/05 and domestic violence now accounts for 25% of all referrals of violent crime (excluding robbery) to Victim Support.

Through our work with individual victims of crime we know that many will seek medical help for both physical injuries and psychological problems as a direct result of their victimisation. However, most health practitioners are not trained in the effects of crime and the significance of victimisation is often not recognised. People may get medical attention and treatment but few receive recognition or understanding to help them cope. This response outlines the considerable evidence linking criminal victimisation to mental distress and discusses ways of addressing issues raised within an overall mental health strategy.

The father of a 15-year-old girl who was missing for a year before her body was found had searched incessantly for her during this time. During the year she was missing he got into rent arrears and was

evicted from his home. Now homeless and suffering from mental health problems he still feels unable to talk about his grief.
Victim Support (2006) 'In the aftermath. The support needs of people bereaved by homicide: a research report'.

Effects of crime on mental health

The emotional impact of criminal victimisation can be devastating and is often more serious and damaging than any physical injury sustained¹.

Many crimes have a range of emotional effects on victims including upset, fear and anger. Street robbery, for example, is predominantly an urban phenomenon, with most robberies taking place in streets near the victims' home and close to transport access points. It has a serious and often prolonged psychological effect on many victims and may also affect the feelings and behaviour of non-victims. For many, the psychological effects are long-lasting with 35% of victims still suffering psychological effects three months after the event². The experience frequently drastically changes the way victims perceive their personal safety and the way they conduct their social and working lives, including changes in lifestyle and personal relationships.

I used to really enjoy my morning walk to the paper shop; but I don't do it any more. I'm just too worried
Victim of assault (Victim Support 2002)

Victims of crime involving force or violence appear to suffer the greatest emotional impact; the effects of moderately serious physical assault can last for years. In one study 40% of victims were still suffering social and psychological effects 30 months after the offence³. Victims of violent crime are more than two and a half times as likely as non-victims to suffer from depression 5 years after the original offence⁴.

Danielle went into a state of deep shock after recovering from the physical wounds and was unable to return to her job as a carer for the elderly. Her 5 children were suffering too. Even long after the attack

¹ Hodgson, B (2005) 'Angry or what? Experiences of being a victim' British Journal of Criminal Justice Vol. 3 No. 3 Summer pp. 61-74

² Gale, J-A. & Coupe, T. (2005) The behavioural, emotional and psychological effects of street robbery on victims. International Review of Victimology Vol. 12 pp1-22

³ Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

⁴ Norris et al (1997) cited in Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

when Danielle had seen her attacker jailed for 8 years, she was still unable to leave the house alone or bear anyone to come too close
Female victim of stabbing, rape and assault 1996 (Victim Support 2004)

Victims of burglary and wounding, crimes that involve the offender directly attacking the victim or invading their privacy, report particularly high levels of emotional distress, whereas victims of car crime may be less affected⁵.

'When I opened the door to the dining room the burglar was standing in front of me. I screamed and my husband came downstairs quickly because he thought I was being attacked. The burglar ran out and drove off with someone. For six months I was afraid to go downstairs at night. I still haven't got over the burglary'
Victim Support press release (20 April 2006)

Being a victim of childhood sexual abuse is a significant predictor of lifetime eating disorder symptoms and a range of other mental health problems⁶.

Disproportionate effects on the disadvantaged

4% of victims experience 44% of all crime and those people who live in the more disadvantaged communities are more likely to be victims of crime than those in more affluent areas⁷. People living in the most deprived neighbourhoods are on average 2.5 times as likely to be mugged and 2.5 times as likely to be burgled as those living in more affluent areas. People who are ill, unemployed, disabled or socially excluded are all also more likely to be victims of crime than others⁸ and significantly those victims from the poorest households are nearly 3 times as likely to report a number of emotional difficulties following victimisation, including depression, anxiety, panic and difficulty sleeping.

Repeat victimisation

The experience of previous victimisation compounds the degree of emotional suffering and repeat victims of crime are more likely to report depression and upset and feelings of resignation than first time victims⁹.

Research carried out in Scotland showed that victims of repeated crimes suffered increasing emotional impact, which in some cases added to social

⁵ Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

⁶ Senior, R., Barnes, J., Emberson, JR., & Golding, J. (2005) Early experiences and their relationship to maternal eating disorder symptoms, both lifetime and during pregnancy. *British Journal of Psychiatry* 187 pp. 268-273

⁷ Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

⁸ Ibid

⁹ Hodgson, B (2005) 'Angry or what? Experiences of being a victim' *British Journal of Criminal Justice* Vol. 3 No. 3 Summer pp. 61-74

exclusion¹⁰. Victims frequently turned away from family and friends and developed mental health and substance misuse problems.

Effects of domestic violence on mental health

Domestic violence is the largest category of violent crime in England & Wales and makes up 16% of all recorded crime¹¹. According to the British Crime Survey (BCS), there are 6.5 million incidents of domestic physical assault every year. Domestic violence is also the biggest repeat crime of all. Studies have indicated that a woman will suffer violence on average, 35 times before ever telling the police¹².

Women who experience domestic violence live with a combination of on-going chronic stress and periods of acute stress related to episodes of physical, psychological and sexual violence. They are significantly more likely to experience physical and psychological health problems and seek help for stress related and chronic illnesses.

Domestic violence can lead to a range of mental health problems including depression, Post Traumatic Stress Disorder (PTSD), phobias, anxiety, panic disorders, substance misuse, self-harm and suicide¹³. Victims of domestic violence are on average 4 times more likely to be depressed than women in general and 4 times more likely to be suicidal. The risk of suicide is particularly strong for those victims who also have symptoms of PTSD. Studies also indicate significantly increased rates of self-harm among young Asian UK women in which domestic violence linked to forced marriages is a factor¹⁴ Victims of domestic violence are also 6 times more likely to abuse alcohol than women in general and a quarter use alcohol or drugs to self-medicate¹⁵.

Psychological abuse alone can be just as harmful. Victims experience intense fear and an undermined sense of self due to the abuser's extreme controlling, blaming and humiliating tactics and behaviour which contributes to high levels of mental distress, suicide attempts and over use of alcohol.

Experience of sexual violence and suicide

For 52% of women who have been seriously sexually assaulted in their lives, their experience led to depression and other emotional problems, and for

¹⁰ Shaw and Pease (2000) cited in Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

¹¹ ODPM/LGA (2006) Options for setting up a sanctuary scheme (draft guidance)

¹²McLean, M (2005) Domestic violence and repeat victimization. International Review of Victimology, Vol. 12 51-74

¹³ Lipsky, S., Field, CA, Caetano, R., and Larkin, GL. (2005) 'Posttraumatic stress disorder symptomatology and comorbid depressive symptoms among abused women referred from emergency care department' Violence and Victims Vol. 20, No.6, December pp.645-659

¹⁴ Humphreys, C. and Thiara, R. (2003) 'Mental health and domestic violence: 'I call it symptoms of abuse'' British Journal of Social Work 33, 209-226

¹⁵ Barnish, M (2004) Domestic Violence: a literature review. HM Inspectorate of Probation

one in 20 it led to attempted suicide¹⁶. 64,000 women living in England and Wales today have tried to kill themselves following a serious sexual assault¹⁷.

It was a long time before I could bear to be touched by anyone...even my grandchild. There were days when I just felt like giving up
Female victim of sexual assault (Victim Support 2002)

Domestic violence and children's mental health

In 90% of domestic violence incidents in England & Wales, children are in the same or next room¹⁸. Research indicates that living in a family where domestic violence is taking place frequently has negative effects on the emotional, behavioural, social and cognitive development of children as well as their physical and mental health¹⁹. The emotional effects include anxiety and depression, low self-esteem, and trauma symptoms (eg nightmares, flashbacks, hypervigilance and emotional numbness).

Typical behaviour problems include aggression, attention problems, destructive behaviour and hyperactivity. Of those children living in refuges, between 35-75% have emotional problems including anxiety, withdrawal, depression, psychosomatic complaints, separation anxiety and sleep disturbances. The long-term problems for children also include depression, low self-esteem, and high levels of psychological distress²⁰.

Older people, crime and social exclusion

A recent government document 'Social Exclusion Interim Report – Excluded Older People' produced by the Office of the Deputy Prime Minister in March 2005 identified that 60% of people aged 65 and over have a long-standing illness and 1 in 6 people in the same age group are affected by depression.

Crime and fear of crime are highlighted as significant factors in preventing older people from leaving their homes and in making them feel isolated and excluded. It is a major issue affecting health, quality of life and older people's experience of their neighbourhoods. Fear of crime is particularly high for those living in more disadvantaged areas, they are up to seven times more likely to feel unsafe compared to those living in better off areas. A third of older people say that fear of crime affects their quality of life, making them feel

¹⁶ Walby, S & Allen, J. (2004) *Domestic violence and stalking: findings from the British Crime Survey*. Home Office Research Study 276. Home Office Research, development and Statistics Directorate

¹⁷ Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

¹⁸ McLean, M (2005) Domestic violence and repeat victimization. *International Review of Victimology* Vol 12, 51-74

¹⁹ Smith J. (2006) What is the impact of intimate partner abuse on children? (Ch.8) in Roberts, G., Hegarty, K., and Feder, G. (Eds) (2006) *Intimate Partner Abuse and Health Professionals*. Churchill, Livingstone, Elsevier

²⁰ Ibid

lonely and isolated. Older property crime victims suffer relatively greater negative effects on their health than younger property crime victims²¹.

Crime hurts the most vulnerable older people most. A small scale Home Office study²² showed that older burglary victims are more than twice as likely to die within 2 years of a burglary as neighbours who are not burgled.

Secondary victimisation and the criminal justice system

The negative effects of being a victim of crime can be made much worse by the processes of the criminal justice system itself. Institutionalised secondary victimisation can involve inappropriate or insensitive behaviour from officials and/or processes of investigation and prosecution, which fail to take account of the victim's experience and perspective.

Stereotypes of and prejudice towards domestic violence and especially rape victims, including blaming victims, not taking their experiences seriously, failing to provide information or excluding them from decision making processes, can add significantly to the experience of mental distress²³. Some victims of crime have commented to Victim Support that the effects of the criminal process were more harmful than the original victimisation itself.

Young people as victims of crime

Victim Support is aware that young people are frequently victims of crime, that the crimes are not always reported to the police and that young people are not always referred to agencies that can help them cope with the effects of crime. Younger people are more likely than older people to be victims of crime and anti social behaviour committed by other young people²⁴. 35% of children aged 10-15 were victims of crime in England & Wales in 2003 and children from disadvantaged groups are more likely to be victims²⁵. In addition it has been shown, in the limited research available, that young people display a variety of 'symptoms' as a consequence of being both a direct and non-direct (witnessing domestic violence for example) victim of crime.

A recent Victim Support survey²⁶ highlighted that young victims experienced a similar range of responses to adults when a victim - 61% of respondents said they felt angry and one in five reported feeling frightened or worried. Only 1%

²¹ Britt, CL. (2001) Health consequences of criminal victimization. International Review of Victimology Vol. 8 pp. 63-73

²² cited in ODPM (2005) Social Exclusion Interim Report – Excluded Older People

²³ Viano (1996) cited in Barnish, M (2004) *Domestic Violence: a literature review*. HM Inspectorate of Probation

²⁴ Millie, A., Jacobson, J., McDonald, E. and Hough, M. (2005) *'Anti social behaviour strategies. Finding a balance.'* Joseph Rowntree Foundation

²⁵ Wood (2005) cited in Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

²⁶ Victim Support (2003) Survey to gauge awareness of Victim Support amongst 12-16 year olds

of the young people surveyed however, had actually had contact from any professional support worker.

Victim Support workers report that there is an absence of or delay in providing treatment for children seriously affected by crime²⁷. In particular it is difficult to gain easy and timely access to appropriate mental health services. The most likely reason for this is a lack of resources specifically for this age group. It is also reported that General Practitioners (GPs) do not always respond to requests for mental health services for young people²⁸. GP recognition of psychiatric disorder in young people is sometimes limited and there can be a wide variation in problem recognition between practitioners²⁹.

Responses of health professionals to victims of crime

- Disclosure of domestic violence and routine enquiry

Research consistently demonstrates that women who are victims of domestic violence do not disclose this to the health professionals they see and that health professionals are reluctant to ask about violence and fail to ask³⁰.

Sexual assaults are even less likely to be disclosed; 4 in 10 women participating in the 2001 British Crime Survey had told no one of their worst ever experience of rape or sexual assault³¹.

Even where domestic violence is suspected health professionals report that they do not ask about it for fear of 'opening a Pandora's box' or offending the patient. Victims of domestic violence would however, more often than not welcome the enquiry³².

Victims of domestic violence may present in health care settings (including substance abuse services) before they present to criminal justice or social services agencies. If violence and abuse are identified at an early stage women can be offered interventions to improve both their safety and their health. All evidence suggests that depression tends to recede once women are free from violence.

Many medical practitioners lack sufficient understanding of trauma and its effects and are inclined to misdiagnosis. Conceptualising abused women's

²⁷ Victim Support (2002) Criminal Neglect. No justice beyond criminal justice

²⁸ Lindsey, C. (2002) 'Meeting the mental health needs of children and adolescents' – keynote presentation at conference of same name 9.09.02

²⁹ Young Minds (2003) Policy Paper

³⁰ Hegarty, K., Feder, G. & Ramsey, J. Identification of IPA in health care settings: should health professionals be screening? Ch5 in Roberts, G., Hegarty, K., and Feder, G. (Eds) (2006) Intimate Partner Abuse and Health Professionals. Churchill, Livingstone, Elsevier

³¹ Walby, S & Allen, J. (2004) *Domestic violence and stalking: findings from the British Crime Survey*. Home Office Research Study 276. Home Office Research, development and Statistics Directorate

³² Lavis, V., Horrocks, C. and Kelly, N. (2006) Exploring the health service response to women experiencing domestic violence in Wakefield: adopting a discursive approach. University of Huddersfield. Report prepared for Eastern Wakefield PCT.

symptoms as a normal response to traumatic distress can help victims understand links between domestic violence and mental health and open up possibilities for intervention, thereby reducing the anxiety and sense of powerlessness arising from the trauma itself. It is essential that health professionals receive training to enable them to sensitively enquire about domestic violence and then provide appropriate advice and referral options.

- Secondary victimisation

Should victims of domestic violence need to access and use the mental health system their experiences are often negative. The fear and suspicion that results from the 'context of a relationship with unpredictable and on-going danger' can seem pathological to health professionals inexperienced in the treatment of domestic violence³³. A recent research study³⁴ identified a number of difficulties encountered by female victims of domestic violence. These included a lack of recognition of the trauma suffered or provision of trauma services by health professionals. The perpetrator was frequently made 'invisible' by focussing on the woman's mental health in isolation and unconnected to her experiences of abuse and violence. The woman's 'mental illness' then became the treatment focus and the abuse context ignored. The victim herself is often blamed for the abuse and subsequently labelled as suffering from mental health problems, such as depression, 'personality disorder' or 'borderline personality disorder'. The woman's continued living with an abusive partner is seen as a symptom or indicator of her mental health problems rather than the source of her problems.

At Victim Support we have a number of reports of responses to victims' experiences that have been unhelpful. For example, when a victim of sexual violence had explained to a doctor what had happened to her he patted her on the shoulder and said 'worse things happen'. Also, a bereaved relative of a homicide victim reported that when expressing her anger towards the perpetrator of the crime to a psychologist treating her for depression, he said that he (the perpetrator) would 'get his punishment in another life'.

Domestic violence victims have felt their views are overlooked by statutory agencies and they have not been believed. In England & Wales, although police and housing agencies are reported to have improved in their responses to survivors recently, overall satisfaction with the health service is low³⁵. In spite of this domestic violence victims remain much more likely to turn to health care providers for help.

³³ Feder, G., Ramsay, J. and Zachary, M. Clinician response to women experiencing intimate partner abuse: what is the evidence for good practice? Ch 6 in Roberts, G., Hegarty, K., and Feder, G. (Eds) (2006) *Intimate Partner Abuse and Health Professionals*. Churchill, Livingstone, Elsevier

³⁴ Humphreys, C. and Thiara, R. (2003) 'Mental health and domestic violence: 'I call it symptoms of abuse'' *British Journal of Social Work* 33, 209-226

³⁵ Barnish, M (2004) *Domestic Violence: a literature review*. HM Inspectorate of Probation

Training needs of health professionals

The response of health professionals to victims of crime is crucial. At least half of all women in touch with mental health services have experienced violence and abuse, yet the level of awareness amongst professionals is low³⁶

The training of health care professionals to help them respond appropriately to victims and encouragement to support liaison with, and referral to, outside agencies are absolutely essential. Domestic violence has been, until recently, largely overlooked in British nursing and medical schools curricula. However, it has been encouraging to see that UK medical schools have started to implement recommendations from the General Medical Council and Department of Health and include domestic violence in the undergraduate curriculum³⁷. This needs to be supported by practical training at postgraduate level and the establishment of links with other key agencies in the voluntary sector, the police and user groups.

All health professionals need to have easy access to information about services for victims of crime and be aware, through training, of the type of support that can be made available to victims. Health professionals need accurate and up to date information so that they can refer victims to organisations like Victim Support for the practical and emotional support they need.

By building an understanding of traumatic stress effects into their work, professionals may be better able to appreciate that victims' mental health problems and self-medication with alcohol and drugs are often associated with the recoverable traumatic effects of abuse rather than being indicators of chronic untreatable problems. Training in trauma recognition would enable health professionals to better identify cases of domestic violence and to arrange appropriate safety planning and other help.

Other responses to victimisation

- Domestic violence and advocacy

Where domestic violence has stopped, the risk of moderate to severe PTSD symptoms is reduced to less than one third. It is therefore essential to identify domestic violence early and effectively intervene to reduce the impact of the violence on mental and physical health³⁸.

Evidence suggests that the provision of specialist domestic violence advocacy to victims of domestic violence is effective in reducing violence, increasing social support, increasing the use of safe behaviours and

³⁶ Department of Health (2002) *Women's mental health: Into the mainstream. Strategic development of mental health care for women*. Department of Health: London

³⁷ Warburton, L (2006) 'A national survey of undergraduate domestic violence teaching in UK medical schools' (Domestic Violence and Health Research Forum presentation – 28-03-06)

³⁸ Coker, AL., Weston, R., Creson, DL., Justice, B., and Blakeney, P. (2005) 'PTSD symptoms among men and women survivors of intimate partner violence: the role of risk and protective factors.' *Violence and Victims*, Vol. 20, No. 6, December, pp.625-643

accessing community resources³⁹. It is therefore important that better links are made between local advocacy providers and health professionals. The core function of specialist support should be around the provision of information on legal, housing and financial options, offering emotional support and facilitating access to community resources such as safe housing.

- **Counselling and psychological therapies**

Psychological interventions such as counselling have proved helpful for women who have left an abusive relationship and led to improvements in depression and low self-esteem⁴⁰. However, in the experience of Victim Support, counselling and talking therapies can prove difficult for victims to access particularly if they cannot afford to pay for it themselves. GPs themselves may not have services to which they can refer their patients. For example, trauma-focused Cognitive Behaviour Therapy (CBT) is the recommended treatment for people with severe PTSD and those who present with PTSD within 3 months of a traumatic event⁴¹. However, this form of treatment is not easily available in all parts of England & Wales and even where it is available waiting times for treatment may be lengthy.

A Victim Support study of a group of people bereaved by homicide reported that satisfaction with counselling services was often mixed. Some found it helped with the grief process and enabled them to make decisions. Others suggested that counsellors who did not have sufficient knowledge of traumatic bereavement were not always able to give the required level of support⁴².

Ethnicity, crime and mental health

There are differences in the kinds of crime people from black and minority ethnic groups face compared with non-minority groups. They are sometimes victims of hate crime – offences motivated by racism or prejudice. Hate crime makes people feel even more isolated and socially excluded than a random assault and can often lead to victims becoming depressed⁴³. Refugees and asylum seekers may be at particular risk of being victims of hate crime. This, in combination with an increased vulnerability to mental health problems related to their previous traumatic experiences in their country of origin means that they need to be considered a high-risk group for developing mental health problems. A study of Somali refugees in London reported that

³⁹ Ramsay, J., Rivas, C. and Feder, G. (2005) 'Interventions to reduce violence and promote the physical and psychological well-being of women who experience partner violence: a systematic review of controlled evaluations.' Barts and the London. Queen Mary's School of Medicine and Dentistry. Final Report June 2005

⁴⁰ Ibid

⁴¹ National Institute for Clinical Excellence (2005) '*Post-traumatic stress disorder (PTSD). The management of PTSD in adults and children in primary and secondary care*' Clinical Guideline 26 March 2005

⁴² Victim Support (2006) 'In the aftermath. The support needs of people bereaved by homicide: a research report'

⁴³ Phillips, C. & Bowling, B. (2003) cited in Dixon, M., Reed, H., Rogers, B., and Stone, L. (2006) *CrimeShare: the unequal impact of crime* Institute for Public Policy Research April 2006

major depression was present in 25% of those surveyed and that access to health services was a problem for those who needed help the most⁴⁴.

In England & Wales, people of mixed ethnicity are more likely to be victims of assault, robbery, vehicle theft, burglary and vandalism even accounting for differences of age and area⁴⁵.

Certain groups of women, such as those with insecure immigration status may be more vulnerable to violence because of their status. This, in combination with a lack of knowledge of and trust in legal, criminal justice and health care systems and fears around losing their children, results in women enduring sustained violence.

Further research

More research is needed in a range of areas related to victimisation and mental health. For example:

- The strategies and therapies that can be most effectively employed when helping victims of domestic violence. Much of the research until now on the efficacy of advocacy in domestic violence and other therapeutic interventions has been carried out in the USA. There is a need for similar studies in a European context.
- The impact of non-violent crime on mental health. Much of current research is focussed upon the effects of domestic violence and sexual violence; there is less information on the effects of other sorts of crime.
- Strategies for training health professionals and undergraduates so that they are able to respond to victims of crime effectively. Although some of the key issues are, on paper at least, being covered in university curricula there needs to be more research on what actually works in terms of changing behaviour, the content and duration of training needed and how this can best be delivered.

Mental health strategy for Europe – key components

A strategy aiming to improve the mental health of the population across Europe should encompass the following:

- Training for health professionals – as has been pointed out earlier in this document we are pleased to see that medical schools in the UK are now including domestic violence in their curricula. It is extremely important that health practitioners are adequately trained and prepared to respond appropriately to their patients where they suspect that domestic violence is taking place. We would like to see this awareness expanded to include all victims of crime and recognition

⁴⁴ McCrone, P., Bhui, K., Craig, T., Mohamud, S., Warfa, N., Stansfeld, SA., Thornicroft, G., & Curtis, S. (2005) Mental health needs, service use and costs among Somali refugees in the UK. *Acta Psychiatrica Scandinavica* 111 pp.351-357

⁴⁵ Salisbury, H. & Upton, A. (2004) Ethnicity, victimisation and worry about crime findings from the 2001/02 and 2002/03 British Crime Surveys. www.homeoffice.gov.uk/rds/rfpubs1.html

that being a victim of crime can and does have serious effects upon mental health.

Mental health service providers as well as GPs would also benefit from this type of training particularly given the frequent pathologising of people's responses to criminal victimisation and the consequent potential for victim blaming and misdiagnosis.

- Training for teachers and other school staff - there needs to be more training for teachers and other staff in schools and colleges around the effects of crime on young people. It is important that schools make the promotion of pupils' emotional health and well being a priority. Staff are well placed to support young victims of crime and/or direct them to appropriate sources of help. Staff need training encompassing mental health and the effects of crime, effective ways of coping with crime and how to access specialist support.

The school curriculum could also incorporate lessons that help children to understand the emotions that might be caused by crime if they, their friends or families are victims and to help children learn the personal skills they need to cope more effectively.

- Access to counselling and talking therapies – more resources should be put into developing the provision of psychological therapies and making them available to all who would benefit from them, including victims of crime. An overall improvement in the quantity and quality of services available will benefit victims of crime and prevent the development of more serious, long-term and entrenched mental health problems. Waiting times for counselling or psychiatric help are a frequent problem, especially when many people would benefit from immediate intervention. We believe that people who have been victims of crime should not have to pay for the services they need simply to get help more quickly.
- Community safety and preventing repeat victimisation - Quality of life involves having adequate security at home and confidence in safety outside the home. The ability to exercise choice and control involve overcoming anxiety and being able to walk comfortably around the neighbourhood, having access to information and being aware of personal risks and how to manage these effectively. Given that being a repeat victim of crime has such a detrimental effect on mental health and negative effects on quality of life then extra efforts should be put into making local neighbourhoods and environments safer and preventing repeat victimisation.

People frequently welcome low-level interventions aimed at preventing them from becoming victims of crime such as, home safety and security schemes and 'Approved Trader' schemes. Other low level

interventions may include the installation of safes; removal of prepayment meters; the marking of property; use of CCTV; gating of alleyways; higher profile policing; community alarms; and improvements in the immediate external environment such as better street lighting. Improving and ensuring community safety should be given high priority by local and national governments.

- Cross departmental working at a government level – those departments responsible particularly for health service provision and the criminal justice system need to work together in a joined up and effective way in order to meet victims' mental health needs. They need to coordinate their strategies. We see attempts to address the mental health needs of offenders across government departments. We believe that similar attention should be paid to the wider social needs of victims of crime. Governments must adopt an integrated approach to meeting the health care needs of victims of crime. Mental health cannot be addressed simply through the provision of mental health services alone. To be successful any mental health strategy must take a holistic approach to meeting needs.
- Working with populations affected by violence - the EU's DAPHNE II programme which aims to combat violence against children, young people and women is very important given the clear links between such violence and mental health problems. It would undoubtedly be beneficial if this workstream were to be continued. It will not only help to prevent the development of long term and serious mental health problems but should also lead to a reduction in suicide.
- Victim support services – Victim Support provides, and believes that, victims of crime benefit enormously from the provision of information, emotional support, and practical help to deal with the consequences of crime. Victim Support trained volunteers assist victims to obtain the services they need when the effects of crime have more serious repercussions on their mental health. As we have said Victim Support is funded by the government to provide services to victims and witnesses of crime throughout England & Wales. We know that many EU member states have similar services provided to their citizens by non-governmental organisations and hope that all member states will be encouraged to consider the needs of victims of crime when developing their own strategies whether in the sphere of criminal justice or social policy.
- The needs of minorities and encouraging access to criminal justice processes and health services – Although the EU Green Paper does not particularly highlight this point, black and minority ethnic (BME) groups may have different needs and services should be tailored to meet these needs. The proportion of black patients in high-security psychiatric hospitals in the England is 8 times greater than in the

overall population⁴⁶. Black people are more likely to be prescribed anti-psychotic medication and less likely to be offered counselling than their white counterparts. They are also significantly more likely to experience longer admissions to in-patient psychiatric facilities than white counterparts. Institutional racism is acknowledged by the government as a serious issue for statutory mental health service providers. It is hoped that the government's recent 'Delivering race equality in mental health care: an action plan for reform inside and outside services' is successful in achieving equality and tackling discrimination in mental health services in England for all people from BME communities, including refugees and asylum seekers. Other European countries may need to consider these issues and develop action plans accordingly.

Refugees and asylum seekers may for a number of reasons, including previous negative experiences of law enforcement agencies in their country of origin and a lack of knowledge of criminal justice processes in their new country of residence, under-report their experiences of crime. It is essential that these particular groups be encouraged to report crime. This may also facilitate their access to health services if required.

Conclusion

An acknowledgement is needed at all levels that being a victim of crime, particularly violent crime, is a risk factor for developing new, or exacerbating existing, mental health problems. Appropriate and accessible mental health services need to be made available at an early stage as a form of prevention. All health practitioners need training to raise awareness of the mental health issues arising from criminal victimisation and be confident in using effective ways of responding. Staff in schools are also key to mental health promotion with young people, and in recognising and supporting young victims of crime and referring them to organisations or services for more specialist help when necessary. A EU strategy aimed at improving the mental health of its citizens needs to integrate these elements.

⁴⁶ Leese, M., Thornicroft, G., Shaw, J., Thomas, S., Mohan, R., Harty, M. and Dolan, M. (2006) 'Ethnic differences among patients in high-security psychiatric hospitals in England'. British Journal of Psychiatry 188 pp.380-385

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